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NHS Foundation Trust

County Durham and Darlington NHS Foundation Trust

Annual Report and Accounts

1 April 2017 – 31 March 2018

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Presented to Parliament pursuant to Schedule 7, Paragraph 25 (4) (a) of the National Health Service Act 2006

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1. Introduction

1.1. Chairman's Statement

I am pleased to introduce County Durham and Darlington NHS Foundation Trust's (CDDFT's) Annual Report for the financial year 2017/18. Whilst the pressures on our resources continued to increase, there is much to acknowledge and indeed celebrate with regard to achieving better outcomes for our patients and their families. Our staff and volunteers have gone to extraordinary lengths to ensure our patients, both in our Hospitals and in the Community, are kept safe and this was particularly demonstrated during one of the worst winters we have had for some time. Their compassion and commitment is truly remarkable and greatly appreciated.

This report brings to your attention our overall performance in relation to meeting our regulatory targets. The Trust has, by and large, been successful in realising most of them but there is always more to be done. In a very challenging environment, we are pleased that we have been able to achieve our positive financial trajectory. We enhanced our engagement with NHS England, NHS Improvement, Local Authorities and our Clinical Commissioning Groups resulting in a more coherent approach to improving and delivering health and social care services. A number of events such as conferences and seminars were again undertaken in line with our core philosophy of learning and improvement.

Our partnership working with our neighbouring NHS Foundation Trusts, and indeed across the region, has continued as all of us face somewhat similar difficulties. It is essential that we collaborate so that we can sustain as well as enhance services. Our Trust Board remains vigilant and our Governors are kept informed on any potential developments or risks which may impact on our strategies. Member engagement events have been held at

various locations but attendance has been disappointing. Feedback on our overall much improved communications has been very positive.

Throughout the report you will read of the many new and ongoing clinical enhancements and investments to further improve the quality of care. Just one of these has been the installation of two new MRI scanners supported by our Charity appeal. We have some way to go to reach our target but I would like to thank the generosity of the many individuals, groups and organisations that have and are supporting us.

I have mentioned earlier how we are engaging with all of our partners to ensure we provide more coherent services for our patients. I am delighted to report that we have been successful, through a formal tendering process, to continue to deliver adult community services across County Durham and Darlington. Whilst the tendering process commenced in the last financial year, we did not get to know the outcome until late April 2018. This is just excellent news for our patients, their families and our 7,000 staff and volunteers. Our Chief Executive, Sue Jacques, will say more about the importance of this in her review.

I do hope you find this report helpful and informative but please do not hesitate to contact us if you require clarification on any matter.

Professor Paul Keane OBE
Trust Chairman

1.2. Chief Executive Officer's Review

I am delighted to add my opening comments to our annual report for the year 2017/18.

This year, like much of the NHS, we faced unprecedented challenges but were able to deliver significant achievements thanks to our outstanding staff. A number of our more recent accolades are outlined in section 1.3 and they are a tribute to the excellent 'Team CDDFT' workforce who work tirelessly to continuously improve our services.

We have been working closely with NHS partners and local authorities to strengthen and support the closer integration of hospital services with community-based teams, primary care, mental health and social care. It was therefore fantastic news to be notified, early in April 2018, of the decision by the three local clinical commissioning groups to award the new adult community services contract to CDDFT. Transformation of community services will be a key focus during 2018/19 and will afford us all a great opportunity to work differently with our health and social care partners – GPs, the voluntary sector and our local authorities – to bring real improvements to both patient care and the overall health and wellbeing of our local communities.

Like many Trusts across the country we experienced significant financial pressures during the year, but our staff worked tirelessly to ensure that we ended the year with a surplus of £7.1m (before impairments); this was some £3.4m

ahead of our plan and allowed us to secure incentive and bonus payments of £5.8m from the national Sustainability and Transformation Fund. We will use this additional money to help fund our major capital investments in 2018/19.

Winter saw significant growth in the demand for our emergency and unplanned care services. This pressure was unprecedented, was much greater than we had planned for, and impeded our ability to deliver against the national A&E waiting times target; however, our performance was, in the main, in the top half of the country. Looking forward we are working with partners across the system to put even more resilient plans in place for 2018/19.

Against other national standards we were pleased to demonstrate good performance. We met and, in many cases, exceeded a number of other national performance targets with our year end position. These included the 92% target for patients to receive treatment within 18 weeks of referral and all cancer services standards. These standards include: the number of patients receiving treatment within 62 days of a referral being received; the percentage of patients starting treatment within 31 days once they have agreed a treatment plan with their clinician; and those patients who require surgery, chemotherapy or radiotherapy receiving any subsequent treatment within 31 days. We also exceeded the national target of 93% for the number of patients waiting under two weeks to see a specialist after urgent referral for suspected cancer.

We continue to perform well with regards to infection control including, being one of the best performers nationally in relation to our rate of Clostridium Difficile infections per 100,000 bed-days.

Our vision for services is 'Right First Time, Every Time' and our patient surveys demonstrate that most of the time we do get things right and that patients have a good experience in our care. During the course of 2017/18 we received over 17,500 compliments. However, we know that this is not the case in every instance and that we also have some challenges. Whilst pleased to see a significant reduction in the number of never events during the year, we will not rest until we have none. During 2017/18, we commissioned support from NHS Improvement to advise and assist our improvement journey which has been realised through a number of local service projects and at a Trust-wide level. We have

an open and transparent culture which supports and embeds learning.

The Board was disappointed that the Trust was unable to move from 'Requires Improvement' to 'Good' in the most recent inspection by the Care Quality Commission. The inspectors acknowledged real improvements in areas such as nursing staffing and care of patients receiving non-invasive ventilation. They also increased their rating, for the well-led domain for the Trust as a whole, to "Good", and similarly increased ratings for the safe domain for Medicine, and the well-led domain for both Maternity and A&E services. However, they concluded – in line with the Trust's own assessment – that there is further to go to embed safety protocols and learning following the never events experienced in 2016/17, and to ensure the responsiveness of our A&E services. It is also clear that we must do better to ensure the safety of patients with mental health conditions and those lacking capacity, and to provide care for patients with mental health issues on an equal footing to those with physical ailments. We have already implemented many of the actions included in our remediation plan and aim to have others in place by October 2018.

CDDFT plays an important role in the local economy and community employing more than 7,000 staff across a wide range of careers and bringing families and business to the area. We are fortunate to have an excellent Council of Governors drawn from our communities as well as our staff and more than 11,000 members who have a say in how we operate.

In addition to this we have hundreds of volunteers supporting our services in many different ways including directly helping with patient care. We are also grateful for the support we receive from the 'Friends' groups at a number of our hospitals and the County Durham and Darlington NHS Foundation Trust Charity. In 2017/18, the Charity became much more proactive and is currently running two significant fundraising appeals to bring state-of-the-art MRI Scanners to Bishop Auckland Hospital and Darlington Memorial Hospital; and to extend and enhance the chemotherapy unit at University Hospital of North Durham.

We are indebted to all of our supporters and could not manage our Trust without them, our committed and loyal workforce and our partners across the health and social care system.

I hope you will enjoy reading this report and look forward, with us, to another year in which 'Team CDDFT' continues to serve our patients and communities to the very best of our ability.

The annual report which follows provides much more information on the matters covered above, and was approved by the Trust's Board of Directors on 23rd May 2018.

Sue Jacques
Chief Executive

1.3. Highlights of the Year 2017/18

There were many highlights during 2017/18, ranging from major building work, to charitable fundraising and the many great ideas and innovations that originate from #teamcddft. They all have one thing in common which is that, ultimately, they all benefit our patients.

Raising the curtain on new £27m theatres

Work was completed on six new state of the art operating theatres at Darlington Memorial Hospital and patients are now benefiting from what are amongst the most modern surgical theatres in the UK.

Over 10,000 patients have a procedure at Darlington each year, in a range of specialties including: ear, nose and throat; ophthalmology; general surgery and gynaecology. Most of these procedures are planned but there are also daily emergency lists. The new facilities will also make it easier for surgeons to adopt new techniques in the future. We are now upgrading our existing theatres which will open later in 2018 giving us a total of 10 state of the art theatres. We're finding that having some of the very best surgical facilities is already attracting excellent staff who are keen to work in such a great environment.

New Bereavement Suite

The new facilities at Darlington Memorial Hospital also incorporate improved mortuary facilities and a new bereavement suite. Losing a loved one can be a devastating experience and, for some time now, we've offered a dedicated bereavement service to provide emotional support, practical information and advice to the families and carers of patients who sadly die in hospital. The new bereavement suite offers a private and peaceful place, away from the busy ward environment, for grieving relatives to ask questions and receive advice and guidance from our bereavement officers.

NEW MRI scanner installed thanks to generous donations

Patients at Bishop Auckland Hospital are now benefiting from the first of two new state of the art MRI scanners which we have purchased thanks to an on-going charitable fundraising campaign. Modern scanners play an important part in helping our consultants diagnose and determine treatment plans for what can be life threatening or life limiting conditions, including many types of cancer and heart disease. This advanced technology, which provides detailed and high quality images, will help to expedite diagnosis and treatment, improving the patient experience.

The scanner has been installed whilst fundraising continues throughout 2018,

thanks to the manufacturer, Philips, who have deferred payment until the end of the year. A second scanner will shortly be installed at Darlington Memorial Hospital following the completion of building work to accommodate it.

MRI scans usually take between 30 and 40 minutes which is a long time to lie still. Our new scanners have wider tunnels, known as 'bores' and are much quieter than older models. Patients can also choose from a selection of lighting programmes which change during the scan. In the past, children and some adults required sedation or a general anaesthetic in order to tolerate being scanned, but we are finding this is now much less likely to be required.

One of the first patients to benefit from the new scanner was seven year old Warren Hubble, from Sacriston.

CDDFT Charity

Your NHS Charity
County Durham & Darlington NHS Foundation Trust Charity
Charity No:1053467

The charitable appeal to bring the new MRI scanners to Bishop Auckland and Darlington Memorial Hospital secured much support throughout the year. Many people made donations and raised funds for very personal reasons; some individuals took part in sponsored sporting and other events and more than one couple asked for donations in lieu of wedding anniversary gifts from relatives and friends. Many people told us they 'wanted to give something back' following care they or a loved one had received. Voluntary organisations including Darlington Lions and local Rotary clubs also got behind the appeal as did a number of local businesses. The year included a number of 'firsts' such as our first Charity Golf Day, held at Rockliffe Hall, in May and our first Charity Ball, held at Hardwick Hall,

in November, raising many thousands of pounds. As fundraising for the MRI scanners continued we launched a second appeal to support the extension of the very busy chemotherapy unit at University Hospital of North Durham, to offer patients greater comfort, privacy and a much better experience generally.

Generous donations help buy new chairs for patients

One great example of how generous donations to our charity from grateful patients and their families have helped enhance patient experience is the replacement of over 700 bedside armchairs, and other chairs, across our hospitals, involving an investment of almost £250k. The new bedside chairs have the latest back support and pressure reducing cushions. They are particularly well used as patients are encouraged to be up and out of bed during the day. Evidence suggests this is much better for them and promotes mobility and recovery.

Nurses and chair of the Trust's charity committee, Jenny Flynn, with Donald Spelling, one of the first patients to benefit from the new chairs, and his wife, Pat.

Healthcall Solutions – a digital collaboration

County Durham and Darlington NHS Foundation Trust has been using digital solutions effectively across a number of services for several years, combining the clinical expertise of medical and other healthcare professionals with technology developed by Harrogate-based digital health specialists, Inhealthcare Limited. This successful and award-winning collaboration led us to establish Healthcall Solutions Limited in 2017 to further develop the use of digital technology. In a bold move, the Trust has now awarded shares in the company to neighbouring NHS acute trusts in return for active participation and collaboration in the development and sharing of a wide range of digital health pathways.

Healthcall Solutions will enable professionals in the North East and across the UK, to implement digital care quickly and at scale. The NHS in the North East is very good at collaboration and sharing ideas and services to benefit the three million people we serve. It makes sense to extend this into the digital age so when one Trust identifies an opportunity to use technology we will all be able to use it.

Apprenticeships – opportunities for all

We've a great track record in providing training and development opportunities for our staff, many of whom work with us throughout their careers and we've wholeheartedly embraced the recent national commitment to apprenticeships. These posts can create openings for talented individuals to come and work with us as well as improving the prospects for those members of our teams who are ready for new challenges or a change in direction. We have over 100 apprentices, working in various clinical and non-clinical roles and we're also about to take on our first cyber security technologist young apprentice, supporting our work in tackling this new age problem. Over 500 apprenticeships have been completed to date and we will shortly be introducing a pilot for a brand new apprenticeship role - Nurse Associate - which will allow health care assistants to take on a more challenging role, combining clinical work with university studies. After all, apprentices are our staff of the future

Protecting skin from damage – leading the way

The skin is an important barrier to infection so the more it can be protected the less chance there is of complications and pain. We are leading the way in preventing our patients from developing pressure related skin conditions such as bed sores, ulcers and blisters. Skin is thinner and more vulnerable in the elderly and those who are ill or have chronic conditions.

Our tissue viability nurses, led by matron, Carol Johnson, work closely with ward teams, educating them on what they can do to protect patients and prevent them developing pressure damage. As a result of this and other measures, many of our wards have not had a patient develop pressure damage in our care, in over six years.

Within hours of admission, patients undergo a skin inspection and, where needed, receive either a pressure-reducing or pressure-relieving mattress very quickly. A third of our mattresses are replaced every year to retain their maximum benefit. We have also recently bought 700 pressure relieving chairs, using money from our Charity, so patients are supported when up and out of bed.

It is testament to our growing reputation in this area that Carol Johnson is now working with the National Institute for Health and Care Excellence in developing national guidance.

Improving our A&E Department at Darlington Memorial Hospital

Building work to transform access to our A&E and Urgent Care services at Darlington Memorial Hospital began in December 2017 and, by the end of March 2018, was almost complete.

Patients not arriving by ambulance will use a new entrance where they will be streamed by a senior clinician, in order that they are seen as soon as possible by the most appropriate person to lead their care. This new entrance will be adjacent to Outpatient Entrance B. Patients arriving by ambulance will continue to use the existing entrance, going straight through to the Emergency Department team.

We already stream patients but introducing this additional entrance and layout will improve the flow of patients when they first arrive, helping to ensure that those who are the most ill are seen quickly. The Emergency Department and Urgent Care Centre will continue to be integrated, working in collaboration to deliver quality care to patients.

The new building includes: a large reception and waiting area; a separate large children's waiting area and several new treatment rooms – all for an improved patient experience.

Celebrating nurses and midwives

Following the success of our inaugural conferences in 2016 celebrating the International Day of the Midwife and International Nurses Day, both events are now embedded in our annual calendar. In May 2017, each conference attracted almost 200 delegates to hear national and internationally renowned speakers. The atmosphere is one of celebration with nurses and midwives taking a chance to network, share expertise, learn from and meet representatives of other specialties, and reflect on the great work they do. An awards evening linked to International Nurses Day has also become an annual event, recognising excellence. Travel bursaries are also awarded during the evening to allow individual members of staff to travel overseas and bring back their learning for the benefit of our patients.

Moving towards electronic patient records (EPR)

In May 2017 the Trust Board heard the case to deliver an integrated care record system, with the ability to connect all accredited clinical stakeholders with the right clinical information; a strategic goal, which had been agreed by the Board in April 2016.

This is an exciting opportunity to change the way we deliver care, helping us to achieve the highest standards and to realise further efficiencies in the way we care for patients. Amongst other things, EPR will give us access to all historical patient assessments and remind us when an assessment is due, or not completed. It will also upload patient observations when they are taken and push results from diagnostic tests automatically to the person who ordered them. Essentially an EPR will

give us improved information technology supporting simpler and better processes, thereby giving clinicians more time to care for patients.

We are engaging with a wide range of clinical staff, within and outside the organisation, so that we will have a system that is designed to meet their needs as effectively as possible.

Recognising excellence #tellusthegoodstuff

Although Excellence Reporting was introduced during late 2016, Excellence Reports have really taken off during 2017/18. These reports are a way for colleagues to highlight the great work they see from each other across CDDFT – using a simple on-line form. It's a ground-breaking system that's really taken off, with other trusts following our lead and over 2,200 reports being submitted to date. Excellence Reporting was the brainchild of Consultant Anaesthetist, Richard Hixson and Therapies General Manager, Jennie Winnard. Anyone working for CDDFT can input details of great work they've witnessed, under a choice of categories, naming the individuals they wish to praise, who then receive an email with the details. It's a way of recognising when an individual or team goes the extra mile, does a piece of work exceptionally well or quietly works really hard. It's a formal 'thank you' and those who have received an Excellence Report say it's a great morale boost.

2. Governance

2.1. Trust Board of Directors

The Trust's Board of Directors ('the Board') is responsible for exercising all of the powers of the Trust and is the body that sets its strategic direction, allocates its resources and monitors its performance.

The Board is made up of six Non-Executive Directors, including a Non-Executive Chairman, and five Executive Directors including the Chief Executive. The Chairman and Non-Executive Directors are appointed by the Nominations Committee of the Council of Governors for varying terms not exceeding three years. All of the Non-Executive Directors identified in Table 1 on page 20 were assessed as independent, or reassessed as such on reappointment, and in the opinion of the Council of Governors remain so. The Executive Directors are appointed by the Nominations Committee of the Board on permanent contracts. The appointments of Non-Executive Directors are for fixed terms and may be terminated for a number of reasons specified within their terms and conditions. Principal reasons include: failure to maintain compliance with the criteria for appointment and / or the Board's Standing Orders; unsatisfactory performance or attendance; and failure to retain the Council of Governors' confidence.

The Board has established a framework of regulation and control for the Trust's business which includes the Trust's Constitution, Standing Orders, a Scheme of Decisions Reserved to the Board and a Scheme of Delegation. The Board: sets the strategic aims of the Trust, taking account of the Governors' and members' views; approves annual plans and budgets; and monitors performance across the whole range of Trust business. The Board delegates the relevant statutory functions to its Audit, Nominations and Remuneration Committees and has established further committees charged with approving management policies and seeking assurance on delivery and risk management. Management functions and financial powers are delegated to Executive Directors in line with their portfolios, within the limits imposed by the Scheme of Delegation, Standing Orders and Standing Financial Instructions.

The Board has an annual schedule of business which ensures that it focuses on its responsibilities and the long term strategic direction of the Trust. It meets no less than six times per year to conduct its business and Board members also attend seminars and training events throughout the year.

The following persons served as Board members for County Durham and Darlington NHS Foundation Trust during the year April 2017 to March 2018. Table 1 below includes details of each Board member's professional background, committee membership and attendance. Mr Andrew Young, Non-Executive Director will reach the end of his term of office on 31 May 2018. The Council of Governors has appointed a new Non-Executive Director with effect from 1 June 2018, who brings skills and knowledge deemed necessary following an assessment by the Board and the Council's Nominations Committee. As a result, the Board remains confident that it has a sufficiently balanced and complete range of skills appropriate to the leadership of a Foundation Trust.

Trust Board of Directors and Council of Governors May 2018

2.1.1. Board Membership

Table 1: The Board of Directors 2017/18

Name and Position	Background	Trust Board, Joint Board & CoG, and AGM*1	Audit Committee*1	Nominations & Remuneration Committees*1	Council of Governors**2
 **Prof Paul Keane OBE** Trust Chairman Appointed 1st March 2015 until 28th February 2018. Re-appointed 1st March 2018 until 28th February 2021.	Qualified and registered nurse. Successful career initially in the NHS and then as the Dean of the School of Health and Social Care at Teesside University. An Appointed Governor of the Trust from 2007 until he was appointed Chairman.	19/19		3/3	4
 **Mr Michael Bretherick** Non-Executive Director Appointed 1st June 2016 to 31st May 2019.	Experienced Non-Executive Director, having served on the Board of North Tees and Hartlepool NHS Foundation Trust and with Tees Valley Housing. Formal Principal and Chief Executive of Hartlepool College of Further Education. Serves on the Boards of two local charities and as a Director of a local primary school.	18/19	6/6	3/3	2

Name and Position	Background	Trust Board, Joint Board & CoG, and AGM*1	Audit Committee*1	Nominations & Remuneration Committees*1	Council of Governors**2
 **Mrs Jennifer Flynn MBE** Non-Executive Director and Senior Independent Director Appointed 1st October 2014 until 30th September 2017. Re-appointed 1st October 2017 until 30th September 2020.	Qualified solicitor. Former Non-Executive Director on the Board of Durham Dales Primary Care Trust (PCT) and County Durham PCT previously. Member of the Joint Audit Committee for the Office of the Police and Crime Commissioner and Durham Constabulary. Awarded an MBE for services to her community of Tow Law in 2001 and in 2005 was appointed a Deputy Lieutenant for County Durham.	18/19		3/3	2
 **Mr Paul Forster-Jones** Non-Executive Director Appointed 1st June 2016 to 31st May 2019.	Management Consultant with experience in performance, turnarounds, re-engineering, contract negotiation and supply chain. Has held a variety of Board roles for blue chip companies, extensive experience in the Pharmaceuticals sector and has held Non-Executive (including Chairman) positions with several third sector organisations. Non-Executive Director of the Trust's wholly owned subsidiary, Synchronicity Care Ltd.	18/19	3/3	3/3	1

Name and Position	Background	Trust Board, Joint Board & CoG, and AGM*1	Audit Committee*1	Nominations & Remuneration Committees*1	Council of Governors**2
 **Mr Simon Gerry** Non-Executive Director Appointed 1st June 2017 to 31st May 2020	Chief Executive of a national charity. Previous roles in the Ministry of Defence covering resource management, estates, governance and human resources. Formerly the Trust's Lead Governor until his appointment as a Non-Executive Director.	16/16	2/3	1/2	2
 **Dr Ian Robson** Non-Executive Director Appointed 1st February 2007 Reappointed 1st June 2010 until 31st May 2013 Reappointed 1st June 2013 to 31st May 2016. ***Left from 31st May 2017***	Independent Consultant with Board level experience in sales, marketing and business development in healthcare, utilities and environmental services. Previously a Non-Executive Director of the County Durham and Darlington Acute Hospitals NHS Trust. Chair of the Trust's wholly owned subsidiary, Synchronicity Care Ltd, a role he has retained since leaving the Trust Board.	5/5		1/1	0

Name and Position	Background	Trust Board, Joint Board & CoG, and AGM*1	Audit Committee*1	Nominations & Remuneration Committees*1	Council of Governors**2
 **Mr Andrew Young** Non-Executive Director and Vice Chair Appointed 1st July 2010 until 30th June 2013 Reappointed 1st July 2013 until 31st May 2016. Reappointed 1st June 2016 to 31st May 2017. Reappointed from 1st June 2017 to 31 May 2018	Former Chief Executive of Durham and Chester-le-Street Primary Care Trust and Durham Dales Primary Care Trust. Former Director of Commissioning and Deputy Chief Executive of County Durham and Darlington Health Authority.	18/19	6/6	3/3	1
 **Mrs Sue Jacques** Chief Executive	Appointed as Chief Executive on 1st March 2012, having previously held the position of Deputy Chief Executive and Chief Operating Officer at the Trust. A Director of Finance for more than 10 years before that and holds an MA in Financial Management.	19/19			3
 **Mr Peter Dawson** Executive Director of Finance ***To 30th June 2017***	Fellow of the Chartered Association of Certified Accountants with over 30 years of experience in NHS finance.	3/3			1

Name and Position	Background	Trust Board, Joint Board & CoG, and AGM*1	Audit Committee*1	Nominations & Remuneration Committees*1	Council of Governors**2
 **Mr David Brown** Executive Director of Finance Appointed from 25th May 2017.[1]	Fellow of the Association of Chartered Certified Accountants and NHS finance professional, with many years' experience in senior finance roles in a range of Trusts and commissioning organisations	16/16			2
 **Mr Jeremy Cundall** Executive Medical Director	Consultant Surgeon for the Trust since 2008 and Care Group Director for Surgery from August 2014 to 31st January 2017. Trained at St George's Hospital Medical School in London, graduating in 1995 and then completed a thesis at Hull before completing his higher surgical training in the North East.	16/19			2
 **Mr Noel Scanlon** Executive Nursing Director	Registered nurse for over 30 years, including 10 years' experience of Executive roles within the NHS.	16/19			2

Name and Position	Background	Trust Board, Joint Board & CoG, and AGM*1	Audit Committee*1	Nominations & Remuneration Committees*1	Council of Governors**2
 **Ms Carole Langrick** Executive Director of Operations	Former Director of Strategic Development and a former Chief Executive. Extensive health service career commencing as a nurse and encompassing a variety of clinical, managerial and leadership roles in hospital and community services, as well as working in commissioning and Strategic Health Authorities areas.	18/19			3

**Note 1: Information recorded = number of attendances at meetings / number of meetings required to attend*

***Note 2: Board attendance at Council of Governors meetings is not compulsory; board members attend by invitation to specific meetings or otherwise on attend on a voluntary basis.*

1 Mr Brown was appointed prior to the end of Mr Dawson's contract period to ensure a period of handover.

2.1.2 Audit Committee

The Audit Committee comprises three Non-Executive Directors. During 2017/18, the Committee was chaired by Mr Andrew Young, an experienced NHS professional and Vice Chairman of the Trust. Mr Michael Bretherick also served on the Audit Committee for the year, joined by Mr Paul Forster-Jones to 30th September 2017, and Mr Simon Gerry from 1st October 2017. The Committee met on six occasions during the year with the Executive Director of Finance, the Senior Associate Director of Assurance and Compliance and both the Trust's internal and external auditors in attendance. Members' attendance is shown in Table 1 above.

The Audit Committee completed an annual programme of work, as agreed with the Board and in line with its terms of reference, to: seek assurance in respect of the Trust's risk management, control and governance systems: monitor the effectiveness of both internal and external audit services; review the Trust's accounting policies and financial statements; seek assurance on anti-fraud controls; and examine the extent to which controls ensure efficiency, effectiveness and economy in the use of resources.

The table below summarises the key elements of the Committee's work during the year and in respect of the 2017/18 financial statements:

Table 2: Key elements of the Audit Committee's work

Financial statements	The Audit Committee received a detailed briefing on the accounts from the Associate Director of Finance (Financial Services) which enabled them to review significant judgments made in areas such as asset valuations, doubtful debts, provisions and deferred income. The Committee reviewed the conclusions of the external auditors in respect of the risks identified in their external audit plan and satisfied themselves of the reasonableness of the Trust's approach and accounting judgments. In particular, the Committee considered the extent to which judgments made in preparing the accounts were balanced and were pleased to note the external auditors' views that judgments made reflected a generally balanced approach. One important judgment, with a material effect on the Trust's overall financial result for 2017/18, concerned the assumptions underpinning the revaluation of the Trust's land and buildings. The Committee explored the basis of the valuation and were satisfied that the associated assumptions and rationale were supported.

Operations	The Committee agreed a wide ranging programme of Internal Audit work covering all aspects of the Trust's operations, supplemented by reports on the assurance framework and key risks from the Senior Associate Director of Assurance and Compliance. The Committee oversaw the delivery of internal audit plans by both the mainstream Internal Auditors and specialist Information Management and Technology Auditors. Significant matters identified by both auditors are summarised in the Annual Governance Statement on page 113 of this report. The Audit Committee reviewed the adequacy of the management response, including meeting with relevant Executive Directors where it considered necessary, and sought evidence that remedial actions were implemented in respect of weaknesses highlighted.
Compliance	The Committee received and scrutinised reports from the Senior Associate Director of Assurance and Compliance at regular intervals during the year, which included reporting on regulatory compliance with the CQC's fundamental standards and the licence conditions with NHS Improvement. These reports supplemented information included in the Board Assurance Framework. The Committee also monitored on-going work to develop a more detailed compliance assurance framework, and to update the Trust's arrangements to manage conflicts of interest in line with national policy.

The Trust's external auditor is KPMG LLP. The Committee evaluated the effectiveness of the external audit service by assuring themselves that the audit was performed in line with the auditors' engagement letter and plan, that the audit plan covered credible and relevant risks and that the auditors' reporting was clear, robust and informative. Credit was also given for the extent to which the auditors have engaged directly with the Governors in involving them in understanding and informing the scope of the external audit. The Committee recommended the reappointment of KPMG LLP for 2017/18, and their recommendation was approved by the Council of Governors.

KPMG LLP provided non-audit services to the Trust during the year with respect to the audit of the Quality Accounts, which is permitted under the Trust's Policy, and IT assurance services to North East Patches (NEP), hosted by Northumbria Healthcare. NEP provides the financial ledger system used by the Trust and a number of others, and is part-funded by the Trust. The value of the work relating to the Trust was £2,171. The Audit Committee approved this work in line with the Trust's policy on non-audit services. The total amount of non-audit services, including work on the Quality Accounts was approximately £9,000 and 18% of the statutory audit fee.

Internal audit services to the Trust were provided in the year, primarily, through 'Audit One': an NHS consortium, hosted by Northumbria, Tyne and Wear NHS Foundation Trust. Audit One completed an annual plan of work, agreed with the Trust Board Audit Committee, covering financial, operational, governance and related systems based on an annual risk assessment.

During the year, Audit One's work was supplemented by specialist internal audit of IM&T systems, which was contracted out

to Price Waterhouse Coopers. Both sets of internal auditors agreed charters and key performance indicators with the Audit Committee and performance was formally monitored.

2.1.3 Charitable Funds Committee

The Trust is the Corporate Trustee of the County Durham and Darlington Acute Hospitals NHS Trust Charitable Fund and Related Charities which is comprised of over 140 individual charitable funds. The Board, as corporate trustee, delegates oversight of the management and use of charitable funds to the Charitable Funds Committee. During 2017/18, the Committee was chaired by Mrs Jenny Flynn MBE who was joined on the Committee by the Trust Chairman, the Director of Finance, a representative from the Council of Governors and a representative of the individual charitable fund managers.

During 2017/18 income from voluntary sources (fundraising events, donations and legacies) remained constant, albeit with a drop in legacy income, with a total of £277,000 received in donations and £7,000 from legacies.

During the year the Committee approved a range of patient-focused projects such as:

- £20,000 on Syringe Drivers which are used to assist ambulant patients who require pain control to carry out daily living tasks and lead as normal a life as possible.
- £11,000 for the Audiology Department which had been looking to expand its range of balance and dizzy test equipment.
- £6,000 on CPEX bikes to help improve the health of patients in care.
- £20,000 on a new system which will enable Cancer Nurse Specialists to complete and record Holistic Needs Assessments on patients.
- £1,000 towards improving the Hospital Radio service.
- £140 on DVDs to support Dementia training and learning.
- £3,000 on machines to assist in monitoring blood pressure.

In total, the individual charitable funds have provided a total of £396,000 to enhance services, facilities and amenities for our patients during 2017/18.

One of the most significant roles undertaken by the Committee during the year was to provide oversight of the on-going fundraising appeals to bring state of the art MRI scanners to our hospitals at Bishop Auckland and Darlington. The supplier, Phillips, agreed to defer payment until the appeals are closed, which enabled the early installation of the scanner at Bishop Auckland Hospital during 2017/18. The scanner for Darlington Memorial Hospital is to be installed early in 2018/19.

2.1.4 Nominations and Remuneration Committees

The Board has a Nominations Committee in place to oversee the appointment of Executive Directors and a Remuneration Committee in place to oversee Executive Directors' remuneration. In practice the two Committees have common membership and meet as one Committee.

During the year, the Board's Nominations and Remuneration Committees agreed the

objectives and performance measures for all of the Executive Directors, together with their remuneration.

The Council of Governors has established a separate Nominations Committee to oversee the appointment of the Chairman and Non-Executive Directors and a Remuneration Committee to oversee their remuneration. These two Committees also share a common membership and meet, in practice, as one Committee. Recommendations are taken to the full Council of Governors for ratification. Meetings are chaired by the Trust Chairman, except where the subject matter concerns his own appointment or remuneration.

During the year, the Governors' Nominations and Remuneration Committee oversaw the process to recruit one new Non-Executive Director for the Trust, which was supported by the Trust Secretary and the Associate Director of Organisation Development. This was to replace Mr Andrew Young who will step down from his post with effect from 31st May 2018. Open advertising in the local press and social media was used to attract a shortlist of potential candidates for the post. The selection and interview process was led by a panel comprising the Chairman and three Governors appointed by the Governors' Nominations Committee, and the panel's recommendation was endorsed by the Committee. In addition, the Committee endorsed the reappointment for a further three years of both Prof Paul Keane OBE, as Trust Chairman, and Mrs Jenny Flynn MBE as a Non-Executive Director. The Committee also agreed recommendations from a three-yearly review of remuneration policy for Non-Executive Directors.

Further information on attendance and the work of the Remuneration Committees can be found within the Remuneration Report on pages 78 to 90.

2.1.5. Directors' Register of Interests

A register is maintained of the interests of Directors in companies or related parties that are likely to do, or may seek to do, business with the Trust. This register is available on our website www.cddft.nhs.uk for inspection by the public, or by arrangement with the Trust Secretary. Contact details for the Trust Secretary are outlined in the section "How to find out more" on page 352 of this report.

2.2 Council of Governors

The Council of Governors is comprised of thirty-nine seats representing the Trust's public and staff constituencies and those stakeholder organisations which are entitled to appoint governors under the Trust's constitution.

During 2017/18, the Council voted to reallocate the appointed governor seat for the North East Chamber of Commerce, which had been vacant for a number of years, to Healthwatch. As the area the Trust serves covers two Healthwatch organisations, it was agreed between all parties to appoint to a shared post, with a Healthwatch Durham representative and a

Healthwatch Darlington representative. For voting purposes, this remains one seat.

The Council of Governors has a number of statutory duties, most importantly holding the Non-Executive Directors to account, individually and collectively for the performance of the Board and representing the views of the Trust's members and stakeholders. Specific responsibilities include: the appointment and removal of the Chairman and Non-Executive Directors, the appointment of the Trust's auditor and the approval of changes to the constitution of the Trust. The Trust values the contribution of its Governors and the particular perspectives that they bring to the development of services. Consequently, the Governors are active in supporting the development of the Trust's strategies and its Annual Plan, providing views through their own Strategy and Planning Committee. Governors act as a conduit between the Trust, its members, members of the public and, in the case of Appointed Governors, the bodies they represent, by canvassing opinions and providing feedback at meetings of the Council of Governors and at sub-committees.

The Council of Governors has strong working links with the Board. Joint meetings between the Board and Governors are held at different times throughout the year and Board members attend relevant Council of Governors' meetings, committee meetings and participate in joint seminars. Similarly, elected governors are engaged in some Committees and working groups established by the Board. The Board considers that these arrangements are an effective way to understand the views of the Council of Governors and maintain engagement with the Trust's members.

To 30th May 2017, the Trust's nominated Lead Governor was Mr Simon Gerry, Public Governor for Derwentside. From 1st June 2017, Mr Gerry became a Non-Executive Director of the Trust following a competitive appointment process. Since that date, the Trust's nominated Lead Governor was Dr Richard Scothon, Public Governor for Durham City.

2.2.1 Council of Governors' Elections

Governors from the public and staff constituencies are elected to office for varying terms up to three years and may seek election for further terms up to a maximum of three. Elections were held in 11 constituencies during the year as shown in Table 3 below. A by-election commenced on 29th March 2018 to attempt to fill current vacancies, comprising those where no nominations were previously received and a small number of other seats becoming vacant following resignations.

Table 3 - Elections to Council of Governors 2017/18

Constituency Type	Name of Constituency	No of candidates	No of Votes cast	Turnout	No of Eligible voters	Date of election
Public	Chester-le-Street	1	n/a	elected unopposed	n/a	12/12/17
Public	Darlington	4	459	18.70%	2454	12/12/17
Public	Derwentside	No nominations received	n/a	n/a	n/a	12/12/17
Public	Durham City	1	n/a	elected unopposed	n/a	12/12/17
Public	Gateshead, South Tyneside, Sunderland	No nominations received	n/a	n/a	n/a	12/12/17
Public	Sedgefield	1	n/a	elected unopposed	n/a	12/12/17
Public	Sedgefield	1	n/a	elected unopposed	n/a	12/12/17
Public	Tees Valley, Hambleton, Richmondshire	1	n/a	elected unopposed	n/a	12/12/17
Public	Wear Valley and Teesdale	4	307	12.97%	2367	12/12/17
Staff	Community Based Staff	No nominations received	n/a	n/a	n/a	12/12/17
Staff	Nursing and Midwifery	No nominations received	n/a	n/a	n/a	12/12/17
Staff	Medical	1	n/a	elected unopposed	n/a	12/12/17

2.2.2 Council of Governors' Membership

The overall makeup of the Council of Governors over the year together with details of the appointments of individual governors and their attendance at council meetings is shown in Table 4:

Table 4 - Council of Governors Members 1st April 2017 to 31 March 2018

Governor	Appointment	Constituency	Meetings*1 from 01 April 2017 to 31-Mar-18
Public Governors			
Kathryn Featherstone	Elected: February 2015 Re-elected: 3 years from February 2018	Chester le Street	12/14
Dr Carmen Martin-Ruiz	Elected: February 2013 Re-elected: 3 years from February 2016	Chester le Street	7/13
Michael Denham	*Elected: February 2015 Retired: February 2018*	*Darlington*	*10/15*
Kath Fawcett	Elected: 3 years from February 2018	Darlington	3/3
Borsha Sarker	Elected: 3 years from February 2017	Darlington	13/18
Dr John Sloss	Elected: 3 years from May 2017	Darlington	7/10
David Lindsay	Elected: 3 years from May 2017	Derwentside	6/14
Ethel Armstrong	Elected: 3 years from February 2016	Derwentside	5/16
Simon Gerry	*Elected: June 2013 Re-elected: February 2015 Resigned: May 2017*	*Derwentside*	*3/3*
Cliff Duff	Elected: 3 years from February 2016	Durham City	10/14
Carole Reeves	Elected: February 2015 Re-elected: 3 years from February 2018	Durham City	10/14

Governor	Appointment	Constituency	Meetings*1 from 01 April 2017 to 31-Mar-18
Dr Richard Scothon	Elected: February 2014 Re-elected: 3 years from February 2017	Durham City	11/12
Chris Boyd	Elected: 2 years from May 2017	Easington	7/11
Vacant	Awaiting Election	Gateshead, South Tyneside, Sunderland	
James Heap	*Elected: February 2010 Re-Re-elected: February 2013 Re-elected: February 2016 Retired: April 2017*	*Hambleton, Richmondshire, Tees Valley and Beyond*	*0/0*
Oliver Colling	Elected: 1 year from February 2018	Hambleton, Richmondshire and Tees Valley	2/2
Marjorie Binks	*Elected: 3 years from February 2015 Retired: September 2017*	*Sedgefield*	*0/6*
Henry Ballantyne	Elected: 3 years from February 2016	Sedgefield	4/16
David Taylor	Elected: 3 years from February 2018	Sedgefield	4/4
Muriel Browne	Elected: 2 years from February 2018	Sedgefield	2/3
Colin Wills	Elected: 3 years from February 2018	Wear Valley & Teesdale	2/2
Alan Cartwright	Elected: 3 years from February 2017	Wear Valley & Teesdale	19/19
Dr Ken Davison	Elected: Feb 2012 Re-elected: February 2015 Re-elected: 1 year from February 2018	Wear Valley & Teesdale	12/15
Cate Woolley-Brown	*Elected: February 2013 Resigned: October 2017*	*Wear Valley & Teesdale*	*9/10*
Staff Governors			
Neil Williams	Elected: 3 years from February 2016	Administrative, Clerical and Managers	12/17

Governor	Appointment	Constituency	Meetings*1 from 01 April 2017 to 31-Mar-18
Revd. Kevin Tromans	Elected: February 2014 Re-elected: 3 years from February 2016	AHPs, Professional & Technical & Pharmacists	8/12
Ronnie Nicholson	Elected: 2 years from May 2017	Ancillary	1/9
Kevin Morley	Elected: April 2016 Re-elected: 3 years from February 2017	Community Based Staff	5/12
Kim Noble	*Elected: April 2016 Re-elected: February 2017 Resigned: September 2017*	*Community Based Staff*	*2/3*
Vacant	Awaiting Election	Community Based	
Dr Mike Jones	Elected: 1 year from February 2018	Medical	4/4
Dr David Laird	*Elected: 3 years from February 2016 Resigned: April 2017*	*Medical*	*0/0*
Michael Appleby	*Elected: February 2015 Resigned: January 2017*	*Nursing & Midwifery*	*2/9*
Vacant	Awaiting Election	Nursing & Midwifery	
Andrea Herkes	Elected: 2 years from May 2017	Nursing & Midwifery	5/10
Patricia Gordon	Elected: June 2013 Re-elected: February 2014 Re-elected: February 2017	Nursing & Midwifery	9/15
Appointed Governors			
Cllr Joy Allen	Appointed: June 2015	Appointed by Durham County Council	5/16
Jennifer Boyle	Appointed: October 2015	Appointed by North East Ambulance Service NHS Trust	9/14

Governor	Appointment	Constituency	Meetings*1 from 01 April 2017 to 31-Mar-18
Mr Joseph Chandy	Appointed: September 2013	Appointed by the Clinical Commissioning Group – Durham Dales, Easington and Sedgefield	1/9
Cllr Veronica Copeland	*Appointed: June 2008 Re-appointed: June 2011 Reappointed: February 2014 Retired: June 2017*	*Appointed by Darlington Borough Council*	*3/4*
Cllr Andy Scott	Appointed: June 2017	Appointed by Darlington Borough Council	3/5
Gordon Mitchell	Appointed: November 2016	Appointed by Universities for the North East	4/10
Dr Andrea Jones	*Appointed: September 2014 Resigned: November 2017*	*Appointed by the Clinical Commissioning Group - Darlington*	*4/4*
Dr Alison Macnaughton-Jones	Appointed: December 2017	Appointed by the Clinical Commissioning Group	2/4
Dr David Robertson	Appointed: November 2016	Appointed by the County Durham Local Medical Committee	0/8
Patrick Scott	Appointed: February 2016	Appointed by Tees, Esk and Wear Valleys NHS FT	2/8
Dr David Smart	Appointed: September 2014	Appointed by the Clinical Commissioning Group – North Durham	6/9

Governor	Appointment	Constituency	Meetings*1 from 01 April 2017 to 31-Mar-18
Shared Post: **Dr Robert Upshall** (1st Nov to 30th April)	Appointed: November 2017	Appointed by Healthwatch (Durham)	3/3
Dr Lakkur Murthy (1st May to 30th Sept)	Appointed: November 2017	Appointed by Healthwatch (Darlington)	

**Note 1: Information recorded = number of attendances at meetings / number of meetings required to attend*

2.2.3 Council of Governors' Register of Interests

A register is maintained of the interests of governors in companies or related parties that are likely to do, or may seek to do, business with the Trust. This register is available on our website **www.cddft.nhs.uk** for inspection by the public, or by arrangement with the Trust Secretary. Contact details for the Trust Secretary are outlined in the section "How to find out more" on page **352** of this report.

2.3 Membership

Our members play a vital role in representing the views of our public and patients and in reinforcing our public accountability. In recent years one of our key priorities has been to increase our membership engagement, alongside strengthening links between the Governors and the Board. Feedback from our Governors, as part of the Chairman's appraisal and the Council of Governors' self-assessment, has acknowledged improvements year on year, whist highlighting an on-going need for the Trust to support Governors to most effectively engage with members in their constituencies. The Trust has two membership groups; a public membership and a staff membership. Public membership is open to anyone over the age of 14 who resides within the geographic area served by the Trust. The public membership group is divided into the following nine public constituencies:

- Chester-le-Street;
- Durham City;
- Darlington;
- Derwentside;
- Easington;
- Gateshead, South Tyneside, Sunderland and beyond;

- Sedgefield;
- Tees Valley, Hambleton, Richmondshire and beyond; and
- Wear Valley and Teesdale.

Of the nine public constituencies above, six reflect local authority borough or ward boundaries and the remaining three reflect traditional links with our hospitals either through the provision of sub-regional services beyond our main catchment areas or because of ease of access.

At 31 March 2018, there were **11,370** members in the public constituency as shown in Table 5.

Table 5- Public Constituency Membership 2017/18

Public Constituency Membership 2017/18	Number of Members
At year start (1st April 2017)	11,504
New Members	351
Members leaving	485
At year end (31st March 2018)	**11,370**

Members of Constituency Class	Number of Members	Percentage of Membership
Chester-le-Street	739	6%
Darlington	2,474	22%
Derwentside	1,584	14%
Durham City	1,917	17%
Easington	255	2%
Gateshead, South Tyneside, Sunderland & beyond	171	2%
Sedgefield	1,594	14%
Tees Valley, Hambleton & Richmondshire & beyond	278	2%
Wear Valley & Teesdale	2,358	21%
Grand Total	**11,370**	

To date, staff who are employed directly by the Trust and / or a wholly owned subsidiary organisation, on permanent contracts or who are employed on temporary or fixed term contracts for more than twelve months have automatically become members, unless they inform the Trust that they do not wish to do so. New arrangements are being put in place to comply with the General Data Protection Regulation for 2018/19 onwards, as automatic enrolment is not permitted by that regulation. In addition, staff working for Trust contractors such as our PFI partners may join a staff constituency after twelve months. Staff members are split into six constituencies which represent the major staff groups in the Trust, as follows:

- Administration, Clerical and Managers;
- AHPs, Professional and Technical & Pharmacists;
- Ancillary;
- Community Based Staff;
- Medical; and
- Nursing and Midwifery.

As at 31 March 2018, there were **6,655** members in the staff group.

The Trust's membership strategy envisages maintaining the public membership constituency but with a strong focus on engaging with the membership. The Trust considers the geographical spread of the membership to be broadly representative, as it reflects the major population centres and demand for the Trust's services.

Membership recruitment activities in 2017/18 included direct recruitment of members by hosting stands in public areas of the Trust such as the restaurant areas. Additionally, Trust officers attended open evenings and recruitment fairs at local Universities and Colleges which proved very successful. Other recruitment activities for the year comprised:

- Passive recruitment using TV screens in restaurants and Outpatients Departments, ensuring that there are stocks of membership forms available, banner headlines on the website home page and the Chairman's Twitter Account;
- Wide and varied distribution of membership application forms, via Governors, staff and third parties; and
- Governors' own recruitment efforts.

Opportunities for the Trust's Directors and Governors to meet the membership were provided through our Board and Council of Governors meetings, and Annual General Meeting which are held in public. In keeping with our focus on increasing public engagement, the Trust Chairman held a number of member meetings at all main sites, to enable members to meet with the Chairman and with Governors on an informal basis. These meetings provided an opportunity for feedback and for members to ask questions. Three Trust Open Days were held during August 2017, which enabled members to undertake a tour of Trust sites and to participate in informal Question and Answer sessions with the Trust Chairman and Chief Executive.

Members were sent a twice yearly magazine ("Your Trust") informing them of the latest news and notifying them of events and meetings which they could attend. Public Members also received a personal invite from the Trust's Chairman to attend the Trust's Annual General Meeting. The Trust runs a "healthy market stall" event prior to its AGM, where specialist staff are on hand to provide members of the public with information about their specific service.

The Trust's website includes a facility for members to contact their local Governor and to provide feedback on specific issues.

Despite seeking to engage members through the various forums and events noted above, attendance and engagement remains lower than the Council of Governors would wish; therefore, for 2018/19 a new approach to engagement will be trialled, where Trust teams will support Governors in engaging with members out in their communities, seeking

opportunities for Governors to speak or have stands at large-scale community events. At least one such event will be supported for each major constituency, and evaluated as to its success.

Members wishing to find out more about the Trust, or to provide views to their local governors, are invited to do so through the Foundation Trust Office. Contact details can be found in the section 'How to Find Out More' on page 352

2.4 Links between the Board, Governors and Members

The Trust has consolidated arrangements to ensure that the views of Governors and Members are effectively communicated to the Board, and in particular Non-Executive Directors, during 2017/18. These arrangements now include:

- Meetings at the Trust's sites with members. Key messages were fed back to the Board by the Chairman;
- Non-Executive Directors have attended Council of Governors meetings to explain their roles and listen to Governors' views;
- Executive Directors are well represented at Council of Governors meetings and frequently take questions and listen to Governors views;
- Joint meetings are held between the Board and Governors, in which the views of Governors can be shared;
- The Chairman meets with the Chairs of the Council of Governors' Committees and the Lead Governor regularly, and makes himself available before Council meetings for informal contact with Governors. The Chairman feeds back key matters from these meetings to the Board; and
- All Governors are encouraged to attend public meetings of the Board, with the Chairs of the Governors Committees being allowed to remain, as observers, for any matters discussed in private.

For 2018/19, there are plans to further develop these arrangements, by formalising plans for Non-Executive Directors' attendance at relevant Governor Committees and for greater involvement of Governors in supporting the Chairman when carrying out Non-Executive Directors' appraisals.

3. Performance Report

3.1 Overview of Performance

This overview of performance is intended to provide a short summary with sufficient information to allow our members and the public to understand who we are, what we do, the key risks to the achievement of our objectives and how we have performed during 2017/18.

3.1.1 Chief Executive's Statement

This year, like much of the NHS, we faced unprecedented challenges but were able to deliver significant achievements thanks to our outstanding staff.

Winter saw growth in demand for our unscheduled care services which was largely unprecedented. This was well beyond what we had planned for, and impeded our ability to deliver against the national 4 hour A & E waiting times standard; however, our performance was, in the main, in the top half of the country. Looking forward we are working with partners to put even more resilient plans in place for 2018/19.

Against other national standards we were pleased to demonstrate good performance. We met and, in many cases, exceeded a number of other national operational performance targets with our year end position. These included the 92% target for patients to receive treatment within 18 weeks of referral. We also achieved all cancer standards. These include: the number of patients receiving treatment within 62 days of a referral being received; patients starting treatment within 31 days once they have agreed a treatment plan with their clinician; and those patients who require surgery, chemotherapy or radiotherapy receiving any subsequent treatment within 31 days. We also exceeded the national target of 93% for the number of patients waiting under two weeks to see a specialist after urgent referral for suspected cancer.

We continue to perform well with regards to infection control including being one of the best performers nationally in relation to our rate of Clostridium Difficile infections per 100,000 bed-days, and on a range of other quality measures. Our vision for services is 'Right First Time, Every Time' and our patient surveys demonstrate that most of the time we do get things right and that patients have a good experience in our care. However, we know that this is not the case in every instance and that

we also have some challenges. Whilst pleased to see a significant reduction in the number of never events during the year, we will not rest until we have none. During 2017/18, we commissioned support from NHS Improvement to advise and assist our improvement journey which has been realised through a number of local service projects and at a Trust-wide level. We have an open and transparent culture which supports and embeds learning.

Like many Trusts across the country we experienced significant financial pressures during the year, but our staff worked tirelessly to ensure that we ended the year with a £7.1m surplus (before impairments); this was some £3.4m ahead of our plan and allowed us to secure additional monies from the incentive and bonus elements of the national Sustainability and Transformation Fund of £5.8m. We will use this additional money to help fund our major capital investments in 2018/19.

The Board was disappointed that the Trust was unable to move from 'Requires Improvement' to 'Good' in the most recent inspection by the Care Quality Commission. The inspectors acknowledged real improvements in areas such as nursing staffing and care of patients receiving non-invasive ventilation. They also increased their rating, for the well-led domain for the Trust as a whole to "Good", and similarly increased ratings for the safe domain for Medicine, and the well-led domain for both Maternity and A&E services. However, they concluded – in line with the Trust's own assessment – that there is further to go to embed safety protocols and learning following the never events experienced in 2016/17, and to ensure the responsiveness of our A&E services. It is also clear that we must do better to ensure the safety of patients with mental health conditions and those lacking capacity, and to provide care for patients with mental health issues on an equal footing to those with physical ailments. We have already implemented many of the actions included in our remediation plan and aim to have others in place no later than October 2018.

Sue Jacques
Chief Executive

3.1.2 Our, Purpose, Activities, Business Model and Strategy

County Durham and Darlington NHS Foundation Trust is one of the largest hospital and community healthcare providers in the NHS, serving a core population of approximately 600,000 people across County Durham and Darlington, together with patients and service users from further afield in North Yorkshire, the Tees Valley and South Tyneside.

We are also one of the largest employers in County Durham, with approximately 7,000 staff employed by the Trust and its wholly-owned subsidiary Synchronicity Care Ltd, across our hospital sites and in the community, delivering integrated hospital and community based health and wellbeing services for patients.

The Trust holds a provider licence from, and is regulated by, NHS Improvement. The quality of care provided by the Trust is regulated by the Care Quality Commission.

The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England. Services provided by the Trust are commissioned, to meet the health needs of the local population, by the three Clinical Commissioning Groups serving the County Durham and Darlington area with some specialist services being commissioned by NHS England, and some public health services commissioned by the two local authorities in County Durham and Darlington. Services are funded by our commissioners, and were paid for – in 2017/18 – either on a block contract basis or in line with activity depending on the specific service and contract. The Trust seeks to retain annual surpluses to build up reserves for capital investment to maintain and upgrade the infrastructure to provide services, on an on-going basis.

Services provided include:

- **Acute and planned hospital services:** including emergency medicine and trauma, emergency surgery and also planned surgery, diagnostics, paediatric, maternity and outpatient services.
- **Community based services:** including adult and specialist services provided in the community, in the home and in health centres across the county.
- **Health and wellbeing services:** including health improvement support and advice, such as stop smoking, alcohol reduction, improving diet and taking exercise.

The Trust provides acute hospital services from:

- **Darlington Memorial Hospital (DMH)**
- **University Hospital of North Durham (UHND)**

and a range of planned hospital services for patients across County Durham at **Bishop Auckland Hospital,** as well as outpatient, urgent care and diagnostic services for local people. We also provide **community services** in patients' homes, and in around 80 premises in the community, including community hospitals at:

- **Shotley Bridge;**
- **Chester-le-Street;**
- **Stanhope (Weardale Community Hospital);**
- **Sedgefield; and**
- **Barnard Castle (Richardson Hospital).**

Please see page 352 for details of how to find out more about County Durham and Darlington NHS Foundation Trust, or visit our website: **www.cddft.nhs.uk**

Our ambition for our services

Our aim is to provide:

- Services that are evidenced based, accessible, safe, sustainable and effective;
- Care that delivers improvements in health outcomes and reduces inequalities; and
- Patient pathways that are integrated across providers.

Our vision and goals

Our vision – "Right First Time, Every Time", has been agreed with staff. It summarises how we envisage services in the future: provided by the right professional, in the right place – in hospital or close to home – at the right time, first time, every time, 24 hours a day, where necessary.

Our mission - "with you all the way" describes our commitment to put patients at the centre of everything we do in delivering the very best integrated healthcare and being the best provider of community, hospital and health and well-being services.

Key to the delivery of our Mission are our four 'touchstones', as follows:

- The **best health outcomes** for patients – we need to achieve the highest possible standards of care and improved results for patients;
- The **best patient experience** – because evidence shows that better outcomes are linked to a better experience;
- The **best efficiency** – reducing our costs so we can continue to invest for the future; and,
- Being a **best employer** – because high levels of staff motivation and satisfaction are closely related to better patient care.

Our strategy

We have defined strategic aims under each touchstone and put in place underpinning and enabling strategies to support their achievement, notably:

- Our Clinical Services Strategy, which is focused upon:
  - Sustaining and improving services: working collaboratively with commissioners and neighbouring providers to provide the best possible services for patients across our localities;
  - Improving our infrastructure and facilities for key services; for example, we plan to develop a new and expanded Emergency Care Centre on our site at University Hospital North Durham by 2020;
  - Taking care closer to home: working with commissioners, primary care and social care to develop infrastructure and wrap-around services to: support patients in their own homes; reduce unnecessary hospital admissions and facilitate earlier discharge. The new contract for Adult Community Services for County Durham and Darlington, which commences from 1st October 2018, provides a real and exciting opportunity to make real progress in developing patient-focused, integrated services with our partners.
- Our Quality Strategy "Quality Matters", which sets out 16 priorities for investment and improvement in patient safety; patients' experience in our care; and clinical effectiveness, together with plans to develop teams and methods to support continuous quality improvement, in all our services.
- Our Workforce Strategy "Staff Matter", which sets out how we plan to attract, retain, engage, develop and support high calibre staff in all our clinical and support services.
- Our Information Strategy, central to which is the development of an Electronic Patient Record, with up-to-date information on each patient, made readily available to those responsible for their care, both within the hospital and within their GP surgery and other supporting services.
- Enabling strategies, setting out how we will deploy our estate and finances, and how we will communicate and engage with all stakeholders, to support the implementation of our core strategies noted above.

3.1.3 Our history

County Durham and Darlington NHS Foundation Trust was authorised as a Foundation Trust on 1 February 2007. In 2011, the Trust took on the community services formerly provided by County Durham and Darlington Community Health Services, with the aim of integrating care pathways requiring both community and hospital based care.

The Trust established a wholly owned subsidiary, Synchronicity Care Ltd (SCL), which commenced trading as County Durham & Darlington Services (CDD Services) on 1st April 2017. Through a managed healthcare contract model CDD Services provides estates, facilities, procurement, materials and supply chain management, equipment maintenance and transport services to the Trust.

Whilst CDD Services' primary focus is the provision of efficient, effective and quality estates and facilities services to the Trust for the benefit of patient of patient care, it operates as a separate legal entity, along commercial lines, with separate governance arrangements and the ability to employ its own staff and to deliver services to other organisations. The Company's operating model enables it to access the commercial benefits of a private company with the ethos and culture of a quality in-house service to maximise efficiencies and income generation opportunities. The financial benefits of this are returned to the Trust to support front line patient services.

3.1.4 Key risks to the achievement of our objectives

Our principal objectives and the risks to their achievement are summarised in **Table 6** below.

Table 6 – Objectives and risks

Our key objectives	The key risks which we manage to achieve them
• Provide services which are safe, clinically effective and responsive to the needs of patients and their carers, and in compliance with recognised and regulatory standards	• Increases in patient demand for non-elective services, requiring flexing of capacity (including workforce, buildings and equipment) to deliver services which meet our standards
• Provide services which are caring and which provide patients with the best possible experience	• The potential for our safety culture and focus on patient care to suffer during times of pressure, requiring relentless focus on patients as our key priority.
• Acquire sufficient skilled staff delivering services which meet our standards	• Inability to attract sufficient skilled medical, nursing and other staff to deliver some specific services, requiring creative and innovative approaches to recruitment and retention.

Our key objectives	The key risks which we manage to achieve them
• Engage, motivate and support staff in delivering high quality and caring patient services	• The potential loss of staff engagement required to deliver and continuously improve services, requiring a strong focus on involving our staff in improving services and tackling challenges as they arise.
• Acquire and maintain the physical capacity, equipment and facilities needed to deliver services which meet our standards in a positive patient environment	• Deterioration of equipment and the patient environment, with age, which must be monitored and addressed • The challenge of understanding the needs of different patient groups and adapting our patient environment to meet their needs
• Secure and maintain the financial resources required to invest in service sustainability and improvements, meeting financial targets agreed with our regulator	• Financial pressures impacting upon the achievement of in-year financial targets and the maintenance of reserves to fund investments in services and facilities.
• Create and maintain excellent relationships with our stakeholders, recognising the need for collaborative working to implement the best services and achieve the best outcomes for patients	• The challenge of aligning different agendas as each commissioner or provider in the locality responds to its own pressures, and the complexity of working together in local and regional partnerships.
• Develop our IT systems to support clinicians in making effective clinical decisions and providing the best possible clinical care	• The need to maintain our IT estate and, alongside it, design and develop, with clinical leadership, systems which are capable of meeting national standards by 2020 and capable of delivering our strategy and vision.

The above sets out a generic outline of the risks handled during 2017/18. One of the key contextual factors remains the lack of definition with respect to any strategy for NHS services within the locality and wider region. Although not a risk in itself, the resulting uncertainty has impacted on the principal risks managed in year, as outlined below. The Trust is now working collaboratively: with neighbouring providers, with respect to clinical services and financial sustainability; with commissioners and local authorities in County Durham as part of an Integrated Care Partnership, and through similar more informal arrangements in Darlington, and with all NHS bodies and local authorities as part of a wider Integrated Care System for Cumbria and the North East. It is expected that this work will result in reduced uncertainty, and collective opportunities to manage risks for the benefit of all our patients, going forwards. Within this context the specific key risks managed by the Trust during the year were:

- **Improving our safety and reliability:** The Trust's relative performance in areas such as infection control, pressure ulcers and cardiac arrest prevention remains strong. However, following eight never events in 2016/17, the Trust has continued to roll out measures to engender and reinforce a stronger safety culture; has rolled out local safety standards for invasive procedures and has strengthened and audited the application of safety protocols in operating environments. Nonetheless, as reported by CQC, this work has further to go and CQC's report has flagged further risks with respect to the environment for patients with mental health conditions in our Emergency Departments, which are being addressed by upgrading relevant facilities.
- **Financial performance and sustainability:** During the year, the Trust managed risk to the delivery of the financial control total agreed with NHSI, arising from reductions in income and over-dependence on non-recurring cost control and cost improvement measures. Reductions in income related, in part, to reductions in elective activity in response to winter pressures, in line with national guidance; however, the underlying trend in activity is falling in line with referral patterns. Whilst the Trust was able, through tight cost control and non-recurring measures to meet its control total for 2017/18, it has also agreed a three-year contracting arrangement with commissioners to provide headroom to jointly reduce costs and capacity in line with activity.
- **Maintaining and strengthening medical staffing rotas across two sites for particular specialties:** The Trust has made significant progress with respect to recruitment of consultants, with a net increase in the consultant workforce during over the year. However, there remain gaps in the medical workforce in some specific services compared to relevant guidelines. Risks are actively managed through the engagement of known locums and additional sessions, as well as collaborative working with neighbouring trusts, and there is a process of escalation to the Medical Director should any patient safety risk arise. Flexible medical staff recruitment plans are in place, allowing services to explore options such as international recruitment where appropriate and joint work is taking place with other Trusts in the region to seek to sustain services going forwards.
- **Meeting demand pressures on our Unscheduled Care Services:** Despite implementing good practice recommendations from NHS Improvement and high-performing Trusts, the Trust was unable to meet the A&E waiting times standard over 2017/18 as a whole. Good progress has been made in improving discharge, medical review and patient flow both within the Emergency Departments and in our acute hospitals as a whole. This resulted in the standard being met in late summer and early autumn 2017. Subsequently, as a result of extremely high demand experienced during winter, on top of what were already the highest levels of demand for Type 1 emergency care in the region, the Trust was not able to sustain performance. The Trust engaged NHS Improvement's Emergency Care Intensive Support Team in reviewing our Emergency Care pathways and is now implementing their recommendations alongside the good practices noted

above and capital works to improve patient flow in both our Emergency Departments. However, to sustain high quality A&E services which meet the waiting times standard will require the longer-term investment planned in our new Emergency Care Centre at University Hospital North Durham.

- **Effectively engaging staff at a time of change and uncertainty:** In addition to the uncertainty with respect to the locality and regional strategy for NHS services outlined above, adult community services provided by the Trust were subject to further significant uncertainty in the year, having been re-tendered. Staff engagement is a key priority for the Board, and the staffing and resources available to the Communications Team were increased during the year. However, despite a real focus on engagement, which has seen a substantial increase in Board visits to wards and teams, more frequent and open access to our Chairman and Chief Executive for our staff and new channels for raising issues or making suggestions, the Trust has not improved its overall engagement score in the national NHS staff survey. All Clinical Care Groups and directorates have a specific 'Staff Matter' action plan, including actions to engage and listen to their staff and Workforce and OD will be providing bespoke support to those teams with lower than average scores from the staff survey.

The risks outlined above are expected to persist, in large part, over the next 12 to 24 months and the Trust will continue to deploy the actions outlined above in order to continue to manage them. In addition, a further significant risk and opportunity relates to the mobilisation of plans to realise a new vision, working with primary care, social care and the voluntary sector, for integrated adult community services from October 2018, following the Trust's success in the recent tender for services in County Durham and Darlington. Aims include providing wrap-around services for patients with long-term conditions, helping to: prevent unnecessary admissions to hospital, to support people in their own homes and to support patients on discharge.

Improving our IT systems will be a further key focus during 2018/19, with a need to complete the roll out of the Trust's cyber-security strategy and to progress the design and implementation of an Electronic Patient Record system to meet requirements for digital systems in the NHS by 2020

3.1.5 Going concern

The Group delivered a £25.5m Cost Improvement Programme (CIP) for 2017/18 and achieved a surplus of £7.1m (after adjusting for impairments) against its 2017/18 £3.7m surplus Control Total. Control Totals are set by NHS Improvement to measure Group financial performance and exclude items such as revaluations, impairments, gains/losses on disposal and donations. The Group has a planned surplus of £8.1m in 2018/19 and this agrees to the 2018/19 Control Total. The financial plan for 2018/19 is dependent upon whole "system" transformation programmes as well as internal CIP's to achieve the control total. The Board is focussed on the risks within the 2018/19 plan, in particular those relating to the significant system benefits assumed therein. NHS Improvement continues to support the Trust to work closely with local stakeholders and partner organisations to

mitigate the system based risks to the plan.

The 2018/19 plan submitted to, and accepted by NHS Improvement, includes a requirement for a revenue loan support of £22.5m as a result of the sudden move towards activity income being received from its clinical commissioning groups in twelfths, rather than the longstanding agreed payment profile, which allowed the Trust to be able to meet its liabilities when they fell due. This loan was agreed and drawn down in April 2018 and provides an uncommitted loan facility for a period of 3 years as detailed in note 36. Whilst the terms of the loan do allow the facility to be withdrawn by the Secretary of State for Health the Trust consider the likelihood of this happening to be remote.

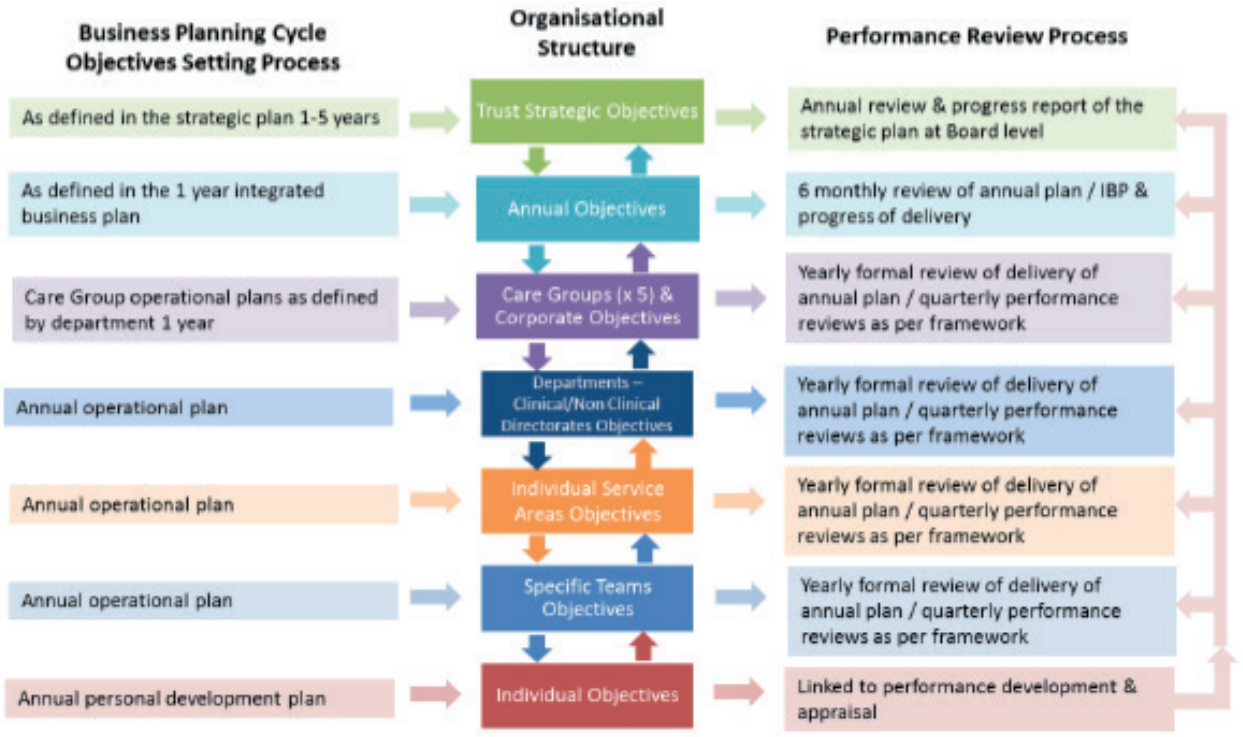
After making enquiries, and as a result of the revenue loan support received in April 2018, the Directors have adopted a going concern basis in preparing these accounts as they do not intend to apply to the Secretary of State for the dissolution of the NHS Foundation Trust without the transfer of services to another entity nor do they believe there is no realistic alternative but to do so.

3.2 Performance Analysis

3.2.1 How we measure performance

The Trust manages and monitors the fulfilment of its business plans using a systematic process covering issues ranging from the strategic objectives of the Trust to the appraisal and training of individual staff.

Integrated Performance Framework



We measure performance against each of our four key touchstones: Best Outcomes, Best Experience, Best Efficiency and Best Employer (see the following pages for more explanation). To this end, the Board receives a monthly Integrated Performance Report summarising major operational performance issues and risks. A recent review of the contents of this report has been conducted and changes will be made for 2018/19 to ensure it stays focussed on the most significant risks and issues.

Underpinning this reporting process is the Trust's Performance Framework, which consists of quarterly Executive Reviews of each Care Group's performance supported by monthly Director-led performance reviews. At each stage, risks and uncertainties impacting on the potential achievement of key performance indicators are also considered and forward plans to mitigate risks are reviewed. Monthly reports from these reviews, together with a summary of progress against NHS Improvement (NHSI) trajectories, are received by the Integrated Quality and Assurance Committee of the Board.

More detailed operational scrutiny of performance also takes place in a range of more regular forums. For example, the 18-week waiting time for Referral to Treatment (RTT) and cancer standards are monitored at the weekly Patient Tracking (PTL) meeting chaired by the Director of Performance, and progress against A&E standards is managed through the Transforming Emergency Care Programme. Variance from targets and emerging risks are reported to the weekly Executive and Clinical Leadership Committee (ECL) meeting.

Internal Audit include testing of the reliability of data and systems used to measure key operational and quality targets, within their annual plans, based on a risk assessment. Key financial systems are subject to regular testing by Internal Audit over the course of the year, broadly once per quarter.

3.2.2 Detailed Performance Analysis

3.2.2.1 Operational Performance

Overview

In line with national trends, the Trust's main operational challenges continue to arise from:

- Unscheduled care pressures, including A&E;
- Access to elective treatment within 18 weeks of referral (RTT); and
- Cancer service standards.

Reflecting the needs of an ageing population and demands arising from new guidance, these trends occurred in spite of increased investment in Primary Care and community services in our local health economy.

The Office of National Statistics (mid-2012 population estimates) suggests that the population of the Trust's core catchment area will increase by 1.4% by 2020, with 4.8% growth in the 65-79 age-group and 14.5% in the 80-plus group. By 2026, the 80-plus age group is projected to have increased by 40.5%. This is likely to put pressure on all health services, including those provided by CDDFT.

The Trust agreed trajectories with NHSI for the year in relation to 18 weeks Referral to Treatment (RTT), 62-day cancer treatment and diagnostics, but the only trajectory with financial consequences was that relating to the A&E 4-hour wait.

Unscheduled Care/A&E

Table 7 - A&E 4-hour wait target

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
NHSI Trajectory	89.91%	92.37%	92.83%	95.16%	95.70%	95.37%	94.32%	91.82%	89.53%	91.26%	92.94%	95.00%
Performance	94.76%	90.82%	93.16%	93.67%	95.07%	96.83%	95.56%	93.64%	85.10%	81.58%	85.95%	89.55%

Key: Green = achieved both NHSI trajectory and 95% standard; Amber = failed either NHSI or national standard; Red = failed both NHSI and the national standard

Over the course of the year, A&E attendances rose by 1.8% due to 4.6% growth at DMH. UHND attendances fell by 0.7%.

In Quarter 4 six of our neighbouring North East Trusts figured in the top-20 best national 4-hour wait performers. CDDFT was placed 45th out of 137 Trusts nationally: an improvement on last year's 63rd. At 85.7%, CDDFT performance was also above the England average. However, the Trust experienced less turbulent activity trends than several other North East Trusts, with only moderate growth in the quarter of 1.2% in A&E attends and 1.9% emergency admissions.

Over the winter months as a whole, however, attendances at the DMH Emergency Department (ED) grew more significantly (8.7%). The same would have been true of UHND had it not been for the primary care streaming service which diverted 2,465 walk-in patients to alternative services. Primary Care streaming is a national initiative which places a GP at the ED front door to stream patients either to A&E or to alternative services, such as the co-located urgent care services at both UHND and DMH.

Attendances of ambulances from the North East Ambulance Service (NEAS) fell over the winter by 4.6% compared to 2016/17, but in spite of this NEAS crews handed over fewer patients to CDDFT staff within 30 mins than in the previous winter.

Bed pressures remained the most important reason why A&E waiting times' performance continued to lag behind trajectory. Several factors continued to dominate:

- Growth in non-elective medical admissions across the full year: 5% Trust-wide and 7.2% at UHND. In Quarters 3 and 4, all specialty non-elective admissions grew by 2.8%; whilst Medicine admissions grew by 7.9% (9.9% at UHND).

Table 8 - Winter (October 2017 – March 2018) Non-elective admissions

	Oct 2016-Mar 17	Oct 2017-Mar 18	% variance
Both sites			
All non-electives	34,350	35,304	2.80%
Surgery	4,671	4,643	-0.60%
Trauma and Orthopaedics	1,255	1,301	3.70%
Medicine	17,358	18,728	7.90%
UHND			
All Specialties	19,892	20,397	2.50%
Surgery	2,831	2,607	-7.90%
Trauma	625	671	7.40%
Medicine	10,407	11,434	9.90%
DMH			
All Specialties	14,406	14,829	2.90%
Surgery	1,838	2,034	10.70%
Trauma and Orthopaedics	629	621	-1.30%
Medicine	6,902	7,244	5.00%

- Medical occupied bed-days. Throughout much of the winter, medical patients occupied more in-patient beds on acute wards than in 2016-17. UHND was particularly affected: bed-days occupied by medical patients were 9% higher in October, 15.5% in December, 10% higher in January, and 13.4% in March.

Table 9 - Variation in medical occupied bed-days, winter 2017-18 compared to winter 2016-17

	Oct	Nov	Dec	Jan	Feb	Mar
DMH	-10.50%	-6.30%	5.70%	8.20%	-0.50%	7.30%
UHND	9.00%	2.20%	15.50%	10.00%	2.30%	13.40%
Total	-2.60%	-4.40%	9.20%	6.70%	-2.70%	7.30%

- Influenza:
  - In January 2018, an average 36 in-patients per day were confirmed as having influenza.
  - In February 2018, this figure rose to 44, peaking at 57 patients in mid-month.
  - In March 2018, the average was 17, peaking at 33.

  The incidence of influenza in 2016-17 was negligible by comparison.

The actions being taken by the Trust and its partners include the following:

Winter escalation schemes

The Trust has retained its winter resilience schemes - acute escalation beds and additional A&E staffing - all year round to manage the continuing high levels of non-elective demand.

Primary care streaming service

A service is in place at both UHND and DMH but estates work is required at both sites to achieve maximum impact. Estates work at DMH is expected to be completed in the first quarter of 2018/19 and work at UHND, being completed in collaboration with our PFI provider, afterwards.

The "SAFER" Programme:

This programme incorporates actions relating to all aspects of the non-elective pathway, including:

- Strengthening our Command and Control arrangements, with increased cover from Sliver (Tactical) and Bronze (Operational) Commanders, in particular at weekends.
- Increased emphasis on morning board rounds to start by 09.00hrs and afternoon rounds to finish by 16.00hrs to facilitate earlier discharge of patients
- Pro-active review before lunch-time and at a weekly Multi-disciplinary Team meeting of patients in beds on wards which do not specialise in treating their condition.
- Continued implementation of a "referrer decides" protocol whereby the A&E Consultant has the final say in whether or not to move a patient to a ward.
- Incremental roll-out of primary care streaming as estates work is completed.
- Use of dedicated staff in ED capable of managing the ambulance handover queue including cohorting patients to allow some ambulance crews to get back on the road more rapidly.
- Use of dedicated porters to ensure patients are moved expeditiously between A&E, medical and surgical assessment units and base wards.
- An escalation protocol allowing Discharge Lounge teams to take patients from base wards when ready, without waiting for the request from the ward.
- Increased emphasis on improving diagnostic turnaround times for A&E patients and those close to discharge.
- Increased pharmacy and phlebotomy support to our Acute Medical Units and base wards.
- Gold Commanders undertake ward walk-arounds, there are "team of the week" awards and clinical staff working mainly in corporate teams will provide hands-on support on wards as necessary.

Perfect Month

The Trust ran 'Perfect Month' initiatives at the end of each quarter during 2017/18. The term 'Perfect Month' denotes an intensive focus, from the whole Trust and its partners in the local economy, on the management of admissions, patient flow within hospital, and patient discharges. We use this NHS methodology to seek to embed local and system-wide process improvements, which we then seek to

sustain in subsequent months. Having undertaken several 'Perfect Month' initiatives, the format is to be refreshed for 2018/19 to retain the engagement of our front-line staff in making further improvements.

Ambulance Handover Plans

The Trust has developed a joint action plan with the North-East Ambulance Service (NEAS) as well as its own Standard Operating Procedure for ambulance handovers. Implementation has commenced and will continue through 2018-19.

Commissioner Plans

Local Clinical Commissioning Groups (CCGs) have indicated an intention to shift the focus of their demand management initiatives onto non-elective care in 2017-18, although the precise schemes are not yet agreed.

Diagnostics

Performance has been unproblematic all year, with the exception of endoscopy and echocardiography, where pressures have developed on occasion. However, this has not prevented the Trust from performing ahead of Diagnostic waiting times throughout the year.

Referral to Treatment Times – 18 weeks' maximum wait

Performance has likewise been unproblematic throughout Quarters 1 to 3, albeit the Trust has at times operated with less margin for error against the 92% national target than in previous years.

In Quarter 4, the margin for error was tighter but the quarterly national target was reached. Quarter 4 performance was particularly affected by operations needing to be cancelled as a result of bad weather and on instruction from NHS England that non-elective work should be stood down, if necessary, to give priority to non-elective work.

Table 10 - Referral to treatment (RTT) results 2017/18

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
NHSI Trajectory	92.50%	92.50%	92.50%	92.50%	92.50%	92.50%	92.50%	92.50%	92.50%	92.50%	92.50%	92.50%
Performance	**92.80%**	**93.40%**	**93.50%**	**92.90%**	**92.60%**	**92.10%**	**92.50%**	**92.80%**	**92.10%**	**92.10%**	**92.30%**	**92.00%**

Key: Green = achieved both NHSI trajectory and 92% standard; Amber = failed either NHSI or national standard; Red = failed both NHSI and the national standard

RTT performance has been supported by several factors:

- Referrals: commissioners have succeeded in reducing GP referrals by a net 10.5%. North Durham CCG has employed an independent referral management company. Darlington CCG and Durham Dales, Easington and Sedgefield CCG have their own internal processes. Non-GP referrals also fell by 2.8%.
- e-RS: the Trust is recognised as a national exemplar in enabling GPs to make 100% of referrals via e-RS. This is an electronic referral system. We are working with NHSI in an advisory capacity to encourage and support other Trusts to do the same.

- Advice and Guidance: in line with national requirements, the Trust was able to earn income from its commissioners, under the Commissioning for Quality and Innovation scheme, for the introduction of arrangements for referrals for advice and guidance, rather than for an outpatient appointment. The national target was for the service to be offered in services covering 35% or more of the referrals into the Trust. In fact, the Trust moved much more quickly in practice, introducing an advice and guidance service covering all specialties by the end of June 2017. The target is to provide clinical advice within two working days of the request.
- Partnership working:
  - Commissioners and the Trust have been active in moving care closer to home in line with national policy. For example, Primary Care staff have been trained by Trust clinicians to provide a wider range of paediatrics and diabetes services.
  - A joint programme of work has been undertaken to achieve savings without compromising on quality in a number of services such as, for example, community dermatology.
  - The Trust has been involved in several partnerships or strategic initiatives at a regional level. For example, it has continued to play a full role in the regional provision of breast surgery services, albeit this has involved a heavy reliance on outsourcing to the independent sector to consistently achieve waiting time targets. It has also participated in the review of regional vascular surgery services, led by specialist commissioners, the outputs of which are currently under consideration by local Overview and Scrutiny Committees.
  - In addition to the outsourcing of breast surgery work, Orthopaedic services continue to have reliance on outsourcing to the independent sector to maintain RTT performance.

Cancer Services Standards

Table 11 - Cancer: 62-day referral to first treatment

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
NHSI Trajectory	85.06%	84.51%	84.48%	85.34%	85.10%	85.25%	85.00%	85.06%	85.12%	85.43%	85.19%	85.19%
Performance	**87.69%**	**89.43%**	**86.72%**	**88.43%**	**88.84%**	**86.99%**	**85.46%**	**86.32%**	**88.36%**	**83.33%**	**81.32%**	**90.32%**

Key: Green = achieved both NHSI trajectory and the 85% national standard; Amber = failed either NHSI or national standard; Red = failed both NHSI and the national standard.
Note: at the time of writing, March data for cancer targets is not yet available

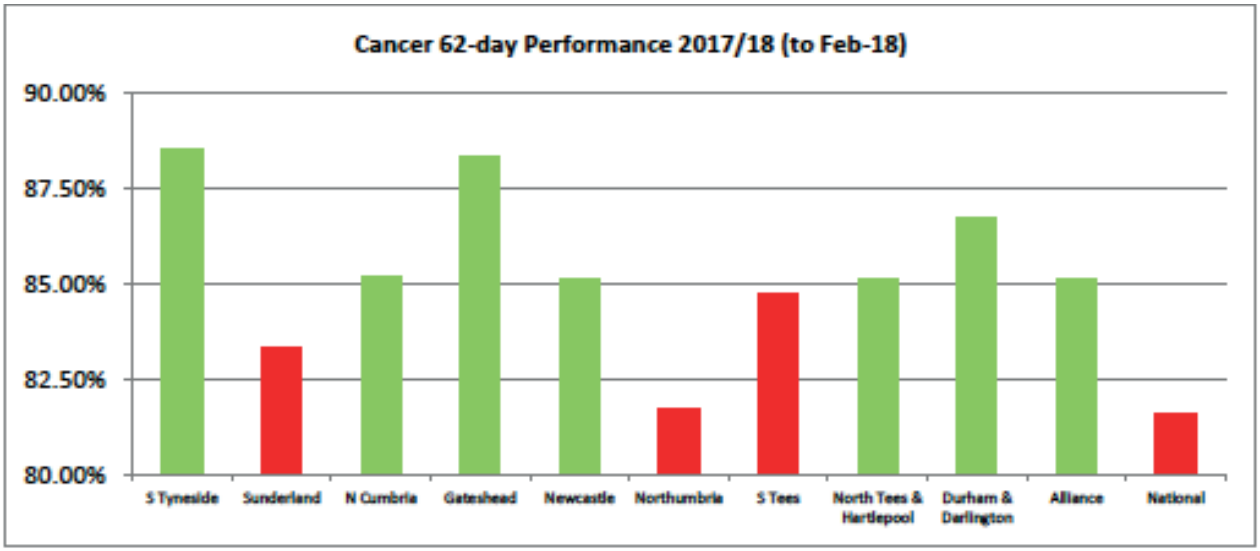
Throughout the year, the Trust has achieved national targets each quarter:

- Commencement of treatment within 31 days of agreeing a treatment plan was unproblematic because the whole pathway is under the Trust's complete control.
- The Trust has also consistently achieved the targets for patients to be seen within two weeks of a referral (including the separate target for breast symptomatic patients) in Quarters 1 to 3 of 2017/18. Due to capacity pressures over Easter 2018, the main two week wait target was not achieved

in March 2018; however, the target for breast symptomatic patients was achieved with the help of regular outsourcing to the independent sector.

- Until Quarter 4, the Trust had a secure grip on the main 62 day target for treating patients following an urgent cancer referral. Performance became more fragile in the first two months of Quarter 4. In spite of this, the Trust's performance compares reasonably favourably with national and local benchmarks.

Figure 2 – Cancer 62 Day Target Performance – Regional Comparison



In support of its Cancer Strategy, the Trust has developed a Cancer Action Plan which is monitored in the weekly RTT Assurance meeting. The Plan contains a wide range of actions including:

- Development of improved cancer capacity and demand reports, ensuring sufficient emergency slots are available.
- Provision of training on 'Understanding Cancer Targets' to administration teams, clinicians in multi-disciplinary teams (MDTs) and others involved in the cancer pathway to enable robust understanding and vigilance when booking surgery, imaging, scoping or outpatient appointments.
- Introduction and implementation of the Somerset Cancer Registry with supporting protocols and procedures.
- A Cancer Services workforce review to ensure adequate tracking and root cause analyses for 'near misses'.
- Cancer Pathway Navigators increasing their focus on the front end of the pathway, particularly in Lower Gastrointestinal (GI) cancers, and Head and Neck cancers, where a number of breaches occur.
- A new National Optimal Lung Cancer Pathway went live from 19th March, with an initial focus on the front end of the pathway.
- Development of improvement plans for each pathway not meeting cancer waiting times standards, with timetabled recovery trajectory.

- Standardisation of each MDT meeting in line with Cancer Alliance recommendations.
- Review and re-modelling of the Upper GI MDT to establish a diagnostic MDT in line with Quality Surveillance measures.
- Re-design and enlargement of the chemotherapy unit at UHND.
- Full implementation E-Prescribing of chemotherapy across CDDFT.
- Development of an electronic directory of services and standardised patient information packs.
- Review of access to chemotherapy treatments for the tumour sites not provided locally.
- Participation in the Cancer Alliance's regional review of breast cancer services.
- Review all 62 day colorectal surgery and endoscopy breaches in the year to learn lessons and ensure daily pre-assessment takes place at each main site.

3.2.2.2 Quality

The Trust's Quality Report, commencing on page 133 of this report, provides a detailed review of our quality performance.

The Trust's Quality Strategy, Quality Matters, sets out improvement priorities under three key headings:

- **Patient Safety:** Improving how we report and learn from incidents; strengthening our safety culture and reliability; reducing harm from falls; reducing harm from Sepsis and rolling out Local Safety Standards for Invasive procedures (LocSSIPs).
- **Patient Experience:** Improving how we listen to and learn from patients and their families; improving our care of patients with dementia; improving end of life care; improving elderly care and improving nutritional care.
- **Clinical Effectiveness:** Reducing mortality and learning from deaths; improving our emergency care services; improving cancer care; implementing national standards for seven day services; enabling patients to live healthier lives and sustaining and improving our services.

These priorities, along with national requirements and other annual priorities agreed with key stakeholders from the focus of an annual quality plan which is reported upon in the Quality Report. In summary, the Trust has made good progress with respect to the 16 key priorities, in Quality Matters, with notable successes and areas for further improvement summarised below:

- Strengthening of our leadership team for falls prevention and agreement of a Falls Strategy with commissioners and partners in primary care, which is now being rolled out. Both of our acute hospitals follow good practice, with both being among the best performers nationally in the National Falls and Fragility Audit 2017. The Trust has further to go, however, to reduce the number of falls in its acute hospitals to the national average. Whilst the age and acuity of many of the patients treated in our acute hospitals makes this target challenging we remain committed to achieving it.
- The Trust now screens all patients for Sepsis appropriately on in-patient wards and in our Emergency Departments and has improved significantly, year on year, with respect to administration

of antibiotics within the first hour.

- The Trust saw a reduction from eight never events experienced in 2016/17 to four in 2017/18 and has undertaken a wide programme of activity to raise awareness and embed safety protocols and learning in response to those events in 2016/17. Despite the improvements achieved there is further to go to fully embed learning as highlighted by our most recent CQC inspection.
- LocSSIPs covering all areas subject to never events have been developed and are in the process of being rolled out. An observational audit tool is being trialled to enable the Trust to monitor adherence to these procedures in practice.
- A Patient Experience and Community Engagement Strategy was developed in 2017/18, was formally approved by the Trust Board in April 2018, and is now being rolled out. Our Patient Experience Forum including representatives from Healthwatch, Governors and local champions from wards and teams has a remit to consider and take forward initiatives to improve patients' experience.
- End of Life Care continues to be strengthened with a number of medical staff appointments and improvements in service provision, monitoring and audit processes. We have been able to help more patients to end their life with dignity in their preferred place of death, year on year and are about to move to a seven day palliative care service in the community.
- Quality indicators for nutrition, including patient screening and care planning have shown improvement over the year based on monthly audit results and we have now rolled out tools within our electronic patient observations system – NerveCentre – which reinforce screening and care planning requirements.
- We achieved good results in the National Dementia Audit 2017; however, feedback from carers identified areas where we could do better and actions are in place to educate and improve dementia awareness among ward-based staff.
- The Trust is within statistical parameters for key mortality ratios, which measure variation between actual and expected deaths. There are two key indicators: the Summary Hospital Mortality Index and the Hospital Standardised Mortality Ratio, both of which have improved year on year.
- We have not sustained the improvements with respect to key targets for A&E services seen in the first half of 2017/18, largely as a result of winter pressures. More details of our performance and planned improvements are included in 3.2.2.1 above.
- Performance with respect to cancer care has remained strong overall, as outlined in 3.2.2.1 above and a range of actions are being taken to further improve our services.
- The North East Tobacco and Alcohol offices, known as 'Fresh' and 'Balance' are hosted by the Trust. Both continue to support public health gains with respect to reductions in smoking and alcohol related disease. The Trust has improved screening rates for patients for alcohol and tobacco use, over the course of the year. In 2017/18 the focus was on community hospitals; all patients will be covered from 2018/19.
- The Trust performs well with respect to the four standards for seven day

services mandated nationally, particularly with respect to medical staff review of patients. However, access to interventional radiology for patients remains a challenge across the North East region due to a shortage of such radiologists. A regional network is in development to help manage access to interventional radiology more effectively.

With respect to other quality indicators covered in the Quality Report, and more generally:

- The Trust continues to perform strongly with respect to pressure ulcer prevention with further reductions in Grade 2 and 3 pressure damage observed in the year, and overall rates of pressure ulcers in line with national and international high-performers.
- Likewise, the Trust has performed well with respect to the risk of infections. Although Clostridium Difficile infections exceeded the threshold of 19 cases, with 21 cases being reported in year, rates per 1,000 bed days remained among the best nationally.
- Over several years, the Trust has continued to improve Cardiac Arrest rates in line with high-performing trusts.
- There is, however, further to go if the Trust is to reach its ambitions in a number of other areas:
- The Trust is currently in line with the majority of Trusts for the numbers and profile of incidents reported. We continue to aspire to reporting rates in line with the top quartile of reporters, with particular emphasis on reporting of no harm, near miss and minor harm incidents as the more of these incidents which are captured, the greater the information to draw on for learning.
- Whilst 91% of electronic discharge summaries are issued within 24 hours, we continue to be challenged to meet the target of 95%.
- We have been unable to reduce readmissions in line with our ambition; however, a recent audit conducted with commissioners found that the substantial majority of readmissions were unavoidable and did not involve lapses in care.

During the year, the Trust was inspected by the Care Quality Commission (CQC). CQC's report, published in March 2018, sets out their ratings for the Trust and for its services and hospitals. We were disappointed to be rated 'Requires Improvement' but pleased that CQC acknowledged real improvements in areas such as nursing staffing and care of patients receiving non-invasive ventilation since their last inspection. They also increased their rating, for the well-led domain for the Trust as a whole, to "Good", and increased ratings for the safe domain for Medicine, and the well-led domain for both Maternity and A&E services to good. Despite these improvements, they concluded – in line with the Trust's own assessment – that there is further to go to embed safety protocols and learning following the never events experienced in 2016/17 and to ensure the responsiveness of our A&E services as outlined in 3.2.2.1 above. It is also clear that we must do better to ensure the safety of patients with mental health conditions and those lacking capacity, and to provide care for patients with mental health issues on an equal footing to those with physical ailments. We have already implemented many of

the actions included in our remediation plan and aim to have all others in place no later than October 2018. We have also enrolled on NHS Improvement's national programme 'Moving to Good' to support our improvement journey.

Service developments and changes

We have set out below some of the developments and changes to services which have taken place during 2017/18. Key points are as follows:

- The Trust continued to provide all Commissioner Requested Services during the year.
- Adult Community Services in County Durham saw the commencement of a significant transformation, with the roll out of 'Teams Around Patients' (TAPS). This concept involves much closer working between our community services teams with partners in primary care and social care in providing wrap-around services for patients in defined localities. The teams have been in place for several months and are aligned to GP Practices. The model provides the springboard for the ambitious transformation programme enshrined in the Adult Community Services contract for County Durham and Darlington, awarded to the Trust in April 2018, for implementation from October 2018. This will include fully integrated working, with shared governance, with both primary care and social services, to develop services which support patients with long-term conditions in their communities and which help to reduce admissions and support discharge. Our commissioners carried out an evaluation of TAPS in the second half of 2017/18, with patients, and feedback was positive.
- Our Tissue Viability Service is working with the National Institute of Health and Care Excellence to develop national guidance for pressure ulcer prevention and management, given the Trust's excellent performance in this area over many years. We are now working with partners in primary care and across local communities to improve care in this important area.
- We have provided an advice and guidance service to GPs covering all our specialties, well ahead of national requirements for such services. Advice and guidance referrals allow GPs to discuss cases with senior clinicians and help to avoid unnecessary hospital admissions.
- Working with our partners in primary care, the Trust has implemented a community-based model of care for patients with diabetes. The County Durham and Darlington Diabetes Alliance won the Diabetes Collaboration Initiative of the Year prize in the recent Care Diabetes Award. The team was recognised for its model, a collaboration between local clinical commissioning groups (CCGs) and acute NHS Foundation Trusts, with primary care input from local GP Federations and GP practices.
- Whilst no service was closed during the year, the Trust did withdraw the on-call out of hours' service for Ophthalmology patients at Darlington Memorial Hospital. An evaluation of the impact on patients was completed prior to the withdrawal of out of hours cover, which noted that the numbers of patients requiring the service were small. Nonetheless, the Trust is mindful of the impact on patients of having to travel to third party

sites out of hours and will review the potential to reinstate the service as the workforce is expanded. Considerable work has been done, and progress made, with support from Newcastle Hospitals NHS Foundation Trust, to strengthen governance and to develop sustainable workforce models for the Ophthalmology service as a whole.

3.2.2.3 Financial Performance

NHS Improvement's Report on NHS Providers' financial performance in the third quarter of 2017/18, confirmed that providers had succeeded in treating more patients within key operational standards, despite the extremely challenging environment they had been working in. However, record demand for services and variation in performance across the sector had led to a decline in finances as at December 2017. The national financial environment in which the Trust operates has become increasingly challenging with the NHS provider sector, which covers 234 separate trusts, reporting an overall forecast deficit of £931m for 2017/18, some £435m worse than planned. The Trust's financial performance must therefore be seen in the context of an increasing challenging environment.

Our regulator, NHS Improvement assesses our financial performance with reference to how far we achieve the financial plan agreed with them, the underlying surplus or deficit and a Use of Resources Risk Rating (UoR rating). The UoR rating is a composite risk indicator which takes into account: the Trust's income and expenditure result; its performance against plan; its liquidity; its ability to service capital and its ability to control agency spend. Accordingly the Trust measures performance against these indicators, as well as underlying targets for cost control and cost reduction in year.

The Trust ended the year with a UoR risk rating of 3, which was in line with the plan, reflecting the financial performance noted above as well as the Trust's underlying liquidity and its ability to service capital. A rating of 1 is regarded as the lowest level of risk and a rating of 4 is regarded as carrying the highest level of risk.

The consolidated accounts for 2017/18 incorporate the results for the Trust, for our wholly owned subsidiary, Synchronicity Care Limited, and for our charitable funds, with the Group posting a deficit for the year of £1.14m which includes:

- £8.07m relating to an impairment resulting from the downward revaluation of the land and buildings on the Trust's balance sheet by the Trust's valuer. This impairment does not impact on cash earnings or on how NHS Improvement assesses the Trust's performance.
- £324k relating to the movement of the Trust's charitable funds. Expenditure exceeded income generated during year as a result of deliberate policy to seek to use accumulated funds for charitable purposes.
- £167k relating to additional monies from the Sustainability and Transformation Fund (STF) for 2016/17, which was received in 2017/18.

The Trust and NHS Improvement focus on the surplus/ (deficit) for the year, excluding impairments, revaluations and movements in charitable funds; this is the primary financial key performance indicator used for regulatory purposes. After excluding

those items the Group is reporting a £7.1m surplus against the target surplus agreed with NHS Improvement ('control total') of £3.7m. The Trust was therefore able to deliver a financial outturn £3.4m better than planned.

During 2017/18, the trust was eligible to receive £12.86m from the STF if it was able to deliver its financial control total and also its performance targets in relation to Accident and Emergency Services. As outlined in 3.2.2.1 above, the Trust failed to meet trajectories agreed for Accident and Emergency waiting times in the third and fourth quarters of 2017/18; consequently £2.5m of STF funding attached to this measure was lost.

Due to other providers' inability to deliver their financial and performance targets and consequently receive the STF funding, NHS Improvement established the following additional STF funds for 2017/18:

- general distribution – for all providers that signed up to a control total in 2017/18;
- incentive scheme – to reward providers that were able to deliver a financial position better than the 2017/18 control total; and
- a bonus fund – paid to providers which delivered their individual control total.

As the Trust had signed up to its 2017/18 control total and was able to exceed it, then in addition to receiving a share of the general STF distribution, it also received additional STF incentive and bonus funding with a total of £5.8m being received. This resulted in total STF funding of £16.2m being received for 2017/18, which is included in the overall surplus of £7.1m.

Despite the financial out-turn noted above, there were significant challenges which needed to be managed in-year:

- The financial pressure of the continued shortage of key clinical staff required to maintain safe services resulting in expenditure on agency staffing of £11.7m, down £6.5m on the previous year;
- Challenging cost improvement targets: the Trust achieved £25.5m of its £32.4m cost improvement target.
- An inability to reduce the structural deficit of specific service lines without a health-economy wide solution, which requires formal public consultation.

The Trust spent £20.1m on capital investment in its estate, information technology and medical equipment assets. The Trust also continued with the rebuilding and improvement of the Darlington Memorial Hospital theatre suite which is a major investment in state of the art facilities for patients.

3.2.3 Information about Environmental Matters

Throughout 2017/18 the Trust has maintained its proactive approach to meeting its obligations under the Carbon Reduction and Sustainability programme. We fully accept our responsibility to consider and be accountable for our impacts on the environment to staff, patients, the local community and our wider stakeholder groups. The Trust recognises the significant impact of its activities on the environment and acknowledges its role in promoting

sustainability and improving environmental efficiency.

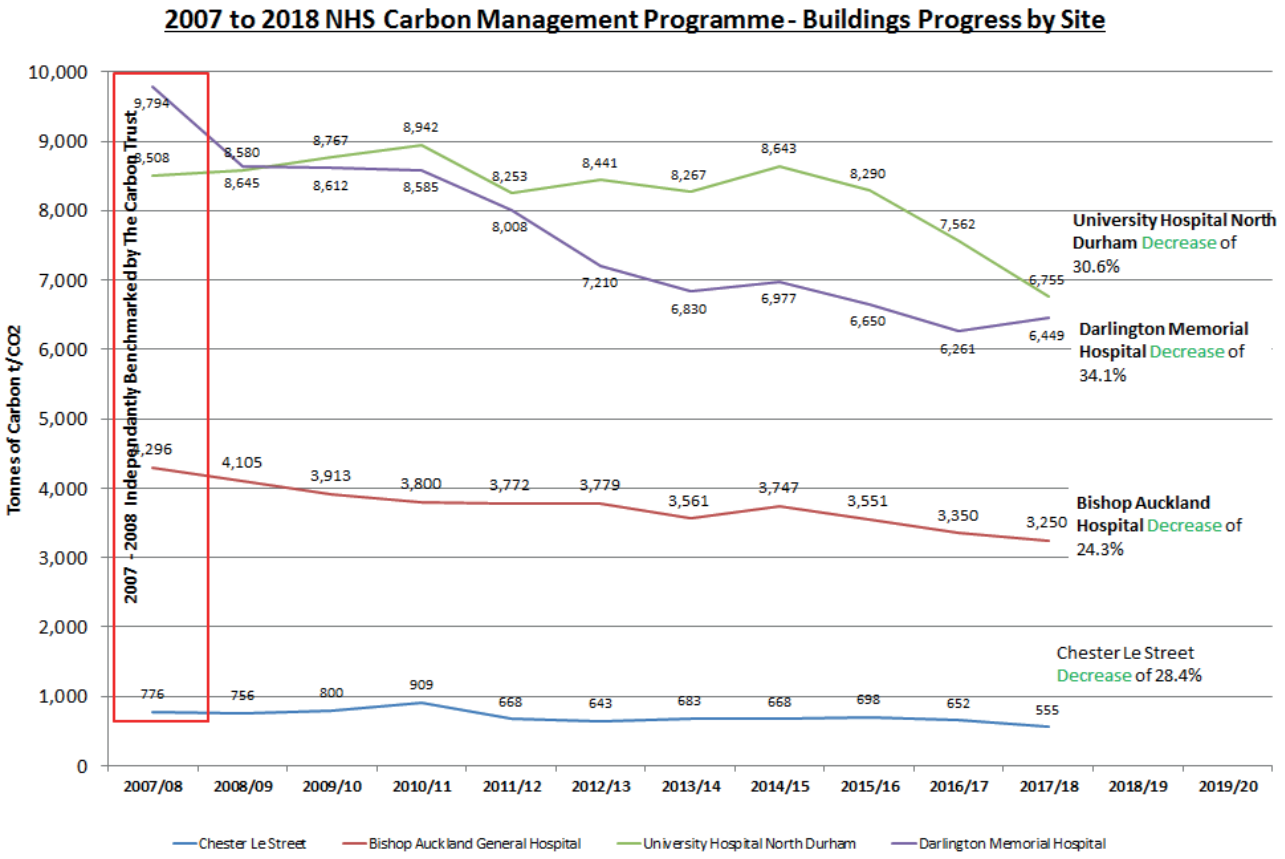
For carbon emissions due to utility/energy consumption, we have met the initial carbon reduction target of 10% by 2015 against a 2007 baseline, achieving a 27.23% reduction to date and we are working towards achieving the target of a 34% reduction by 2020.

Table 12: Carbon Reduction Targets

Carbon reduction targets	2007/08	2017/18
Carbon emissions from energy consumption / tonnes CO2e	23,374	17,009
% reduction		27.23%

At all four of our main sites the carbon associated with gas and electricity has reduced. The Carbon Trust measured our 2007 buildings carbon footprint as 23,289 t/CO2. For one of our sites, Darlington Memorial Hospital we have achieved the 2020 goal early, during 2017/18.

Figure 3: Carbon Management Programme Buildings by Site



Darlington Memorial Hospital is our best performing carbon reduction site, with 55.4% of the site's electricity requirement being met through on-site generation via a Combined Heat & Power (CHP) unit. In 2017-18 our CHP generated enough electricity to power 1,500 UK homes (OFGEM calculated usage of 3,200 kWh/a).

We have continually monitored our carbon footprint since the "Carbon Trust" benchmarked the organisation in 2007. Through careful monitoring of reductions, performance and through investing in efficient equipment - for example internal and external LED lighting upgrades; efficient controls, including a new Building Management System installed in 2012; pipework and valve lagging; digital boiler controls; window upgrades; efficient running of the CHP and sub metering - and by introducing innovative technologies, we endeavour to continue to reduce our impact on the environment. These investments support the recommendations made by Lord Carter in his report on Operational Productivity and Performance in English NHS Acute Hospitals.

The Trust submits data for the mandatory Estates Returns Information Collection (ERIC) for all NHS Acute Trusts. ERIC includes information relating to the costs of providing, maintaining and servicing the NHS estate, including energy use, we expect data for 2017/18 to be published on the gov.uk website in September 2018.

Summary Performance – Non Financial and Financial

The table below summarises our performance last year with reference back to the preceding two years.

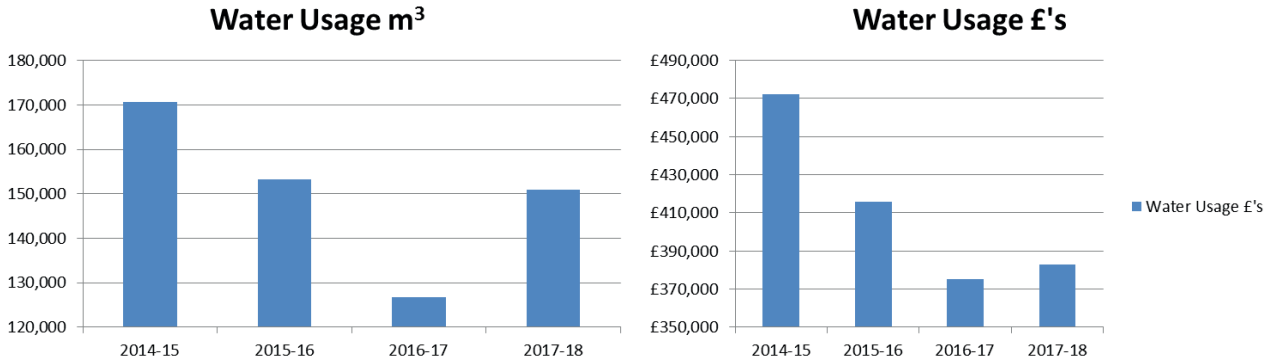
Table 13: Data from ERIC Return 2017/18

Greenhouse Gas Emissions		Non Financial Indicators			Financial Indicators		
Area		Non-Financial data 2015/16	Non-Financial data 2016/17	Non-Financial data 2017/18	Financial data 2015/16	Financial data 2016/17	Financial data 2017/18
Finite Resources	Scope 1 Emissions						
	Carbon Reduction Commitment	12,742 t/COe	11,844 t/COe	Information not available until September 2018	£175,620	£196,610	Information not available until September 2018
	Electricity	86,075 Gj	84,834 Gj	68,517 Gj	£4,326,482	£3,304,890	£3,116,541
	Gas	199,709 Gj	190,345 Gj	196,883 Gj			
	Oil	2,140 Gj	1,311 Gj	481 Gj			
	Electricity	12,850 t/CO2	10,588 t/CO2	7,317 t/CO2	Not Applicable		
	Gas	10,260 t/CO2	9,729 t/CO2	10,072 t/CO2			
	Oil	342 t/CO2	210 t/CO2	40 t/CO2			
Waste	Scope 3 Emissions						
	Total Waste	2,135.3 t/volume	2,280.8 t/volume	2,109.3 t/volume	£402,741	£378,710	£383,080
Hazardous waste	Clinical waste to alternative treatment or incineration	803.7 t	781.4 t	830.7 t	£295,626	£238,168	£261,141
Non Hazardous Waste	Landfill	-	-	-	-	-	-
	Reused/Recycled	964.6 t	1,133.98 t	316.6 t	£72,270	£97,093	£13,886
	Incinerated with energy recovery	350.0 t	342.69 t	945.9 t	£33,282	£39,531	£104,210
	Electrical waste (WEEE)	16.99 t	22.8 t	16.1 t	£1,563	£3,920	£3,843
Travel	Scope 3 Emissions						
	Commercial Vehicles Diesel	324,186 miles	290,159 miles	273,888 miles	£56,775	£58,651	£49,572
		64.6 t/CO2e	57.77 t/CO2e	65.93 t.CO2e			
	Leased Vehicles Petrol	804,161 miles	794,317 miles	906,255 miles	£95,963	£95,318	£109,432
		139.0 t/CO2e	155.37 t/CO2e	149.75 t/CO2e			
	Leased Vehicles Diesel	2,095,493 miles	1,750,008 miles	1,769,876 miles	£205,764	£297,501	£206,182
		416.8 t/CO2e	328.69 t/CO2e	297.48 t/CO2e			
	Business Miles Petrol	4,116,160.8 miles	3,698,910 miles	3,574,692 miles	£1,704,919	£1,501,132	£1,374,684
		1,266.24 t/CO2e	1,132.68 t/CO2e	1,063.15 t/CO2e			
	Business Miles Diesel	74,158 miles	33,437 miles	20,600 miles	£31,222	£13,965	£9,905
		18.73 t/CO2e	8.31 t/CO2e	5.02 t/CO2e			
Water	Water Consumption	153,228 m^3	126,653 m^3	150,974 m3	£415,695	£375,211	£382,848

Water

It is recognised that acute hospitals are high consumers of water as it is used for multiple purposes including: Central Sterile Supplies Departments; Renal Dialysis; increased hygiene; infection control; the legislative flushing regime for low usage outlets, and water safety compliance. Our annual consumption of water has been falling; however, in the last year this increased by 19%; with costs increasing by 2% against the previous year. The higher usage can be attributed to the sewerage charges associated with our borehole at Darlington Memorial Hospital and increased activity, new build activity and loss of water through leaks which have since been repaired.

Figure 4: Water Usage 2017/18



Waste Management

The Trust has continued to reuse a significant quantity of furniture which may otherwise have ended up as waste; this has been achieved by logging details of surplus equipment and matching it with requests made by members of staff. This has helped to achieve savings in procurement as well as a reduction in the volume and cost of waste.

There have been significant challenges in the waste management industry over the past 12 months; none more so than the severe restrictions imposed by China on the importation of recycled materials. The knock on effect has caused the Trust's waste management contractor to no longer be able to extract recyclables from the general waste stream for the foreseeable future. This is reflected in a sharp reduction in quantity of waste recycled during 2017/18.

More positively, general waste from all Trust sites is processed into a fuel and used in power generation as opposed to being sent to landfill. There have also been smaller but very innovative initiatives over the past 12 months, such as the launch of a recycling initiative for used patient oxygen masks within UHND, DMH and BAH. Since the start of the initiative in August 2017, nearly a quarter of a tonne of masks have been recycled into tree ties. This is wholly subsidised by our supplier, Recomed, and has also achieved some small cost savings.

Within 2017/18, the volume of clinical waste has increased, particularly at UHND, which can largely be attributed to clinical activity. The volume of general, or household waste, has fallen which is partly related to a reduction in the number of skips required for building clearances.

From a cost perspective, the overall cost of waste disposal has remained stable compared to the previous year. It is also significantly less that it was nearly a decade ago which is due to long-term contracts and careful day-to-day management.

Sustainable Procurement

The Trust's Procurement Service considers sustainable procurement in all requirements for goods, services, works and utilities in a way that achieves value for money on a whole life basis. This means generating benefits not only to the Trust, but also to

society and the economy, whilst minimising damage to the environment.

All Trust procurement activities involve consideration of the environmental, social and economic consequences of: design; non-renewable material use; manufacture and production methods; logistics; service delivery; use; operation; maintenance; reuse; recycling options; disposal; and suppliers' capabilities to address these consequences throughout the supply chain.

The Trust has been working to include sustainability considerations in its procurement for many years. Reducing carbon emissions and improving labour standards through procurement are two very important aims for the Trust. We are also exploring how we can further reduce carbon emissions associated with everyday business operation.

3.2.4 Social, Community and Human Rights Issues

The Trust's approach to equality, diversity and human rights is enshrined within its values and behaviours framework. Staff are made aware of the standards expected of them by ensuring that training on equality, diversity and human rights forms part of all staff essential training and development requirements, regardless of their role or level. An updated e-learning programme has been launched and continues to be the main source of delivery of such training for staff already within the organisation. Equality and diversity is part of the corporate induction programme for new staff.

The Trust's commitment to equality, diversity and human rights and supporting arrangements is embedded through the implementation of a number of policies and procedures including:

- Equality, Diversity and Human Rights Policy;
- Disability Policy;
- Religious Observance by Employees Policy;
- Dignity at Work Policy;
- Dignity and Respect Policy;
- Learning Disability Policy;
- Interpreting and Translation Policy; and
- Transgender Support Framework for Staff and Managers.

Prior to this financial year, the Trust's focus for Equality, Diversity and Inclusion was on building secure foundations, by ensuring that robust policies and practices were in place for staff and patients, and promoting excellence in this field. The next phase was to produce an Equalities, Diversity and Inclusion (E,D&I) Strategy and this work was undertaken during 2017/18. The strategy focuses on developing new and innovative ways of engaging staff in this important agenda in order to engender an organisational culture that fosters inclusion and leads to exceptional standards of patient care. The ED&I strategy has been approved by the Board and was launched in April 2018. Roll out of the strategy will continue throughout 2018.

The Trust is also taking part in Project Choice which is a supported internship hosted by CDDFT and managed by Health Education England (North East). The project is designed to give young people with learning difficulties, disabilities or autism, the chance to gain work

experience, undertake an employability qualification and complete a work-based internship. The project tailors a programme to the needs of the young people which enables them to meet and develop their individual skills. Our first induction onto this programme was held on 25th September 2017.

In 2017 we continued to work with a local organisation, Amacus, on the "Leapfrog" project. This involved recruiting people with a background of long term unemployment and from socially excluded backgrounds to work as Health Care Assistants. To date, we have interviewed 104 applicants and 72 have been offered employment with the Trust.

CDDFT continues to sign up to the Learning Disability NHS Employment Pledge which enforces our commitment to supporting the recruitment of people with learning disabilities into the Trust through supported internships, traineeships and apprenticeships.

Working in partnership with Derwentside College we have recruited and trained apprentices in a number of areas, including Health Care Assistants and Business Administration Support staff. Apprentices receive both vocational training and a qualification, making them ideal candidates for permanent positions at the end of the training period. We have had over 400 apprentices over the past four years, 60 of which were young apprentices and we have also offered apprenticeships to older employees.

In March 2018, the Trust welcomed 200 pupils from local schools and colleges as part of "Healthcare Sciences Week". Colleagues from our scientific disciplines, including Biochemistry and Nuclear Medicine, showcased their work with fun and interactive demonstrations as well as offering advice on how to pursue a career in healthcare science

We have also introduced a new system "Speak in Confidence" to support staff who would like to raise concerns or share feedback anonymously with the Trust's senior managers. The system is an online system which enables colleagues to anonymously raise concerns, provide feedback or share ideas, and to continue a dialogue with a senior member of staff, who may require further information to fully investigate or respond to a concern, without compromising their anonymity.

The Trust has in place a Freedom to Speak Up Guardian, Cate Woolley-Brown. The role of the guardian, and Cate's responsibility to us, is to: engender a culture in which staff feel supported in raising concerns; help staff to raise concerns about patient safety; and to provide confidential advice and support to any member of staff who does so.

A Clinical Psychologist joined the Staff Health and Wellbeing team in January 2017. Their role is to work closely with staff teams, and with colleagues in Workforce & Organisation Development, line managers and individual staff to offer advice, guidance and sign-posting to relevant services, particularly for those with mental health conditions including work related stress/ other stress, and to facilitate brief interventions which enable staff to either remain at work or to return to work in a timely manner

The Trust has also introduced a physiotherapy service for two days of the

week. The service is offered between DMH and UHND on a Monday and Thursday and is available for all staff members. The aim of this service is to provide education, advice and support as well as short term physiotherapy intervention to help promote physical health and wellbeing in the workplace. The service is available to both the individual and to teams and groups of staff within departments.

During 2017/18, a series of Staff Health and Wellbeing roadshows was delivered across the three main hospital sites and Community hospitals which included advice on weight reduction, healthy eating and smoking cessation. The roadshows also promoted the Occupational Health Service, staff physiotherapy and psychological services and shared back care information for staff and offered staff flu vaccines

The Equality Delivery System2 (EDS2) sets out our commitment to taking equality and human rights into account in everything we do; whether in providing services, employing people, developing policies, communicating, consulting or involving people in our work. The four main goals of the EDS2 are:

- Better health outcomes for all;
- Improved patient access and experience;
- Workforce – The NHS as a fair employer; and
- Inclusive leadership at all levels.

We are committed to monitoring our progress and reporting regularly and openly in line with the specific duties of the Equality Act 2010. EDS2 goals and objectives were published in September 2017 and we will monitor progress on the delivery of our objectives and formulate plans for further improvements for the future, ensuring that we continuously improve, year on year.

The Workforce Race Equality Standard (WRES) requires organisations providing NHS services to show progress against a number of indicators of 'Workforce Race Equality'. The focus is on complying with implementing the standard, as well as helping to improve the wider culture of the NHS to benefit all staff and patients. The Trust has monitored its compliance with the standard, reporting to the Board's Integrated Quality and Assurance Committee on the current position and planned developments.

During 2018/19 as part of the ESR Manager Self Service roll out, we will continue to encourage staff to update their personal records; in particular, with respect to their protected characteristics, to ensure that we have representational information on all staff demographics.

Essential steps have been identified to support people with learning disabilities accessing our services:

- All patients identified on admission with a learning disability are flagged on our patient admission system (eCaMIS);
- A complete learning disability risk assessment pathway is in place and patients then progress onto an appropriate learning disability pathway;
- Reasonable adjustments required are evidenced on pathway documentation; and
- A "Hospital Passport" is completed and the lead Learning Disability /

Acute Liaison Nurse is informed of the patients admission

To provide more support and to reduce readmissions for people with learning disabilities the team have developed an outreach service that provides support following discharge home after an acute admission of 48 hours or more. This service provides support to the individual, family members and support staff on the management of a new and/or existing health need

The roll out of our Electronic Clinical Document Management and Electronic Prescription Management and Administration system has also improved patient transfers between services. When patients are transferred into other services inside or outside of the Trust any individual needs related to their protected characteristic will be identified on the referral letter.

The patient assessment records the number of ward transfers and follows the patient when transferring across services. This is also recorded on the electronic care record.

Specialist pathways have been introduced for groups of patients with protected characteristics to prevent a breakdown of their care pathways. Patients with learning disabilities have a flag placed on the electronic patient record to highlight that the person may require reasonable adjustments and to ensure these are arranged in advance of their visit.

The opening of a new sensory garden at DMH has created a peaceful place for patients, visitors and staff. The idea came from a locally-based young man who developed the garden as part of his National Citizen Service. Sections of the garden are devoted to each of the senses, using herbs and plants such as lavender to bring colour and aromas, and established trees provide shade and are decorated with wind chimes. The sensory element is particularly good for people with dementia who struggle with so much of everyday life, but who can still get pleasure from sight, smell and sounds

The Trust continues to benefit from the services of a volunteer therapeutic musician who plays live acoustic music, using a lyre, Native American flute or voice for patients and relatives and staff in UHND helping to enhance the healing environment, reducing stress and anxiety.

Training sessions have been held to share information on Female Genital Mutilation (FGM), Forced Marriage (FM) and Honour Based Violence (HBV) to enable staff to react sensitively and effectively in the event of disclosure or detection of these issues in order to safeguard those children and adults affected.

A new chaplaincy suite has opened at DMH for the use of patients, their relatives, staff and any visitors to the hospital. People of all faiths including non-believers are encouraged to use the chapel which has a Wudu, a facility where Muslims may wash before prayer. As well as a modern chapel, the chaplaincy suite incorporates an office and quiet room.

In July 2017, the Trust launched the Baby Buddy app, a personalised guide for all mums to be, but young mums in particular. Covering pregnancy and the first six months after birth, the interactive app delivers personalised pregnancy and

parenting information in the voice of a chatty, knowledgeable friend. It also offers an avatar that the user can customise and answers to frequently asked questions, appointment reminders, useful videos and much more.

As part of the Trust's commitment to developing dementia-friendly environments in key public areas, large faced clocks with day and date have been introduced and signage has been standardised with writing and pictures. In some areas orientation boards have also been successfully introduced. Over the last 12 months 1,274 staff have undertaken dementia training. Following a survey of carers, a Dignity leaflet has been developed for patients affected by dementia. All patients aged 75 years and over are asked about their memory on admission.

A group of *'Twiddle Muff'* creators have produced knitted or crocheted muffs with decorations attached so patients have something to do with their hands while on our wards and in the Emergency Department. These are gifted to patients to take home.

The County Durham Rapid Elderly Specialist Team (CREST) provide geriatric assessment for complex elderly patients meeting specified criteria within the first few days of admission; ideally on the day of admission into the Acute Medical Unit, or attendance in our Emergency Departments. The team implements an appropriate management and discharge plan that aims to avoid readmission where possible and/or reduce length of hospital stay. By putting more appropriate care plans in place the Trust has significantly reduced patient's length of stay.

The Trust continues to support patients whose first language is not English through the provision of professional interpreting and translation services, and a range of leaflets in the most common, second languages.

We continue to monitor and embed the Accessible Information Standard which aims to make sure that people who have a disability or sensory loss get information that they can access and understand, and any communication support that they need. The Trust aims to make sure that patients and service users, and their carers and parents, can access and understand the information they are given.

The Trust complies with the provisions of the Bribery Act, with key policy statements and requirements specified within the Trust's Anti-Fraud Policy. Procedures are in place to consider risks of bribery in appropriate activities and to respond effectively to any instance of bribery brought to management's attention. The Trust uses its counter fraud service to support and strengthen its anti-bribery arrangements and response, with more detail being included in Section 4.3.5.5.

3.2.5 Modern Slavery Act

All clinical and non-clinical staff within the Trust have a responsibility to consider issues regarding modern slavery and to incorporate their understanding of these issues into their day to day practice.

In accordance with the Modern Slavery Act 2015, County Durham and Darlington NHS Foundation Trust is committed to preventing acts of modern slavery i.e. human trafficking and slavery, within both its business and supply chain. Furthermore,

the Trust imposes those high standards on its suppliers.

The Trust is fully aware of the responsibilities it bears towards patients, employees and the local community and as such, we have a strict set of ethical values that we use as guidance with regard to commercial activities.

In compliance with consolidation of offences relating to trafficking and slavery within this Act, we are currently reviewing our supply chains with a view to seeking confirmation that suppliers have arrangements to present trafficking or slavery.

3.2.6 Important Events since the end of the financial year affecting the FT

On 15th April the Trust applied for, and received a £22.5m interim cash support loan from Department of Health. The loan is a three year loan at 1.5% interest, to be repaid in April 2021. This cash support will ensure that the Trust has positive cash balances going forward.

In 2017/18 the local CCGs retendered the contract for providing adult community services within County Durham and Darlington. In April 2018 it was announced that County Durham and Darlington NHS FT had retained the contract which extends the scope of the current service.

3.2.7 Details of Overseas Operations

The Trust has had no overseas operations in the year.

4. Accountability Report

4.1 Directors' Report

4.1.1 Details of Directors serving during the year

Details of the Directors serving during the year are set out in Section 2.1.1 (pages 20 to 25) of this report: Trust Board of Directors.

4.1.2 Statement of Compliance with Cost Allocation and Charging Guidance Issued by HM Treasury

The Trust has complied with the costs allocation and charging requirements set out in HM Treasury and Office of Public Sector Information Guidance.

4.1.3 Better Payment Practice Code

4.1.3.1 Public Sector Payment Policy

Unless other terms are agreed, we are required to pay our creditors within 30 days of the receipt of goods or a valid invoice, whichever is the later. This is to ensure that we comply with the Better Payment Practice Code.

The Trust's performance against this metric is shown in **Table 14** as follows:

Table 14 – Better Practice Payment Code Compliance

Non NHS Creditors		NHS Creditors	
Target:	95.00%	Target:	95.00%
Result by number:	78.09%	Result by number:	96.14%
Result by value:	91.71%	Result by value:	99.90%

Because of the relatively small number and high value of NHS invoices, a small number of late paid NHS invoices can result in dramatic shifts in the percentage paid on time.

A detailed breakdown of the figures is shown below

Table 15 – Better Practice Payment Code Detailed Breakdown

	Non NHS Creditors		NHS Creditors	
	Number	£000's	Number	£000's
Total bills paid in the year to 31 March 2018	76,944	317,017	2,075	20,262
Total bills paid within target	60,083	290,727	1,995	20,241
Percentage of bills paid within target	78.09%	91.71%	96.14%	99.90%
Average values and payment periods				
Average value		£4,120.10		£9,764.82
Average payment period		60 days		107 Days

During 2017/18 the Trust, along with many other trusts across the country, experienced cash shortages as a result of the pressures felt across the NHS. This resulted in payment for inter NHS invoices being withheld completely during March 2018, and non NHS invoices experiencing payment delays. The Interim Cash Support provided by Department of Health in April 2018 allowed all overdue invoices to be settled, and should allow prompt payment going forward.

4.1.3.2 Late Payment Interest

Legislation is in force which requires Trusts to pay interest to small companies if payment is not made within 30 days, known as the Late Payment of Commercial Debts (Interest) Act 1998. The Trust paid £2,690 in claims under this legislation.

The total potential liability to pay interest on invoices paid after their due date during 2017/18 would be £658,180. There have been minimal claims under this legislation, therefore the liability is only included within the accounts when a claim is received.

All of this relates to non NHS invoices, and none relates to NHS healthcare contracts.

4.1.4 Statement of Disclosure to Auditors

The Board of Directors of County Durham and Darlington NHS Foundation Trust is responsible for preparing this annual report and the annual accounts. The Board of Directors considers the annual report and accounts, taken as a whole, to be fair, balanced and understandable and to provide the information necessary for patients, regulators and other stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

So far as the Directors are aware, there is no relevant audit information of which the auditors are unaware and the Directors have taken all steps that they ought to as Directors to make themselves aware of any relevant information and to establish that the Trust's auditor is aware of that information.

4.1.5 Political Donations

The Trust made no political donations during 2017/18.

4.1.6 Meeting NHS Improvement and CQC's Well-Led Framework

The Trust has arrangements in place to implement good practice as defined in the Well-Led Framework. These are summarised in the table below, for each of the 10 Domains within the framework, signposted to other sections of this report where more detail is available. The Board completed a detailed self-assessment against the framework in 2016/17, which was validated by a subsequent external review, for which the final report was received in July 2017. The reviewer's assessments are also noted in the table below. All but one domain was assessed as 'Amber-Green', which in essence denotes no significant omissions in good practice arrangements and credible action plans to address gaps; one area was rated 'Amber-Red' which again denotes no major omissions from the framework, but further and more concerted action being required to address areas for improvement.

Table 16 – Well-Led Framework

Domain	Arrangements in place	Reviewer's assessment	
Credible Strategy	Issues arising from the external review and actions taken are set out in detail on page 124. Current arrangements are summarised below. The Board's strategy has been summarised in Section 3.1.2 above. This is contained in a Strategy Handbook and is supported by a series of Infographics at Trust and Care Group level to aid communication. The Strategy is refreshed and approved by the Board annually and progress against all elements of the Strategy is monitored by a Strategic Change Board – comprising Executive Directors and Clinical Leaders – meeting once per month.	AMBER	RED
Board Understanding and Management of Risks	A comprehensive risk management strategy is place, supported by training of risk owners, monitoring and oversight by a specialist Assurance and Compliance team and review of risk registers by a Risk Management Committee. More detail is included in the Annual Governance Statement starting on page 113	AMBER	GREEN

Domain	Arrangements in place	Reviewer's assessment	
Board Capacity and Capability	The current experience of the Board is set out in Section 2 of this report. The Board annually reviews the skills, capacity and capability it requires and a range of training is provided through Board seminars. During the year Executive Directors underwent a number of externally facilitated development sessions and a further session took place for the whole Board.	**AMBER**	**GREEN**
Board engendering of a Quality-focused culture	Quality is the first item on the Board's agenda for each meeting. The Board has a dedicated Integrated Quality and Assurance Committee, the agenda for which covers all quality assurance requirements except for Safe Staffing, which is reported to the Board directly in line with the recommendations of the National Quality Board. Board members perform regular ward walk-arounds and have ready access to Care Group leadership teams to enable them to listen to staff, promote the quality agenda and triangulate assurance. More detail on the Executive Committees in place to drive the quality agenda and the work of the Integrated Quality and Assurance Committee are set out in the Annual Governance Statement starting on page 113.	**AMBER**	**GREEN**
Culture of Learning and Improvement	The Board has undertaken development activities, including seminars and an externally facilitated development discussion in the year. A Strategic Leadership Development Programme is in place for senior managers in the Trust, as part of an overall Talent Management approach. The Trust has invested in facilities to support learning for clinical staff, including a training centre at Prospect House and a Clinical Simulation Centre, used to simulate situations (including some based on incidents) to support learning and improvement. The Trust has engaged a team from Salford Royal Hospitals in working with all Care Groups on quality improvement projects and dissemination of quality improvement skills.	**AMBER**	**GREEN**

Domain	Arrangements in place	Reviewer's assessment	
Governance processes	Governance structures are outlined in detail in the Annual Governance Statement starting on page 113	**AMBER**	**GREEN**
Processes to manage risk, issues and performance	Processes to manage risk, issues and performance are summarised in the Annual Governance Statement starting on page 113. Information on the Integrated Performance Framework is included in 3.2.1 above.	**AMBER**	**GREEN**
Patient and Public Engagement	The Trust uses the Friends and Family Test interviews, analysis of complaints and compliments, patient stories, local and national surveys to obtain the views of patients on services. This is information is shared with operational teams to improve services by ward or team and with Board Committees for executive direction and assurance. Expert patient groups and Healthwatch are engaged in discussions at service level and through the Trust's Patient Experience Forum, which has a remit to identify and take through service improvements. Over 90,000 patient contacts per annum are processed. Arrangements to engage our membership through our Governors are set out in section 2.3 above.	**AMBER**	**GREEN**
Information and reporting	Key reports to the Board include the Integrated Performance Report outlined in Section 3.2.1 above, the quarterly Assurance and risk report (including the Board Assurance Framework) Monthly Finance Report, and the Monthly Patient Safety and Experience Report. More information on how reports are scrutinised and challenged through the Board Committee structures is set out in the Annual Governance Statement starting on page 113	**AMBER**	**GREEN**

Domain	Arrangements in place	Reviewer's assessment	
Reliability and quality of information systems	Arrangements to assure the reliability of information systems are summarised in our Annual Governance statement starting on page 113. The Trust's Information Services team applies a series of validation controls to key datasets, including kite-marking for some of the most important datasets used to report on regulatory compliance and key performance targets. Internal Auditors carry out testing, based on a risk assessment, of key datasets and further assurance of key datasets used to report mandatory indicators in the quality accounts can be taken from external audit testing.	AMBER	GREEN

The key issues identified from the external review with respect to strategy related to: the need for a single integrated strategy, which is clearly articulated to all staff and stakeholders, and stakeholders' perceptions that they should be more fully engaged in the development of the Trust's strategy. Since the fieldwork for the external review was completed the Strategy Handbook has been refreshed and rolled out widely within the Trust, with simpler, pictorial communications issued to staff and stakeholders. The Chairman and the Chief Executive have sought feedback from stakeholders on the Trust's strategy and the Trust is working with commissioners on joint plans and strategies to improve services, particularly in the community. When CQC completed a three-day well-led assessment as part of their most recent inspection, similar issues were not highlighted; however, there was a need to ensure a consistent understanding of the strategy among senior managers.

Throughout the last year, the Board has overseen the implementation of a detailed action plan agreed with the external reviewers, covering all 10 domains. The action plan has been closed down; however, a small number of actions are iterative in nature and will continue to be followed through.

CQC rated the Trust's Well-Led arrangements as 'Good' based on their inspection. Areas for improvement, in addition to the issue concerning strategy above, were: staff engagement; introducing a formal board development programme and register of training for Non-Executives; more proactive oversight of role-specific essential training and review of information reported to the Board to ensure that it is timely and free from unnecessary duplication. Action is being taken in response to each area for improvement and the effectiveness of those actions will be monitored by the Board.

4.1.7 Income Disclosures

The Trust has met the requirement, within Section 43 (2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2013) that income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of

goods and services for any other purpose.

Other income received during the year related primarily to funding for education and training (for mainly clinical staff) and income from non-patient care services to other bodies. Income from the latter is used to offset the costs of providing such services and any surplus used to support the provision of goods and services for the purposes of the health service in England.

4.2 Remuneration Report

4.2.1 Annual Statement on Remuneration

The Trust has two separate Remuneration Committees:

- The Board's Remuneration Committee, which sets and directs the implementation of remuneration policy for senior managers; and
- The Council of Governors' Remuneration Committee, which sets and directs the implementation of remuneration policy for Non-Executive Directors.

As the Chairman of both Committees, it is my pleasure to set out this Remuneration Report for 2017/18.

The major decisions made by the Committees during the year consisted of:

Decisions by the Board's Remuneration Committee:

- Approval of an increase in Directors' pay by 1%, in line with the national pay award to staff.
- Agreement of the remuneration package for the Executive Director of Finance, who commenced in post on 1st June 2017. This was set in line with the remuneration of the previous post-holder, adjusted to take into account the incoming officer's experience and responsibilities.

Decisions by the Council of Governors' Remuneration Committee

- Approval for a 1% increase in the basic remuneration and additional responsibility allowances paid to Non-Executive Directors, a recommendation which was ratified by the Trust's Council of Governors.
- Approval for the recommendations of a triennial review of remuneration policy for Non-Executive Directors, which concluded, firstly, that any increase in basic remuneration must be approved by the Committee and the Council of Governors and must not exceed any national pay award and, secondly, that no increase in additional responsibility allowances should be awarded during the coming three years. Again, the Committee's recommendation was ratified by the Council of Governors.

These decisions were made within the context of the Trust's remuneration policies, which remained unchanged during the year, and on the basis of advice from the Trust's Workforce and Organisation Development Director and her senior team,

complemented by external benchmarking where appropriate.

In agreeing the remuneration for senior management appointments, the Board's Remuneration Committee balances the need to attract and retain high calibre managers capable of implementing the strategic changes required within the Trust over the next five years, with the need for any remuneration levels to be justifiable in the context of benchmarking, constraints on the pay of our general staff, and the productivity and efficiency targets which the Trust must meet.

Professor Paul Keane OBE
Chair of the Board's Remuneration Committee, and Chair of the Council of Governors' Remuneration Committee

4.2.2 Senior Management Remuneration Policy

Tables 17 and 18 shown below and overleaf summarise the components of remuneration for the Trust's senior managers and Non-Executive Directors respectively. Differences in policy relating to Directors of Synchronicity Care Ltd (SCL) are noted in the table.

Table 17 - Future Policy– Senior Managers

Component	Alignment to strategic objectives	Rules of operation
Annual salary	Salaries are set at a level capable of attracting and retaining high calibre managers with the skills to develop, direct and implement change in line with the Trust's strategic objectives and underpinning strategic plans.	Annual salaries are fixed. Annual uplifts are agreed by the Board's Remuneration Committee on the basis of recommendations from the Chief Executive, supported by benchmarking, and assessment of performance against objectives reviewed by the whole Committee. For 2017/18, the Committee agreed to an uplift of 1% for all Directors, on the recommendation of the Director of Workforce and OD in line with the national pay award. For the Chief Executive, annual uplifts to the salary are agreed by the Board's Remuneration Committee based upon recommendations from the Chairman, supported by benchmarking and an assessment of performance against objectives reviewed by the whole Committee. The Trust does not set predetermined maximum limits in respect of annual salary increases. Performance against objectives is reviewed over the financial year. The Trust does not apply weightings to particular performance objectives or attach pre-determined levels of increase to particular performance objectives. The Board's Remuneration Committee considers performance against individual objectives, and Directors' contributions to the Trust's overall objectives alongside benchmarking and the prevailing rates of pay for similar posts in neighbouring and similar Trusts; however, none of the Executive Directors' pay is directly linked to performance. The Committee has discretion not to increase salaries where it considers that increases are not merited.

Component	Alignment to strategic objectives	Rules of operation
Access to the NHS Pension Scheme	Determined by the salary level which is set to secure appointments capable of implementing the Trust's clinical and quality strategy.	In line with the rules of the scheme.
SCL Directors	Salary Pension entitlements	Under the company's Articles of Association, Directors salaries are determined by the Trust. This is done through the Board's Remuneration Committee as noted above. The relevant Executive Director transferred to SCL under TUPE on a spot salary and with access to the NHS Pension scheme. Any newly appointed Directors' salaries will be determined as above. Pension entitlements will be accrued in the NEST scheme rather than the NHS Pension Scheme, in line with the rules of that scheme.

There have been no new elements introduced into senior managers' remuneration packages during the year and no changes have been made to existing elements.

The Trust's policy with respect to remuneration of senior managers is consistent with its general policy on employees' remuneration.

Each Director's annual objectives are agreed by the Chief Executive following review and approval of a draft by the Board's Remuneration Committee. The Chief Executive's objectives are agreed by the Chairman following review of a draft by that Committee. The Chief Executive and Executive Directors are appraised annually, with performance against objectives reviewed by the Committee in year. .

Senior managers paid more than £150,000

Three Executive Directors were paid more than £150,000 during 2017/18, comprising the Chief Executive, the Executive Medical Director and the Executive Director of Operations.

The Chief Executive's remuneration was set on the basis of benchmarking information and external advice when she took up her post in 2012, and the level of remuneration was deemed to be that necessary to attract and retain a candidate of suitable calibre.

The remuneration of the Executive Medical Director was – for his duties as Medical

Director - capped at the same level as the previous incumbent and set in line with rates of pay for Medical Directors regionally and nationally. Pay for clinical sessions is in line with that paid to senior consultants within the Trust for similar clinical activities.

The remuneration of the Executive Director of Operations was set on external advice from Gatenby Sanderson who provided benchmarking information to assist the Board's Remuneration Committee in agreeing a remuneration package designed to attract and retain a candidate with suitable skills and experience, recognising both the wide range of responsibilities falling to the Executive Director of Operations and the requirement for the post-holder to deputise for the Chief Executive.

Within the Directors Remuneration Table 22 page 88, the total pay for the Commercial Director, who left during 2016/17, exceeded £150,000. However, the total amount of remuneration included approximately £125,000 compensation for loss of office in line with contractual entitlements.

Table 18 - Future Policy – Non-Executive Directors (NEDs)

Component	Alignment to strategic objectives	Rules of operation
Annual salary	Remuneration is determined at a level capable of attracting and retaining high calibre NEDs with the skills to support the direction and implementation of change in line with the Trust's strategic objectives and underpinning strategic plans.	The Chairman is paid an annual remuneration in accordance with terms and conditions approved by the Council of Governors. Non-Executive Directors' remuneration is specified in their contracts, and agreed with the Council of Governors. All NEDs receive the same basic salary, set in accordance with regional and national benchmarking.

Component	Alignment to strategic objectives	Rules of operation
Additional salary payments for additional responsibilities	Payable in respect of additional time required from NEDs to chair Committees which are closely involved in scrutinising the achievement of strategic objectives and the management of strategic risk or to fulfil duties on behalf of the Trust with external stakeholders which further the strategy.	Any such additional payments must be recommended by the Council of Governors' Remuneration Committee and approved by the Council of Governors. All NEDs now chair Board Committees and / or have other elements of additional responsibility. Such payments currently do not exceed £3,500 and have been frozen for the next three years.
SCL Directors	Salary Responsibility allowance	The Chairman of SCL's pay is aligned to the salary paid to Trust Non-Executive Directors, adjusted for any difference in the expected time commitment. No responsibility allowance is paid. There is no payment to the Trust's Non-Executive Director appointed to the SCL Board. Payment is deemed to be covered by his responsibility allowance paid through the Trust. Decisions on SCL Director's pay are made by the Trust's Board rather than the Council of Governors.

Annual performance objectives for Trust Non-Executive Directors are agreed with the Chairman by the Council of Governors' Remuneration Committee. The Committee appraises the Chairman's performance annually, a process facilitated by the Senior Independent Director.

Trust Non-Executive Directors' objectives are set annually by the Chairman. Annual performance evaluations are carried out by the Chairman and reported to the Council of Governors' Remuneration Committee. For 2018/19, the Chairman is to be supported by two senior Governors in undertaking Non-Executive Directors' appraisals.

Service contracts obligations

There are no specific service contract obligations in the senior managers' contracts other than the six month notice period for Executive Directors and for the

Workforce & Organisation Development Director, together with standard national NHS redundancy provisions. It is not proposed that any others will be entered into. The standard national NHS redundancy provisions are capped and the Trust has applied this cap in its contracts with senior managers.

Policy on payments for loss of office

The principles on which determination of pay for loss of office will be based are as detailed above although the Board's Remuneration Committee and the Council of Governors' Committee can apply some discretion as they consider necessary. Senior manager performance is not formally relevant in the exercise of discretion, although it is likely to be taken into account. Any severance payment outside of contractual terms must be approved by the Board's Remuneration Committee following receipt of appropriate advice and any required regulatory approval.

Consideration of employment conditions elsewhere in the Trust

The pay and conditions of other employees were considered when setting the pay and conditions of senior managers to ensure that they were in keeping save for any differences arising from specific circumstances.

The Foundation Trust did not consult employees when setting the senior managers remuneration policy. However, as noted above, in 2017/18, pay increases for senior managers were limited to 1% in line with the national pay award to NHS staff.

No external advice was taken in respect of senior managers' and Non-Executive Directors remuneration during the year. Non-Executive Directors remuneration was subject to a triennial review based on external benchmarking of remuneration.

4.2.3 Annual Report on Remuneration

Table 19 shown below summarises the components, contract terms and notice periods for those senior managers and Non-Executive Directors serving all or part of 2017/18:

Table 19 - Senior Managers' Service Contracts

Name	Contract date	Term / expiry	Notice period
Mrs S Jacques, Chief Executive	01/03/12	Permanent contract	Six months
Mr P Dawson, Executive Director of Finance (to Trust 30th June 2017)	25/04/13	Permanent contract	Six months
Mr D Brown, Executive Director of Finance (from 25th May 2017)	25th May 2017	Permanent contract	Six months
Mr J Cundall, Executive Medical Director	01/03/17	Permanent contract	By agreement.
Mrs C Langrick, Executive Director of Operations	09/02/15	Permanent contract	Six months
Mr N Scanlon, Executive Director of Nursing	04/06/15	Permanent contract	Six months
Mrs M Smith, Workforce and Organisation Development Director	01/06/15	Permanent contract	Six months
Professor P Keane OBE (Chairman)	1 March 2015 1 March 2018 (reappointed in year)	28 February 2018 28 February 2021	None specified
Mr M Bretherick, Non-Executive Director	01/06/16	31/05/19	None specified
Mrs J Flynn MBE, Non-Executive Director	1 October 2014 1 October 2017 (reappointed in year)	30 September 2017 30th September 2020	None specified
Mr P Forster-Jones, Non-Executive Director	01/06/16	31/05/19	None specified
Dr I Robson, Non-Executive Director (to 31st May 2017)	1 June 2016 (reappointment)	31/05/17	None specified
Mr S Gerry, Non-Executive Director	01/06/17	31/05/20	None specified
Mr A Young, Non-Executive Director	1 June 2016 1 June 2017 (reappointed in year)	31 May 2017 31 May 2018	None specified

There appointments of Mr Brown and Mr Dawson overlapped to allow for a handover period.

4.2.4 Membership of the Remuneration Committees

Membership of the two Remuneration Committees is provided in Table 20 shown below.

Table 20 – Remuneration Committee Membership

Board Remuneration Committee		Council of Governors Remuneration Committee	
Member	**Meetings attended**	**Member**	**Meetings attended**
Prof. P Keane OBE	3/3	Prof. P Keane OBE	3/3
Mr M Bretherick	3/3	Mr H Ballantyne, Public Governor, Sedgefield	1/3
Mrs J Flynn MBE	3/3	Dr K Davison, Public Governor, Wear Valley and Teesdale	2/3
Mr P Forster-Jones	3/3	Ms P Gordon, Staff Governor, Nursing and Midwifery	2/3
Dr I Robson	1/1	Dr D Laird, Staff Governor, Medical and Dental	0/3
Mr S Gerry	1/2	Dr C Martin-Ruiz, Public Governor, Chester le Street	1/3
Mr A Young	3/3	Dr R Scothon, Public Governor, Durham City	3/3
		Ms C Woolley-Brown, Public Governor, Wear Valley and Teesdale (to 16th October 2017)	1/1
		Mr N Williams, Staff Governor, Administrative, Clerical and Management	3/3

The Board's Remuneration Committee met on the following dates during the year:

- 16th May 2017;
- 7th November 2017; and
- 14th March 2018.

The Council of Governors' Remuneration Committee met on the following dates during the year

- 11th September 2017
- 11th December 2017
- 23rd January 2018

4.2.5 Expenses paid to Governors and Directors

Governors may claim for basic expenses necessarily incurred in the performance of their duties (such as mileage to and from meetings) in accordance with Trust policies and in compliance with HMRC regulations or other legislation. Mileage and travel expenses are reimbursed in line with the standard rates applied for NHS staff. The time and travel commitment for each Governor differs, depending on which committees they must attend and the location of the meetings/events attended on behalf of the Trust.

Directors may claim reimbursement for basic expenses necessarily incurred in the performance of their duties. Expenses are claimed in compliance with Trust policies and (where applicable) are subject to income tax and national insurance deduction in accordance with HMRC regulation and other legislation.

Table 21 – Expenses paid to Governors and Directors

	2017/18			2016/17		
	Number in office	Number claiming expenses	Total sum paid £'00	Number in office	Number claiming expenses	Total sum paid £'00
Governors	35	13	30	30	12	42
Directors	16	13	100	17	14	181

4.2.6 Senior Managers' Remuneration and Fair Pay Multiple

Information in this section has been subject to audit as part of the external audit of the Trust's financial statements

Table 22 – Salary and Pension-related Benefits of Senior Managers

2017-18		Salary banding £'000s	Taxable expenses and benefits in kind £'000s	All pension-related benefits £'000s	Total £'000s	Effective period
		nearest £5,000	nearest £100	nearest £2,500	nearest £5,000	
Mrs S Jacques	Chief Executive	200-205	0	57.5-60	260-265	
Mrs M Smith	Director of Workforce and Organisation Development	110-115	0	25-27.5	135-140	
Mr N Scanlon	Executive Director of Nursing and Patient Experience	125-130	0	52.5-55	180-185	
Mr P Dawson	Executive Director of Finance	30-35	0	-1.0-1.25	25-30	To 30th June 2017
Mr D Brown	Executive Director of Finance	100-105	0	137.5-140.0	240-245	From 25th May 2017
Mrs C Langrick	Executive Director of Operations	150-155	0	0	150-155	
Mr J Cundall	Executive Medical Director	165-170	0	400-400.25	565-570	
Miss A McCree	Director - SCL	100-105	2	67.5-70.0	170-175	SCL
Prof P Keane	Chairman	55-60	0	0	55-60	
Mr A Young	Non-Executive Director	15-20	0	0	15-20	
Mrs J Flynn	Non-Executive Director	15-20	0	0	15-20	
Mr M Bretherick	Non-Executive Director	15-20	0	0	15-20	
Mr P Forster-Jones	Non-Executive Director - Trust and SCL	20-25	0	0	20-25	
Mr S Gerry	Non-Executive Director	15-20	0	0	15-20	From 1st June 2017
Dr I Robson	Non-Executive Director of the Trust	0-5	0	0	0-5	To 31st May 2017
Dr I Robson	Chairman - SCL	10-15	0	0	10-15	From 1st June 2017

2016-17		Salary banding £'000s	Expense payments	All pension-related benefits £'000s	Total £'000s	Effective period
Mrs S Jacques	Chief Executive	200-205	0	55.0-57.5	255-260	
Mrs M Smith	Director of Workforce and Organisation Development	105-110	0	25.0-27.5	135-140	
Mr P Dawson	Executive Director of Finance	120-125	0	27.5-30.0	150-155	
Mr N Scanlon	Executive Director of Nursing and Patient Experience	125-130	0	75.0-77.5	200-205	
Mrs C Langrick	Executive Director of Operations	145-150	0	0	145-150	
Prof C Gray	Executive Medical Director	185-190	0	0	185-190	To 28th February 2017
Mr J Cundall	Executive Medical Director	10-15	0	20.0-22.5	35-40	From 1st March 2017
Miss A McCree	Director of Estates and Facilities	100-105	10.0	102.5-105.0	200-205	
Mr T Hunt	Commercial Director	155-160	0.0	0	155-160	To 30th June 2016
Prof P Keane	Chairman	50-55	0	0	50-55	
Mr A Young	Non-Executive Director	15-20	0	0	15-20	
Mrs J Flynn	Non-Executive Director	15-20	0	0	15-20	
Mrs L Snowball	Non-Executive Director	0-5	0	0	0-5	To 31st May 2016
Dr I Robson	Non-Executive Director	20-25	0	0	20-25	
Dr R Waterston	Non-Executive Director	0-5	0	0	0-5	To 31st May 2016
Mr M Bretherick	Non-Executive Director	15-20	0	0	15-20	From 1st June 2016
Mr P Forster-Jones	Non-Executive Director	15-20	0	0	15-20	From 1st June 2016

In addition to his role as Executive Medical Director, Mr Cundall has continued to practice as a Colorectal Surgeon within the Trust. The salary and total pay quoted in the table above cover both roles, with £150,155 relating to his Executive role, and the remaining £19,019 relating to his clinical role.

Total remuneration includes salary, non consolidated performance related pay, benefits in kind, but not severence payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Where senior managers in the above table are members of a the NHS Pension Scheme, pension-related benefits have been determined in accordance with the rules set out, for defined benefit schemes, in the Foundation Trust Annual Reporting Manual. These include:

- The increase in the lump sum which would be payable to the individual, calculated by comparing the amount payable at the beginning and end of the year;
- The increase in the pension-benefit payable, calculated in the same way, extrapolated over an assumed 20 year payment period.

The application of the assumed 20-year payment period for pension benefits can therefore result in significant increases in benefits for senior managers that have received increases in salary as a result of promotions or additional responsibilities taken on during the year. The amounts should not be confused with monetary contributions paid into a defined contribution scheme.

The Board's Remuneration Committee has determined that, in the light of the assets managed by Synchronicity Care Ltd since 1st April 2017 and the Trust's dependence on the estates, facilites and services provided from that date by 1st April 2017, the Directors of SCL – namely Dr I Robson and Miss A McCree exercise significant inluence on group operations and strategy and should therefore be included in the above table. Prior to the transfer of estates, facilities and procurement services to SCL on 1st April 2017, SCL existed only as a small-scale trading venture with marginal impact on the Trust and the wider Group's operations.

Ms A McCree left the Trust to become a full-time Director of its subsidiary company, Synchronicity Care Ltd with effect from 1st April 2017. Dr I Robson ceased to be a Non-Executive Director of the Trust from 31st May 2017, but remained as the Chairman of SCL.

Nine employees earned more than the highest paid director.

The midpoint of the banded remuneration of the highest paid director during 2017/18 was £202,500 (2016/17: £202,500). This is 8.0 times (2016/17: 8.0 times) the median remuneration of the workforce, which was £25,298 (2016/17 £25,298). The calculation includes remuneration based on the whole time equivalent of all staff employed within the CDDFT Group at 31st March 2018.

Senior Managers' Total Pension Entitlements

Information in Table 23 below/overleaf has been subject to audit as part of the external audit of the Trust's financial statements.

Table 23 – Pension Benefits

Name and title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2018	Lump sum at pension age related to accrued pension at 31 March 2018	Cash Equivalent Transfer Value at 31 March 2018	Cash Equivalent Transfer Value at 01 April 2017	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension
	(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	£000	£000	£000	To nearest £100
CDDFT								
Mrs S Jacques	2.5-5.0	0.0-2.5	60-65	155-160	1091	1,000	81	0
Mr N Scanlon	2.5-5.0	7.5-10.0	50-55	155-160	1139	1,007	122	0
Ms M Smith	0.0-2.5	0.0-2.5	5-10	0-5	71	44	26	0
Mr P Dawson (left 30 June 2017)	0.0-2.5	0.0-2.5	50-55	155-160	0	1,042	-265	0
Mr J Cundall	17.5-20	30-35	55-60	130-135	852	548	299	0
Mr D Brown (from 25 May 2017)	5.0-7.5	15-17.5	35-40	85-90	518	392	104	0
SCL								
Ms A McCree	2.5-5.0	5.0-7.5	40-45	110-115	765	661	98	0
Total	**40-42.5**	**67.5-70.0**	**305-310**	**805-810**	**4,436**	**4,695**	**463**	**0**

4.2.7 Payments for loss of office and payments to previous senior managers

There were no payments for loss of office or payments to previous senior managers made during 2017/18.

Chief Executive
Date: 24th May 2018

4.3 Staff Report

4.3.1 Analysis of Staff Costs

Table 23 – Staff Costs	2017/18				2016/17
	Total	Permanently employed total	Business with other WGA bodies (permanently employed)	Business with bodies external to Government (permanently employed)	Total
Staff costs	**£000**	**£000**	**£000**	**£000**	**£000**
Salaries and wages	239,353	239,353		239,353	234,011
Social security costs	21,308	21,308	21,308		22,170
Apprenticeship levy	1,061	1,061	1,061		
Pension cost - employer contributions to NHS pension scheme	25,892	25,892	25,892		27,179
Pension cost - other					
Other post employment benefits					
Other employment benefits					
Termination benefits	88	88		88	1,001
Temporary staff - external bank					
Temporary staff - agency/contract staff	11690				18,224
TOTAL GROSS STAFF COSTS	**299,392**	**287,702**	**48,261**	**239,441**	**302,585**
Recoveries from DHSC Group bodies in respect of staff cost netted off expenditure	-122	-122		-122	
Recoveries from other bodies in respect of staff cost netted off expenditure	-67	-67		-67	
TOTAL STAFF COSTS	**299,203**	**287,513**	**48,261**	**239,252**	**302,585**
Included within: Costs capitalised as part of assets	665	665		665	421

4.3.2 Analysis of Average Staff Numbers

The staff group breakdown is based on the average staffing count throughout the financial year. These figures include staff that have transferred out of the Trust and highlight fluctuations due to starters and leavers. The analysis is provided separately for Trust employed and subsidiary employed staff.

Table 25 – Average Staff Numbers

TRUST Staff Report for Y/E 31st March 2018	Permanent Staff		Temporary Staff	
Staff Group	**Average Headcount**	**Average FTE**	**Average Headcount**	**Average FTE**
Add Prof Scientific and Technic	190	169	4	3
Additional Clinical Services	1,390	1,193	61	45
Administrative and Clerical	1,316	1,137	68	59
Allied Health Professionals	387	330	16	11
Estates and Ancillary	54	44	1	1
Healthcare Scientists	149	135	4	3
Medical and Dental	364	333	182	171
Nursing and Midwifery Registered	2,223	1,952	103	62
Students	5	5	7	7
All Staff Average	**6,079**	**5,297**	**446**	**361**

SCL Staff Report for Y/E 31st March 2018	Permanent Staff		Temporary Staff	
Staff Group	**Average Headcount**	**Average FTE**	**Average Headcount**	**Average FTE**
Additional Clinical Services	9	6	1	0
Administrative and Clerical	80	78	2	2
Estates and Ancillary	366	296	5	4
Healthcare Scientists	13	13	1	0
Nursing and Midwifery Registered	1	1		
All Staff Average	**469**	**394**	**10**	**6**

4.3.3 Breakdown of Staff

Table 26 – Breakdown of staff

TRUST Gender Summary as at 31st March 2018	Female	Male
Directors	**3**	**8**
• Non-Executive Director/Chair	1	5
• Executive Directors	2	3
Senior Managers/Managers	**162**	**75**
• Senior Managers Including Other Directors	75	45
• Managers B6+	60	24
• Nurse Managers B6+	27	6
All Other Employees	**5,321**	**912**
All Staff	**5,486**	**995**

SCL Gender Summary as at 31st March 2018	Female	Male
Directors	**1**	**2**
• Non-Executive Director/Chair		2
• Executive Directors	1	
Senior Managers/Managers	**12**	**9**
• Senior Managers Including Other Directors	7	9
• Managers B6+	5	
• Nurse Managers B6+		
All Other Employees	**363**	**147**
All Staff	**376**	**158**

The gender summary details the number of female/male staff in post on 31st March 2018. Staff members are only counted once where they hold they hold multiple posts in the organisation.

4.3.4 Sickness Absence Data

The absence summary details the total number of absences due to sickness over the financial year broken down into long and short term episodes and by staff group. The analysis shows CDDFT staff and the Trust's subsidiary company's staff separately.

Table 27 – Staff Absence Summary

TRUST Absence Summary as at 31st March 2018			
Staff Group	**Absence Occurrences**	**LT Absence Occurrences**	**ST Absence Occurrences**
Add Prof Scientific and Technic	232	26	206
Additional Clinical Services	2,325	327	1,998
Administrative and Clerical	1,116	199	917
Allied Health Professionals	420	50	370
Estates and Ancillary	54	14	40
Healthcare Scientists	137	11	126
Medical and Dental	327	26	301
Nursing and Midwifery Registered	3,133	447	2,686
Students	0	0	0
Grand Total	**7,744**	**1,100**	**6,644**

SCL Absence Summary as at 31st March 2018			
Staff Group	**Absence Occurrences**	**LT Absence Occurrences**	**ST Absence Occurrences**
Additional Clinical Services	10	3	7
Administrative and Clerical	63	5	58
Estates and Ancillary	490	102	388
Healthcare Scientists	5	0	5
Nursing and Midwifery Registered	1	0	1
Grand Total	**569**	**110**	**459**

4.3.5 Staff Policies and Actions

Relevant policies and procedures are set out in Section 3.2.4 of our annual report: Social, Community and Human Rights Issues.

4.3.5.1 Disabled Persons

Our policies and procedures, and developments in year have been summarised in Section 3.2.4 of our annual report: Social, Community and Human Rights Issues.

4.3.5.2 Employee Communications, Consultation, Involvement and Engagement

We have continued to work closely with Staff Side Representatives and meet regularly in a joint forum, to ensure that employment policy, practice and delivery of service change, which inevitably impacts on the workforce, are well managed. The Trust's Joint Consultative and Negotiating Committee meets on a bi-monthly basis, and covers matters such as Trust performance, consultation on service

changes, and impacts on employees.

This established joint process has served us well when managing organisational change or undertaking actions affecting the interests of staff and we will continue to take the same partnership approach in the coming year. As the Trust progresses work on its clinical services strategy, we are actively consulting with, and involving our clinical teams in developing future service models.

The Trust's people strategy "Staff Matter" sets out the strategic workforce priorities for 2017–2020 (reviewed annually) and the work that is required to realise our workforce ambitions.

Staff Matter is bold, ambitious and visionary and builds upon the excellent foundations which we have put in place during previous years. It seeks to develop and sustain a workforce able to operate effectively, in a culture where "can do" becomes the norm. Staff Matter provides a framework for the development of local workforce strategies and plans which have been owned and delivered by all Corporate and Care Group services to ensure a consistent and high quality employment experience for all of our staff.

To realise our aim of becoming a Best Employer we aim to create a workforce that, as well as being engaged, resilient and competent is also agile and prepared to adapt to a health service that continues to experience unprecedented change. We empower both managers and staff to enable them to do their best and provide high standards of service and care for our patients. This aim is underpinned by six key objectives:

- Recruit and attract our workforce;
- Develop Talent;
- Support and embed a high performance culture;
- Maintain workforce health and wellbeing;
- Develop our supporting infrastructure; and
- Create a workforce for the future.

The Trust has continued to strengthen programmes in place to support, engage and communicate with staff as outlined below.

Retention Strategy

A strategy, "Retention – Through Your Eyes", which outlines our approach to addressing areas of high staff turnover was developed during 2017/18 and will inform activity for 2018/19. The strategy was designed in partnership with our dedicated employees who shared their experiences of working for the Trust. Their feedback will be used to assist us in celebrating our successes and in developing effective and innovative approaches to improve retention. Ultimately, our aim is to create a working environment in which all our staff can reach their potential, remain motivated and productive, whilst creating a workplace in which staff can thrive and continue to achieve their goals year on year.

An Implementation Plan has been created setting out key activities to address our retention challenges. These activities are out across seven main themes (domains):

- Reward, Recognition & Appreciation;
- Staffing Levels;

- Flexible Working;
  - Equipment / Facilities & Physical Working Environment,
  - Communication & Engagement;
  - Learning Organisation;
  - Leadership / Management Practices.

The primary purpose of our Retention strategy is establish a Trust-wide framework for local plans that will help Care Groups and directorates to improve and sustain retention levels. Whilst voluntary turnover within the Trust benchmarks reasonably, both regionally and nationally, and is within the target we have set, it is vital that we maximise staff retention given shortages of supply for some medical and nursing staff especially. Our strategy will remain flexible to meet the needs of the organisation taking into account the future agendas for healthcare organisations as articulated within the NHS Five Year Forward View. The Trust will make reference to lessons learned from national reports where staffing has been a focus; for example, the Cavendish Review and Francis Report.

In addition, the Trust will build upon the positive feedback gained from focus groups held in the year. Key themes identified from feedback will inform the Implementation Plan to ensure ongoing improvement and positive reporting.

To build upon the foundations of this strategy and ensure that learning is taken from many sources the Trust has attended national events and participated in programmes of work with both NHS Employers and NHS Improvement. This latter programme of work saw the design of the national Retention Toolkit, and provided a useful and informative opportunity to benchmark our approach together with the sharing of good practice from nationally.

Supporting line managers in engaging with their staff

The Trust recognises the importance of great line management in staff engagement and provides a comprehensive range of leadership and management development programmes: These include: the Strategic Leadership Development Programme, which covers a range of strategic leadership topics and is designed as a foundation programme for leaders, both clinical and non-clinical; the Great Line Management Fundamentals programme which consists of a portfolio of activities designed to develop managers as leaders and prepare them for the Strategic Leadership Development Programme; and Senior Manager and Heads of Department monthly meetings with the Chief Executive and Board which offer an opportunity for open, two-way discussions on important topical issues. In addition to the internal Leadership and Management Development programmes staff are encouraged to attend the programmes offered by the North East Leadership Academy.

Other supporting developments

The Staff Annual Awards programme recognises staff for their outstanding contribution in eight categories which are: the Shining Star Award; the Making a Difference Award; the Supporting Change Award; Research and Innovation; the Enhanced Patient Care Award; the Chief Executive's Team Award; the Governors' Making You Feel Better Award, and the Chairman's Quality Award. In addition Learner and Service Loyalty awards are also

awarded.

Given the unprecedented change facing the NHS, staff development sessions promoting personal resilience strategies have continued and due to high levels of demand, additional sessions were added to the Lifelong Learning Directory to support the workforce to develop coping strategies in a changing environment. These will continue to be offered throughout the coming year.

'Breakfast with Sue' provides a random selection of staff with a genuine opportunity to meet the Chief Executive and talk to her about working life at the Trust. These events were held each month during 2017/18 and were small and personal rather than a large group event, thereby providing every attendee the chance to speak. Latterly the Chairman has supported the Chief Executive at these events, to hear staff views first hand. In addition, Board members undertake frequent visits to wards and teams, on both our acute and community sites, to meet with staff members, listen to any concerns and observe the excellent and compassionate care which they provide.

4.3.5.3 Information on Health and Safety Performance

Compliance with Health and Safety legislation and regulations has continued to be monitored and managed by the Trust's specialist Health and Safety Team. The team investigates all staff-related and contractor/visitor incidents and accidents, monitors trends and, as part of a rolling programme, audits each ward and team's risk assessments and local safety documentation.

Reports are produced for the each Care Group to support learning and action to maintain a safe working environment, including implementation of safety measures in their areas of responsibility.

During 2017/18, there were 543 staff and 55 contractor/visitor accidents/incidents reported, excluding incidents involving security and violence and aggression.

There has continued to be a decrease in the number of incidents reported to the Health and Safety Executive with regards to Reporting of Injuries, Diseases & Dangerous Occurrences Regulations 1995 (RIDDOR) incidents. Over the last 12 months the department has investigated a total of 15 RIDDOR-reportable incidents; this is a decrease on the 25 RIDDOR-reportable incidents reported in 2016/17.

Following the Trust's Core Essential Training programme being aligned to the UK Core Skills training Framework, all staff were provided with fire training during 2017/18. Health & Safety and Fire training is also provided to all new staff and volunteers as part of the Trust's Corporate Induction Training.

In the last 12 months the Health and Safety Team have audited local safety documentation and risk assessments, including those relating to use of Display Screen Equipment and control of substances hazardous to health, in 116 wards and departments. All managers were advised of any corrective actions to improve their health and safety.

There have been no Health and Safety Executive (HSE) inspections in 2017/18 and no Improvement or Enforcement Notices issued during the last 12 months.

The Trust remains committed to providing a safe and healthy working environment to minimise risks, incidents of fire and false alarms through training and education. All sites are audited with continuous improvements implemented in fire detection, and in reduction and elimination of fire risks and unwanted fire alarms.

Two Committees oversee Health and Safety and Security.

The Health & Safety Committee, which

- meets on a quarterly basis with staff, unions and PFI staff in attendance;
- monitors Health and Safety incidents/ accidents, trends and audits;
- initiates actions and recommendations to improve staff health, safety and wellbeing; and
- escalates any serious issues to the Risk Management Committee.

The Security Group, which:

- meets on a quarterly basis with staff, PFI staff and the local Police in attendance;
- discusses security incidents/ accidents and implements remedial actions where appropriate; and
- escalates serious issues to the Risk Management Committee.

4.3.5.4 Staff Health and Wellbeing

The Trust is fully committed to supporting and improving the health and wellbeing of all employees to enhance staff engagement and reduce sickness absence rates, by promoting collaborative working relationships and work environments that encourage wellbeing. This, in turn, helps to facilitate the delivery of quality and safe patient care through improved attendance and motivation.

The Staff Health and Wellbeing (SH&WB) Occupational Health Service strives to maintain the highest degree of health, safety and wellbeing of all staff by working in partnership with all employees, line managers and Workforce & Organisational Development (OD) Colleagues to achieve a healthy working environment.

A SH&WB Strategy is in currently in place which describes the aims of the Trust for a healthy workforce and is underpinned by a three year Action Plan (2016–2019) both of which will be reviewed in 2018. The SH&WB Action Plan supports and reinforces the SH&WB Strategy and includes key priorities to ensure that staff are engaged in their health and wellbeing thus reducing sickness absence rates.

A Health & Wellbeing Working Group monitors the Strategy and Action Plan on a quarterly basis. The group is chaired by the Associate Director of Workforce with representatives from across the Trust.

The Trust's SH&WB Service gained the national accreditation as a Safe, Effective, Quality, Occupational Health Service (SEQOHS) in 2014 (for five years). Annual assessment is undertaken and re-accreditation is awarded and a full and comprehensive five-year assessment will take place in 2019.

The Trust has various policies in place that offer support to staff throughout their employment within the Trust including: Flexible Working Policy, Dignity

at Work Policy, Supporting Staff Involved in Potentially Traumatic Stressful Work Related Incidents Policy; Management of Stress in the Workplace Policy; Parental Policy; Management of Attendance Policy; Rehabilitation and Redeployment Policy.

A full Employee Assistance Programme is available to all staff. This is a free, confidential, information and counselling service available via a free-phone number 24 hours a day, 365 days a year.

A Clinical Psychologist has been in post since January 2017 and has worked closely with teams, colleagues in Workforce & Organisation Development, line managers and individual staff to offer advice, guidance and sign-posting to relevant services, particularly for mental health conditions including work related stress/ other stress, and to enable quick brief intervention strategies for staff to either remain at work or to return to work in a timely manner. A Physiotherapist joined the team in May 2017, and, in a similar way, has worked with various staff groups and colleagues providing a service for staff who may suffer from Musculoskeletal (MSK) Conditions.

During 2017/18 the Trust was once again awarded 'Continuing Excellence Status' from the North East Better Health at Work Awards. This is for the fifth consecutive year and followed both local and regional assessment. Health Advocates are in place and they support the SH&WB team in promoting health and wellbeing to colleagues throughout the Trust playing an integral part in organising health and wellbeing events throughout the year. We carried out a variety of health campaigns in 2017/18 including Stop Smoking, Carbon Monoxide Monitoring, Step Challenge, Cycling Skills, Mental Health Awareness, the Annual Flu Vaccine Campaign and eight Staff Health & Wellbeing Road-shows at which over 1,000 health and wellbeing packs given to staff

The SH&WB service supports staff by acting as independent advisers to both employees and managers, through early intervention, prevention and rehabilitation and provision of advice and guidance for staff to improve their health and wellbeing. The SH&WB Service works closely with other services in the Trust, in particular Workforce & Organisation Development; the, Back Care Advisory Service; Infection Control; Microbiology, and Health & Safety to ensure a safe and secure environment for patients, visitors and staff.

4.3.5.5 Information on Policies and Procedures with respect to Countering Fraud and Corruption

The Trust's counter fraud service is provided by Audit One, an NHS shared service providing internal audit, IT audit and counter fraud services to the public sector in the North of England. We have an Anti-Fraud Policy in place which outlines our approach to fraud and identifies the specified fraud reporting lines. In addition, we have a Raising Concerns (Whistleblowing) Policy which provides contact details for reporting concerns in respect of any potentially fraud related issues. This has been updated in line with the NHS national whistle-blowing policy. Our Local Counter-Fraud Specialist (LCFS) reports to the Audit Committee and performs a programme of work designed to provide assurance to the Board with regard to fraud and corruption. The LCFS provides fraud awareness sessions and

induction packs to our staff, investigates any concerns reported by staff and liaises with the national NHS counter fraud service, the Police and the Crown Prosecution Service as appropriate. If any issues are substantiated, we take appropriate criminal, civil or disciplinary measures.

4.3.6 Staff Survey Results

Headline results for the Trust, from the NHS Staff Survey 2017 are reviewed below.

The overall Staff Engagement score was 3.67 (out of 5, where 5 is the most and 1 is least engaged). This was slightly lower than the 2016 score of 3.69 but is not a statistically significant change. The score remains below the national average which is 3.78 for combined acute and community trusts, hence it is clear that we still have work to do to fully engage our staff.

Table 28: NHS Staff Survey 2017 – Response Rates

	2017		2016		Trust improvement/ deterioration
Response Rate	Trust	National Average	Trust	National Average	Improvement
	49%	45%	38%	44%	

The 2017 response rate for the Trust increased by 11% compared to 2016. The Trust's response rate for 2017 was 4% higher than the national average for combined acute and community trusts in 2017.

Areas of Improvement and Deterioration from 2016 to 2017

For 28 of the 32 key findings there was no statistically significant change when comparing the Trust results for 2017 against the Trust results for 2016. For the remaining four key findings one was a positive change and three were negative. The indicator with an improved score was:

- Key Finding (KF)11- The percentage of staff appraised in last 12 months: 90% for 2017 in comparison to 83% in 2016, representing a significant increase.

The areas where staff experience has deteriorated were:

- KF18 – The percentage of staff attending work in the last three months despite feeling unwell because they felt pressure from their manager, colleagues or themselves has increased from 47% in 2016 to 54% in 2017 (the lower the score the better). This is also slightly higher than the national average for 2017 of 53%.
- KF32 - Effective use of patient and service user feedback, for which the 2017 score was 3.58 compared to 3.7 in 2016 and was also below the national average for 2017 of 3.69.
- The percentage of staff experiencing harassment, bullying or abuse from staff increased from 20% in 2016 to 24% in 2017. However, this score was in line with the national average for 2017.

When benchmarking our scores against the national average there was no change in 13 of the key findings; a positive change for six key findings; and deterioration for the remaining 13 key findings.

The tables below summarise the Trust's five top and bottom rankings, noting both the Trust's score and the national average score for combined acute and community trusts, for each indicator.

Table 29 – Top Five Rankings (NHS Staff Survey 2017)

Top 5 ranking scores	2017		2016		Trust improvement/ deterioration
	Trust	National Average	Trust	National Average	
KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	90%	85%	90%	87%	Trust score maintained and increase on national average
KF11. Percentage of staff being appraised	90%	86%	83%	86%	Increase on Trust score and better than national average
KF27. Percentage of staff reporting most recent experience of harassment, bullying or abuse	49%	47%	48%	45%	Increase on Trust score 2016, better than national average
KF16. Percentage of staff working extra hours (the lower score the better).	68%	71%	70%	71%	Improvement on Trust score, better than national average
KF28. % of staff witnessing potentially harmful errors, near misses or incidents in the last month (the lower the better)	25%	29%	28%	24%	Improvement on Trust score better than national average

Table 30 – Bottom Five Rankings (NHS Staff Survey 2017)

Bottom 5 ranking scores	2017		2016		Trust improvement/ deterioration
	Trust	National Average	Trust	National Average	
KF12. Quality of appraisals	2.93	3.11	2.93	3.11	Remained the same as in 2016 and below the national average
KF13. Quality of non-mandatory training, learning or development	3.95	4.06	3.98	4.07	Slight deterioration on 2016, and below the national average
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.5	3.75	3.46	3.71	Slight improvement in Trust score but lower than the national average
KF6. Percentage of staff reporting good communication between senior management and staff	28%	33%	30%	32%	Slight deterioration on 2016 lower than the national average
KF32. Effective use of patient/service user feedback	3.58	3.69	3.7	3.68	Deterioration on 2016 and lower than the national average

Progress

During 2017/18, we continued to focus our efforts on staff engagement activity to improve the responses for staff recommending the Trust as a place to work and receive treatment. Key programmes and work streams that have been undertaken and introduced include:

Staff Matter

The new people strategy Staff Matter was launched on 1 April 2017. This document sets out our strategic workforce priorities for the next three years (reviewed annually) and builds on the foundations that were developed through our outgoing 'Staff Matter' strategy.

Following the launch of the new strategy each Care Group and Corporate area produced a Staff Matter action plan for 2017/18, and these plans have guided Trust-wide and departmental work on staff engagement. The action plans are monitored on a quarterly basis by the Trust's Strategic Change Board and

Integrated Quality Assurance Committee. The plans will be reviewed to reflect current priorities and monitored in the same way throughout 2018/19. Monitoring activity with respect to staff satisfaction will, however, be intensified with respect to those aspects impinging on staff job satisfaction given the survey outcomes noted above.

Staff Survey

The results of the Staff Survey are widely shared with all managers and staff and used to identify the key priorities for the Trust. Staff Matter Action Plans identify the actions necessary to address the issues arising from the staff survey.

In addition to a range of Trust-wide actions we have supported teams/services where issues or concerns have been raised. This has been done by designing and delivering bespoke interventions designed to address the needs of the service. This work will be intensified for 2018/19 in response to the survey outcomes noted above.

Many of the core elements of our staff engagement programme have already been covered in 4.5.3.2 above, including Breakfast with Sue; ward walk-arounds; Senior Manager and Heads of Department Meetings, and Staff Awards. More detail on other elements is noted below:

- **Strategic Leadership Development Programme**
  The Strategic Leadership Programme (SLDP) is a broad framework covering a range of strategic leadership topics and is designed as a foundation programme for leaders, both clinical and non-clinical. The programme focuses on developing effective leadership skills using internationally recognised psychometric tools; evidence based research on leadership; and Trust specific data analysis and feedback metrics; to ensure both theory and practice are considered within the context of CDDFT and the future needs of the Trust. The programme has been rolled out across the Trust, with priority originally being given to the new senior care group management teams. The programme has since been extended to include corporate areas and by the end of March 2018, over 100 senior leaders had benefited from the programme.
- **Leadership Conferences**
  The Trust has a programme of bi-annual Leadership conferences featuring guest speakers from the world of leadership, staff and patient engagement and healthcare. The aims of the sessions are to challenge our thinking around how we operate as leaders at both Trust and individual level. Two conferences took place in 2017/18, with 130 delegates attending and a further two conferences are planned for 2018/19.
- **Developing Managers as Leaders**
  The Great Line Management Fundamentals Programme was rolled out in 2017/18. This programme consists of a portfolio of activities designed to develop managers as leaders and prepare them for the SLDP. Great Line Management Fundamentals focuses on developing an individual's understanding of their role as a manager and the skills needed to influence and work effectively through others; for example, people management skills. The programme offers a comprehensive range of workshops beginning with an introductory day, followed by a series of free-standing modules covering key

areas such as staff engagement, personal resilience, effective communication, workforce policy and processes. In addition to a wide range of workshops, HR for Managers mini guides are available and include information on topics such as recruitment and selection and disciplinary and grievance procedures. The programme has been reviewed and refreshed to meet the changing needs of the organisation.

- **Talent Management**
  The Trust has taken an inclusive approach to talent management which consists of a "grow your own" approach coupled with a new graduate trainee programme designed to attract talent from outside of the organisation. The first two graduates were recruited in January 2017 and have taken up posts in Surgery and Acute and Emergency Care. The newly recruited graduate management trainees have been provided with a high level of support in the form of a Leadership Mentor, Clinical Mentor, Coach and Programme Manager. Both have had a very successful year.

  Under the umbrella of "grow your own" further work has been undertaken during 2017/18 particularly with the introduction of the apprenticeship levy which is now being used to develop career pathways for all key roles across the Trust. Current pathways include Nursing, Leadership and Management, Procurement and Pathology and we have staff enrolled on 20 different apprenticeships at present with more to be introduced during 2018/19. Our apprenticeship programmes currently offer opportunities in Health Care; Business Administration; Management; IT; Cyber Security; Workforce; Customer Service and Accountancy.

- **Personal Resilience**
  Given the unprecedented change facing the NHS, staff development sessions promoting personal resilience strategies have continued throughout 2017/18. .

- **Appraisal**
  For the past two years the Trust has had 95% rate of appraisal completion; however staff survey feedback has shown that the quality of appraisal needs to be improved. In response to this feedback, The Appraisal Framework; Role Review and Aspiration Discussion has been developed which sets out a new approach for the Trust. Following on from the development of team objectives, the focus of the appraisal is on the value of the conversation with individuals. A collaborative approach to the appraisal will be encouraged and the appraisal will consider not just performance, but also future aspirations and possible career progression, leading to meaningful and tailored personal development plans for individuals. Guidance has been developed and Appraiser and Appraisee training has been refreshed to reflect the new approach, with the first training sessions taking place in March 2018. The new process will be fully rolled out from April 2018.

- **Equality, Diversity and Inclusion**
  Full details of the development of our Equality, Diversity and Inclusion Strategy, and our performance have been set out in Section 3.2.4 above.

Key priorities for staff engagement, moving into 2018/19 include:

- Roll out of the revised appraisal

process as part of the Trust's wider approach to talent management;

- Further development of our talent/ career pathways for all staff roles;
- Continuation of our inclusive approach to talent management which consists of a "grow your own" approach utilising the apprenticeship levy;
- Continued roll-out of the Trusts comprehensive leadership and management programmes covering all managers and leaders;
- Piloting of the "Shadow Board" Programme, which allows aspiring Directors to better understand the wider role of a Board member and to experience working as a Board, on behalf of the northern region;
- Taking part in the "Building Leadership for Inclusion" pilot which will help us to inform our ED&I priorities going forward; and
- Establishing the Strategic ED&I Group and the ED&I Working Group.

4.3.7 Expenditure on Consultancy

Expenditure on consultancy for the year amounted to £66,420 (2016/17: £45,445). This is not directly comparable with the expenditure reported in the Trust's Annual Accounts for 2017/18, which includes expenditure not covered by the agreed definition for reporting purposes.

4.3.8 Off Payroll Engagements

Table 31: For all off-payroll engagements as of 31 Mar 2018, for more than £245 per day and that last for longer than six months	2017/18 Number of engagements Number
No. of existing engagements as of 31 Mar 2018	0
Of which:	
Number that have existed for less than one year at the time of reporting	0
Number that have existed for between one and two years at the time of reporting	0
Number that have existed for between two and three years at the time of reporting	0
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of reporting	0

Table 32: For all new off-payroll engagements, or those that reached six months in duration, between 01 Apr 2017 and 31 Mar 2018, for more than £245 per day and that last for longer than six months	2016/17 Number of engagements Number
Number of new engagements, or those that reached six months in duration between 01 Apr 2017 and 31 Mar 2018	0
Of which:	
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	0
Number engaged directly (via PSC contracted to trust) and are on the trust payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 33: For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 Apr 2017 and 31 Mar 2018	2017/18 Number of engagements Number
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility". This figure should include both off-payroll and on-payroll engagements.	11

All Agency posts have been assessed and established to not be outside the remit of IR35 and all shifts are paid following deduction of the required deductions.

4.3.9 Exit Packages

Exit packages are summarised below. Redundancy and other departure costs have been paid in accordance with the provisions of the appropriate scheme. Exit costs provided are the full costs of departures agreed in the year. Where CDDFT has agreed early retirements, the additional costs are met by CDDFT and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

Table 34 - Exit Packages 2017/18

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
Exit package cost band (including any special payment element)			
<£10,000	5	32	**37**
£10,001 - £25,000	3	5	**8**
£25,001 - 50,000	4	-	**4**
£50,001 - £100,000	2	-	**42**
£100,001 - £150,000	-	-	**0**
£150,001 - £200,000	1	-	**1**
>£200,000	-	-	**0**
Total number of exit packages by type	**15**	**37**	**52**
Total resource cost (£)	£490,000	£164,000	**£654,000**

Comparative information is provided below:

Table 35 - Exit Packages 2016/17

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
Exit package cost band (including any special payment element)			
<£10,000	10	51	**61**
£10,001 - £25,000	7	3	**10**
£25,001 - 50,000	3	3	**6**
£50,001 - £100,000	3	1	**4**
£100,001 - £150,000	-	1	**1**
£150,001 - £200,000	1	-	**1**
>£200,000	-	-	**-**
Total number of exit packages by type	**24**	**59**	**83**
Total resource cost (£)	£676,000	£527,000	**£1,203,000**

Table 36 – Exit packages: non-compulsory departure payments

	2017/18	
	Payments agreed	Total value of agreements
	Number	£0.00
Voluntary redundancies including early retirement contractual costs	-	-
Mutually agreed resignations (MARS) contractual costs	-	-
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice*	37	164
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval**	-	-
Total	**37**	**164**
Of which:		
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-

Comparative information is provided below:

	2016/17	
	Payments agreed	Total value of agreements
	Number	£0.00
Voluntary redundancies including early retirement contractual costs	-	-
Mutually agreed resignations (MARS) contractual costs	-	-
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice*	37	164
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval**	-	-
Total	**37**	**164**
Of which:		
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-

As a single exit package can be made up of several components each of which will be counted separately, the total numbers above will not necessarily match the total numbers in the exit packages table which will be the number of individuals.

*any non-contractual payments in lieu of notice are disclosed under "non-contractual payments requiring HMT approval" below.

**includes any non-contractual severance payment following judicial mediation, and non-contractual payments in lieu of notice. No (zero) non-contractual payments were made to individuals where the payment value was more than 12 months' of their annual salary.

The remuneration report includes disclosure of exit payments payable to individuals named in that report.

4.4 The NHS Foundation Trust Code of Governance Disclosures

The NHS Foundation Trust Code of Governance ("the Code") is published by NHS Improvement. Its purpose is to further the development of corporate governance in individual Foundation Trusts by making Governors and Directors aware of the principles of good governance and how to develop best practice in their application.

The Board ensures compliance with the Code through the arrangements it puts in place for its governance structures, policies and processes and how it keeps them under review. These arrangements are set out in documents that include:

- The Constitution;
- Schedule of Matters Reserved to the Board;
- Standing Orders;
- Standing Financial Instructions;
- Scheme of Delegation and Decisions Reserved to the Board;
- Terms of Reference of the Board and Council of Governors' Committees;
- Dispute Resolution Procedure; and
- Codes of Conduct.

County Durham and Darlington NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a "comply or explain" basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

A full review of compliance has been completed by the Trust Secretary and reviewed by the Trust's Audit Committee. The Directors consider that the Trust complied with the provisions of the Code during 2017/18 with the exception of Provision E1.2 which requires a policy on engaging patients and the public to be in place. Elements of the Trust's approach to the representation of patient and public interests are set out in the constitution, and there are a number of other documents in place which set out how the Trust seeks to engage patients and the public in providing views on a range of matters. However, there was no over-arching statement of principles agreed by the Board, to ensure that the individual activities were co-ordinated within an approved framework. An over-arching Patient Experience and Community Engagement Strategy was

agreed by the Board in April 2018, and the Trust is now compliant with this requirement.

In addition, Code Provision D2.3 requires that Non-Executive Directors' remuneration be reviewed every three years, taking account of expert, external advice. The Trust completed such a triennial review in 2017/18 and used external benchmarking data, and there are no material changes to the remuneration package currently contemplated. However, advice to the Council of Governors Remuneration Committee was provided by the Workforce and Organisation Development Director rather than an external, professional adviser. External validation of the recommendations will be taken during 2018/19.

4.4.1 Other Disclosures in the Public Interest

The Trust has sought to cover all of the content required by NHS Improvement's NHS Foundation Trust Annual Reporting Manual 2017/18, and additional information to allow the public to understand the Trust's position and prospects elsewhere in this report. The Trust considers that there are no further matters required to be included in the public interest.

4.5 Regulatory ratings

4.5.1 NHS Improvement's Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care;
- Finance and use of resources;
- Operational performance;
- Strategic change; and
- Leadership and improvement capability.

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support and '1' reflects providers with maximum autonomy. A Foundation Trust will only be included in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's Risk Assessment Framework (RAF) was in place. Information from the prior year, and the first two quarters of 2016/17, has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

Following the most recent Quarterly Review Meeting with NHS Improvement on 19th March 2018, the Trust was confirmed as remaining in Segment 2. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website.

NHS Improvement has not considered it necessary to take enforcement action or to

mandate any support to the Trust. We did, however, request and receive additional support in specific areas; for example, support, through the secondment of a regional NHS Improvement Quality Lead, with quality improvement and embedding our safety culture in response to the trend in never events reported in 2016/17, and recommendations from NHSI's national Emergency Care Intensive Support Team to improve our Emergency Care pathway. We have also enrolled in NHSI's national 'Moving to Good' programme for Trusts with ratings of 'Requires Improvement' from CQC who are looking to move to an overall rating of 'Good' in the short-term.

The 'Finance and use of resources' theme is based upon measures from '1' to '4', where 1 reflects the strongest performance. These scores are then weighted to given an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above is not the same as the overall finance score here.

Table 37 – Finance and Use of Resources Scores

Area	Metric	2016/17 Quarter 3 score	2016/17 Quarter 4 score	2017/18 Quarter 1 score	2017/18 Quarter 2 score	2017/18 Quarter 3 score	2017/18 Quarter 4 score
Financial sustainability	Capital servicing capacity	4	4	4	4	4	3
	Liquidity	3	4	4	4	4	4
Financial efficiency	I&E margin	1	1	4	4	4	4
Financial controls	Distance from financial plan	1	1	1	1	2	1
	Agency spend	1	1	1	1	1	1
Overall score		**3**	**3**	**3**	**3**	**3**	**3**

4.5.2 Care Quality Commission

The Care Quality Commission inspected the Trust in September and October 2017, reporting in March 2018. Overall, the Trust was rated as 'Requires Improvement' with DMH and UHND rated as 'Requires Improvement' and our Community Services rated as 'Good'. Further details of the ratings for individual services and the actions being taken since the inspection can be found in our Annual Governance Statement on page 113 and in our Quality Report on page 133

4.6 Statement of The Chief Executive's Responsibilities as the Accounting Officer of the County Durham and Darlington NHS Foundation Trust

The National Health Service Act 2006 (NHS Act 2006) states that the chief executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the

propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require County Durham and Darlington NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of County Durham and Darlington NHS Foundation Trust and of its income and expenditure, items of other comprehensive income and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and the NHS Foundation Trust Annual Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- Assess the CDDFT Group and County Durham and Darlington NHS Foundation Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- Use the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CDDFT Group or County Durham and Darlington NHS Foundation Trust without the transfer of its services to another public sector entity.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The accounting officer is also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error, and for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities. The accounting officer is also responsible for ensuring that the use of public funds complies with the relevant legislation, delegated authorities and guidance.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Chief Executive
Date: 24th May 2018

4.7 Annual Governance Statement

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to: identify and prioritise risks to the achievement of the policies, aims and objectives of County Durham and Darlington NHS Foundation Trust; evaluate the likelihood of those risks being realised and the impact should they arise; and manage them efficiently, effectively and economically. The system of internal control has been in place in County Durham and Darlington NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the Annual Report and Accounts.

The Trust relies on the system of control to manage risks to the fulfilment of its core purpose, providing safe, high quality patient care to our patients in County Durham and Darlington and neighbouring areas, in line with our mission 'with you all the way' and our vision 'Right First Time'. 'With you all the way' encapsulates our commitment to put patients at the centre of everything we do, providing integrated healthcare to meet their needs. 'Right First Time, Every Time' captures our intention for services to be provided by the right professional, in the right place – in hospital or close to home – at the right time, first time, every time, 24 hours a day, where necessary.

Capacity to handle risk

As Chief Executive and Accounting Officer I am responsible for risk management. However, the day to day responsibility for clinical risk management is delegated to the Medical Director and the Director of Nursing. Management of risks to operational performance is delegated to the Director of Operations, financial risk is delegated to the Director of Finance and responsibility for the overall risk management framework is delegated to the Senior Associate Director of Assurance and Compliance.

Managers with responsibility for the risk management process, patient safety, health and safety, information governance, operational performance and financial risk support the Executive Leads. They also provide support to managers across the Trust on risk assessment, risk management, staff training and the development of good

practice. Members of staff receive training via a range of training programmes to ensure that they achieve the appropriate levels of competence and expertise. The Trust has an Assurance, Risk and Compliance (ARC) Team in place to provide expert review of operational risk registers including coaching, challenge and support to risk owners. This team has trained over 340 leaders and middle managers in the Trust's risk management process. Formal training is provided to all senior managers and risk owners and informal coaching and support is provided through ARC team members' support for risk management meetings at Trust, Care Group and directorate levels.

Awareness, understanding and ownership of risk is reinforced by coverage of key risks as part of monthly performance and risk reviews with each Clinical Care Group's management team.

The risk management process is informed by the analysis of incident reports, complaints, compliments and survey feedback, risk identification exercises, planning processes, national guidance, legislation and studies of best practice. There is a commitment within the Trust to being candid when things go wrong and to learn lessons from adverse events and near misses. The Trust has implemented systems to ensure that all staff are aware of their professional and statutory duties of candour and tracks compliance with the statutory duty of candour through its incident management system.

The risk and control framework

Risk management strategy

The Trust's risk management strategy covers the period 2017 to 2020. The overall objectives of the Trust's risk management strategy are to:

- Anticipate and effectively manage risks to the delivery of safe, effective and responsive care, risks to the achievement of strategic objectives and risks to operational delivery and regulatory compliance; and
- To support the achievement of the Trust's strategic objectives, and the delivery of the strategic plans which underpin them.

The strategy is published on the Trust's intranet site together with supporting operational policies and procedures. Progress against the strategy is reported to the Risk Management Committee and outcome-based KPIs are in place.

The key elements of the Trust's risk management strategy are:

- Agreed standards for the management of risk within the organisation;
- A clear framework of accountability and responsibility for the management of risk, including a requirement for regular, documented reviews of risk registers and emerging risks within each Clinical Care Group and corporate directorate, in accordance with the above standards;
- A defined committee structure, which supports decision making and actively seeks assurance in response to organisational risk. This includes the Risk Management Committee which reviews the assessments and mitigation plans for significant risks, and which seeks assurance on the operation of the risk management process within Clinical Care Groups and corporate directorates;

- Systems for the identification, analysis, prioritisation and mitigation of risk, with reference to a view of risk appetite endorsed by the Board;
- Monitoring of the status of principal inherent risks to the achievement of objectives, including strategic risks, through the Board Assurance Framework;
- Patient Safety and Health and Safety teams to support risk control processes and the development of capacity within the Clinical Care Groups and Corporate Directorates;
- On-going review, coaching, challenge, training and support from the ARC team to embed risk management processes into the day to day activities of the Trust;
- Communication processes which aim to ensure that, when things go wrong lessons learned are disseminated at all levels of the Trust;
- Quarterly reporting to the Board on all risks with current risk scores beyond the Board's risk appetite within the risk register and the full Board Assurance Framework; and
- External communication with stakeholders and the public through the Council of Governors and other established forums.

Quarterly Risk and Assurance Reports are prepared with reference to the Board's risk appetite. During 2017/18 reports were aligned to the risk appetite and risk tolerances defined by the Board in February 2018. The Board reassessed both its risk appetite and set new risk tolerances, for 2018/19, on 28th March 2018.

Trajectories are in place for the strategic risks within the Board Assurance Framework, showing anticipated progress towards target risk scores over time. The Board monitors reductions in risk against the agreed trajectories and seeks further mitigation where required. These trajectories were set in February 2017, alongside the review of risk appetite and the setting of risk tolerances, and reviewed in March 2018.

The role of the Board and Committees

The Trust Board sets the strategy and policy framework within which the Trust's operations are handled. The Board has implemented structures and processes to allow it to exercise oversight of Trust affairs, and to provide reasonable assurance that significant risks to the achievement of key Trust objectives are identified and mitigated through the effective operation of systems of control. The Board receives a quarterly report on the Board Assurance Framework and all risks beyond its risk appetite within the Trust's risk register.

The Board delegates oversight of the risk management process to a Risk Management Committee, comprising all of the Executive Directors and senior leaders within each Care Group and corporate function. I chair meetings of the Risk Management Committee, with four meetings being held during 2017/18 to review the significant risks escalated by Care Groups and corporate functions, including validating the assessment of risk and seeking assurance as to the adequacy and implementation of mitigating actions. All risks beyond the Board's risk appetite were reviewed. Once validated, significant risks are presented to the full Board, either through quarterly Assurance and Risk Reports or through formal escalation reports from the Committee in between

times.

The Board delegates its oversight of Trust business to two Board assurance committees: the Finance Committee and the Integrated Quality and Assurance Committee. Both Committees are constituted from full Board members, are chaired by Non-Executive Directors and include a second Non-Executive Director. Both Committees met every month during 2017/18.

The terms of reference of each Committee require the Committee to satisfy itself with respect to the identification of risks and the assurance available that mitigating actions and controls are effective. Both Committees are focused on seeking assurance that action is being taken and achieving desired outcomes where risks and issues are identified. Each Committee reviews the Board Assurance Framework, for the principal objectives within their remit.

The Finance Committee focuses closely on the management of risks to in-year financial performance and the future financial sustainability of the Trust, receiving and reviewing reports on performance against the financial plan and the delivery of cost improvement programmes at each meeting.

The Integrated Quality and Assurance Committee seeks assurance in respect of: the safety and effectiveness of the Trust's clinical practice and operations, and on the patient experience resulting from them, together with assurance in respect of workforce, operational performance, IT systems and the patient environment. The Committee uses a number of sources of assurance including: triangulation of data on incidents, complaints, litigation, and compliance audits of individual wards; patient feedback; clinical audit; internal audit and third party visits. Workforce, operational performance, Information Systems and Governance and the patient environment are monitored with reference to key performance indicators, management reports and the results of independent reviews from internal auditors and third parties. The Committee enables the Board to seek a more holistic view of assurance, taking account of the close linkages between quality, workforce and operational performance. The Executive Patient Safety and Experience Committee and the Clinical Effectiveness Committee both report into the Integrated Quality and Assurance Committee for assurance purposes.

Both Committees have procedures in place to escalate risk to the Board through formal reports from the Chair of each Committee, and can direct relevant managers to capture risks in the risk register for their particular department or Care Group. Where they are not assured as to performance or the robustness of actions to address emerging risks or actions, the Committees will seek further assurance from the relevant Executive Directors.

The Executive and Clinical Leadership Committee (ECL), a further Board sub-committee, is the Trust's senior and clinical leadership team and meets weekly to: seek clinical consensus on strategic and significant operational issues; review and communicate action on behalf of the Board, on policy and service issues; and to set performance frameworks in place for Care Groups and corporate functions. ECL is the forum which directs and monitors actions to address risks and issues requiring

co-ordinated Trust-wide effort and meets regularly.

A Strategic Change Board (SCB), comprising all Executive Directors and clinical leaders, meets once per month to facilitate on-going grip on the development of strategy and the delivery of major programmes and projects in support of strategic objectives. The SCB also reviews business cases for investment in support of strategic programmes and related post-implementation reviews.

Two further Executive Committees were established from November 2017: the Executive Patient Safety and Experience Committee, chaired by the Director of Nursing, and the Clinical Effectiveness Committee, chaired by the Medical Director. The former Committee meets every month and the latter bi-monthly. Both Committees report to the Integrated Quality and Assurance Committee for assurance purposes; both were established to provide Executive-level oversight and co-ordination of the quality agenda, including the identification and response to emerging quality risks and issues.

The Trust has an Integrated Performance Framework in place. This framework requires Clinical Care Groups to monitor their own performance, and to identify and escalate risks for Executive Directors' support where necessary. Each Care Group has a monthly meeting with heads of corporate monitoring functions to validate and, as necessary, strengthen their local risk assessment with key issues identified then forming the agenda for quarterly reviews with all Executive Directors. Key risks are also reviewed within these meetings. Risks identified in-between performance review meetings are escalated to ECL for support or action as necessary.

The Trust Board has established an Audit Committee charged with seeking reasonable assurance of the adequacy of risk management, control and governance systems within the Trust, including the Trust's overall governance structures. The Committee consists of three Non-Executive directors with extensive, relevant experience. During 2017/18, the Committee met six times and sought assurance based on reports from the Trust's internal auditors (including separately appointed IM&T auditors), external audit, third parties, and through its own enquiries of senior managers. The Committee met with the Chairs of the Board Committees outlined above to ensure that the assurance agenda was co-ordinated and, where appropriate, to place reliance on the work of those Committees. The Chair of the Committee provides updates to the Board on significant matters arising through formal escalation reports.

On 1st April 2017, the Trust transferred the majority of its Estates, Facilities and Procurement teams into its subsidiary company, Synchronicity Care Ltd (SCL), to establish an Operated Healthcare Facility. Board and Committee reporting arrangements have been reviewed to define reporting requirements for SCL and to enable operations to be monitored across the County Durham and Darlington Foundation Trust Group. In particular, there is a quarterly assurance report on the Patient Environment to the Integrated Quality and Assurance Committee which includes performance against KPIs and assurance outcomes for services delivered by SCL.

Clinical Care Groups

The Trust's healthcare services are provided through five Clinical Care Groups aligned to care pathways. Each Care Group has a leadership team comprising a Clinical Director, Lead Nurse and Associate Director of Operations, with similar teams in place at the general management and speciality levels. Each Care Group has a dedicated Governance structure and a governance support team working to Trust-wide standards.

The Board Assurance Framework and Risk Register

A Board Assurance Framework is in place, which captures the significant risks to the achievement of the Trust's objectives, together with both the controls in place to mitigate them and the specific evidence available to provide assurance that these controls are effective. Gaps in controls and gaps in assurance are identified and action plans put in place to address them. The Board uses this framework to identify and track the mitigation of strategic risks towards target risk positions, and monitors the progress of action plans against agreed trajectories.

All operational risks are captured in a single risk management system (Safeguard) allowing risk registers to be generated for each Clinical Care Group and corporate directorate, and for reports on significant risks to be extracted for the Risk Management Committee and the Board. Risks which are shared with SCL are also included in Safeguard. The risk registers record the nature of the risk, its relative priority with regards to other risks, the risk owner and the action plan in place to mitigate or manage it. Decision making about risk management priorities is made by the Risk Management Committee. Priorities are then fed into decision making including the allocation of resources.

The Audit Committee seeks assurance on the robustness of the Board Assurance Framework through periodic scrutiny of reports from the Senior Associate Director of Assurance and Compliance, discussion with the Chairs of each Board Assurance Committee and reports from the Trust's internal auditors. As noted above the Board receives a quarterly report on the Assurance Framework.

The Safeguard system is also used by the Trust for incident reporting. It is available to all staff via a link from the intranet home page ensuring that all staff members have the opportunity to report incidents easily. The Trust has an Incident Management Policy in place which requires that all incidents are investigated within specified timeframes.

The Trust recognises that it is neither possible nor always desirable to eliminate all risks and that systems should not stifle innovation. When all reasonable control mechanisms have been put in place there will inevitably remain some residual risk and this level of risk must be accepted. Risk acceptance within the Trust is systemic and transparent. Risk is assessed both in terms of its current likelihood and impact, and in terms of the target likelihood and impact following implementation of mitigations. Current risk levels can be compared against the Board's risk appetite and, where different, its risk tolerance. Target scores are reviewed by the Risk Management Committee. Once the target position is reached, the risk can be closed. Significant inherent risks continued to be monitored through the Board Assurance Framework.

Risk and assurance with respect to subsidiary companies

Synchronicity Care Ltd provides an Operated Healthcare Facility at Darlington Memorial Hospital and additional estates, facilities and procurement services to the Trust, operating as 'County Durham and Darlington Services (CDD Services). CDD Services maintains a register of risks which are shared with, or which could impact significantly on the Trust. These risks are captured in reports to the Trust's Risk Management Committee and senior officers from CDD Services are able to escalate risks requiring more urgent action by the Trust to the Trust's Executive Directors Group and Executive and Clinical Leadership Committee where required. The risk management approach is consistent across the CDDFT Group.

The Integrated Quality and Assurance Committee reviews quarterly assurance reports with respect to estates and facilities services on all Trust sites. These reports capture the outcomes of management monitoring processes and independent sources of assurance such as inspections and accreditations. They also set out the outcomes of the contract monitoring reviews for CDD Services and our PFI providers. These reports effectively collate the outcomes from assurance work on the patient environment, which are reported to the full Board, every quarter, through the Board Assurance Framework.

The Finance Committee monitors the overall performance of SCL in meeting its financial plan, data for SCL being included as an appendix to the Director of Finance's monthly reports. The Finance Committee also reviews the implementation of cost improvement schemes involving savings on procurement, where there is dependence on SCL's Procurement Service to the Trust and considers the relative efficiency of the service in the light of benchmarking information such as the 'Model Hospital' datasets.

The Audit Committee commissions a number of audits annually from our Internal Auditors, to provide independent assurance to the Trust Board with respect to the adequacy and effectiveness of corporate governance, financial control and operational performance within SCL. The results of these audits are reported to the Committee and inform quarterly Assurance and Risk Reports to the Board.

Foundation Trust Governance (including 'well-led' arrangements and principal risks and mitigations)

The Board actively reviews and seeks assurance over the principal risks to compliance with Condition FT4 of its provider licence, relating to governance. Principal inherent risks include lack of clarity and effectiveness within the governance structure, unclear reporting lines and accountabilities between the Board, its sub-committees and the executive team, omissions or errors in key datasets, and inability to secure succession for key executive and non-executive posts. The Board has approved terms of reference and work plans covering the decision-making and assurance seeking roles of each Board Committee and reviewed its needs from each Committee during the year. This resulted in the changes to the Committee structure outlined on pages 116 and 117 above.

A programme of data quality testing is in place through the internal audit

plan, which comprises cyclical testing of indicators relied on by NHS Improvement as part of their Single Oversight Framework. This is supplemented by external audit testing of certain quality account indicators, to provide the Board with assurance over the reliability of performance information. Data kite-marking procedures are in place for those indicators relied on for regulatory monitoring by NHS Improvement and data validation procedures are operated by the Trust's Information Services team.

Sources of assurance with respect to the Trust's arrangements for risk management, control and governance are captured and reported to the Board through the Board Assurance Framework. The Assurance Framework, supported by further evidence collated by the Senior Associate Director of Assurance and Compliance, provides the evidence on which the Board is able to consider and make submissions to NHS Improvement, including the self-certification statements required annually. This includes the outcomes of an independent review against the well-led framework, the final report for which was issued in July 2017 and the well-led review undertaken as part of the Care Quality Commission's inspection of the Trust in October 2017. The Trust received a 'Good' rating for the well-led domain overall but was rated 'Requires Improvement' with respect its services, specifically for Surgery, because of the need to further embed improvements implemented following a high number of never events reported in 2016/17 and to embed actions arising from a review of culture in operating theatres, and for End of Life Care. The last of these has not been re-inspected since 2015, during which time the Trust has developed and begun to roll out a strategy for end of life care in line with best practice and has strengthened its leadership of the service.

The Trust follows the Quality Governance requirements within the Well-Led Framework set out by NHS Improvement and the Care Quality Commission. The Trust has a quality strategy "Quality Matters", which defines the key quality priorities for the Trust together with measures of success, owners and key actions. The strategy informs the setting of annual quality priorities within the Annual Quality Report and reflects annual consultation on quality priorities with stakeholders both inside and outside the Trust.

The Board receives reports at each of its meetings from the Executive Director of Nursing and Executive Medical Director which include performance against annual and longer-term priorities, together with on-going risks to particular services and issues identified from benchmarking (for example, mortality information). The Integrated Performance Report provides further detail of performance against key quality metrics. Risks to the achievement of strategic goals are reflected in the Board Assurance Framework and reported on through the quarterly Risk and Assurance reports to the Board. There are six objectives within the Quality Domain covering: mortality; minimising patient harm; providing care in the right place at the right time; clinical effectiveness; patient experience and the patient environment. Sources of assurance include third party reviews, such as the review of the Trust's management of unscheduled care by NHS Improvement's Emergency Care Intensive Support Team and clinical audit.

Non-Executive Directors chair and participate in the Trust's Integrated Quality

and Assurance Committee, providing challenge to quality governance and leadership of the quality agenda. A network of lower-level committees is in place to give attention to specialist areas: examples include the Clinical Standards and Therapeutics Committee and the Trauma Committee. All such Committees are overseen by two Executive Committees: the Executive Patient Safety and Experience Committee and the Clinical Effectiveness Committee.

At the Executive-Level, patient outcomes and patient experience comprise two of the four strands of performance (along with workforce and financial performance) monitored through the Integrated Performance Framework. Quality-related risks are also monitored more frequently at fortnightly Patient Safety Forum and Healthcare Acquired Infections Reduction Forum meetings led by the Executive Director of Nursing.

Staff members are actively encouraged to make suggestions to improve quality, and to report harm and errors. Based on national benchmarking data from the National Reporting and Learning System the Trust's incident reporting rates are in line with the majority of similar organisations. Work continues to increase reporting rates in line with the upper quartile, in support of the Trust's focus on becoming a highly reliable provider. There are defined processes and structures in place for escalating issues through the governance chain to the Board, and for developing and monitoring action plans in respect of issues identified.

The Audit Committee monitors the effectiveness of internal audit processes, together with the implementation of the Trust's Freedom to Speak Up arrangements. In addition to the proactive work of the Freedom to Speak Up Guardian, which is reported to the Board every six months, the Trust has in place an anonymous reporting and dialogue system which allows any member of staff to report concerns or improvement suggestions directly to a Board Director or to the Chairman, whilst remaining anonymous.

A variety of mechanisms is in place to collect patient feedback – with over 90,000 patient contacts captured in the last year - and to consult with external stakeholders on the design of new pathways and processes. A Patient Experience Forum is in place, reporting to the Integrated Quality and Assurance Committee to co-ordinate such arrangements.

Regulatory risks, including risks to compliance with the Care Quality Commission's standards are monitored through the Board Assurance Framework. Systematic, monthly audits take place to monitor compliance with nursing and regulatory standards at ward and team level – with built in triggers to highlight strong performance and to escalate where performance needs to be improved. In addition, a periodic peer review process is undertaken where teams from one site audit clinical practice on another site, with reference to each of the CQC's Fundamental Standards. Further details of the CQC's most recent inspection of the Trust, and the actions taken are set out on page 111.

With respect to financial governance, a Financial Sustainability Programme (FSP) is in place involving:

- A Programme Office to support the

development of, and monitor the delivery of, cost improvement programmes.

- Weekly meetings led by the Chief Executive, Director of Operations and Director of Finance, to monitor productivity, efficiency, income, expenditure and the delivery of cost improvement schemes for Care Groups and corporate directorates and to agree mitigating actions for any emerging risks. Care Groups and corporate directorates attend these meetings according to a planned rotation.
- Monthly reporting on the FSP to the Finance Committee.

There is also a Finance Committee as outlined on page 116 above.

Data Quality and Security

The Trust Board has in place a programme of independent validation of datasets used to report against NHS Improvement's quality governance indicators, taking into account the results of internal and external audit testing, supplemented by other sources of assurance through the Board Assurance Framework.

The Trust has robust procedures in place for the management of risks associated with the holding and processing of personal information. The Trust has a dedicated manager with responsibility for information governance and data security. In my capacity as Senior Information Risk Owner, I have oversight of information governance and data security. The Trust has in place a full information risk management structure and I am regularly updated on all incidents and risks monthly. Information Asset Owners are responsible for the information held in their areas, recording information on Information Asset Registers, assessing risks and implementing actions to mitigate those risks as required.

Emergency Planning, Resilience and Response (EPRR)

The Trust Resilience Forum, which reports into the Risk Management Committee, meets every quarter to co-ordinate, and seek assurance with respect to, arrangements for contingency planning, handling of major incidents and emergency preparedness. The Trust has assessed its arrangements against the national EPRR core standards, concluding that a "substantial" level of assurance can be provided. 'Substantial assurance' means that: Arrangements are in place however the organisation is not fully compliant with **one to five** of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed".

Areas require further action have been captured in the Trust's EPRR Work Plan and are monitored by the Trust Resilience Forum.

Governors and third parties

As a Foundation Trust, the Trust's Board of Directors is accountable to the Council of Governors. The Council of Governors receives updates on performance and is able to ask questions of Directors at each of its four meetings per annum. The Council has established sub-committees, with particular roles for the Strategy and Planning Committee, and the Quality and Healthcare Governance Committee in respect of risks and controls.

The Strategy and Planning Committee

scrutinises draft plans and strategies (including component strategies) and the management of the strategic risks within the Board Assurance Framework on behalf of the Council of Governors.

Quality related risks are discussed by the Council of Governors' Quality and Healthcare Governance Committee. This committee also reviews the Complaints, Litigation, Incidents and Patient Advice and Liaison Service (CLIPs) report at every meeting and reports on these matters to the Council of Governors. During 2017/18, the Committee received updates on the implementation of the Quality Strategy, audits of nursing standards, medical and nursing staffing, quality-related risks, and patient feedback.

In addition, the Trust reports all Serious Incidents to its commissioners as part of its contractual arrangements and works with the local Overview and Scrutiny Committees to address issues of concern raised by the public or local councillors.

Head of Internal Audit Opinion – areas for control improvement

Whilst providing good assurance in respect of the Trust's control environment overall, the Head of Internal Audit Opinion for 2017/18 highlighted a number of areas from audits completed during the year where controls were deemed to be in need of improvement. In addition, two high risk audit reports were issued by the Trust's IM&T Auditors. These are summarised below, together with the action taken by the Trust.

- Duty of Candour: Internal Audit testing found that apologies to those affected were not consistently recorded, and were not always timely, together with gaps in supporting information held in patient records. Since the audit was undertaken, Governance Teams within Care Groups have provided education and training to clinical staff to reinforce awareness of the statutory requirements. A pro forma has been introduced to record all elements of Duty of Candour, and the date on which they were fulfilled, which is to be held in the patient record. The Patient Safety team will carry out annual audits of compliance with the Duty of Candour policy.
- Recruitment: weaknesses in compliance with Trust policies and procedures including a lack of evidence to demonstrate adherence to shortlisting and interviewing requirements as well as the requirement for references to cover a three-year period. The Trust plans to further utilise the Electronic Staff Record system in 2018/19 as the primary record for recording data on completed pre-employment checks, which should assist in retaining a complete audit trail to demonstrate completion of checks in line with policy.
- SCL Key Financial Controls: At the time of the audit, the service level agreement for financial services between the Trust and SCL was being reviewed and new KPIs were agreed. There was no cash collection function activated on SCL's bank account; hence SCL income was being collected by the Trust on SCL's behalf and there were delays in the transfer of SCL income to SCL's bank account. In addition, there was a need to reinforce segregation of duties through access restrictions with respect to the Trust and / or SCL's ledgers. All actions were agreed and are being implemented. Roles, separation of duties

and financial procedures have all been reviewed since the audit took place.

- Effectiveness of Portering: Portering services are provided to the Trust by SCL. The software used by SCL to record portering activity was no longer fit for purpose and not all activity was being captured. Whilst performance levels were contained in the SLA, there was no reference to expected quality standards for the service or how these would be measured. There was also a need to review portering capacity against demand. Following the completion of the audit, new software has been purchased which will enable requests to be tracked and filled and to allow a complete and accurate picture of demand to be built up over time. Capacity will then be reviewed and matched with the assessed demands on the service.
- Cyber security: A planned penetration test had been delayed; hence no end to end network or wireless penetration test had been performed during 2017/18. The Trust is in the process of preparing for a test in the first quarter of 2018/19.
- IT General Controls: There were weaknesses in controls over leavers for two applications used in Pathology and in the Emergency Department. In both cases controls were manual and relied on the system managers' knowledge because a full list of users could not be generated from the system. Controls over new starters granted access to the Symphony system used in the Emergency Department also needed to be strengthened. New leavers' controls have been introduced for both systems and controls over the granting of access to Symphony have been strengthened and brought into line with the Trust's access control policy.

In addition to the above, the Head of Internal Audit has challenged the sufficiency of assurance received by the Trust with respect to cyber security, in the light of ransomware attack and threats impacting on the NHS in the last year. The Audit Committee has reviewed the totality of assurance received from IM&T Audit and other sources and further work has been commissioned from the IM&T Auditors in 2018/19.

Well-Led Review

The Trust underwent an external review of compliance with the well-led framework for NHS Trusts published by NHS Improvement and CQC in February and March 2017, with the report and action plan being finalised in the first quarter of 2017/18. The reviewers assessed the Trust as Amber-Green for nine out of the 10 key domains and Amber-Red for the domain relating to Strategy. In both cases, this assessment confirms that there are no significant omissions in the Trust's arrangements. For those domains rated Amber-Green, the external reviewers' judgment confirmed that credible action plans were in place to deliver further improvements.

With respect to the Strategy Domain, whilst there were no significant omissions from the good practice requirements within the well-led framework, the review highlighted areas for further improvement. The action plan agreed with the reviewers was monitored at each Board meeting during 2017/18 and was largely complete by 31st March 2018. All agreed actions had been taken with respect to the Strategy Domain. None of the issues identified by the

external reviewer for the Strategy Domain, remained by the time of CQC's well-led framework review in October 2017.

CQC Inspections

The Trust is fully compliant with the registration requirements of the Care Quality Commission. We have set out the result of most recent inspection, and the actions being taken below.

CQC inspected the Trust in September and October 2017, inspecting four core services: Maternity, Accident and Emergency Services; Medicine and Surgery. In their inspection report they acknowledged that actions from the 2015 inspection were, in the main, fully implemented and noted a number of improvements, in particular:

- In most areas nurse staffing had improved.
- Staff investigated incidents quickly, and shared lessons learned.
- Wards and department areas were clean and equipment was well maintained. Staff followed infection control policies that managers monitored to improve practice.
- Staff provided care and treatment based on national guidance and evidence and used this to develop new policies and procedures.
- Staff cared for patients with compassion, treating them with dignity and respect.
- Patients, families and carers gave positive feedback about their care.
- The hospital escalation policy and procedural guidance was followed during busy times

The overall rating for the Trust was 'Requires Improvement', based upon the ratings for the four services inspected in September 2017 and ratings brought forward from the 2015 inspection for the remaining acute services: Critical Care, Outpatients, Diagnostics, Paediatrics (all rated 'Good') and End of Life Care rated (requires improvement), and for the six community-based services (all rated 'Good').

The CQC chose not to include End of Life Care in their 2017 inspection, based on an internal risk assessment of the Trust's services; hence the ratings for that service remain in line with those determined by the previous inspection in 2015. The Trust has evidence that it has achieved real improvements in its End of Life care and we look forward to a re-inspection of that service in the near future.

Requirements and recommendations included in CQC's final reports can be summarised by theme as follows:

- The need to further embed learning from never events, including further strengthening of the culture and staffing within operating theatres. CQC acknowledged the work undertaken by the Trust in response to a high number of never events reported in 2016/17, together with an active programme to improve staffing and culture in theatres but concluded, in line with the Trust's own assessment, that both work-streams needed to go further.
- The need to strengthen policies, training and education and systems with respect to the application of the Mental Capacity Act and Deprivation of Liberty Standards and related matters such as

the administration of covert medications.

- The need to review and improve the safety of facilities within the Trust's Emergency Departments used to assess and treat patients with Mental Health conditions, in line with national best practice.
- Actions and recommendations in respect of specific findings concerning administration and security of medications and oxygen; nursing assessments and record-keeping.

The Trust submitted a 51 point action plan to CQC on 23rd March 2018. This captured both initial actions, which had been taken in response to verbal feedback and CQC's draft reports, and the further actions required to address 'Must Do' requirements and 'Should Do' recommendations included in the final reports. The majority of the actions identified are already being implemented. Governance arrangements are in place to drive and assure delivery of the specific actions.

With respect to the above themes:

- Work is well underway to upgrade mental health rooms in our Emergency Departments in line with the recommendations of the Psychiatry Liaison Accreditation Network, and a risk assessment with respect to ligature risks has been completed.
- The policy on Mental Capacity has been overhauled and is about to be reissued, supported by a refreshed training programme. Updates are being made and piloted with respect to our nursing assessment tool, to prompt both consideration of capacity in response to specific indicators and further actions as necessary.
- Executive Directors continue to support and closely monitor all work with respect to the Theatres Culture review and with respect to embedding local safety standards for invasive procedures and safety protocols.
- Initial actions have been taken with respect to medicines administration and security and record-keeping issues, which will be reinforced through audit and monitoring checks.

More details of the actions taken and oversight arrangements are set out in our Quality Report on page 113 of the Annual Report.

NHS Improvement

The Trust has remained within Segment 2 of the Single Oversight Framework throughout 2017/18.

Other matters

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all of the Trust's obligations under equality, diversity and human rights legislation are complied with.

The Foundation Trust has undertaken risk assessments with respect to its impact on the environment and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Principal risks managed during the year

One of the key contextual factors remains the lack of definition with respect to any strategy for NHS services within the locality and wider region. Although not a risk in itself, the resulting uncertainty has impacted on the principal risks managed in year, as outlined below. The Trust is now working collaboratively with neighbouring providers, with respect to clinical services and financial sustainability; with commissioners and local authorities in County Durham as part of an Integrated Care Partnership, and through similar, less formal arrangements in Darlington; and with all NHS bodies and local authorities as part of a wider Integrated Care System for Cumbria and the North East. It is expected that this work will result in reduced uncertainty, and collective opportunities to manage risks for the benefit of all our patients, going forwards. Within this context the principal risks managed by the Trust during the year were:

- **Improving our safety and reliability:** The Trust's relative performance in areas such as infection control, pressure ulcers and cardiac arrest prevention remains strong. However, following eight never events in 2016/17, the Trust has continued to roll out measures to engender and reinforce a stronger safety culture; has rolled out local safety standards for invasive procedures and has strengthened and audited the application of safety protocols in operating environments. Nonetheless, as reported by CQC, this work has further to go and CQC's report has flagged further risk with respect to the environment for patients with mental health conditions in our Emergency Departments, which are being addressed by upgrading relevant facilities.
- **Financial performance and sustainability:** During the year, the Trust managed risk to the delivery of the financial control total agreed with NHSI, arising from reductions in income and over-dependence on non-recurring cost control and cost improvement measures. Reductions in income related, in part, to reductions in elective activity in response to winter pressures, in line with national guidance; however, the underlying trend in activity is falling in line with referral patterns. Whilst the Trust was able, through tight cost control and non-recurring measures to meet its control total for 2017/18, it has also agreed a three-year contracting arrangement with commissioners to provide headroom to jointly reduce costs and capacity in line with activity. As noted above, there is a lack of definition with respect to the medium to long-term financial strategy within the locality and the region.
- **Maintaining and strengthening medical staffing rotas across two sites for particular specialties:** The Trust has made significant progress with respect to recruitment of consultants, with a net increase in the consultant workforce during the year. However, there remain gaps in the medical

workforce in some specific services compared to relevant guidelines. Risks are actively managed through the engagement of known locums and additional sessions, as well as collaborative working with neighbouring trusts, and there is a process of escalation to the Medical Director should any patient safety risk arise. Flexible medical staff recruitment plans are in place, allowing services to explore options such as international recruitment where appropriate, and joint work is taking place with other Trusts in the region to seek to sustain services going forwards.

- **Meeting demand pressures on our Unscheduled Care Services:** Despite implementing good practice recommendations from NHS Improvement's Emergency Care Intensive Support Team (ECIST) and high-performing Trusts, the Trust was unable to meet the A&E waiting times standard over 2017/18 as a whole. Good progress has been made in improving discharge, medical review and patient flow both within the Emergency Departments and in our acute hospitals as a whole. This resulted in the standard being met in late summer and early autumn 2017. Subsequently, as a result of extremely high demand experienced during winter, on top of what were already the highest levels of demand for Type 1 emergency care in the region, the Trust was not able to sustain performance. Further support from ECIST was requested and the Trust is now implementing some additional recommendations alongside embedding the good practices outlined above. Of themselves, however, these actions are unlikely to lead to sustainably high performance; therefore a new Emergency Care Centre at UHND is planned for 2020 and the Local Area Delivery Board is reviewing the model of urgent care to optimise the way in which patient demand is catered for.
- **Effectively engaging staff at a time of change and uncertainty:** In addition to the uncertainty with respect to the locality and regional strategy for NHS services outlined above, adult community services provided by the Trust were subject to further significant uncertainty in the year, having been re-tendered. Staff engagement is a key priority for the Board, and the staffing and resources available to the Communications Team were increased during the year. However, despite a real focus on engagement, which has seen a substantial increase in Board visits to wards and teams, more frequent and open access to our Chairman and Chief Executive for our staff and new channels for raising issues or making suggestions, the Trust has not improved its overall engagement score in the national NHS staff survey. All Clinical Care Groups and directorates have a specific 'Staff Matter' action plan, including actions to engage and listen to their staff and Workforce and OD will be providing bespoke support to those teams with lower than average scores from the staff survey.

Principal risks going forward

The risks outlined above are expected to persist, in large part, over the next 12 to 24 months and the Trust will continue to deploy the actions outlined above in order to continue to manage them and further actions as outlined below:

- **Safety and reliability:** Continuing to embed local safety standards for invasive

procedures and protocols in place to prevent incidents and never events, reinforced through observational audits; completing work on mental health facilities in our emergency departments; implementing the recommendations of the national confidential enquiry 'Treat As One' to improve the care of patients with mental health conditions, and rolling out a new policy, training and processes with respect to mental capacity.

- **Financial sustainability:** Working collaboratively with our commissioners to adapt our collective workforce in line with need and demand, securing productivity and efficiency improvements over the life of the three year deal agreed with our Clinical Commissioning Groups; agreeing a patch-wide financial strategy with neighbouring Trusts and as part of the wider Integrated Care System, and securing funding for essential capital investments such as our Emergency Care Centre at UHND. In addition, the Trust has drawn down interim support funding from NHS Improvement, and will need to closely manage cash to ensure that repayments are made as agreed.
- **Medical workforce:** Following through on recruitment plans for specialties with medical staffing vacancies, including exploring additional options such as international recruitment where appropriate, and working with commissioners and neighbouring providers to optimise service provision to patients in line with the available workforce.
- **Demand pressures on Unscheduled Care:** Continuing to implement good practices with respect to patient flow within our Emergency Departments, aided by the completion of building adaptations, and throughout our acute hospitals; developing and deploying capability within the community to support earlier discharge where it is in the patients interests; reviewing the model of urgent care with our commissioners, and progressing the design and implementation of the new Emergency Care Centre at Durham.
- **Staff engagement:** Refreshing our 'Staff Matter' strategy, including Trust-wide and local engagement plans; holding listening events with services with respect to our 2018/19 plans and longer-term strategy; and targeted interventions in relevant teams.

In addition, a further significant risk and opportunity relates to the mobilisation of plans to realise a new vision, working with primary care, social care and the voluntary sector, for integrated adult community services from October 2018, following the Trust's success in the recent tender for services in County Durham and Darlington. Aims include providing wrap-around services for patients with long-term conditions, helping to: prevent unnecessary admissions to hospital, to support people in their own homes and to support patients on discharge.

Improving our IT systems will be a further key focus during 2018/19, with a need to complete the roll out of the Trust's cyber-security strategy and to progress the design and implementation of an Electronic Patient Record system to meet requirements for digital systems in the NHS by 2020. Risks arising with respect to both will be monitored through the Board Assurance Framework.

The Trust has agreed block-based

contracting frameworks with the three Clinical Commissioning Groups in County Durham and Darlington over three years for acute services and five years for community services, to facilitate collaboration on productivity and efficiency improvements in the local health economy and improving services for patients. The longer-term nature of these frameworks, which provides greater certainty for planning purposes, coupled with structures for collaboration to reduce costs for both parties, is novel. Alongside this arrangement, the Trust is part of an Accountable Care network for County Durham and similar arrangements in Darlington, working closely with commissioners, primary care, local authorities and the voluntary sector to develop integrated services on behalf of patients. Regionally, the Trust is working with a wide range of partner organisations as part of the development of an Integrated Care System for Cumbria and the North East. All of these developments introduce risks through working in partnership but, more importantly, provide a real opportunity for system-wide working to address mutual challenges in the interests of patients.

Review of economy, efficiency and effectiveness of the use of resources

The Trust Board monitors performance against the Trust's Annual Plan on a monthly basis, receiving detailed monthly reports on financial performance, associated risks, and the actions in place to mitigate them, as well as delivery of the Cost Improvement Plan throughout the year. The Trust Board has also reserved to itself decision making with respect to major capital investment and disinvestment. As outlined above, a Finance Committee is in place to provide focus on, and scrutiny over, the identification and realisation of productivity and efficiency improvements and the management of financial risks both in-year and with respect to the Trust's future financial sustainability.

The Trust has a framework of controls, set out in its Standing Financial Instructions, designed to achieve economy, efficiency and effectiveness in the use of resources. The Trust Board receives assurance from the following sources via the Audit Committee:

- Internal Audit reports, including "value for money" reports;
- Counter-fraud preventative work and investigations; and
- External Audit reports.

The external auditors have advised that an unmodified opinion on the Trust's arrangements for value for money during 2017/18 is expected to be issued.

The Trust uses benchmarking information from a variety of sources to evaluate the economy, efficiency and effectiveness of its corporate services and its productivity and efficiency in the delivery of healthcare, including reference cost data. Efficiency opportunities highlighted by the Model Hospital datasets are investigated and schemes developed where appropriate.

During the year, NHS Improvement visited the Trust to review the governance and delivery of the cost improvement programme. No support needs were identified.

Information Governance

The Trust is obliged to formally report any Level 2 serious incidents requiring investigation to commissioners via STEIS and as part of its Information Governance Toolkit submissions. There were no incidents occurring which were rated, by the Trust's Information Governance team, at Level 2, during 2017/18.

The Trust conducts an annual review of its arrangements using the Information Governance Toolkit Assessment and was rated "Green - Satisfactory" with 93% compliance against the relevant standards.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) 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 in the NHS Foundation Trust Annual Reporting Manual.

A number of steps have been taken to provide assurance to the Trust Board that the Quality Report for 2017/18 presents a balanced view and that appropriate controls are in place to ensure the accuracy of data.

These include the following:

- The Executive Director of Nursing provides executive leadership on all aspects of the Quality Report;
- The Trust Board receives monthly performance and patient safety reports, the data from which informs the Quality Report. Datasets are subject to validation controls and review with the Trust's Information Services Department;
- The Quality Report priorities were formulated through discussion with the Trust Board, the Council of Governors, staff, commissioners, the local authority Overview and Scrutiny Committees and other stakeholders;
- Both the Board's Integrated Quality and Assurance Committee and the Governors' equivalent committee receive updates on progress against Quality Report targets during the year;
- Controls over the completeness quality and timeliness of data were rated as Amber-Green in the external well-led review. Actions arising have, for the most part, been implemented during the year.
- Prior to formal approval of the Quality Report it is reviewed by a Joint Meeting of the Trust Board Audit Committee and the Governors Audit and Governance Committee, and a Joint Board and Council of Governors meeting; and
- The Trust obtains independent assurance with respect to the adequacy and effectiveness of the systems of control over data collection and reporting, including controls to ensure the accuracy of reported data, for the Quality Report, through periodic testing of data systems by Internal Audit and year end testing by External Audit.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the

executive managers and clinical leads within the NHS Foundation Trust that have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report contained within this Annual Report and other performance information available to me. My review is also informed by the external auditors in their reports to those charged with governance and reports from other third party reviewers.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, the Finance Committee, the Integrated Quality and Assurance Committee and the Risk Management Committee. Plans to address weaknesses and ensure continuous improvement of the system are in place, consolidated through the Board Assurance Framework.

My review of the effectiveness of the system of internal control has been further informed by the outcomes of internal audit work, the Head of Internal Audit Opinion, third party reviews and the outcomes of regulatory assessments, including our quarterly review meetings with NHS Improvement and inspections. In addition, I have taken into account the results of the external review of the Trust against NHS Improvement and CQC's well-led framework, and CQC's own well-led review as outlined above.

Conclusion

My review has identified no significant control weaknesses; however, I have outlined some areas for improvement in controls elsewhere in this Annual Governance Statement, in particular in the references to:

- The annual Head of Internal Audit Opinion;
- The well-led review;
- The CQC's most recent inspection; and
- Key risks managed during the year.

Action plans have been, or are being, developed and implemented to strengthen controls in these areas.

During 2017/18 the Trust has consolidated improvements in governance arrangements, performance management, and operational management, and continues to implement improvements in services agreed with CQC. Our risk management, governance and internal control systems remain in line with good practice and are continually reviewed and strengthened to fully support the achievement of our objectives.

Chief Executive
Date: 24th May 2018

This Accountability Report set out above, and which forms Section 4 of our overall annual report, was approved by the Board on 23th May 2018.

Chief Executive
Date: 24th May 2018

5. Quality Report

5.1 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
- University Hospital of North Durham
- A range of planned hospital care at Bishop Auckland Hospital

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

- Shotley Bridge
- Chester le Street
- Weardale
- Sedgefield
- The Richardson in Barnard Castle

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

Our mission "With you all the way" represents our commitment to put the patient at the centre of everything we do.

All the way - means across the care pathway for:

- Prevention
- Treatment
- Rehabilitation

And in different care settings:

- In the home
- In community facilities
- In local hospitals

Working with our partners:

- Our patients
- Our staff
- Our stakeholders

A Guide to the Structure of this Report

The following report summarises our performance and improvements against

the quality priorities we set ourselves in the 2017/2018 period. It also outlines those we have agreed for the coming year (2018/2019).

The Quality Accounts are set out in three parts:

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

Part 2: Priorities for improvement and statements of assurance from the Board

Part 3: A review of our overall quality performance against our locally agreed and national priorities.

Annex: Statements from the NHS Commissioning Board, 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 Monitor's additional reporting requirements.

Whilst we continue to see significant improvement and success in some of our goals, it is acknowledged that for some we have not reached our Trust ambition. We will continue to aim for the standards that we have set, and are committed to ensuring that we continue the work in place to meet and move further ahead with meeting those challenges.

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

Part 1: Statement from Chief Executive

I am delighted to introduce to you our Quality Account and Quality Report for County Durham and Darlington NHS Foundation Trust for 2017/2018.

Our mission 'with you all the way' places patients at the centre of all that we do. Delivering the highest quality patient care remains our top priority and this is reflected in our mission and values as well as our annual objectives. We could not do this without our dedicated workforce and we are proud to be able to present an outline of our achievements and successes against our quality priorities over the past 12 months.

2017/2018 has been about further embedding good practice in line with the Trust's 'Quality Matters' strategy launched in 2017 and which takes us through to 2020. Working with colleagues and partners, we set ourselves a number of quality priorities for the three year period, to improve patient safety, clinical outcomes and the experience of those who need our care. These are the areas where we know we can make the greatest difference.

Just as importantly, however, we are working to equip and support our staff with the tools, techniques, training and support needed to deliver quality improvements in all areas, day in day out.

During 2017/2018, the consistent focus on our priority areas has been rewarded with improved performance and positive movement forwards in terms of meeting our targets.

High level highlights to which I would like to draw your attention include our performance against our targets for the reduction of pressure sores and the prevalence of falls across our acute hospitals. We perform consistently well on infection control and are positively positioned nationally in terms of mortality rates.

We know we also have challenges and whilst pleased to see a significant reduction in never events, we will not rest until we have none. A never event does not imply that significant harm has occurred but does identify those incidents which can occur if processes or procedures are not fully embedded. The report gives more detail on these incidents.

The Board was disappointed that the Trust was unable to move from 'Requires Improvement' to 'Good' in the most recent inspection by the Care Quality Commission. The inspectors acknowledged real improvements in areas such as nursing staffing and care of patients receiving non-invasive ventilation. They also increased their rating, for the well-led domain for the Trust as a whole, to "Good" and similarly increased ratings for the safe domain for Medicine, and the well-led domain for both Maternity and A&E services. However, they concluded – in line with the Trust's own assessment – that there is further to go to embed safety protocols and learning following the never events experienced in 2016/2017, and to ensure the responsiveness of our A&E services. It is also clear that we must do better to ensure the safety of patients with mental health conditions and those lacking capacity, and to provide care for patients with mental

health issues on an equal footing to those with physical ailments. We have already implemented many of the actions included in our remediation plan and aim to have others in place by October 2018.

During 2017/2018 we worked with support from NHS Improvement to advise and assist our improvement journey which has been realised in a number of local service projects and at a Trust-wide level. In June 2018, we will hold the third in our series of 'Becoming a Highly Reliable Organisation' (BAHRO) conferences. These large scale engagement events have proved to be fantastic learning opportunities bringing together internal audiences with national experts and speakers to share experiences and support improvements.

We have also performed well in relation to the introduction and implementation of national and local safety standards (LocSSIPs) and have benefitted from the drive and dedication brought to the project by the clinical leadership supporting the roll out across the organisation.

Sharing and embedding learning play a strong role in the culture of CDDFT and in addition to the BAHRO conferences we have now also established annual conferences for our nursing and midwifery colleagues. In 2017, we also launched our 'Nursing Travel Award' which supports applications from nursing colleagues to spend time with a different organisation either in the UK or abroad to learn and share practice which can be brought back for the benefit of our County Durham and Darlington communities.

Nationally and locally there continues to be an increasing demand for services against a challenging financial climate, however based on our track record of success I am confident that #TeamCDDFT will continue to rise to these challenges and I hope this Quality Account provides you with a clear picture of how important quality improvement and patient safety are to us at County Durham and Darlington NHS Foundation Trust.

And as we present our Quality Accounts for 2017/2018, I would like to take the opportunity to thank all #TeamCDDFT colleagues, partners and stakeholders for their continued commitment and support as we continue to work together on delivering our vision; 'Right First Time, Every Time'.

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

Part 2: Priorities for Improvement and Statements of Assurance from the Board

Review of our key priorities for 2017/2018

Last year we set 20 priorities. These have been set under the following headings:

- Safety
- Patient Experience
- Clinical Effectiveness

A summary of our progress and achievements is shown below and further detail on each priority is included in the pages that follow.

☒	Improvement not demonstrated
☑	Trust ambition achieved
⊖	Trust ambition not achieved but improvements made

		2016/17	2017/18 Ambition	2017/18 Position	
Falls	Patient falls – reduce falls/1000 bed days community hospital	6.1 ☑	8.0	5.9	☑
	Patient falls – reduce falls/1000 bed days acute hospital	6.2 ☒	5.6	6.0	⊖
	Follow up patients with fragility fracture	66.3% ☑	50%	37.6%	☒
	Complete root cause analysis for falls resulting in fractured neck of femur	All complete ☑	All complete	All complete	☑
Care of patients with dementia	Development of a dementia pathway and monitoring of care, to include enhancements to environment	Complete ☑	Introduce dementia strategy and produce an action plan to monitor	Complete	☑

		2016/17	2017/18 Ambition	2017/18 Position	
Healthcare Associated Infection (HCAI)	Meticillin Resistant Staphylococcus aureus (MRSA) post 48 hour bacteraemia	5 ✗	0	4	⊖
	Clostridium difficile post 72 hour	16 ✓	19	21	✗
Pressure Ulcers	To have no avoidable grade 3 or above pressure ulcers within acute or community services	4 ⊖	0	4	✗
Venous thromboembolism (VTE)	Maintain venous thromboembolism assessment compliance at or above 95%	96.9% ✓	95%	96.45%	✓
Discharge	Discharge summaries	93.60% ⊖	95%	91.9%	✗
Incidents	Rate of patient safety incidents reported via National Reporting and Learning System (NRLS)	Reporting to within 50% ⊖	Reporting to within 75%	Reporting to within 50%	⊖
	Rate of patient safety incidents resulting in severe injury or death from National Reporting and Learning System (NRLS)	0.30% ✓	Within national average	Apr-Sep 2017 data 0.4%	✓
Sepsis	To improve management of patients identified with sepsis	Complete ✓	Ensure patients are screened appropriately	Improvement demonstrated	✓
Duty of Candour	To monitor implementation	Complete ✓	Demonstrate compliance and monitoring	Embedded in practice	✓
Local Safety Standards for Invasive Procedures (LocSSIPs)	To deliver a programme of work to review LocSSIPs across the Trust	N/A	Introduce by 2019/2020	Progressing as plan	✓

		2016/17	2017/18 Ambition	2017/18 Position	
PATIENT EXPERIENCE					
Nutrition and Hydration	Move nutrition assessment to Nervecentre 16/17 ambition and 17/18 to complete To audit against new indicators	Planning continues ⊖ Review continues ⊖	Complete To continue to refine	Complete Monitoring and refinement introduced	☑
End of Life Care	We want our workforce to be equipped to provide high quality end of life care We want patients approaching the end of life to be confident in receiving high quality care in accordance with their wishes	Progress made but work to continue ⊖	To improve and monitor care of patients at end of life as per Trust plan	Preferred place of death audit demonstrates improvement	☑
Patient personal needs	Responsiveness to patients personal needs	2016 68.8%	Improved positive response in comparison to this year's results	2017 79%	☑
Percentage of staff who would recommend the provider to family or friends needing care	To achieve average national performance against staff survey	On a scale of 1 to 5 3.46 ⊖ -2016	3.75	On a scale of 1 to 5 3.50	☒
Percentage of staff experience harassment, bullying or abuse from staff in the last 12 months		2016 20% ☑	Within national average 24%	2017 24%	☑
Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion		2016 90% ☑	Within national average 85%	2017 90%	☑

		2016/17	2017/18 Ambition	2017/18 Position	
Friend and family test	To increase Friends and Family response rates	13.20% (March 16 – Feb 17) ✗	Over 20% in Emergency Department	16%	⊖
		17.80% ✗	Over 30% inpatient areas	32%	✓
CLINICAL EFFECTIVENESS					
Reduction in risk mortality indices	To monitor mortality indices (HSMR and SHMI) on a monthly basis – indices as expected	YTD 2016/17 (Feb16-Jan17) SHMI: 106.09 ⊖ HSMR: 101.57 ✓	To remain within expected parameters for mortality indices To introduce Learning from Deaths national policy	YTD 2017/2018 (Jan17-Dec17) SHMI: 102.32 HSMR: 96.05	✓ ✓
Reduction in readmission to hospital (within 28 days)	To reduce emergency readmissions (provisional data results)	0-15 years 12.9% ✗	7%	0-15 years 11.8%	⊖
		16 years and over 11.8% ⊖		16 years and over 12.7%	✗
		Total 12.0% ⊖		Total 12.5%	✗
	Patient impact indicators: • Unplanned re-attendance no more than 5% • Left without being seen no more than 5%	0.90% ✓ 1.90% ✓	<5%	1.5% 2.4%	✓ ✓
To reduce length of time to assess and treat patients in accident and emergency department	Timeliness indicators: • 95% to be treated/ Admitted/discharged within 4 hours • Time to initial assessment no more than 15 minutes • Time to treatment decision no more than 60 minutes	3.19% ✗ 60mins ✗ 36mins ✓	95% 15mins 60mins	91.4% 57mins (Annual Average) 43mins (Annual Average)	✗ ⊖ ✓

		2016/17	2017/18 Ambition	2017/18 Position	
Patient Reported Outcome Measure (PROM) *EQ-5D Index*	To gain better understanding of patient's view of their care and outcomes • Hip • Knee • Hernia	2015/16 0.394 ✗ 0.323 ✓ 0.075 ✓	Improved Rates (case mix adjusted health gain)	2016/17 (Provisional) 0.439 0.324 0.072	✓ ✓ ✗
Maternity Standards (new indicator following stakeholder event)	To monitor compliance with key indicators: • Breastfeeding intention • Smoking in pregnancy • 12 week booking • Complete gap analysis against @Saving Babies lives" NHS England document	58.1% ⊖ 16.7% ✓ 90.2% ✓ Complete ✓	60% 22.4% 90% Complete gap analysis	8.7% 17.6% 90.9% Complete	⊖ ✓ ✓ ✓
Paediatric care (new indicator following stakeholder event)	Improved paediatric pathways for urgent/ emergency care	Pathway improved	Demonstrate improved pathway	Year 1 improvement demonstrated	✓

Introduction to 2018/2019 priorities

Key priorities for 2018/2019 have been agreed through consultation with staff, governors, Healthwatch, commissioners, health scrutiny committees and other key stakeholders. As an integrated organisation it is important that our priorities are applicable to both acute and community services. The priorities therefore cover both of these care providers wherever appropriate. Throughout the year we have updated both our staff and stakeholders on progress against our quality improvement targets. In addition an event was held earlier in the year where a series of presentations were given to a wide range of staff and stakeholders. All were in agreement that these events were very useful in informing the priorities for the coming year and identifying the areas for continued monitoring.

The table below summarises the specific priorities and objectives that have been agreed for inclusion in the 2018/2019 Quality Accounts. The table also indicates where this is a new or mandatory objective and where this is a continuation of previous objectives. While most of the priorities are not new we have introduced different methods for monitoring where the priority has changed or the service objectives have changed.

Priority	Rationale for choice	Measure
SAFETY		
Patient Falls1 (Continuation)	Targeted work continued to reduce falls across the organisation. To ensure continuation and consolidation of effective processes to reduce the incidence of injury. To continue sensory training to enhance staff perception of risk of falls. To continue a follow up service for patients admitted with fragility fractures.	To introduce the new Trust Falls Strategy, covering a 3 year period. To agree a plan of year 1 actions. To monitor implementation of year 1 actions against the Strategy.
Care of patients with dementia$_1$ (Continuation)	Continued development and roll out of a dementia pathway and monitoring of care for patients with dementia.	Continued adherence to the national standards on assessment of patients aged 75 and over to ensure they are asked about their memory on admission; and measure ongoing referral rate. Monitoring to continue. Explore feasibility of introducing the screening tool into existing electronic assessment tool will continue through this period. Action plan developed from the results of the National Dementia audit to be monitored for improvement. Carers survey has been completed. The recommendations are to be monitored alongside the national dementia audit recommendations. The action plans have been merged and form the Strategy Action Plan 2018/2019.This will be monitored. Participate in a 5 year research project of dementia services within the Durham area to continue during 2018/2019. Participation to continue. Continue the study in the development of a good practice audit tool for assessing patient care and services for those living with dementia. Participation to continue.
Healthcare Associated Infection **MRSA bacteraemia$_{1,2}$** **Clostridium difficile$_{1,2}$** (Continuation and mandatory)	National and Board priority. Further improvement on current performance.	Achieve reduction in MRSA bacteraemia against a threshold of zero. No more than 18 cases of hospital acquired Clostridium difficile. Both of these will be reported onto the Mandatory Enhanced Surveillance System and monitored via Infection Control Committee.

Priority	Rationale for choice	Measure
Venous thromboembolism risk assessment[1,2] (Continuation and mandatory)	Maintenance of current performance.	Maintain VTE assessment compliance at or above 95% within inpatient beds in the organisation. This mandated indicator will continue during 2017/2018. Assessment will be captured onto a Trust database and reported weekly to wards and senior managers. Performance will be reported and monitored at Trust Board using performance scorecards. This indicator will move to part 3 of the report as background monitoring as process is now well developed.
Pressure ulcers[1] (Continuation)	To have zero tolerance for grade 3 and 4 avoidable pressure ulcers.	Full review of any identified grade 3 and 4 pressure ulcers to determine if avoidable or unavoidable. Reduce incidence from last year to zero avoidable grade 3 or 4 pressure ulcers.
Discharge summaries[1] (Continuation)	To continue to improve timeliness of discharge summaries being completed.	Monitor compliance against Trust Effective Discharge Improvement Delivery Plan. Enhance compliance to 95% completion within 24 hours. Data will be collected via electronic discharge letter system and monitored monthly with compliance reports to Care Groups and Trust Board via performance scorecards.
Rate of patient safety incidents resulting in severe injury or death[1,2] (Continuation and mandatory)	To increase reporting to 75th percentile against reference group.	Cascade lessons learned from serious incidents. NRLS data. Enhance incident reporting to 75th percentile against reference group. Carry out bespoke Trustwide work to embed and improve reporting of near miss and no harm incidents.
Improve management of patients identified with sepsis[3] (Continuation)	To monitor roll out of sepsis screening tool via electronic system.	Continue to implement sepsis care bundle across the Trust. Roll out of sepsis screening tool via electronic system. Continue to implement post one hour pathway. Continue to audit compliance and programme. Hold professional study days.
Local Safety Standards for Invasive Procedures (LOCSSIPS) (new indicator from Stakeholder event)	To ensure full implementation of national guidance embedding Local Safety Standards into all areas conducting Invasive Procedures trust-wide.	The Trust has formed a LocSSIP Implementation and Governance Group (LIGG) which brings together members of the Corporate Governance body with Care Group representatives in order to develop LocSSIPs. The LIGG will work with procedural teams to support the implementation of developed LocSSIPs ensuring all individuals understand why the programme is required and how the additional steps are to be conducted. The LIGG will co-ordinate both quantitative and qualitative audits to ensure procedural LocSSIPs are being conducted to a high standard providing reports to IQAC and the Trust Board.

Priority	Rationale for choice	Measure
EXPERIENCE		
Nutrition and Hydration in Hospital[1] (Continuation)	To promote optimal nutrition for all patients.	Focus on protected meal times. Continue to use nutritional bundle for weekly nutritional care planning of patients nutritionally at risk for inpatients – move the nutritional assessment tool to Nerve Centre and once embedded move the care planning bundle to nerve centre also. Trust wide menu implementation of finger foods. Report and monitor compliance monthly via Quality Metrics.
End of life and palliative care[1] (Continuation)	We now have an effective strategy and measures for palliative care. The measures are derived from the strategy and will support each patient to be able to say: "I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including my carer(s)"	Continue to ask the 5 key questions and aim for improvement in positive responses in comparison to last years results. Quarterly Reports to Integrated Quality and Governance Committee and any emerging themes monitored for improvement through the Patient Experience Forum. The Trust will continue to participate in the national inpatient survey.
Responsiveness to patients personal needs[1,2] (Continuation and mandatory)	To measure an element of patient views that indicates the experience they have had.	Continue to ask the 5 key questions and aim for improvement in positive responses in comparison to last years results. Quarterly Reports to Integrated Quality and Governance Committee and any emerging themes monitored for improvement through the Patient Experience Forum. The Trust will continue to participate in the national inpatient survey.

Priority	Rationale for choice	Measure
Percentage of staff who would recommend the trust to family or friends needing care[1,2] (Continuation and mandatory) **Percentage of staff experience harassment, bullying or abuse from staff in the last 12 months[2]** (Mandatory measure) **Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion[2]** (Mandatory measure)	To show improvement year on year bringing CDDFT in line with the national average by 2018/2019.	To bring result to within national average. Results will be measured by the annual staff survey. Results will be reviewed by sub committees of the Trust Board and shared with staff and leaders and themes considered as part of the staff engagement work. In addition we will continue to report results for harassment & bullying and Race Equality Standard.
Friends and Family Test[1] (Continuation)	Percentage of staff who recommend the provider to Friends and Family.	During 2018/2019 we propose to increase or maintain Friends and Family response rates. All areas participating will receive monthly feedback and a quarterly report of progress and will be monitored by the Trust Board.
EFFECTIVENESS		
Hospital Standardised Mortality Ratio (HSMR)[1] **Standardised Hospital Mortality Index (SHMI)[1,2]** (Continuation and mandatory)	To closely monitor nationally introduced Standardised Hospital Mortality Index (SHMI) and take corrective action as necessary.	To monitor for improvement via Mortality Reduction Committee. To maintain HSMR and SHMI at or below 100. Results will be captured using nationally recognised methods and reported via Mortality Reduction Committee. We will continue to benchmark both locally and nationally with organisations of a similar size and type. Monthly updates will be submitted to Trust Board via the performance scorecard. Weekly mortality reviews led by the Medical Director will continue, and any actions highlighted monitored through Care Group Integrated Governance Reports. Embed "Learning from Deaths" policy.

Priority	Rationale for choice	Measure
Reduction in 28 day readmissions to hospital[1,2] (Continuation and mandatory)	To improve patient experience post discharge and ensure appropriate pathways of care. To support delivery of the national policy to continue to ensure patients receive better planned care and are supported to receive supported self – care effectively.	To aim for no more than 7% readmission within 28 days of discharge. Information will be submitted to the national database so that national benchmarking can continue. Results will be monitored via Trust Board using the performance scorecard and any remedial actions measured and monitored through the performance framework.
To reduce length of time to assess and treat patients in Accident and Emergency department[1,2] Continuation and mandatory)	To improve patient experience. To improve current performance.	No more than expected rate based on locally negotiated rates. Monthly measure. Information will be submitted to the national database so that national benchmarking can continue. Results will be monitored via Trust Board using the performance scorecard.
Patient reported outcome measures[1,2] (Continuation and mandatory)	To improve response rate.	To aim to be within national average for improved health gain. NHS England are removing groin hernia and varicose vein from mandatory data collection, hip and knee will continue.
Maternity standards (new indicator following stakeholder event)	To monitor compliance with key indicators.	Continue to monitor for maintenance and improvement in relation to breastfeeding, smoking in pregnancy and 12 week booking. Monitor actions taken from gap analysis regarding "Saving Babies Lives" report.
Paediatric care (new indicator following stakeholder event)	Embed paediatric pathway work stream.	Continue development of more direct and personal relationships with individuals within Primary and Secondary care by building on the work already undertaken.
Excellence Reporting (new indicator following stakeholder event)	To ensure that CDDFT continues to embed learning from excellence into standard culture and practice through Excellence Reporting.	A monthly report to the Executive and Clinical Leadership Committee (ECL) incorporating total Excellence Reports for the preceding month, a Care Group breakdown, highlights of departments with the most excellence reports and common themes. A quarterly report to the Integrated Quality Assurance Committee (IQAC) summarising the ECL report and encompassing summary from learning from excellence group.

1 - continuation from previous year

2 - mandatory measure

3 - new indicator following stakeholder events

Review of performance against priorities 2017/2018

The following section of the report focuses on our performance and outcomes against the priorities we set for 2017/2018. These will be reported on individually under the headings of Safety, Patient Experience and Clinical Effectiveness. Wherever available, historical data is included so that our performance can be seen over time.

During 2018/2019 we will incorporate a section to include changes to services and their impact, with a particular emphasis on access to clinical services and whether their effectiveness has been diminished through service change.

PATIENT SAFETY

Patient Falls

☑	Patient falls – reduce falls/1000 bed days community hospital.
☒	Patient falls – reduce falls/1000 bed days acute hospital.

Our Aim

We are committed to and focused on continued improvement in this area. We set our target in 2017/2018 but have not reached all of the targets agreed. The number of falls within the organisation is identified from the incident reporting system and reporting to the Falls Group on a monthly basis so that any remedial action can be taken. Data is captured in a monthly incident report and as part of the Board performance monitoring data.

Patient falls that result in fractured neck of femur are reported as a Serious Incidents and an in depth analysis of the cause of the fall is carried out to establish whether there are any lessons that can be learned to prevent falls for other patients.

Progress

For monitoring purposes the Trust continues to measure the number of falls against the national mean. This remains at 5.6 per 1000 bed days for acute and 8.0 per 1000 bed days for community. Focused work remains fundamental to ensuring a continued reduction in falls.

Sensory awareness training has continued this year with on-going positive feedback from members of staff. The training focuses on the vulnerability of people with sensory impairments and their risk of falls which also links with dementia/cognitive impairment problems.

Mandatory training for all registered nurses continues, with an overview given of multifactorial risk assessments and intervention given to all attendees. Themes from previous Root Cause Analysis are included this training.

The National Falls Audit was carried out in May 2017 with positive results when measured against regional performance.

A falls strategy has been developed which all stakeholders in the region have agreed to follow so focused work will be taking place in the next year:

1. Education, awareness and training around falls prevention amongst the workforce and wider community.
2. Improved partnership working between community and acute

services to streamline services.

3. Increased accuracy of identifying those at risk of falls.
4. Map out and develop a clear pathway for falls and fragility services in acute and community settings.

Next Steps

- Dedicated multidisciplinary team focussed on reducing falls and falls with harm in acute hospitals and community hospital with the aim is to reduce falls by 10% every year over the next three years.
- Monitoring of safe staffing levels with identification of any areas that require remedial action following a cluster of falls.
- Risk assessments and patient roundings - continue a targeted approach based on patient outcomes with remedial work when any area identified.
- Monitor access to mental health liaison services to have consistently good and meaningful engagement by all staff.
- Patients who require 1:1 or cohorting are provided with this service.
- Explore work with Care Homes to prevent admission following a fall.
- Explore work and improve falls prevention in patients own homes to prevent falls and admission to acute sector working with district nurses, and falls clinics.

Care of Patients with Dementia

☑ Trust ambition achieved

Our Aim

To provide appropriate care for patients with cognitive impairment and monitor effectiveness of interventions using the Trust dementia strategy as the principle monitoring tool. To ensure patients with dementia and their families have a positive experience of the care provided by the Trust.

Progress

The Trust dementia strategy has been introduced and an action plan to monitor implementation of this has been developed. The areas for action and improvement are identified below and these have been shared across the Trust.

Outcome	Actions
Cognitive tests assessed on admission and again before discharge.	Highlight at training sessions for medics and nurses. Promote amongst clinical leads. Promote in team meetings, handovers and in supervision.
Record factors which may cause distress and the action or actions which can help calm the patient.	

Outcome	Actions
Promote the use of "This is me" booklet involving patients and carers.	Ward managers and clinical teams to promote the use of the booklet in initial training, team meetings, handovers and in supervision.
Implement the use of personal patient information from "this is me/hospital passport "into care plans.	Ward managers and clinical teams to promote the use of the booklet in initial training, team meetings, handovers and in supervision.
Information regarding the episode of delirium recorded on the electronic discharge summary.	Highlight at training sessions for medics and nurses. Promote amongst clinical leads. Promote in team meetings, handovers and in supervision.
Implementation of carers' passport to enable carers to be given appropriate support.	Highlight at training sessions for medics and nurses. Promote amongst clinical leads. Promote in team meetings, handovers and in supervision.
Staff are trained in mental capacity, consent, best interest's decision making, lasting powers of attorney and supportive communication with family/carers on these topics.	Safeguarding lead to ensure training is in place for medical and nursing staff. Highlight at training sessions for medics and nurses. Promote amongst clinical leads. Promote in team meetings, handovers and in supervision.

Outcome	Actions
Site nurse practitioners and bed managers to develop expertise in dementia care to ensure support for staff 24 hours per day 7 days per week.	Dementia care to be built into Trust training. Clinical supervisors to promote attendance at training by relevant staff.
Ensure staff receive training in delirium and its relationship with dementia, manifestations of pain, behavioural & psychological symptoms treatment, care.	

Outcome	Actions
Further develop, implement and promote the finger food menu.	Nutritional steering group to continue to lead nutritional improvements.
To promote the variety of ward based snacks available to patients in their area.	At local level, appoint nutritional champions. Ward managers and clinical teams to promote the use of the booklet in initial training, team meetings, hand-overs and in supervision.

Outcome	Actions
Patients, families/carers are involved in discharge planning. Carers are identified at first contact or as soon as possible after this.	Discharge policy embodies good practice principles.
Before a person is discharged, their physical, psychological and social needs will be assessed. The person with dementia and someone involved in their day-to-day care should be fully involved in this assessment. Plans about the date and time of discharge should be discussed with the person and their carer.	Discharge management, Ward teams and discharge lounges work together with patients, carers and with other agencies to ensure discharge care packages take account of the dementia-related needs of patients.
Any organisations that will be providing services must be informed of the date and time of the person's discharge, and when they should start to provide the services.	
Documented evidence in the notes that the discharge planning and support needs have been discussed with the multi – disciplinary team , patient, family, carer, care home.	

Theme 6: Governance

Action/s agreed	By whom?
Continue to offer dementia awareness training to all staff.	Dementia training to be provided for all medical and nursing staff.
Compliance with training and good practice is encouraged and supported.	Feedback to Trust dementia lead. Use of national Audit data and processes.

Next Steps

- Formal monitoring against the elements of the strategy as identified above with clear escalation for support if there is any lapse in implementation

Healthcare Associated Infections

MRSA bacteraemia

✗	Trust ambition not achieved.

Clostridium difficile

✗	Trust ambition not achieved.

What is MRSA? Meticillin resistant Staphylococcus aureus is a bacterium found on the skin and in the nostrils of many healthy people without causing problems. It can cause disease, particularly if there is an opportunity for the bacteria to enter the body, for example through broken skin or during a medical procedure. If the bacteria enter the body, illnesses which range from mild to life-threatening may then develop. Most strains are sensitive to the more commonly used antibiotics, and infections can be effectively treated. MRSA is a variety of Staphylococcus aureus that has developed resistance to meticillin (a type of penicillin) and some other antibiotics used to treat infections.

Our aim

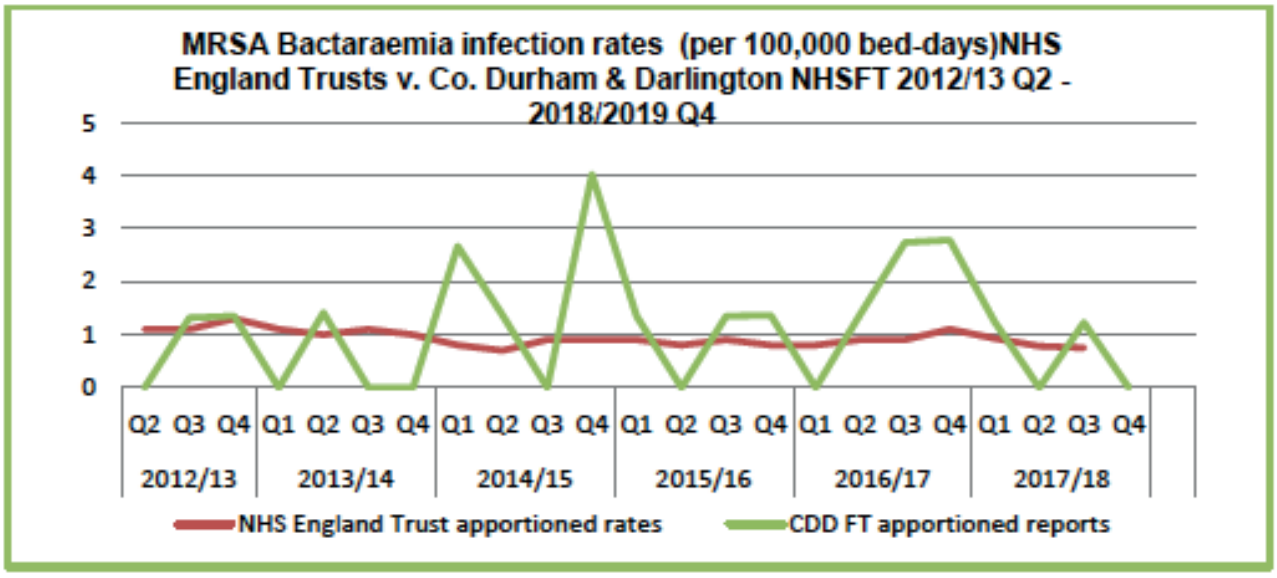
The trust aims to deliver on the zero tolerance approach to MRSA Bloodstream infections NHS commissioning boards planning guidance "Everyone Counts; planning for patients 2014/2015 to 2018/2019 and reiterated in Guidance on the reporting and monitoring arrangements and post infection review process for MRSA bloodstream infections from April 2014 (version 2) March 2014.

Progress

CDDFT has reported 4 cases of MRSA Bacteraemia since April 2017 which puts the Trust above its annual threshold of zero avoidable infections.

All 4 were very complex patients with a number of co-existing medical conditions increasing their infection risk. Some key issues were identified and are being shared through the organisation as lessons to be learned.

Graphs below indicate the trust position at the May 2018 and Trust performance against trajectory from Q2 2012/13.



Actions for improvement

- Focus on MRSA Screening and decolonisation.
- Focus on monitoring Intravenous line care.

Clostridium difficile

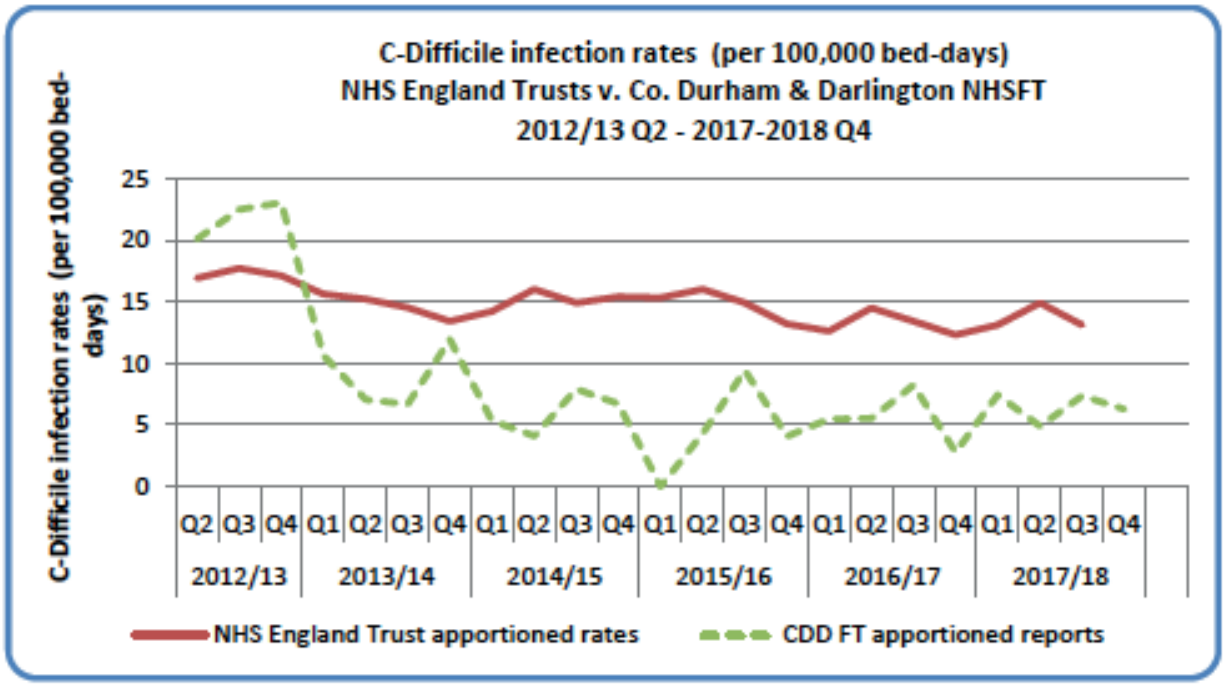
What is Clostridium difficile? It is a bacterium that can live in the gut of a proportion of healthy people without causing any problems. The normal bacterial population of the intestine usually prevent it from causing a problem. However, some antibiotics used to treat other illnesses can interfere with the balance of bacteria in the gut which may allow Clostridium difficile to multiply and produce toxins. Symptoms of Clostridium difficile infection range from mild to severe diarrhoea and more unusually, severe bowel inflammation. Those treated with broad spectrum antibiotics, with serious underlying illnesses and the elderly are at greatest risk. The bacteria can be spread on the hands of healthcare staff and others who come into contact with patients who have the infection or with environmental surfaces contaminated with the bacteria.

CDDFT have reported 20 cases against an upper threshold of 19. Although we have exceeded this year trajectory by 1 case, our performance in rate /100,000 bed days remains one of the best nationally. Many strategies and focused interventions have been introduced throughout this year and will be continued.

- Executive led HCAI Reduction group.
- Focus on increasing awareness around antibiotic stewardship.
- Quarterly hand hygiene Trust wide observational audits with results being feedback to individuals and care group leads.
- Focus on determining the root cause and lapses in care and sharing lessons learn.

Clostridium difficile appeals process

Clostridium difficile appeal meetings have been held with CCG and NHS England local area team where 2 cases have been



presented for appeal and were upheld. This means that following a review of each case no lapses of care have been identified as a cause or contributory to the Clostridium difficile infection.

Actions for Improvements

- Focus on early identification and isolation.
- Targeted work with the areas where Clostridium difficile has been identified.
- Continue with Antimicrobial stewardship programme.

Next steps

A comprehensive action plan has been developed for all hospital acquired infection improvement goals.

The actions include:

- Further focus on antibiotic stewardship in particular monitoring of antibiotic prescribing across the health economy. The Trust antimicrobial team will continue their work in reviewing the Antimicrobial policy and guidelines, evaluating antimicrobial use, and providing feedback to physicians. The team are responsible for optimising antimicrobial use in the hospital by improving compliance with the guidelines, through education and regular audit of practice.
- Continuation of hand hygiene audit with a focus on publically displaying results and awarding areas with 100% compliance for more than a year.
- Implement new guidelines to respond to the risk of infection from emerging infectious disease, new strains and antibiotic resistance.
- We will continue to monitor and maintain progress in reducing the number of infections attributable to the Trust.

E-Coli Bacteraemia

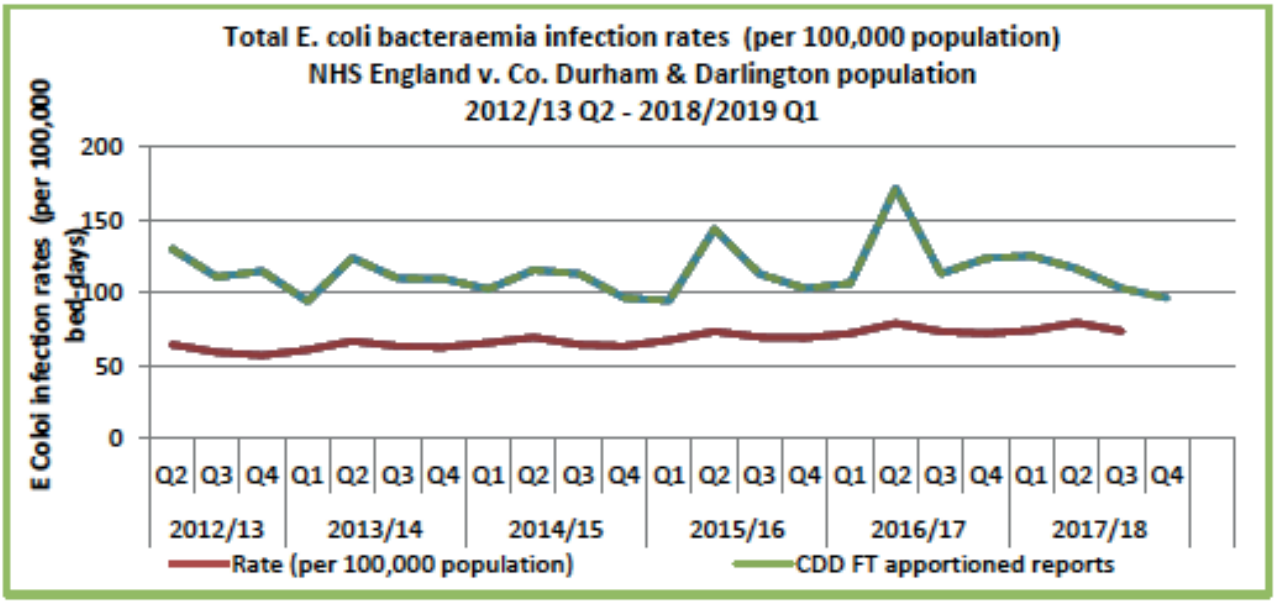
What is Escherichia coli? Escherichia coli (abbreviated as E. coli) is a Gram-Negative bacteria found in the environment, foods, and intestines of people and animals. Although most strains of E. coli are harmless, others can make you sick. Some kinds of E. coli can cause diarrhoea, while others may cause urinary tract infections, respiratory illness pneumonia, blood stream infections and other illnesses. In May 2017 the Secretary of State for Health launched an ambition to reduce healthcare associated Gram-negative bloodstream infections by 50% by 2021 and reduce inappropriate antimicrobial prescribing by 50% by 2021.The initial focus is on reducing E.coli Blood stream infections by 10%.

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

The Trust reported a total of 357 cases for year 2017-2018 with 47 of these being "hospital onset" we have developed a local action plan and will continue to complete a review. During year 2017/2018 the Trust reported a 5% drop in total number of cases this is in line with national performance, the Trust apportioned cases were reduced by 23%. This performance was recognised by NHS Improvement and members of the Trust Infection Control team were invited along with CCG Infection Control colleagues to an E COLI masterclass for CEO and NED's where we demonstrated the benefits of working in collaboration across the whole health economy.

Actions for Improvement

- Sepsis recognising when something is not normal and escalating adhering to best practice for recognising and treating sepsis.
- Preventing Catheter Associated Urine Infections; Management of patients with Urinary catheter, understanding need for catheter and planning



trial without catheter, considering alternative methods, ensuring patient has been given completed hand held passport. Adhering to trust policy and best practice.

- Preventing urinary infection: keeping patients hydrated. Ensure patient able to wash hands after using the toilet and before meals.
- Don't use urine dipsticks to diagnose urinary infection.
- Good antimicrobial stewardship.
- Education and Training. Ward/ department Link Champions.
- Intravenous access, monitoring and management of lines.

Venous thromboembolism assessment (VTE)

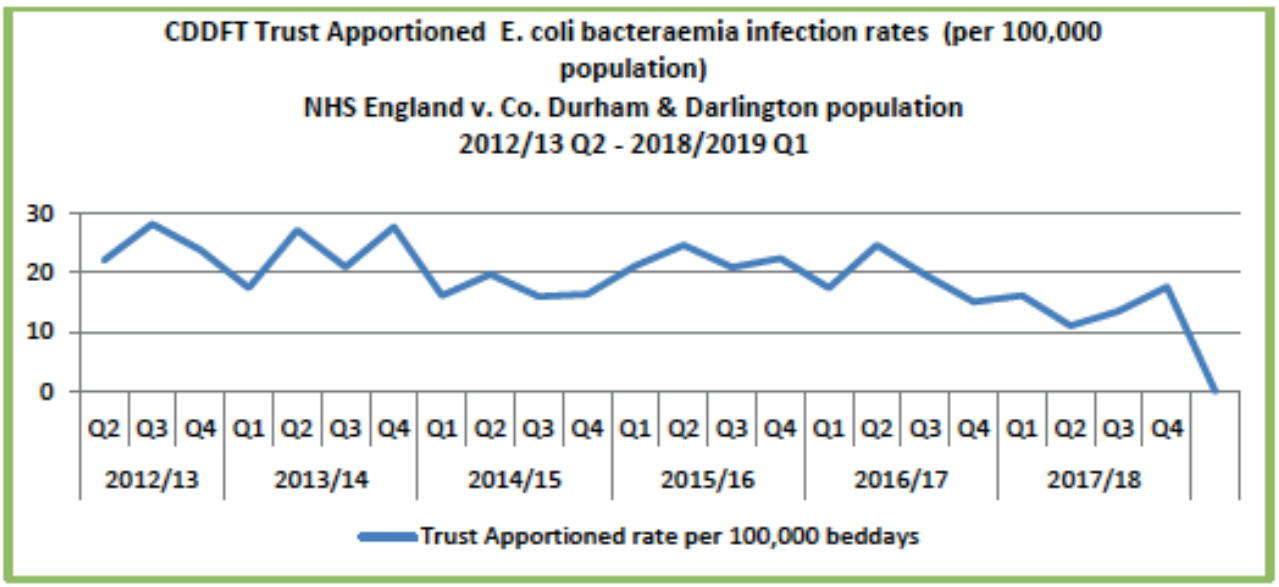
Assessment

☑ Trust ambition achieved

What is VTE? - Thrombosis is a condition caused by formation of a blood clot in a vessel, obstructing or stopping the flow of blood.

The VTE task & finish group has been re-established and the policy and information leaflets have been reviewed.

Risk Assessments are undertaken on all patients admitted to the organisation with compliance monitored via the Assurance Risk and Compliance department we have been 96.4% compliant in the last year.



Pressure Ulcers

✗	Trust ambition not achieved.

Our aim

For patients within our care to have no avoidable grade 3 or above pressure ulcers.

Progress

We have continued to carry out a full review of all patients identified with grade 3 and above pressure ulcers whilst in our care. Whilst we have seen increased focus and improvement in this area, we still have further to go and are disappointed that there have still been incidences of these throughout the year as identified below.

Within the Trust hospitals data there has been a reduction in avoidable grade 2 and 3 pressure area damage. This has been a significant improvement on previous performance and is as a result of targeted education and audit on prevention and recognition of pressure ulcers. In addition the tissue viability team have been involved in research into the reduction of heel damage post operatively with some encouraging early results.

Acute Services Hospitals – DMH, UHND, CLS, Shotley Bridge	Avoidable Grade 2	Avoidable Grade 3/4
2012/13	34	3
2013/14	16	4
2014/15	13	7
2015/16	2	1
2016/17	4	1
2017/18	0	1

Community Services Richardson Hospital, Weardale Community, Sedgefield Community and all patients under care of DN teams	Avoidable Grade 2	Avoidable Grade 3/4
2012/13	23	3
2013/14	2	3
2014/15	2	2
2015/16	0	4
2016/17	2	3
2017/18	0	3

This will remain a primary objective for 2018/2019 as we continue with improvement measures to achieve our aspiration of zero avoidable pressure ulcers.

Next steps

We will continue to report all incidents of skin damage onto the Safeguard Incident Reporting system. A root cause analysis will

be undertaken for all grades 3 and above incidents so that any remedial actions are identified and addressed.

Tissue viability education across acute hospitals has been rolled out across all areas and will be commencing in April for all community areas with a dedicated module and competency assessments.

There is current an ongoing revision of policy following the implementation of new higher specification mattresses as standard. New chairs with pressure reduction cushions introduced as standard, 700 installed in 2017 across all areas of the trust.

New innovative projects for the prevention of heel blisters in orthopaedic patients now in protocol and implemented as a NICE guideline.

New innovative prevention work commencing in April 2018 within paediatric areas for prevention of pressure ulcers.

Discharge Summaries

✗	Trust ambition not achieved.

Our aim

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

Progress

This remains a high priority for GPs who maintain that without timely discharge information they are unable to provide effective and safe follow-up care for their patients after a hospital stay.

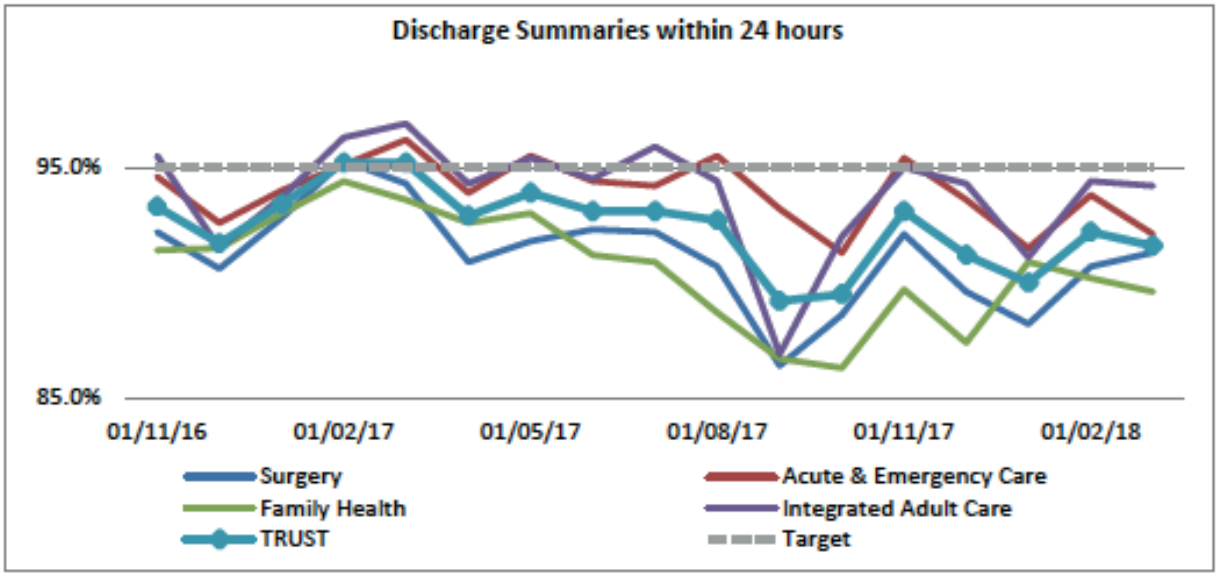
During 2017/2018 Integrated Adults and Acute/Emergency Care Groups are the only ones who managed to exceed the 95% target in individual months. At Trust-level, performance continues to exceed 90% but to fall short of the 95% target.

Care Group	2017/2018 Average
Surgery	90.4%
Acute & Emergency Care	93.7%
Family Health	89.8%
Integrated Adult Care	93.5%
Trust	91.9%

The significant dip in September performance is thought to be due to the inexperience of the new intake of junior doctors; that in December-January to increased winter pressures.

Training is provided to new staff and regular reminders are sent emphasising the importance of this target. Each Care Group has a responsible lead manager. A task group, led by Integrated Adults has been reconvened to explore ways to achieve 95% consistently.

The performance of each Care Group is monitored in monthly Performance Reviews and Executive-led quarterly reviews. Progress is also reported monthly to the Executive and Clinical Leaders Group, the Integrated Quality and Assurance Committee and to the Trust Board.



Next steps

The Trust will continue to monitor this priority and re-emphasise to all front-line staff its clinical importance. Current reporting arrangements will continue.

Rate of patient safety incidents resulting in severe injury or death (from NRLS)

⊖	Improvement demonstrated but ambition not achieved

The National Reporting and Learning Service (NRLS) system enables safety incident reports to be submitted to a national database on a voluntary basis and is designed to promote learning. It is mandatory for NHS Trusts in England to report all serious incidents to the Care Quality Commission as part of the registration process. The Trust's NRLS results for April 2017 to September 2017 show that we are in the mid 50% of reporters. This is calculated as a comparison against a national peer group, which is selected according to type or trust.

Never Events

Disappointingly, the Trust reported four never events during the period. A never event is defined as an incident that should not occur if correct procedures and policies are in place. The Never Events are shown below alongside a brief description of actions implemented to prevent recurrence. These are also described below.

Retained foreign object Retained Foreign Object Post-Operation and injury to bowel	Internal process to be agreed on how staff raise risks identified with equipment/devices to be highlighted to manufacturers and Trust Governance Meeting • Consideration of including an area in WHO checklists to identify theatre staff roles and responsibilities, in line with Trust LocSIPPs and guidelines. • Development of LocSIPP for procedure in conjunction with manufacturers guidelines • Inclusion of guidance on the checks required for single use equipment/device to be in the Trust Medical Device policy • Immediate withdrawal of device whilst undertaking of the RCA and MHRA investigation • All committees approving use of medical devices/ equipment to be quorate in line with Trust guidelines • All theatre staff to have an understanding of equipment and devices used within the theatres environment, to troubleshoot where applicable. • Medical Device Training for MiniTouch device to be recorded for all staff members learning records who have attended • Liaison with MHRA and manufactures regarding the fitness for purpose of this device and whether consideration should be given to withdrawal of the device from market.
Wrong site block Wrong side femoral nerve block	• Stop before you block procedure not undertaken despite being aware of it. • Complex intubation involved with this patient, which reinforces further the need for stop before you block process to double-check site and side of the block.

Retained foreign object Tampon retained post-delivery following a forceps delivery, episiotomy and 2nd degree

- Continuity of swab counts Continuity of swab counts - same people, stay in room
- Any change of operator requires swab count and a new swab count to be started
- White board must include tampon
- Perineum's should be inspected daily whether in hospital or community
- Avoid interruption intra procedures
- If registrar hands over procedure trainee should still be supervised, i.e. he / she should not leave room
- Only the midwife can hand items to obstetrician
- Apply clip to tape of tampon at time of insertion so anything internal is indicated with a visible marker outside
- After doing a repair always do a PV then a PR
- If patient attends with unusual discomfort - patient should be examined with a speculum - at least one finger pv - to look for a foreign body

Wrong Route Administration of Medication

Oral oramorph given intravenously

- IV syringes **MUST NOT** be used to measure or administer oral liquid medicines by mouth or enteral feeding tube.
- A medicine cup of 5ml spoon should be used to measure and administer oral liquid medication except in the following situations where:-
- PURPLE oral/enteral syringe MUST be used: The dose cannot be accurately measured using a medicine cup of 5ml spoon e.g. less than 5ml or not a multiple of 5ml, or where dose measurement is critical e.g. digoxin, phenytoin
- Case discussed with all staff in duty it is a rare event that oral medication is used in resus but the trust policy should have been followed.

In considering the never events the following key themes have been identified:

- Human factors.
- Failure to comply with policy/procedures.
- Increased stress regarding site capacity and workload.

NHS Improvement worked alongside the Trust for the first part of 2017/2018, to assist with understanding of the analysis of the Never Events and to co-ordinate an improvement programme.

The never events that have occurred and learning identified have been shared widely across the organisation and through communications and presentations. Organisational learning events took in April and September 2017, where over 600 staff attended, in addition to external speakers and delegates from neighbouring Trusts. Feedback obtained from these events is being analysed to capture and inform further actions required to improve safety across the Trust.

Regulation 28

The Trust received no Regulation 28 letters of the Coroner's Investigation Regulations from 2013 during 2017/2018.

Serious incidents

The Trust reported 76 serious incidents during 2017/2018. All of these incidents have a full root cause analysis review and themes are identified from these.

Falls remain the highest reported incidents and actions taking place are reported in the falls section of the report.

County Durham & Darlington NHS Foundation Trust considers that this rate is as described for the following reasons:

The data is cleansed by a member of the patient safety team prior to upload.

The data within this category is agreed through Safety Committee and at Executive level prior to upload to NRLS.

Period	Apr14 Sep14	Oct14 Mar15	Apr15 Sept15	Oct15 Mar16	Apr16 Sept16	Oct 16 Mar17	Apr 17 Sept 17
Patient safety incidents	4300	5631	6100	5998	5238	5527	5334
CDDFT %age reporting Rate (1000 bed days)	26.28	35.27	40.5	38.85	35.17	37.66	36.75
CDDFT %age severe injury & death	0.1	0.2	0.2	0.4	0.3	0.2	0.4
National %age reporting rate (1000 bed days)	35.1	35.34	38.25	39.31	40.02	40.12	* Not available
National %age severe injury & death	0.5	0.5	0.4	0.4	0.4	0.3	* Not available

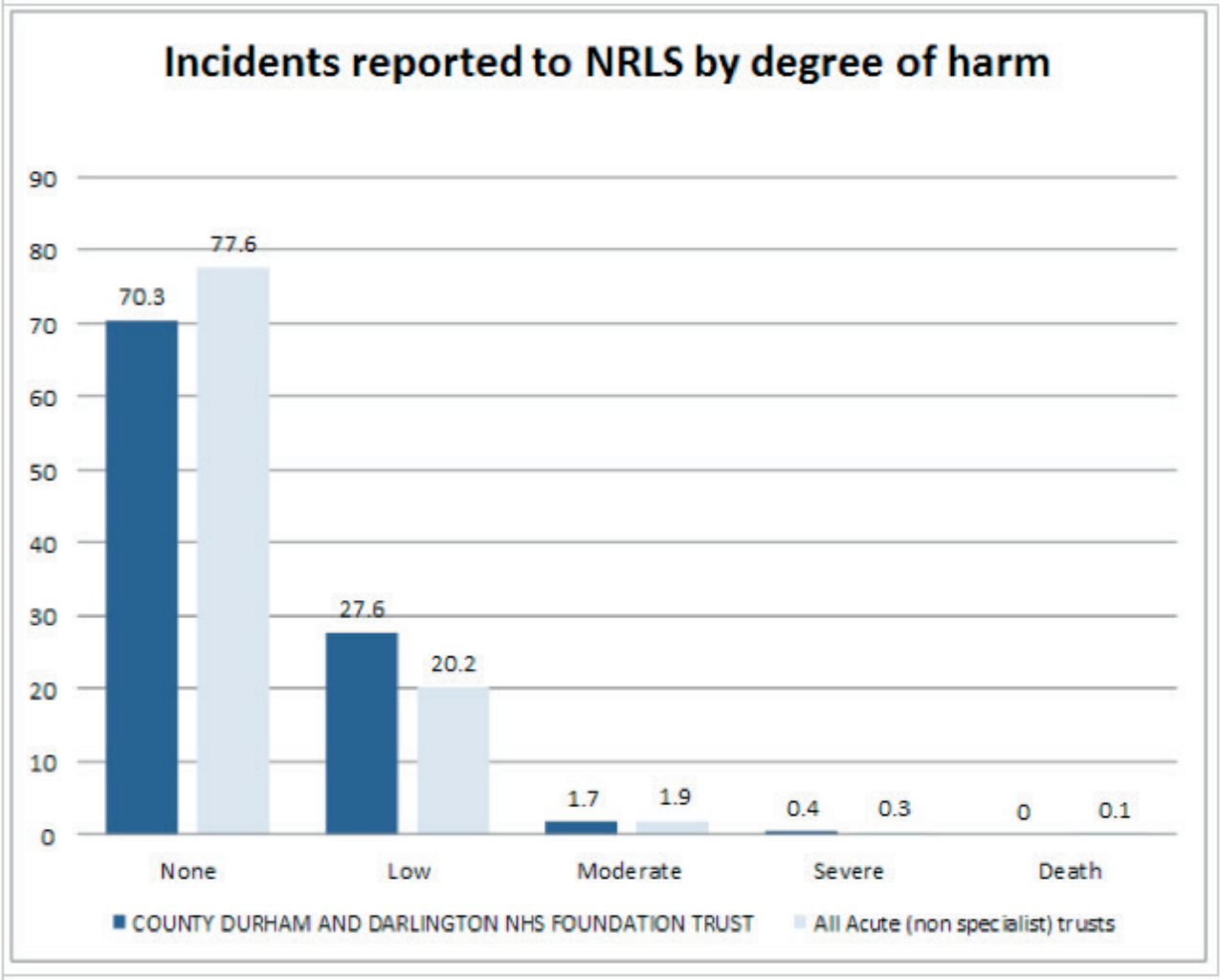
*From April 2018 the release of the organisation patient safety incident data workbook (official statistics) the NRLS organisation level summary report no longer include national average statistics.

Our aim

- To continue to aim for an increase in incident reporting to within the top 75% of reporters.
- To improve timeliness of reporting to and completion of reviews for moderate harm incidents.
- To encourage and support staff to report all incidents and near-misses so that we are sure there is an accurate and complete picture of patient safety issues.
- To monitor timeliness of reporting and completing serious incident reviews as per national guidance.
- To ensure that if a patient suffers moderate or above harm from an incident whilst in our care, they are given the opportunity to discuss this in full with relevant clinical staff and are assured that a review has taken place.

Progress

Incident Rate and National Median (Apr – Sep17 NRLS Data)



Harm rating

The Trust remains an under reporter of no harm incidents (no harm and near miss on Safeguard) compared to the cluster average, whilst the percentage of low harm incidents reported is higher than average but further improvements have been seen in this period with both figures moving in the right direction.

Further work has been undertaken by the Patient Safety team to identify why we are under reporting no harm incidents and through analysis of the no harm and low harm incidents reported it seems that the incidents aren't always graded appropriately during the management process. In relation to the incidents reported and the percentages as outlined below by grading, CDDFT would be in line with other Acute (Non-specialist) organisations if the grading of some of the low harm incidents were correctly graded as no harm.

Therefore work is underway to encourage the managers to review the grading of harms when reviewing incidents, whilst encouraging staff to increase reporting of no harm and near miss incidents across the trust.

Next steps

County Durham & Darlington NHS Foundation Trust intends to take the following actions (outlined below) to improve this number and/or rate, and so the quality of its services.

- Progress against the themes highlighted above will be monitored at the bi-weekly Patient Safety Forum and Safety Committee dashboards.
- Care Groups will be expected to complete reviews within the specified time period and include the position in their Integrated Governance report that is produced quarterly.
- To undertake audit of current reporting of incidents to establish innovations to improve reporting of near miss/ no harm incidents within 2018/2019.
- To explore the standardisation of lessons learnt documentation.
- To consider the sharing of incident themes by speciality to involve staff in learning from
- incidents and mitigate the potential risk.

Improve management of patients identified with sepsis

☑ Trust ambition achieved

Our Aim

To build on the foundations of the work we have done in relation to Sepsis over the last 3 years, and continue to improve the identification and treatment of patients with sepsis in our care.

Progress

The regional sepsis screening tool is now integrated within Nervecentre for inpatients and Symphony for ED patients, meaning that all patients within CDDFT are automatically screened for sepsis. For those inpatients screening positive for sepsis the Sepsis bundle is also within Nervecentre allowing the staff to complete it electronically.

Next Steps

Continue to closely monitor the e-screening and timeliness of bundle delivery to target education in specific areas of weakness and improve the quality of care for patients with Sepsis.

Measure: Trust wide audit and Sepsis Mortality.

Duty of Candour

☑ Trust ambition achieved

What is duty of candour?

From the 27 November 2014 Duty of Candour placed a statutory requirement on health providers to be open and transparent with the 'relevant person' (usually the patient, but also family members and/or carers) should an incident resulting in harm occur. The Care Quality Commission Regulation 20 prescribes health providers to inform and apologise to the 'relevant person' if the provider has caused harm. The statutory duty is activated when a 'notifiable' patient safety incident occurs which causes harm. The definitions of harm are:

- The **death** of a patient occurs when due to treatment received or not received (not just the patient's underlying condition).
- **Severe** harm is caused – in essence permanent serious injury as a result of care provided.
- **Moderate** harm is caused – in essence, non-permanent serious injury or prolonged psychological harm (a minimum of 28 days).

Our Aim

The regulation outlines that where the harm threshold has been breached; specific reporting requirements need to be followed. Therefore the Trust has implemented the process below for **moderate harm and above events,** to ensure they meet statutory requirements:

- An apology must be given as soon as possible following identification of a patient safety event that is considered moderate or above harm.
- All information must be documented in the patient notes, which includes that a verbal apology has been given and letter of apology is being prepared to be sent within the 10 day framework, using the agreed Duty of Candour template.
- A written apology must be sent or given to the patient and/or relatives/ carers within 10 working days of event being identified. A copy of the letter of apology should be attached to the Safeguard Incident Management system.

This information is recorded by staff completing the manager's actions on the electronic Safeguard Incident Management system, which is extracted fortnightly to illustrate compliance with the duty of candour process.

Progress

The Trust current compliance with Duty of Candour is 94%.

Since the implementation of the Duty of Candour regulation the Trust has undertaken a number of actions to ensure compliance as outlined below:

- Ulysses Incident Management system enables staff to record the elements of Duty of Candour to allow monitoring of Trust compliance.
- The development of an agreed patient record template for staff to document that Duty of Candour has been completed e.g. verbal apology, that is to be scanned into the patient's record. This has been incorporated into the Trust Being Open/Duty of Candour Policy.
- Internal and external audits have been undertaken with 2017/2018 and recommendations have been implemented to strengthen the Duty of Candour process within the Trust.
- Duty of Candour continues to be included in various Trust wide training programmes such as corporate staff induction, essential training, and root cause analysis.
- A standalone training programme is available for Duty of Candour; however, the uptake continues to be poor.
- Fortnightly Duty of Candour compliance reports are reviewed at the Patient Safety Forum.
- Care Group Leads alongside their Service Manager(s) will ensure that Duty of Candour is recorded in Ulysses Incident Management system.

Next Steps

County Durham & Darlington NHS Foundation Trust intends to take the following actions (outlined below) to improve this number and/or rate, and so the quality of its services. The further actions identified to ensure compliance is maintained are to:

- Continue to monitor Duty of Candour compliance fortnightly in Patient Safety Forum.
- Further education with staff groups in recording Duty of Candour via Trust wide training programmes and bespoke training days.
- To embed the use of the patient record template to document that Duty of Candour has been completed and evaluation of the implementation within 2018/2019.

Local Safety Standards for Invasive Procedures (LocSSIPs)

☑ Trust ambition achieved

Our Aim

To deliver a programme of work to review local standards for invasive procedures across the Trust and ensure that current practice is harmonised with the National Safety Standards for Invasive Procedures (NatSSIPs). The programme will implement Local Safety Standards for all Invasive Procedures that have the potential to be associated with a Never Event, in order to standardise the safety processes underpinning these procedures, to improve consistency of practice in all clinical settings, thereby delivering the safest care possible and reducing the number of associated patient safety incidents including Never Events.

Progress

The LocSSIP Implementation and Governance Group (LIGG) continues to meet regularly; co-ordinating and supporting LocSSIP development within

the Care Groups. A LocSSIP programme plan details and monitors associated stages of work and the programme's project portfolio; progress is now reported to the Trust Board via the Clinical Effectiveness Meeting, with delivery currently on schedule.

The LIGG has designed a strategy to engage junior medical staff and has developed LocSSIP pages on the intranet so that all staff can access LocSSIP related resources. A successful application to CDDFT's Dragons Den has secured funding for additional education and marketing.

A LocSSIP audit strategy continues to be developed:

- A quantitative audit tool has been tested in one procedural area and will be utilised to support further audit within the Care Groups;
- Options for an observational audit tool and staff survey are being explored.

The LocSSIP programme scope was extended in August 2017 to review the existing World Health Organisation Surgical Safety Checklist which required revision following a Never Event. This work is now complete with the new checklist due to be implemented in February pending completion of a 'how to conduct' video by the Care Group.

All of phase one's 25 procedural LocSSIPs (checklists) will be fully approved and externally printed ready to commence deployment within Care Groups by 31-3-18. 6 out of 7 Safety Notices are in place and work relating to extending the Team Brief concept to procedural areas outside theatre is progressing alongside the introduction of the procedural checklists.

Next Steps

County Durham & Darlington NHS Foundation Trust intends to take the following actions (outlined below) to improve this number and/or rate, and so the quality of its services.

The priority is to ensure all procedural checklists are received from the external printers and available to commence deployment. During this time, the LIGG will support the Care Groups to ensure checklists and additional materials are in place and individuals responsible for monitoring and stocking the procedural areas are identified.

Work will be undertaken to complete the Safety Notices, consolidate Team Brief development and further progress will be made on the 'Area LocSSIPs' which describe in detail what each Care Group expects from its staff with respect to the conduct of Invasive Procedures. Further communications with substantive staff will take place through governance groups and supported by posters, bulletins, direct email to Care Group governance and management leads and potentially pull-up banners located in key areas.

The audit programme will continue to be developed through the LIGG who will work with Care Group Governance Teams and advise how the tool should be implemented to measure metrics such as LocSSIP completion. The observational tool will continue to be developed with the LIGG working with specific teams where appropriate to ensure appropriate qualitative analysis is undertaken. Audit results will provide assurance of successful

implementation and adoption and will guide future intervention if required.

The LIGG will remain in place throughout 2018 to ensure the programme is implemented fully. During this time it will be flexible to the ongoing needs of the Trust responding when required to ensure newly identified requirements are accommodated within the programme.

MATERNITY STANDARDS

Maternity Standards: Breastfeeding

⊖ Improvement demonstrated but ambition not achieved

Our Aim

To improve breastfeeding initiation rates – Target 60%.

This data collected is CSC breastfeeding intention in relation to this indicator.

Progress

Year to date performance 2017/2018 – 58.7%.

Next Steps

County Durham & Darlington NHS Foundation Trust intends to take the following actions (outlined below) to improve this number and/or rate, and so the quality of its services.

- Implementation of Baby Buddy App.
- Monitor the usage of the Bump Buddy App through the data provided by Best Beginnings.
- Roll out of Solihull approach to parenting.
- UNICEF UK Baby Friendly Reaccreditation June 2017.
- Progress to UNICEF Gold Award following successful UNICEF reaccreditation.
- Work with Durham County Council Director of Public Health in making County Durham a
- Breastfeeding Friendly County.
- Maintain staff skills and knowledge through UNICEF accreditation with regular staff skills audits and revised training programme.

Other considerations:

- Review of the Maternity Care Assistant role in the Community and across the Acute Sites.
- Establish Specialist Clinics run by the Infant Feeding Co-ordinator for those mothers with complex pregnancies.
- Review of the frenulotomy (tongue tie) service.
- Setting up of Maternity Care Assistant clinics in the Community to make access easier for pregnant women.

Maternity Standards: Smoking in Pregnancy

☑ Trust ambition achieved

Our Aim

To reduce the number of women smoking at delivery – Target 22.4%.

Progress

2017/2018 performance – 17.6%.

Next Steps

County Durham & Darlington NHS Foundation Trust intends to take the following actions (outlined below) to improve this number and/or rate, and so the quality of its services. The further actions identified to ensure compliance is maintained are to:

- Work with commissioners and FRESH in targeting women in DDES CCG area (high prevalence) offering an incentivised voucher scheme.
- CDDFT and NECA have secured tender for Darlington area and work is underway to engage with maternity services to re-establish stop smoking support, pharmacology and data capture.
- Continue to work with Solutions 4 Health in training, support and data capture to continue to improve quit rates.
- Review training provided to Community Midwives and MCA's, to develop the brief intervention offered to women at the Booking appointment and throughout pregnancy.
- Review of the risk perception clinics (BabyClear) to ensure that these are being utilised for those women most in need.

Maternity Standards: 12 week booking

☑	Trust ambition achieved

Our Aim

To increase the number of women booked for maternity care by 12 weeks + 6 days

– Target 90.0%.

Progress

2017/2018 Performance 90.9%.

Next Steps

County Durham & Darlington NHS Foundation Trust intends to take the following actions to improve this number and/or rate, and so the quality of its services. The further actions identified to ensure compliance is maintained are to:

- Include information about early booking on new maternity web page.
- Continue to monitor weekly data.
- Continue to validate weekly data.
- Continue to communicate with Information Department on women who transfer into Trust during pregnancy.
- Circulate information to wider health population including school nurses.
- Work with GP surgeries to ensure enough capacity for Midwives to carry out Booking Clinics, providing a service which ensures women have access to early booking appointments.
- Development of Early Bird classes.

Other considerations:

- Currently in discussion with Public Health regarding a late booking campaign.

Saving Babies Lives

☑ Trust ambition achieved

- **Element 1** – Reducing smoking in pregnancy by carrying out a Carbon Monoxide (CO) test at booking to identify smokers (or those exposed to tobacco smoke) & referring to stop smoking services as appropriate.
- **Element 2** – Identification and surveillance of pregnancies with fetal growth restriction.
- **Element 3** – Raising awareness amongst pregnant women of the importance of detecting & reporting reduced fetal movement (RFM) & ensuring providers have protocols in place, based on best available evidence to manage care for women who report RFM.
- **Element 4** – Effective fetal monitoring in labour.

Gap Analysis

Element	Achieved Yes/No	Planned Actions
Element 1	Yes	Post-delivery CO monitoring of all women. DDES funding initiative from PHE to support voucher incentive scheme.
Element 2	Yes	GROW implemented and subject to continuous audit. Presentation of specific audit of outcomes for SGA/IOL/NNU admissions etc. On-going scanning pathway & capacity work stream.
Element 3	Yes	Exploring barriers to women accessing services promptly in presence of reduced fetal movements.
Element 4	Yes	Central CTG monitoring & archiving system including Dawes-Redman capacity.

Next Steps

County Durham & Darlington NHS Foundation Trust intends to take the following actions (outlined below) to improve this number and/or rate, and so the quality of its services. The further actions identified to ensure compliance is maintained are to:

Continue to monitor against the standards identified in "Saving Babies Lives" to ensure that the elements remain embedded in practice

Element 1 – Reducing smoking in pregnancy by carrying out a Carbon Monoxide (CO) test at booking to identify smokers (or those exposed to tobacco smoke) & referring to stop smoking services as appropriate - see above for update.

Element 2 – Identification & surveillance of pregnancies with fetal growth restriction.

All Community Midwives to have GROW training redelivered including assessments

of measuring SFH and completion of online learning.

SABINE task and finish group set up to monitor achievements towards the above measures. SABINE champions in all Maternity areas.

Continuous audit in place to monitor the success of the GROW initiative which is linked to the Perinatal Institute.

Element 3 – Raising awareness amongst pregnant women of the importance of detecting & reporting reduced fetal movement (RFM) & ensuring providers have protocols in place, based on best available evidence to manage care for women who report RFM.

Further work being undertaken with commissioners to look at barriers to women attending as there have been delays in women accessing services when they have had episodes of reduced fetal movements.

Trust has been involved in the Tommy's Sleep on your Side campaign aimed at reducing stillbirths in the third trimester.

Element 4 – Effective fetal monitoring in labour.

All Obstetric and Midwifery staff to complete K2 training package.

Fresh eyes has become hourly review, fresh ears to be implemented hourly for all low risk labours including home births.

As part of electronic patient record project, implement Central CTG monitoring & archiving system including Dawes-Redman capacity.

Within the Maternity Service there has been a tremendous amount of work targeted at improving communications and information for women and their families in line with 'Better Births' and this has resulted in the update and development of the service website which now includes up to date information on all aspects of care and provides details on local, regional and national contacts available for further information.

Paediatric Care

☑ Trust ambition achieved

Our Aim

Most of the urgent/ emergency admissions to paediatric wards come directly from GP/ Primary care to the paediatric ward based assessment areas. The average, and most frequent length of stay for children is less than 1 day (0 days).

We aimed to improve the pathway for children referred to hospital through developing a number of initiatives which require sharing of knowledge and expertise and strengthening the interface between Primary care and Secondary care clinicians.

Specific aims were focused on enabling more children and young people to receive more of their care in Primary Care by making Secondary Care expertise more available locally by:

- Providing additional education for GPs.
- Being more accessible to GPs for clinical advice.
- Providing Consultant-led sessions in Primary Care.

To begin to reshape local children's services in line with local priorities, the CDDFT Clinical Strategy and remain consistent with the direction of travel within the Sustainability and Transformation Programme.

Progress

There are assessment teams in place on both sites:

Consultant Paediatrician available from 10 – 10 weekdays and 10 – 6 at weekends.

In addition -

- UHND assessment area offers focused assessment 24 hours per day 7 days per week with nursing and medical staff (1st and 2nd tier).
- DMH offers focused assessment at weekends.

All of the individual elements of the plan have been implemented resulting in changes to the pathway. Some of the most successful changes have been those made in building relationships with primary care colleagues, and developing shared ownership of the pathway.

Next Steps

County Durham & Darlington NHS Foundation Trust intends to take the following actions (outlined below) to improve this number and/or rate, and so the quality of its services.

Establish Consultant Paediatric Clinics in GP Surgeries working alongside the GP Federations. Not only will this bring care closer to home for children and families but it will support the GP's by offering advice regarding individual cases and contribute towards their continuing professional development.

This year has been about developing and testing the various elements and developing a blueprint for what has worked well, what may require further work, and a better understanding of how to adapt and apply what has been learned and developed across the entire referral pathway.

Excellence Reporting

Why is this a priority?

Excellence in healthcare is prevalent but has not previously been formally captured. CDDFT have developed and implemented a trust-wide system for reporting excellence of our staff, by our staff. Our peer reported excellence system provides us with qualitative and quantitative data and the Trust's Learning from Excellence Group will provide outputs to inform quality improvement and celebrate excellence within the Trust.

Our aim

To ensure that Excellence Reporting is embedded within CDDFT and that learning from excellence provides both qualitative and quantitative data for the Trust to ensure we can learn from the everyday excellence that is peer reported.

Next steps

County Durham & Darlington NHS Foundation Trust intends to take the

following actions (outlined below) to improve this number and/or rate, and so the quality of its services. The following actions will continue to be embedded

- The Trust has developed an Excellence Reporting Policy and Learning from Excellence Group, which brings together representatives from all Care Groups.
- Learning from Excellence outputs will include celebration of excellence as well as learning outcomes.
- The Learning from Excellence Group will ensure that both qualitative and quantitative data outputs are produced.

Measuring

- Care Groups receive monthly reports into governance meetings.
- ECL will receive a monthly summary of reports and breakdown by Care Group.
- IQAC will receive a quarterly summary incorporating a summary of ECL data and learning from excellence.

PATIENT EXPERIENCE

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

We aim to create an environment within which "delivering excellence" in patient experience is seen as essential to the management and delivery of health services and the strategy outlines our engagement principles.

Our vision for services is 'right first time, every time' and our mission is with you all the way which means that we put our patients at the centre of all we do. The engagement of our patients, members, staff and public is key in understanding how we are performing against our vision and mission and how we develop and evaluate our services to ensure that the care we are providing is meeting the needs of our patients. The strategy sets out how we will increase engagement and involvement within our local communities which will promote trust in our services, support reputational management and help position us as the provider of choice.

The Patient Experience agenda encompasses a wide variety of objectives at CDDFT. The below chart highlights the Patient Experience Team objectives ensuring the patient / carer is central to all Trust activity.

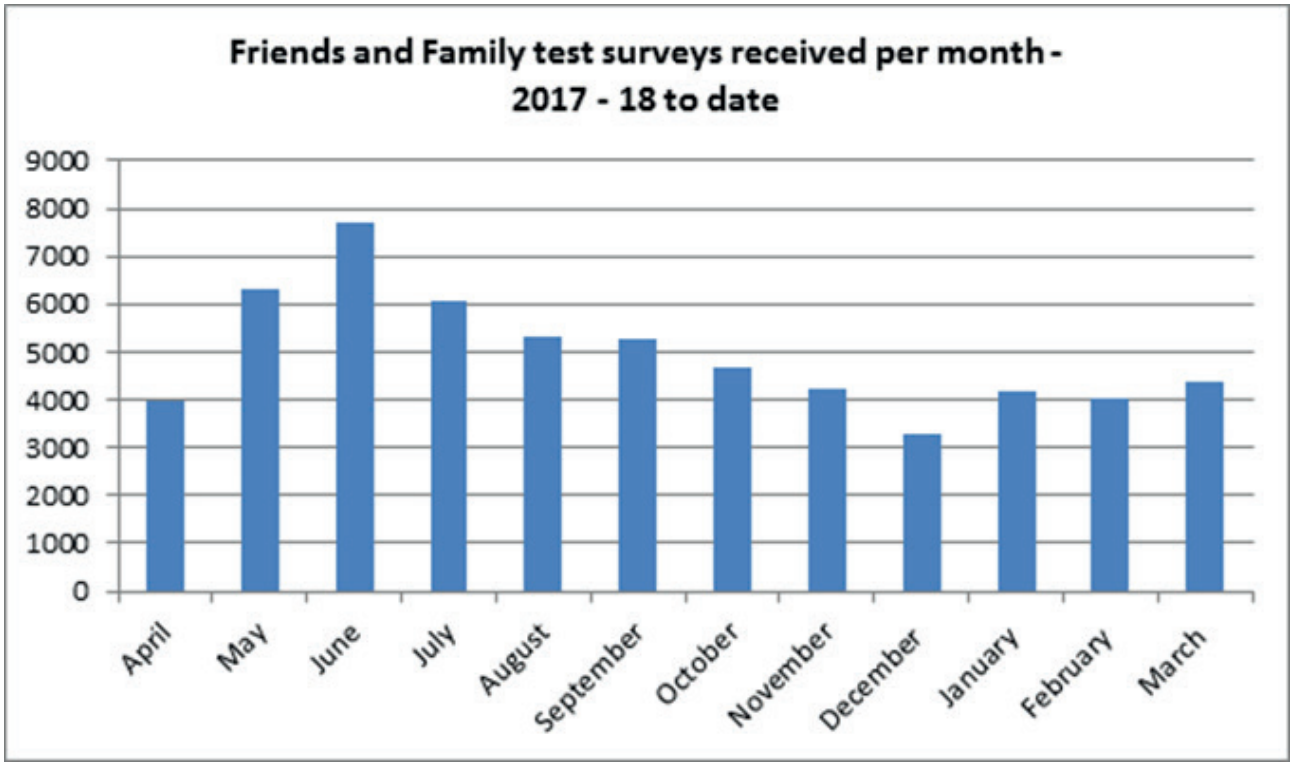
The Trust will continue to raise staff awareness and continue to capture data advising Care Groups of their compliance rates and of areas where actions are required for improvement.

Friends and Family Test (FFT) for patient feedback

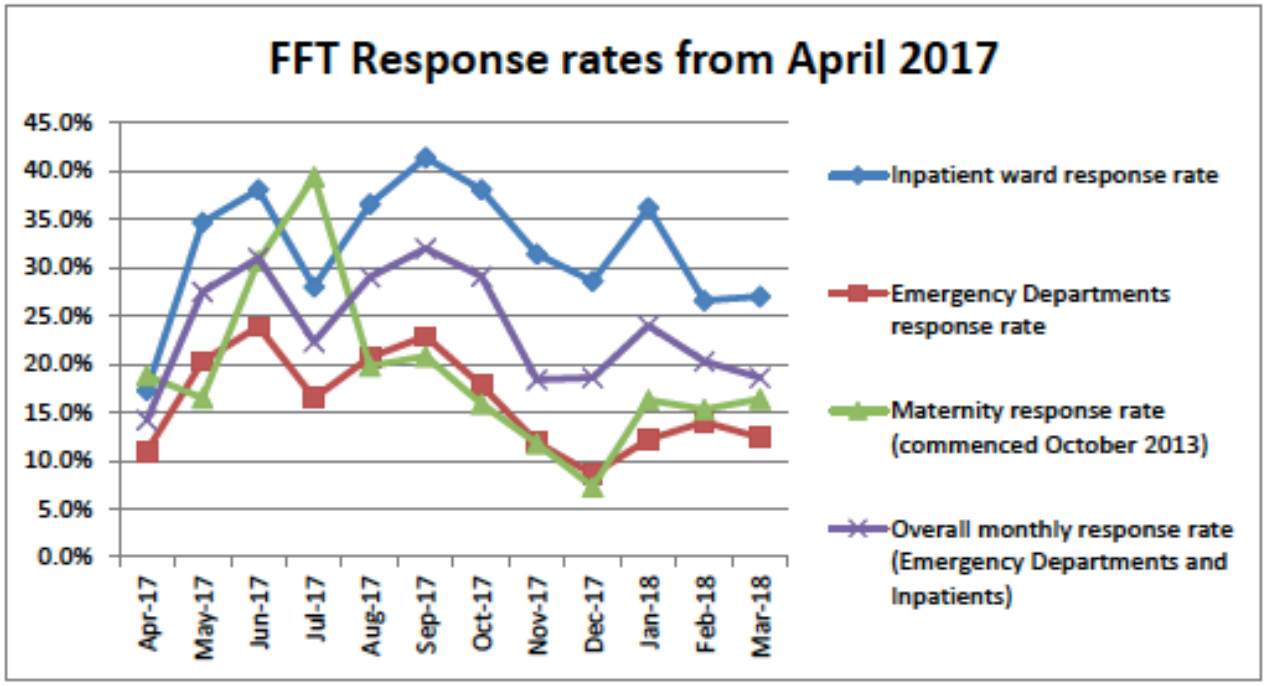
Throughout 2017-2018, all patients were provided with the opportunity to complete a questionnaire asking if they would recommend the service they had received to a friend or family member.

The data is collected monthly and response rates are returned to UNIFY, Department of Health. Data is available via the NHS Choices website.

Data collected from Emergency Departments are combined with Urgent Care Centres. Similarly, Inpatient data is combined with Day case data.



The below table shows the Trust's response rates for 2017/2018 for Emergency Department/ Urgent Care Centres, Inpatient / Day case areas and Maternity, showing the response rates since adopting a new internal process. In September response targets were met for In-patient and Emergency Departments. The drop in maternity has been identified as a direct result from changing how women receive information as the F&F questionnaire was missed from the pack. This was addressed, however it was noted following receipt of December data that we were experiencing a gradual reduction in responses across all areas. This issue has been escalated. The significance of positive engagement with this process has been encouraged via meetings with senior nurse and midwifery teams as well as sisters, charge nurses and ward managers.



All areas are requested to complete "you said we did" posters and display in their respective areas.

FFT Headline Measure

The percentage measures are calculated as follows:

$$\textit{Recommend}\ (\%) = \frac{\textit{extremely likely} + \textit{likely}}{\textit{extremely likely} + \textit{likely} + \textit{neither} + \textit{unlikely} + \textit{extremely unlikely} + \textit{don't know}} \times 100$$

$$\textit{Not recommend}\ (\%) = \frac{\textit{extremely unlikely} + \textit{unlikely}}{\textit{extremely likely} + \textit{likely} + \textit{neither} + \textit{unlikely} + \textit{extremely unlikely} + \textit{don't know}} \times 100$$

The following chart shows the Trust-wide recommendation score from April 2017 for Emergency Department / Urgent Care Centres, Inpatient / Day cases and Maternity Services:

Month	Inpatient		A&E		Maternity	
	% Rec	% Not	% Rec	% Not	% Rec	% Not
April 2017	96	0	94	2	82	0
May 2017	98	1	93	2	99	0
June 2017	98	1	94	2	98	0
July 2017	97	1	94	2	98	0
August 2017	97	1	93	2	99	0
September 2017	97	1	94	2	99	1
October 2017	97	1	94	2	99	0
November 2017	97	1	92	2	98	0
December 2017	97	1	94	2	93	0
January 2018	98	1	94	2	98	0
February 2018	97	1	93	2	98	0
March 2018	96	2	94	2	97	0

FFT Feedback

The Patient Experience Team provides all wards and departments with individual ward reports and trust wide reports on a monthly basis. This provides wards and departments with the opportunity to develop improvements in service based on patient feedback, an example of a "you said, we did" poster and action plan is demonstrated below:

Training

Training sessions and presentations are provided by the Patient Experience Team on a regular basis to internal and external stakeholders in order to promote the importance of patient/ carer feedback within CDDFT.

The Patient Experience Team continues to deliver training at student nurses and medical students programmes upon invitation. When available, service users attend these sessions and relay their experience which provides valuable insight from a patient perspective. The sessions are evaluated and feedback has been extremely positive. Awareness sessions and updates have been delivered to Trust governors. The Customer Care e learning package is available to all staff groups. Bespoke customer care programmes have been taken forward within individual care groups, and the Great Expectations customer care course is available to all CDDFT staff and volunteers.

Dignity for All

In 2017, we celebrated Dignity Action Day, taking this opportunity to consult with attendees on the CDDFT dignity campaign, with the intention of aligning "Hello My Name Is" project to our "Dignity For All – Our Promise to You" project. Feedback from staff, visitors, volunteers, carers and governors, was very positive and work is on-going to take this campaign forward.

National Patient Survey (NPS) Reports

National Inpatient Survey – Reported June 2017

The National Inpatient survey was reported in June 2017.

CDDFT rated about the same as other trusts for all questions asked with an overall experience rate of 79% which was also about the same as most trusts.

There were 5 questions where CDDFT performed statistically worse than our 2015 survey results

- Did you feel that you had to wait a long time to get to a bed on a ward?
- Did you feel threatened during your stay in hospital by other patients or visitors?
- In your opinion, did the members of staff caring for you work well together?
- Did you have confidence in the decisions made about your condition or treatment?
- Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?

There were no questions with a 'significant' increase in performance (4% or greater) in 2016 compared with the 2015 Survey. Although the Trust did score well on the following areas:-

- Provision of information and explanation from anaesthetists.
- Confidence of doctors and nurses.

Emergency Department Survey – Reported October 2017

The National Emergency Department Survey was reported in October 2017. The results show that CDDFT scored about the same as most other trusts for 33 of the 35 questions.

One scored better than most Trusts, in the top 20% and one scored lower than most trusts in the bottom 20%.

Did a member of staff tell you when you could resume your usual activities such as when to go back to work or drive a car?	42%
Did a member of staff explain the purpose of medications you were to take at home in a way that you could understand?	98%

National Children Inpatient and Day Case Survey - Reported November 2017

The National Children and Young People Inpatient and Day Case Survey was reported in November 2017. Results show that CDDFT compared "the same as most trusts" for all except two questions.

The two remaining questions, CDDFT scored better than most Trusts, in the top 20%.

Provision of information for parents & carers before an operation or procedure.	99%
Provision of answers to questions before an operation or procedure.	98%

The below areas will be monitored and actioned via Patient Experience Forum throughout 2018:

- Did staff play with your child at all while they were in hospital?
- Did members of staff treating your child communicate with them in a way that your child could understand?
- Did you have access to hot drinks facilities?
- Were you given enough information about how your child should use medicine?

National Maternity Survey – Reported January 2018

The 2017 survey of women's experiences of maternity services was reported in January 2018. This survey was analysed in three sections including Ante-natal care, Labour and birth and Post-natal care.

Ante-natal care – CDDFT scored about the same as most trusts for 10 of the 12 questions asked (83%) of questions. Two further questions identified below were in the lowest 20% of all trusts.

Did you get enough information from a MW or Dr. to help you decide where to have your baby?	60%
During your ante-natal check-ups, did a midwife ask you how you were feeling emotionally?	66%

Labour and birth – CDDFT scored about the same as most trusts for 17 of 19 questions asked (89%). The 2 remaining questions were within the top performing Trusts and were:

Were you (and / or a partner or a companion) left alone by midwives or doctors at a time when it worried you? **This was the top performing Trust score of all Trusts in England.**	88%
Thinking about the care you received in hospital, after the birth of your baby, were you given the information or explanations you needed?	86%

Post-natal care – CDDFT scored about the same as most trusts for 16 of the 20 questions asked (80%). The 4 remaining questions, as identified below, were within the top performing trusts.

Were your decisions about how you wanted to feed you baby respected by the midwives?	95%
Did you feel that midwives and other professionals gave you consistent advice about feeding your baby?	77%
Did you feel that midwives and other professionals gave you active support and encouragement about feeding your baby?	84%
When you were at home after the birth, did you have a telephone number for a midwife or midwifery team that you could contact?	99%

The above issues form part of the National Survey action plan which is monitored and reviewed at Patient Experience Forum.

Post Discharge Survey

The Post Discharge Survey is posted to a sample of 400 patients on a quarterly basis; this represents 1600 patients a year which is twice the sample used in the national survey. The questions mirror that of the National Inpatient Survey in order that we capture issues in real time and develop actions to address identified issues in a timely manner.

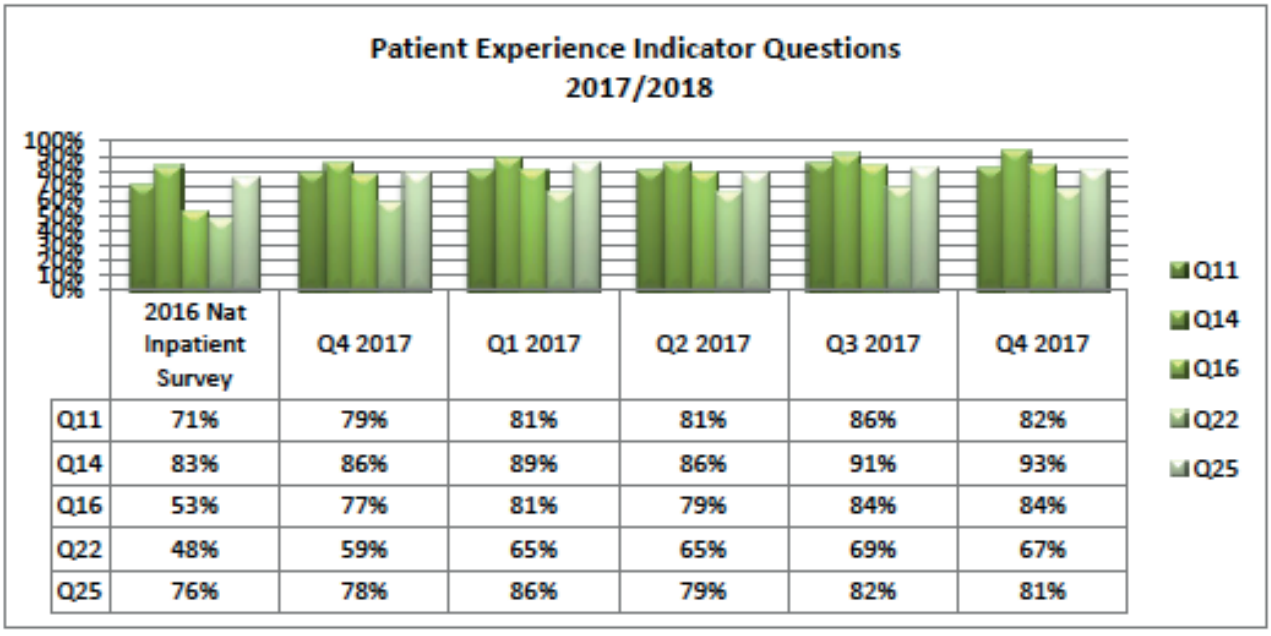
The data below shows the responses in relation to the CQUIN indicator questions comparing each quarter with the National Inpatient Survey results for 2016 (reported 2017).

Patient Experience Indicator Questions	National Inpt 2016	Q1 2017/2018	Q2 2017/2018	Q3 2017/2018	Q4 2017/2018
Did you feel involved enough in decisions about your care and treatment? (Q11)	71%	81%	81%	86%	82%
Were you given enough privacy when discussing your condition or treatment? (Q14)	83%	89%	86%	91%	93%
Did you find a member of staff to discuss any worries or fears that you had? (Q16)	53%	81%	79%	84%	84%
Did a member of staff tell you about any medication side effects that you should watch out for after you got home in a way that you could understand? (Q22)	48%	65%	65%	69%	67%
Did hospital staff tell you who you should contact if you were worried about your condition or treatment after you left hospital? (Q25)	76%	86%	79%	82%	81%

Post Discharge Survey Reports are presented quarterly at Patient Experience Forum and qualitative and quantitative data and themes are shared with senior staff to disseminate and action where appropriate.

Themes for 2017/2018 are identified below:

Theme	Q1 17-18	Q2 17-18	Q3 17-18	Q4 17-18
Food	2	7	1	1
Medication	1	2	0	3
Treatment and care				10
Response to buzzers / for help	1	0	3	
Communication	6	3	13	12
Feeling safe	2	1	3	
Attitude	2	1	5	3
Personal care	2	1		2
Discharge	2	2	2	2
Noise at night / disturbance	1	1	1	1
Transfer between wards	1	1	2	3
Cleanliness	1	2		
More information / choice		1	1	
Environment/TV/entertainment		1	3	2
Confidentiality		1	1	1
Dignity			1	4
Staffing			5	5
Parking			1	

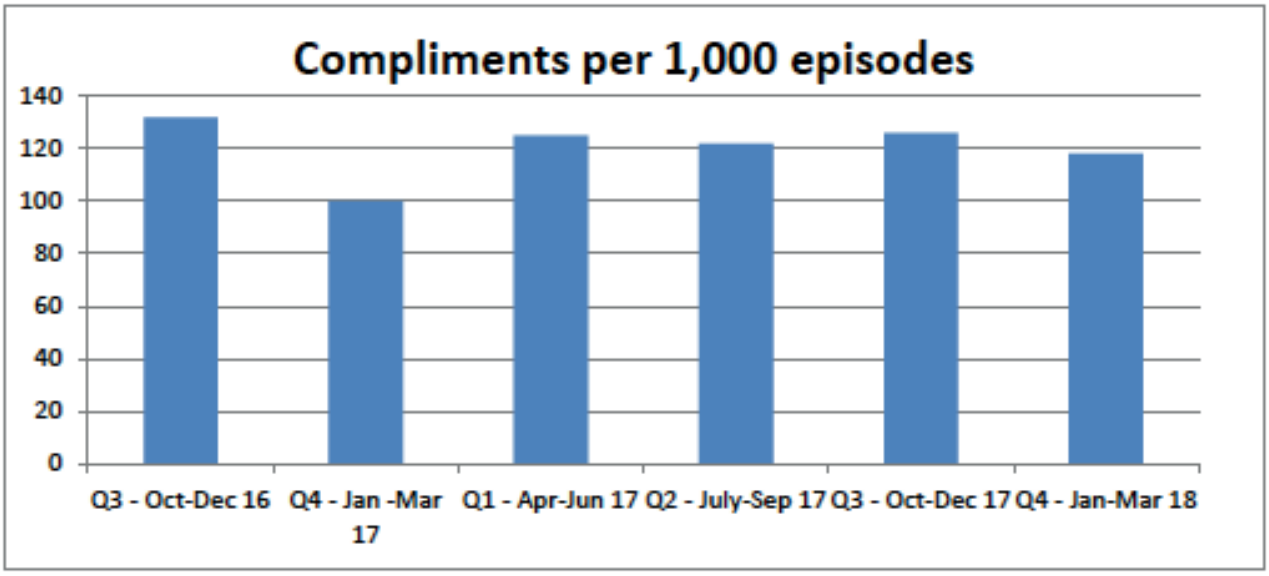


	2016 Nat Inpatient Survey	Q4 2017	Q1 2017	Q2 2017	Q3 2017	Q4 2017
Q11	71%	79%	81%	81%	86%	82%
Q14	83%	86%	89%	86%	91%	93%
Q16	53%	77%	81%	79%	84%	84%
Q22	48%	59%	65%	65%	69%	67%
Q25	76%	78%	86%	79%	82%	81%

Compliments

The below table and chart highlight the number of compliments received for 2017/2018 in comparison to previous years. Ward teams have been reminded of the reporting process to ensure all compliments are captured and reported. A quarterly report is available to all staff via the Trust intranet. Patients and carers are also encouraged to share their comments on the CDDFT website, as well as NHS Choices.

Quarter	2012-13	2013-14	2014- 15	2015-16	2016-17	2017/2018
1	3,662	5,297	5,288	6,058	4,761	4,409
2	4,698	5,782	5,473	7,406	4,953	4,339
3	5,730	4,523	6,123	6,078	5,355	4,628
4	4,493	4,863	6,228	3,902	4,093	4,195
Total	18,583	20,465	23,112	23,444	19,162	17,571



Working in Partnership with Healthwatch

CDDFT work in partnership with Healthwatch County Durham and Healthwatch Darlington. Healthwatch play a vital role liaising with the general public and capturing feedback about health services which is shared with the trust in order that we can learn from general trends or specific issues.

Representatives of Healthwatch County Durham and Healthwatch Darlington are members of the trust's Patient Experience Forum which is held 6 times per year. Healthwatch provide constructive feedback from service users and members of the community. Healthwatch teams have provided invaluable support and feedback and are currently supporting the Invest in Rest project.

Healthwatch members continue to support a peer review process whereby current anonymised complaint reports and responses are reviewed to ensure a fair and balanced response is provided to patients. Feedback is shared at Integrated Quality and Assurance Committee.

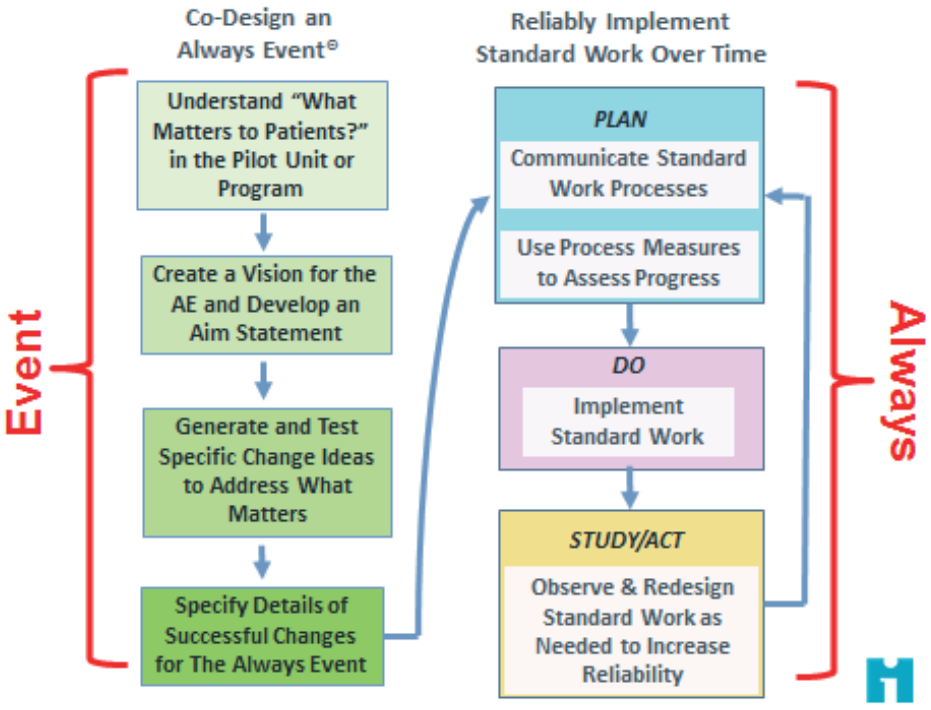
Learning from Experience

From the quarterly analysis of patient feedback, themes are identified and included in thematic action plans which are presented to the Care Groups for action, these action plans are monitored through the Complaints, Litigation, Incidents and Pals (CLIP) reports and discussed at Safety Committee.

Individual action plans are developed in response to partly and founded complaints and shared with the complainant. Examples of action plans and "You said, we did" posters are mentioned earlier in this report. To ensure learning across the organisation the Patient Experience Team continue to produce the newsletter called 'Quality Vibes' which identifies examples of lessons learned throughout the quarter, this is disseminated via the weekly bulletin and available on the intranet.

Always Events Initiative

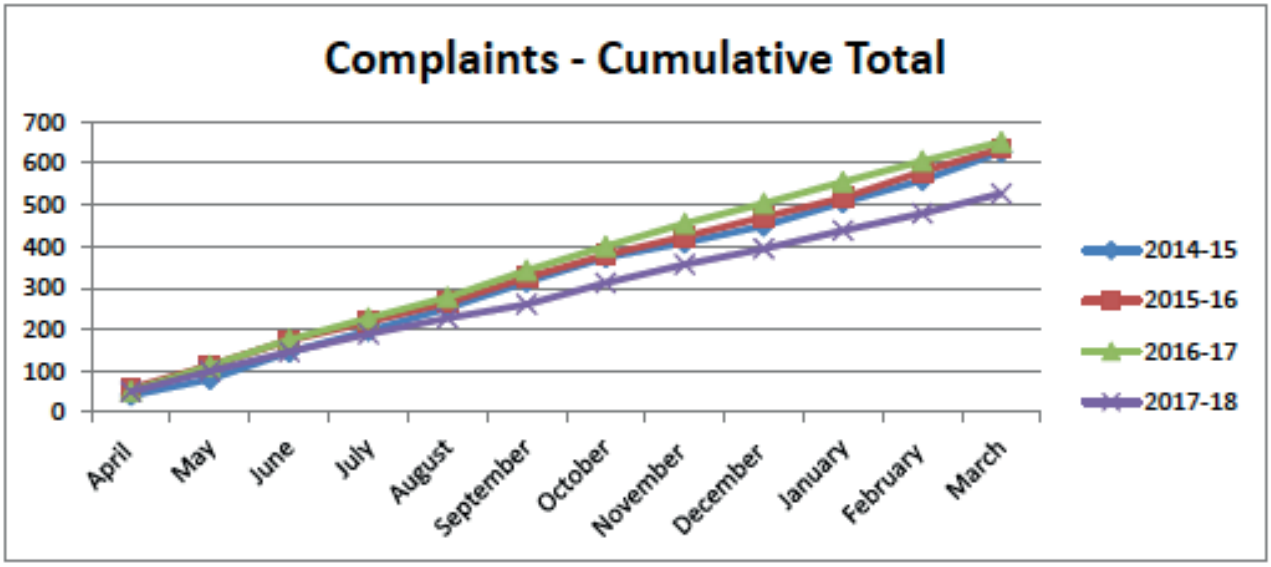
This is a national project lead by NHS England with 10 pilot sites nominated. In February 2018, CDDFT became an Always Event pilot site to look at co-designing / co-production delivery , supported by front line teams. Always Events are aspects of care that should always occur when patients, carers, service users interact with healthcare professionals and the healthcare delivery system.

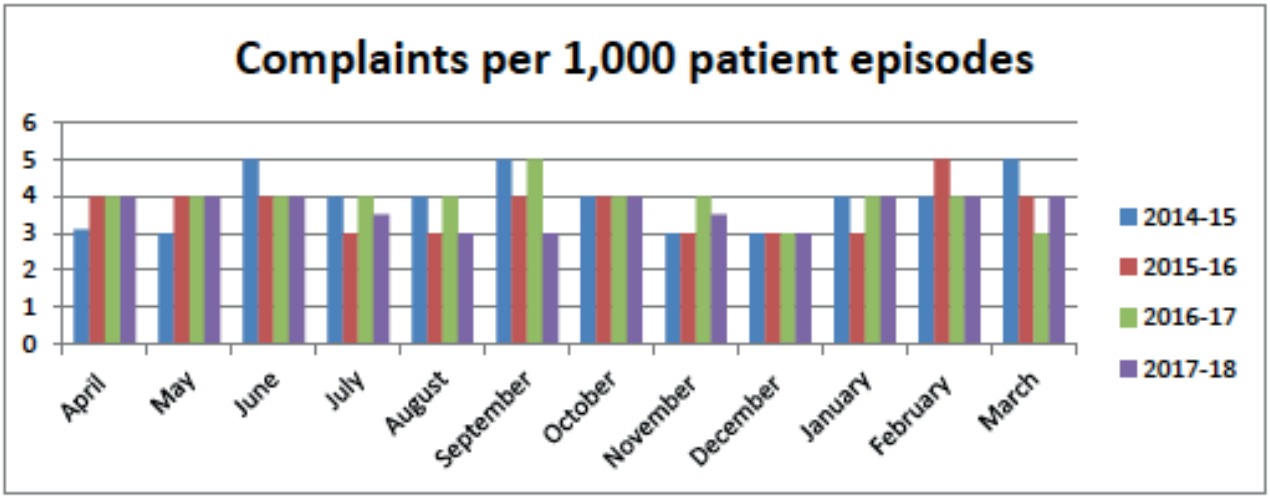


Complaints

As well as proactive patient feedback the Trust also receive formal complaints and informal concerns via the patient experience team. The Trust follows the NHS complaints procedure and accepts complaints either verbally or in writing. If complaints are founded or partially founded the complainant receives an action plan to address the issues identified as well as a response. Complainants are offered a meeting and or a written response and are encouraged to participate in action planning to turn 'complaints into contributions'. Complaints and concerns form part of the quarterly CLIP analysis and themes identified are included in the Care Group thematic action plans.

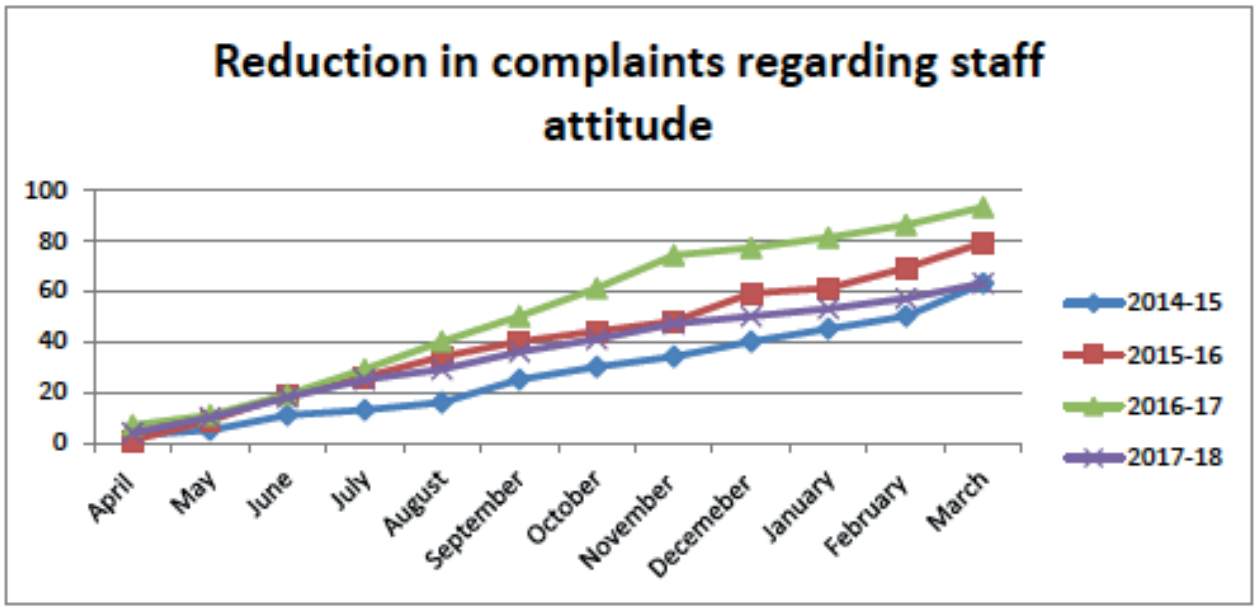
The below charts show the number of formal complaints received Trust-wide throughout 2017/2018 as well as number of complaints per 1000 patient episodes in comparison to previous years.





Complaints Monitoring

The Trust continues to monitor complaints in relation to staff attitude. Our aim is to remain below the threshold set in the 2012-13 Quality Accounts of 70 per year. In 2015-16, this number increased to 79 and in 2016-17 this increased further to 93. This has been monitored closely ay Integrated Quality and Assurance Committees. Throughout 2017/2018 we have received 63 complaints regarding attitude of staff as a primary cause of concern, which is an improvement over the previous three years.



Patient Stories

Patient stories continue and have been instrumental formulating lessons learned and actions for staff to improve patient experience. We listen to both positive and negative stories from our patients and share these with commissioners, staff and governance committees within the Trust.

A Patient Story is shared monthly at Integrated Quality and Assurance Committee. Appropriate actions where required are highlighted and monitored. We are exploring various ways of sharing stories across the organisation moving forward. Where possible we encourage service users to attend strategic meetings and share their experiences, which has been very powerful and constructive.

Nutrition and hydration in hospital

⊖	Improvement demonstrated but ambition not achieved

Nutrition

Our aim

To ensure that inpatients are adequately screened for under nutrition and dehydration and that they have onward referral as appropriate. To ensure that inpatients are regularly monitored for their risk of under nutrition and hydration and that remedial action is taken in a timely fashion. To ensure that where therapeutic dietetic intervention is identified, these inpatients are referred as appropriate.

Progress

The Quality Metrics have now been introduced and these provide a monitoring tool to audit compliance with nutritional standards.

In addition the dietetic service has also consolidated the Nutrition Trustwide role and in 2017/2018 the following areas have become business as usual.

- Nutritional Assessment (Must) in Nerve Centre.
- End of life nutritional care pathway.
- Nutrition policy.
- Parenteral Nutrition Policy.
- Nutrition Subgroups to review parenteral and enteral nutrition, nutritional screening, nutrition and hydration.
- Registered Nurse Nutrition Training offered monthly by Nutrition Nurse Specialist.
- WASP framework for nasogastric training in RN.
- Further roll out of metrics capture via Quality Matters audit.

Next Steps

County Durham & Darlington NHS Foundation Trust intends to take the following actions (outlined below) to improve this number and/or rate, and so the quality of its services.

The service will in 2018/2019 work to review the Nutrition Bundle documentation in line with Quality Matters audit.

The Nutrition and Dietetic Department and Catering Service continue to work closely together on hospital menu development and nutritional analysis.

In terms of hydration we will consider how we maintain and monitor sufficient hydration status of patients requiring both artificial (intravenous or enteral) and non-artificial hydration support.

In addition, we will explore how CDDFT might require alternative ways of measuring oral fluid intake at ward level. This may include evaluation of a trust wide initiative linked to hydration – similar to the campaign from 2012-13 'Hydrate, Estimate, Escalate' or further innovative measures such as water drop stickers or simple measure mugs.

Patient Led Assessments of the Care Environment

The Department of Health and the NHS Commissioning Board requires all hospitals, hospices and independent treatment centres to undertake an annual Patient Led Assessment of the Care Environment (PLACE).

April 2013 saw the introduction of PLACE, which is the system for assessing

the quality of the patient environment, replacing the old Patient Environment Action Team (PEAT) inspections. The assessments primarily apply to hospitals and hospices providing NHS-funded care in both the NHS and private/independent sectors but others are also encouraged and helped to participate in the programme.

The assessments involve local people (known as Patient Assessors) going into hospitals as part of teams to assess how the environment supports the provision of clinical care, assessing such things as privacy and dignity, food, cleanliness and general building maintenance and, more recently, the extent to which the environment is able to support the care of those with dementia. From 2016 the assessment will also look as aspects of the environment in relation to those with disabilities.

Trusts are advised by the Health and Social Care Information Centre (HSCIC) six weeks in advance when they are authorised to conduct the PLACE assessment on a named site. Once this notification is received the assessments are arranged and teams must be made up of at least 50% patient assessors whilst including representatives from Infection Control, Dementia Lead, Estates, Catering, Facilities and Nursing respectively. The timeframe for assessments took place between March and June 2017. The results were published in August 2017.

The following table illustrates the final results for the Trust's overall organisation score set against the national average and a breakdown of the individual sites:

Organisation Name	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
National Average 2017	98.40%	89.70%	88.80%	90.20%	83.70%	94.00%	76.70%	82.60%
County Durham And Darlington NHS Foundation Trust - 2017	98.12%	96.89%	97.12%	96.90%	90.48%	93.90%	79.72%	85.48%
Site	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Weardale Hospital	100.00%	98.06%	97.57%	98.50%	95.45%	99.19%	94.07%	94.32%
Chester Le Street Community Hospital	98.50%	99.16%	99.19%	99.12%	99.12%	97.90%	91.32%	95.89%
Richardson Hospital	98.39%	96.99%	97.47%	96.49%	97.62%	99.04%	80.56%	93.62%
Sedgefield Community Hospital	100.00%	97.04%	99.19%	95.07%	97.67%	96.72%	86.42%	88.96%
Shotley Bridge Community Hospital	97.18%	95.00%	95.95%	94.10%	86.38%	94.55%	76.86%	85.25%
Bishop Auckland General Hospital	99.53%	96.09%	95.08%	97.07%	90.63%	95.66%	79.52%	83.68%
University Hospital North Durham	98.05%	96.84%	96.05%	97.26%	88.06%	95.87%	79.92%	89.83%
Darlington Memorial Hospital	97.60%	97.02%	98.38%	96.57%	91.52%	90.73%	77.92%	80.43%

Scores highlighted in **green** indicate above the national average score.
Scores highlighted in **orange** indicate below the national average score.

Food Hygiene

The NHS has had a legal obligation to comply with the provisions and requirements of food hygiene regulations since 1987 and there are now several pieces of legislation governing food safety, including the requirement to have a food safety management system based on Hazard Analysis Critical Control Point (HACCP) principles.

Food Safety Officers, authorised by the Council, inspect food premises to assess compliance with food hygiene legislation, which includes Food Hygiene and Safety, Structure and Cleaning and Confidence in Management and Control Systems, to ensure food is being prepared in a safe and clean environment and all relevant records are being maintained. All main kitchens must be inspected at regular intervals by Environmental Health Officer's (EHO). The frequency of EHO inspections depends on the type of food business. The EHOs use a star rating system of which one is the lowest and 5 is the highest. The following table illustrates the date and star rating from the last inspection for food premises within CDDFT.

Environmental Health Officer inspections	Last Inspection	Star Rating
Darlington Memorial Hospital	October 2017	★★★★★
University Hospital North Durham	March 2017	★★★★★
Bishop Auckland Hospital	March 2016	★★★★★
Chester le Street Hospital	September 2015	★★★★★
Shotley Bridge Hospital	January 2017	★★★★★
Sedgefield Community Hospital	September 2014	★★★★★
Weardale Community Hospital	June 2015	★★★★★
Richardson Community Hospital	November 2016	★★★★★

As a result of the Trust providing food to external companies and to provide additional safeguards, we also commission an annual independent food safety inspection by a company known as Support Training Services (STS). STS are UKAS accredited and undertake audits for food suppliers, including manufacturers and distributors. The Catering Department has held STS accreditation since the year 2000. Previously the external Support Training Services (STS) accreditation has been based on the Code of Practice and technical standard for food processors and supplies.

In August 2017 the catering department were assessed at a higher level of accreditation which is aimed at food suppliers for the public sector. The higher level audit places more emphasis on effective environmental monitoring programmes to reduce the risk of the growth of listeria monocytogens which is a higher risk within a cook chill environment. The Catering Department were successful in achieving the higher level accreditation.

The following table illustrates the external accreditation held by Facilities:

Accreditation	Service	Last Audit	Next Audit/Inspection
STS (Support Training Solutions)	Catering DMH	25th July 2017	01/07/18

End of Life Care

☑ Trust ambition achieved

Our aim

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

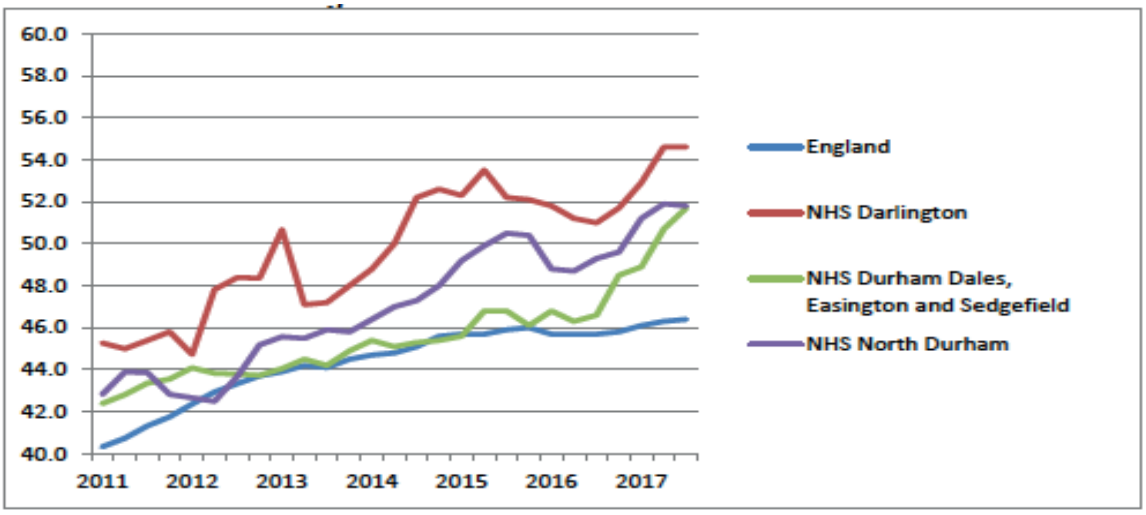
Progress

CDDFT is the largest provider of palliative care services in County Durham and provides care to most of the people who die in our area and specific palliative care to at least a third of those. The specialist service continues to improve and deliver more care. It also plays a key role in supporting other specialties and services with training and service improvement.

Death in Usual Place of Residence

This is a complex area which is difficult to measure. The national proxy (see graph below) measure for improvements in palliative care is 'death in usual place of residence' County Durham and Darlington continues to improve on this measure and is above the English National Average.

Percentage of Patients who died in their Usual Place of Residence



Source: Public Health England

Our local measure is achievement of preferred place of death. Over the last year this has increased from 57% to 88%.

In addition to this we have conducted an audit of care of the dying and are in the process of a survey of bereaved relatives (VOICES) to establish how effective we are in delivering care to dying patients.

Our End of Life Strategy was agreed by the board on March 2017 and we have made good progress. We have completed all the key recommendations from the 2015 CQC inspection including Out of hours advice for professionals and a new 7 day specialist service. We have established mandatory palliative care education for all staff. We are able to identify issues far better with the integration and analysis of incident reports and other sources of feedback.

The trust and service are well positioned to make substantial further improvements in the coming year.

Next Steps

County Durham & Darlington NHS Foundation Trust intends to take the following actions (outlined below) to improve this number and/or rate, and so the quality of its services. The further actions identified to ensure compliance is maintained are:

Further improvement to personalised care planning through education, incident monitoring and cultural change.

Work with regional partners to develop ePaCCS.

Support and monitor new out of hours advice service.

Deliver palliative care mandatory training for all staff.

Deliver local repeat of postal questionnaire of bereaved relatives (VOICES).

Continue the successful training fellow programme to develop palliative care consultants for the future.

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

✗ Trust ambition not achieved.

Our aim

To increase the weighted score of staff who would recommend the provider to friends and family as a place to work or receive treatment within the national average for acute trusts.

Work continues to engage with staff at all levels of the organisation and the Organisation Development Strategy "Staff Matter" complements the Quality strategy. As reported by the Health and Social Care Information Centre and NHS Staff Survey National Co-ordination Centre overall results are as follows:

Key Finding	2016		2017		Trust Improvement/ Deterioration
	Trust	National Average	Trust	National Average	
KF1. Staff recommendation of the Trust as a place to work or receive treatment	3.46	3.71	3.5	3.75	Improvement of 0.4 on last year

The results for key finding 1 staff recommendation of the Trust as a place to work or receive treatment has seen an improvement of 0.4% on the Trust score for last year however the national average has increased to 3.75 which means that we have not met our ambition to achieve the national average score. The Trust score of 3.5 (on a scale of 1 to 5 where 5 is best and 1 is worst) falls short of the national average for combined acute and community Trusts by 0.25.

The results for the key finding are comprised of three individual questions which are outlined in the table below:

Question	2016		2017		Trust Improvement/ Deterioration
	Trust	National Average	Trust	National Average	
Q21a Care of patients/ service users is my organisation's top priority(strongly agree and agree)	62%	75%	64%	75%	Improvement of 2% whereas the national average has remained static.
Q21c I would recommend my organisation as a place to work (strongly agree and agree)	49%	59%	49%	59%	The Trust score remains the same as last year which follows the national trend.
Q21d If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation (strongly agree and agree)	59%	68%	58%	69%	Deterioration of 1% whereas the national average has increased by 1%.

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

☑ Trust ambition achieved

NHS Staff Survey results for indicator KF26 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months). The overall score for 2017 has increased slightly (the lower the score the better) from 20% in 2016 to 24% in 2017. However this score is still in line with the national average which stands at 24% for 2017. Further analysis of the results reveals that the % of white staff that reported experiencing harassment, bullying or abuse from staff in the last 12 months has gone up from 20% in 2016 to 24% in 2017 (the lower the score the better). This score is higher than the national average for this group which is 23%. However for BME staff reporting the figure has gone down from 35% in 2016

to 32% in 2017. The national average for this group is 29%. The Trust's performance on this level has improved in contrast to the national average which has deteriorated since 2016.

Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion

☑ Trust ambition achieved

Staff survey results identified above

NHS Staff Survey results for indicator KF21 (percentage believing that Trust provides equal opportunities for career progression or promotion) for the Workforce Race Equality Standard.

The overall score for the Trust has remained at 90% in 2017. This is better than the national average which stands at 85% for 2017. The % of white staff believing that the trust provides equal opportunities for progression has gone down slightly from 91% in 2016 to 90% in 2017. The Trust score for this group is better than the national average for Combined Acute and Community Trusts which is 88%. The % of black and minority ethnic staff believing there is equal opportunity for career progression has significantly increased from 67% in 2016 to 85% in 2017. This response is significantly better than the national average for this group, which is 67% for 2017.

Progress

During 2017/2018 CDDFT has continued to focus effort on staff engagement activity to improve the responses for staff recommending the Trust as a place to work and receive treatment. Key programmes and work streams that have been undertaken and introduced include:

Staff Survey

Work continues to engage staff at all levels of the organisation. The results of the Staff Survey are widely shared with all managers and staff and used to identify the key priorities for the Trust. Staff Matter Action Plans identify the actions necessary to address the issues arising from the staff survey.

In addition to the Trust wide actions we have supported teams/services where issues or concerns have been raised. This has been done by designing and delivering bespoke interventions designed to address the needs of the service.

Staff Matter

The new people strategy Staff Matter was launched on 1 April 2017. This document sets out the strategic workforce priorities CDDFT have agreed for the next three years (reviewed annually) and builds on the foundations that were developed through our outgoing 'Staff Matter' strategy.

Following the launch of the new strategy each Care Group and Corporate area produced a staff matter action plan For 2017/2018 and these plans have guided the work around staff engagement. The action plans are monitored on a quarterly basis via Strategic Change Board and Integrated Quality Assurance Committee. The plans will be reviewed to reflect current priorities and monitored in the same way throughout 2018/2019.

Senior Managers and Heads of

Departments (SMHODs)

Senior Manager and Heads of Department monthly meetings with the Chief Executive and Directors are an opportunity for open, frank two way discussions on important topical issues. Every quarter an extended SMHOD's is organised to focus on development needs that have been identified for the senior leaders within the Trust. Over the last 12 months these have concentrated on issues such as staff engagement, improving quality and patient safety, ongoing changes within the NHS.

Leadership and Management Development Framework

Based on the priorities falling out of the staff survey and discussions with managers and staff CDDFT's Leadership and Management Framework has been further developed to provide a comprehensive programme of development activities, aimed at the key stages of strategic and operational management. The various options available for leadership development are brought together within the framework, which will enable Managers to access the most appropriate development activity for them. The framework will also facilitate talent management and succession planning. It identifies the corporate offering; development activities available from the North East Leadership Academy and National Leadership Academy and external provision such as level 3, 5 and 6 vocational qualifications.

The leadership and management development programmes are divided into three routes and cover a mix of both transformational and transactional skills and behaviours:

Strategic and Clinical Leadership – to develop key skills appropriate for a senior leader whether in a Clinical or non-clinical role

Operational Management – to develop managers as leaders

Entry Level Management – to develop some people management skills appropriate to an aspiring manager's first management role.

The Framework continues to be reviewed and refreshed on a regular basis to ensure it is fit for purpose.

Strategic Leadership Programme

The Strategic Leadership Programme (SLP) is a broad framework covering a range of strategic leadership topics and is designed as a foundation programme for leaders, both clinical and non-clinical. The programme focuses on developing effective leadership skills using internationally recognised psychometric tools; evidence based research on leadership; and Trust specific data analysis and feedback metrics; to ensure both theory and practice are considered within the context of CDDFT and the future needs of the Trust.

The programme has been rolled out across the Trust, with priority originally being given to the new senior care group management teams. The programme has since been extended to include Corporate areas and by the end of March 2018 100 Senior Leaders have attended the programme.

Leadership Conference

The Trust has a programme of bi-annual

Leadership conferences featuring guest speakers from the world of leadership, staff and patient engagement and healthcare. The aims of the sessions are to challenge our thinking around how we operate as leaders at both Trust and individual level. Two conferences took place in 2017/2018, with 130 delegates attending each one and a further two are planned for 2018/2019.

Developing Managers as Leaders

The Great Line Management Fundamentals Programme was rolled out in 2017/2018. This programme consists of a portfolio of activities designed to develop managers as leaders and prepare them for the strategic leadership programme. Great Line Management Fundamentals focuses on developing an individual's understanding of their role as a manager and the skills needed to influence and work effectively through others e.g. people management skills which is the area most managers find difficult to master. The programme offers a comprehensive range of workshops beginning with an introductory day, followed by a series of free-standing modules covering key areas such as staff engagement, personal resilience, effective communication, HR policy and processes. In addition to a wide range of workshops, HR for Managers mini guides are available and include information on topics such as recruitment and selection and disciplinary and grievance procedures. The programme has been reviewed and refreshed to meet the changing needs of the organisation.

As part of a bridging programme for Band 7 staff two additional modules, Patient Safety and Operational Performance have been piloted during 2017. Further sessions have been planned for 2018/2019.

Talent Management

The Trust has taken an inclusive approach to talent management which consists of a "grow your own" approach coupled with a new graduate trainee programme designed to attract talent from outside of the organisation. The first two graduates were recruited in January 2017 and have taken up posts in Surgery and Acute and Emergency Care. The newly recruited graduate management trainees have been provided with a high level of support in the form of a Leadership Mentor, Clinical Mentor, Coach and Programme Manager. Both have had a very successful year.

Under the umbrella of "grow your own" further work has been undertaken during 2017/2018 particularly with the introduction of the apprenticeship levy which is now being used to develop career pathways for all key roles across the Trust. The apprenticeship levy is a Government initiative where large employers must pay 0.5% of their payroll bill into the levy which can only be used to fund apprenticeship training and CDDFT have in the region of £1.1million in their levy pot.

Current pathways include Nursing, Leadership and Management, Procurement and Pathology and we have staff enrolled on 20 different apprenticeships at present with more to be introduced during 2018/2019. Our apprenticeship programmes currently offer Health Care at level 2, 3 and 5; Business Administration at levels 2, 3, and 4; Management level 3 4,5,6,7; IT level 2 and Cyber Crime and HR at levels 3 and 5, Customer service 2 and 3; Accountancy 4 and 7.

Prior to the levy the Trust had 439 apprentices, 341 were existing staff and

98 young people. Of the young people, 65 were healthcare apprentices and 33 Business and administration and 55 of them still work for the Trust

Public sector bodies with 250 or more staff have a target to employ an average of at least 2.3% of their staff as new apprentice starts over the period of 1 April 2017 to 31 March 2021. CDDFT currently stands at 2.03% which is very pleasing indeed. In the past 5 years we have had 559 apprentices within the Trust, 439 Existing staff and 120 young people and we hope to build on this success in the coming year.

Both the Strategic Leadership Programme and the Great Line Management Fundamentals programme will provide leadership and management skills for graduates and those staff who have demonstrated potential and an interest in moving into a management or leadership role, thereby developing our leaders and managers of the future.

Personal Resilience

Given the unprecedented change facing the NHS, staff development sessions promoting personal resilience strategies have continued throughout 2017/2018. The 2016 staff survey scores for the percentage of staff feeling unwell due to workplace stress has increased since 2015 and in order to address this issue a "Managing Stress in Others" workshop has been designed and delivered to support managers in recognising and dealing with stress in others.

Staff Annual Awards

Staff Annual Awards 2017/2018 recognise staff across CDDFT for their outstanding contribution to patient care and over 1,200 staff were nominated this year under seven main categories of; Chief Executive Award; Enhanced Patient Care; Making a Difference Award; Making You Feel Better Award; Research and Innovation Award; Shining Star Award; Supporting Change Award. Ultimately an overall winner has been selected to receive the Chairman's Quality Award.

Breakfast with the Chief Executive

'Breakfast with Sue' gives a random selection of staff a genuine opportunity to meet the Chief Executive and talk to her about working life at the Trust. These events held each month are small and personal rather than a large group event which gives every attendee the chance to speak. These sessions continue to be popular and are planned for 2018/2019.

Appraisal

For the past two years the Trust has had 95% rate of appraisal completion; however staff survey feedback has shown that the quality of appraisal needs to be improved. In response to this feedback, The Appraisal Framework; Role Review and Aspiration Discussion has been developed and indicates a new approach for the Trust. Following on from the development of team objectives, the focus of the appraisal is on the value of the conversation with individuals. The appraisal will take a collaborative approach, and consider not just performance, but also future aspirations and possible career progression. This will then inform meaningful and tailored personal development plans for individuals. Guidance has been developed and the Appraiser and Appraisee training has been refreshed to reflect the new

approach, with the first training sessions taking place in March 2018 and the new process will be fully rolled out from April 2018.

Equalities, Diversity and Inclusion (ED&I)

Prior to this financial year the Trust's focus for ED&I has been on building secure foundations by ensuring robust policies and practices have been developed for staff and patients, together with activities to promote excellence in this field. The next phase was to produce an Equalities, Diversity and Inclusion Strategy and this work was undertaken during 2017/2018. The strategy focuses on developing new and innovative ways of progressing this important agenda in order to achieve an organisational culture that fosters inclusion and leads to exceptional standards of patient care. The ED&I strategy has been approved by the Board and will be launched in April 2018.

Other work around this agenda includes taking part in Project Choice which is a supported internship hosted by CDDFT and managed by HEENE. The project is designed to give young people with learning difficulties, disabilities or autism, the chance to gain work experience, undertake an employability qualification and complete a work-based internship. The project tailors a programme to the needs of the young people which enables them to meet and develop their individual skills. Our first induction onto this programme was held on 25th September 2017.

In 2017 we continued to work with a local organisation Amacus on the Leapfrog project. This focussed on recruiting people with a background of long term unemployment and from socially excluded backgrounds to gain employment as Health Care Assistants. To date we have interviewed 104 people through this project and 72 have been offered employment with the Trust.

Next Steps

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

Leadership and Management Development Framework

The leadership and management development framework will be reviewed and refreshed for 2018/2019 to ensure it meets current and future leadership and management development needs.

Board Development

A bespoke programme of Board Development has been designed and will be rolled out across 2018/2019. The first of the four days will take place in June 2018.

Strategic Leadership Programme (SLP)

The SLP will continue to be rolled out across the organisation throughout 2018/2019 and extra places allocated in order to ensure all Senior Leaders are afforded the opportunity to attend. A further five cohorts have been planned for this financial year.

Leadership Conference

The third Leadership Conference will take

place on 24 April 2018. The keynote speakers for this conference are Andy Hope on the Art of being Brilliant and Chris Andreou sharing his views on Emotional Intelligence. The second conference will take place on 16 October 2018.

Talent Management

- CDDFT has been chosen to pilot the Shadow Board Programme for the North East Region. This is a development programme aimed at aspiring leaders who wish to become the Directors of the future. The programme will be rolled out during the first half of the new financial year.
- The Trust will continue to utilise the apprenticeship levy to further develop apprenticeship opportunities across a range of career pathways (including traineeships).
- Both the Strategic Leadership Programme and the Great Line Management Fundamentals programme will continue to be used to provide leadership and management skills for graduates and those staff who have demonstrated potential and an interest in moving into a management or leadership role, thereby developing our leaders and managers of the future.

Appraisal

The new Appraisal Framework will be rolled out from April 2018. The appraisal will take a collaborative approach, and consider not just performance, but also future aspirations and possible career progression. It will form an important part of the talent management framework and will also support senior managers in identifying the leadership strength and profile of their team(s) and aid in succession planning.

The monitoring of appraisal completion and quality audits will continue throughout 2018/2019 to in order to evaluate the new appraisal process.

Equalities, Diversity and Inclusion

The next phase of this work involves:

- The establishment of the Strategic ED&I Group in order to drive the ED&I agenda and establish priorities for the coming year. The Group will be jointly chaired by the Medical Director and the Director of Nursing and Transformation
- An ED&I working group will also be established and will consist of representatives from Care Groups and Corporate areas. This group will be responsible for actively driving the ED&I agenda across the wider organisation into all ward, service areas and departments.
- CDDFT have been one of six organisations successful in bidding for a place on the national pilot Building Leadership for Inclusion. The pilot will commence in April 2018 and the outcomes from this will inform both our ED&I agenda and our wider strategy around staff engagement.

Staff Engagement Activities

In addition to the activities outlined above other staff engagement activities include:

- The staff annual awards process will be reviewed and refreshed in readiness for 2018/2019 awards.

- Staff engagement will continue to be measured via the quarterly Staff Friends and Family Test. Results will be used to further inform staff matter action plans.
- Continued use of quarterly survey monkey questionnaires to look at key themes from staff survey, well-led, CQC and which link to Health and Wellbeing CQUIN targets.
- The Trust has put in place a programme of structured cross-site visits by Executive and Non- Executive Directors to support the work being done to understand the feeling of the organisation and collect evidence to inform action plans.
- Work will continue to communicate interactive channels available for staff to feedback comments, share views and suggestions including promoting the role of the Freedom to Speak Up Guardian and when appropriate feeding back on actions undertaken as a result of staff comments, and the speakinconfidence (confidential system to allow staff to share concerns).

CLINICAL EFFECTIVENESS

Reduction in Hospital Standardised Mortality Ratio (HSMR) and Standardised Hospital Mortality Indicator (SHMI)

☑	Trust ambition achieved

There are a number of different published mortality indices that seek to provide a means to compare hospital deaths between trusts. Mortality measurement is a complex issue and much has been written about the usefulness of mortality ratios with academics and trusts getting involved in wide debate regarding their accuracy and validity.

NHS England use the Summary Hospital-level Mortality Indicator (SHMI) as their standard indicator. SHMI reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published quarterly as an official statistic by the Health and Social Care Information Centre (HSCIC).

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The indicator includes deaths in hospital and within 30 days of discharge.

The Trust's information providers, Healthcare Evaluation Data (HED) and the North East Quality Observatory Service (NEQOS), supply the SHMI data as well as the Hospital Standardised Mortality Ratio (HSMR) as comparators of mortality.

The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 diagnosis groups in a specified patient group. The expected deaths are calculated from logistic regression models with a case-mix of: age band, sex, deprivation, interaction between age band and co-morbidities, month of admission, admission method, source of admission, the presence of palliative care, number of previous emergency admissions and financial year of discharge.

The Trust also uses 'Crude Mortality' as a measure of mortality rates. This is simply

the number of deaths as a percentage of the total number of discharges. It does not, unlike other indices, take into account any other factors.

In keeping with our commitment to openness and transparency we continue to review and analyse our mortality data in a continuing attempt to understand what the data is telling us.

Our aim

Our aim is to remain be comparable to the national average and regional peers for mortality rates and lower than comparable regional peers.

Progress

County Durham & Darlington NHS Foundation Trust considers that this data is correct for the following reasons:

The data is collected as prescribed nationally and reported as per national guidelines.

The data presented is as shown by the Health and Social Care Information Centre.

The next series of graphs shows our comparative position when measured across hospitals in England and an indication of what that means.

HSMR

The timelines below shows that HSMR has generally been below the 100 standard with the exception of seasonal rises in January and February, before peaking at 112 in April. Weekend HSMR follows a similar trend, but peaks in July 17 at 112.

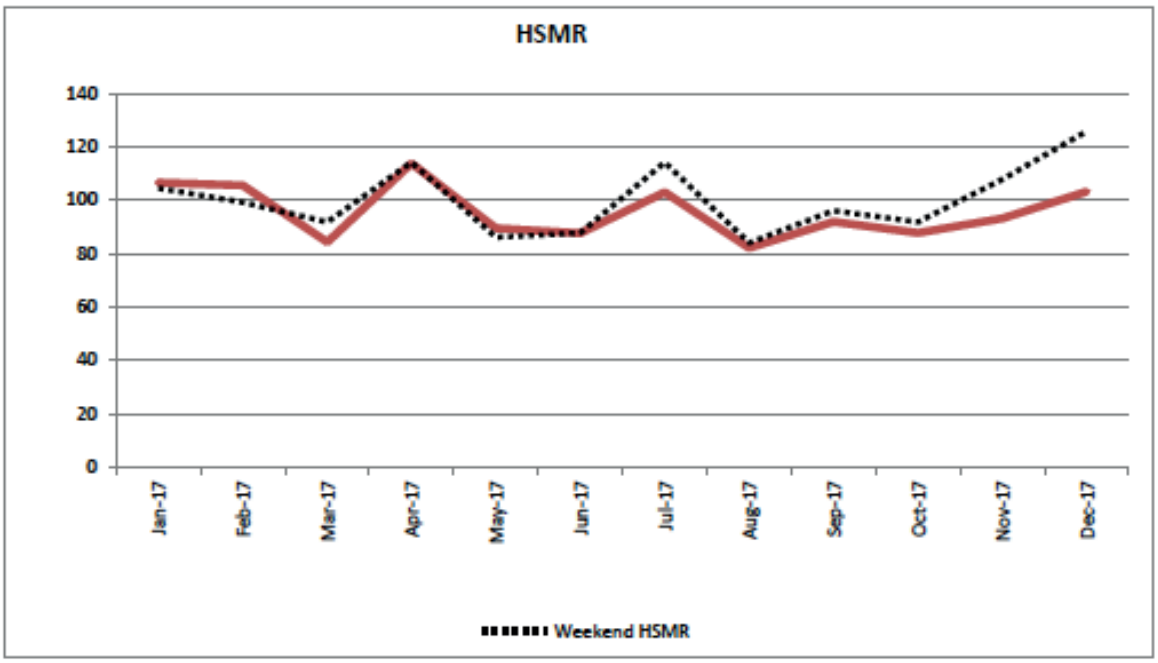


Figure 1 – HSMR timeline (Jan17-Dec17)

The funnel plot for this time period displays expected number of deaths versus HSMR (Figure 2) and shows that the Trust sits at the lower 'green' control limit.

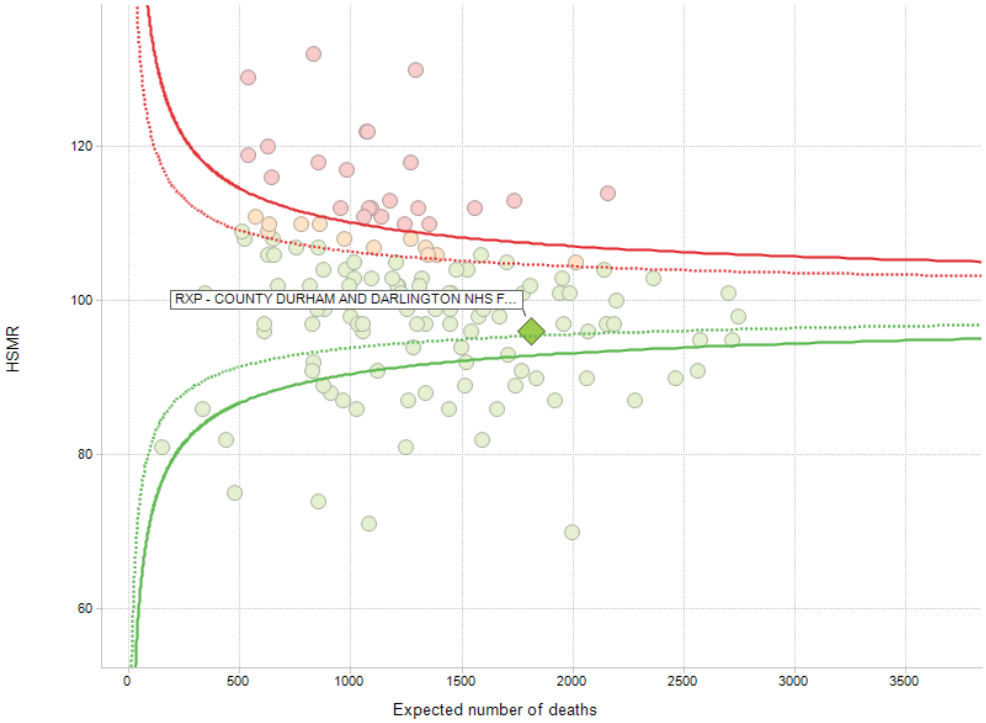


Figure 2 - Funnel plot showing expected number of deaths and HSMR (Jan17-Dec17)

SHMI

The SHMI data (Figure 3) shows a peak in January 17, then fall to below the standard of 100 for the rest of the year with the exception of April. April 17 showed a slight rise to 103, mirrored by HSMR which showed a more pronounced rise that month. For the 12 months up to Dec 17, the Trust sits comfortably in the middle of the funnel plot (Figure 4).

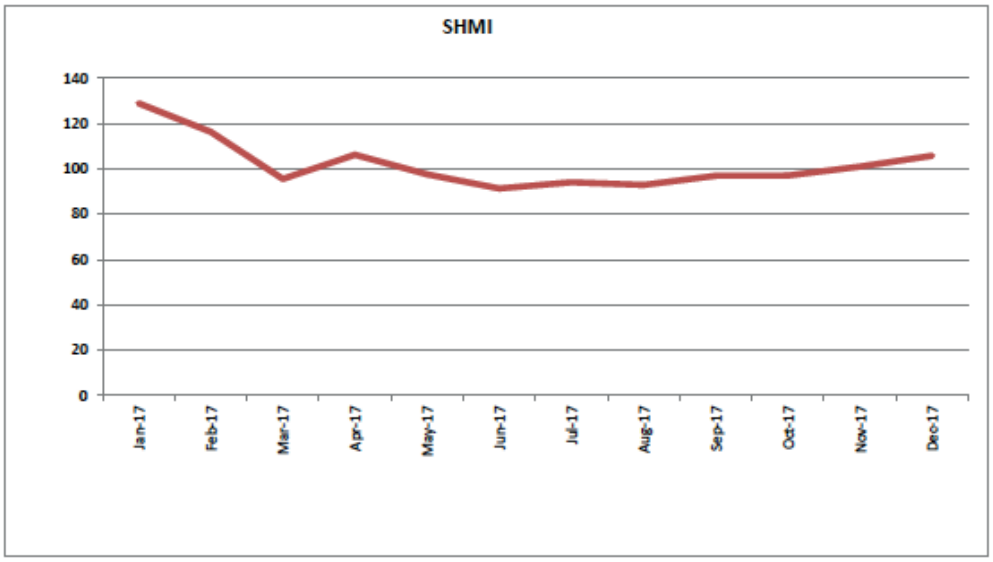


Figure 3 – SHMI timeline (Jan17-Dec17)

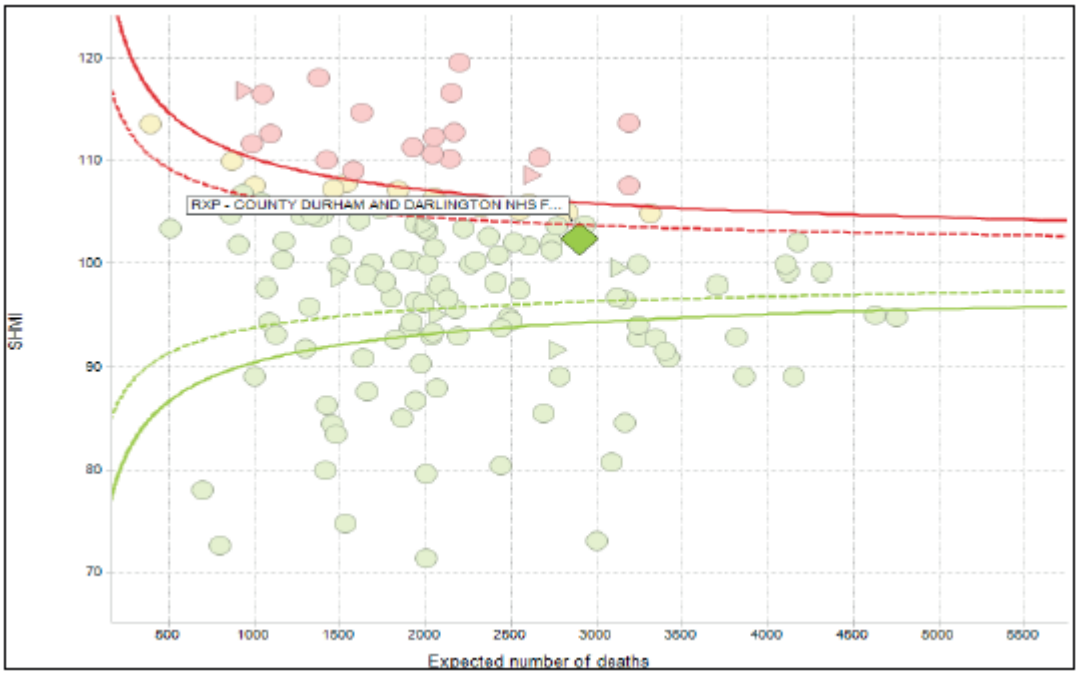


Figure 4 - Funnel plot showing expected number of deaths and SHMI for period Jan17-Dec17.

Crude Mortality

The Trust's crude mortality reached a peak of 5.18% in January 17, and showed a similar trend to HSMR, with subsequent peaks in April (5.07%) and July (4.65%).

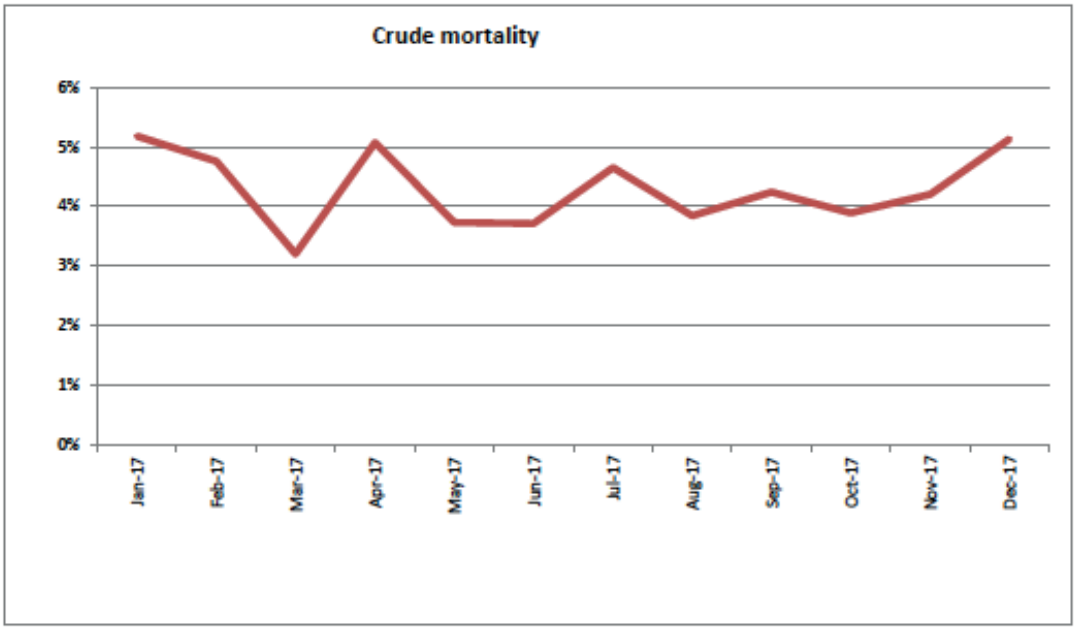


Figure 5 – Crude Mortality timeline (Jan17 – Dec17)

Next Steps

County Durham & Darlington NHS Foundation Trust intends to take the following actions (outlined below) to improve this number and/or rate, and so the quality of its services. The further actions identified to ensure compliance is maintained are to:

- Ensure that mortality remains a strong focus for the Trust, by;
- Continuing to embed the recommendations of the CQC's report 'Learning, candour and accountability', and the National Quality Board's National Guidance on Learning from Deaths for Trusts March 2017.
- Build on the redesigned mortality review process within the organisation.
- Continue to develop ward/speciality mortality reports and dashboards to ensure learning from the mortality review process is relevant to individual areas and results in a reduction in harm.
- Continue to develop links with Regional and Primary Care colleagues to ensure joint learning.

In support of the above, the Trust is in the process of appointing a substantive Mortality Lead who will embed the processes and progress made by the mortality project lead - anticipated start date May 2018.

It is generally accepted that the overriding purpose of mortality rates is to promote enquiry into clinical practice and in the context of mortality this necessitates critical review of deaths.

The Trust has defined which deaths are mandated for a case note mortality review, and this criteria is detailed within the Trusts Learning from Deaths policy which is published on the Trust website. A central mortality review team will review these deaths, along with a sample of 30% of all other deaths. The central review team is fully recruited to, and training of it's members is either complete or planned. The outcome of these reviews is presented on the Trust Mortality review Dashboard at the Trust board quarterly. Work is underway to ensure information from all other review forums outside the central team is also captured and presented on the dashboard. Maternity and paediatrics have a separate mortality review process that fulfils statutory requirements in these areas. This work is currently co-ordinated by the Project Lead, and moving forward the Associate Director for Mortality. All data is reported into the Trust's Mortality Reduction Committee.

Whilst undertaking mortality reviews are essential it is equally important the information gained from the reviews are fed back to clinical teams in a timely fashion. To try and achieve this, the Trust will produce quarterly feedback reports to ward areas. These reports included information relating to;

- Main Diagnosis on Admission.
- Comorbidities.
- Appropriateness – on ward at admission / of ward at time of death.
- Outcome - rate of expected deaths / proportion of deaths from cardiac arrests / NCEPOD and Hogan scores.
- Number receiving further review / escalation.
- Lessons Learnt.

These data should then be used by the clinicians in the ward, speciality and care group governance meetings to inform staff of outcomes, generate debate and lead to change in practice. In 2018/2019 these reports will be developed further in line with the Trust level dashboard.

The trust continues to collaborate with peers across the region and with colleagues in primary care to share learning and to undertake joint work to improve patient care. Regionally there are projects looking at the management of sepsis, acute kidney injury and community acquired pneumonia that have been generated from the regional mortality work.

The Trust have appointed a Deputy Medical Director for Primary Care and work will progress 2018/2019 to engage with primary care colleagues to ensure that learning is shared with community matron and Primary care colleagues. The collaborative effort with primary care colleagues will be developed in accordance to the leaning from deaths national agenda.

To reduce the number of emergency readmissions to hospital within 28 days of discharge

✗	Trust ambition not achieved.

Our aim

The Trust aims to minimise avoidable re-admissions and to understand the reason for them. This may shed light on opportunities to improve patient care which are not being taken.

Progress

The Trust-wide re-admission rate for 2017/2018, as at the end of February 2018, was 12.5%. At Care Group level the figures were: Acute/Emergency – 14.1%; Integrated Adults – 15.4%; Family Health – 11.9%; Surgery – 9.7%.

The Trust, local GPs, commissioners and Durham County Council Social Care Dept. undertook an audit of re-admissions. The audit resulted in a re-admissions threshold of 25%; that is, 25% of re-admissions were deemed avoidable had the right alternative services been in place. As a result, the payment for 25% of re-admissions will be withheld for investment in alternative services.

Next Steps

County Durham & Darlington NHS Foundation Trust intends to take the following actions (outlined below) to improve this number and/or rate, and so the quality of its services. The further actions identified to ensure compliance is maintained are to:

Re-admission avoidance investments hitherto have contributed to the Trust's intermediate care services, CCG schemes focussed on improved community nursing and schemes to support care homes.

In addition, a major re-configuration of community services into Community Hubs and multi-disciplinary teams around patients (TAPS) has taken place during 2017. Some instability has been caused by the commissioners' decision to put out to tender the community services currently provided by CDDFT, but the recent decision to award the new contract to CDDFT is

expected to create stability.

A wide range of actions, which bear on admission and re-admission rates, are also in train under the Transforming Emergency Care Programme. The key themes are assess to admit, today's work today and discharge to assess. Actions include:

- Primary care streaming at the A&E front door.
- More robust command and control mechanisms.
- Revised emergency pressures policy.
- Joint CCG-Council appointment of a County Durham Director of Integration.
- Moving towards "discharge to assess" and "trusted assessor" models to reduce duplication of effort.
- Roll-out of SAFER care bundles across all wards (setting minimum standards for Ward and Board rounds and activities to minimise unnecessary delays.
- Extended hours discharge lounges.
- Nurse-led first responder pilot to assess patients when ambulance delays are being experienced.

To reduce the length of time to assess and treat patients in Emergency Department

⊖ Improvement demonstrated but ambition not achieved

Our Aim

We aim to assess and treat all patients in A&E in a timely and safe manner. Key standards are:

- 95% patients are assessed and treated within 4 hours of arrival at A&E.
- Ambulance crews can hand over the care of patients to CDDFT staff within 30 minutes of arrival.

Progress

In order to access Sustainability Transformation Fund monies the Trust agreed performance trajectories with the NHS Improvement Agency (NHSI) at the beginning of the year. The aim was to recognise that at some points in the year it would be more difficult to achieve the national standard than at others. At times of least pressure, the NHSI trajectory is more challenging than the national standard. This balances times of greater pressure when Trust performance is more likely fall below the national standard.

A&E 4hr Wait Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
NHSI Trajectory	89.91%	92.37%	92.83%	95.16%	95.70%	95.37%	94.32%	91.82%	89.53%	91.26%	92.94%	95.00%
Performance	94.76%	90.82%	93.16%	93.67%	95.07%	96.83%	95.56%	93.64%	85.10%	81.58%	85.95%	89.55%

Key: Green = achieved both NHSI trajectory and 95% national standard; Amber = failed either NHSI or 95% national standard; Red = failed both NHSI and the 95% national standard

In Quarters 1 (Q1) and Q2, Trust performance exceeded the NHSI trajectory whilst falling short of the 95% national standard. However, in Q3 and Q4, performance fell short of the STF trajectory in spite of Perfect Month initiatives in December and March, and a range of other actions. These included opening extra escalation beds (including temporary conversion of day case and ambulatory care units for overnight in-patient use), introducing Primary Care Screening at both A&E Departments, and being the only Trust in the N.E. to open up Advice and Guidance services to GPs in all Specialties as an alternative to out-patient referral or admission.

In a national context, this performance was reasonable. In Q4, CDDFT was placed 45th out of 137 Trusts nationally for 4-hour wait performance: an improvement on last year's 63rd. At 85.7%, performance was above the England average. Nevertheless, the shortfall against trajectory resulted in the imposition of financial penalties by NHS England. The main reasons for this shortfall were:

- A&E activity in Q3 2017/2018 grew modestly by 1.8%, including 4.6% at DMH. Growth at UHND would have been larger but for the introduction of the Primary Care screening service at the front-door.
- As a result of commissioning changes in Durham Dales, Sedgefield and Easington CCG, Urgent Care activity fell by 45.1%. Since Urgent Care patients are always treated within 4 hours of arrival this fall artificially inflated the figure for the percentage of patients who were not treated within 4 hours.
- Bed pressures remained the most important reason why ED performance continues to lag behind that of last year. Several factors continue to dominate:
  - Growth in non-elective medical admissions across the full year: 5% Trust-wide and 7.2% at UHND.
  - In Q3/Q4 alone, all specialty non-electives grew by 2.8%; whilst Medicine grew by 7.9% (9.9% at UHND).
  - Medical occupied bed-days. Throughout much of the winter, medical patients have occupied more in-patient beds on acute wards than in 2016-17. UHND has been particularly affected: bed-days occupied by medical patients were 9% higher in October, 15.5% in December, 10% higher in January, and 13.4% in March.
  - 'Flu:
    - January an average 36 in-patients per day were confirmed 'flu victims.
    - In February, this figure rose to 44, peaking at 57 patients in mid-month.
    - In March, the average was 17, peaking at 33.

Next Steps

County Durham & Darlington NHS Foundation Trust intends to take the following actions (outlined below) to improve this number and/or rate, and so the quality of its services. The further actions identified to ensure compliance is maintained are to:

Continue to implement the SAFER programme, as part of its overall

Transforming Emergency Care Programme, overseen by the Local A&E Delivery Board. As reported previously, this programme incorporates actions relating to all aspects of the non-elective pathway. This includes:

- Optimising patient flow by improved silver and bronze command and control coverage, including at w/ends.
- Emphasis on morning Board rounds to start by 09.00 and afternoon rounds to finish by 16.00 to support the "one bed free by 11.00" initiative and to minimise the number of patients who are left in an acute bed until too late in the day to discharge them.
- Improved medical rota arrangements including review of "stranded" patients before lunch-time and at a weekly MDT.
- Continued implementation of "referrer decides" protocol.
- Incremental roll-out of primary care streaming as estates work is completed.
- HALO in ED and dedicated porters.
- Implement escalation protocol for the discharge lounges to assist them to "pull" patients out of the base wards.
- Improving diagnostic turnaround times for A&E patients and those close to discharge.
- Increased pharmacy and phlebotomy support to AMU and base wards.
- Gold command ward walk-around; team of the week awards; corporate clinical staff provide hands-on support on wards.

It is also looking at ways to refresh the Perfect Month format to reinvigorate its impact; whilst LADB partners are being asked to dial in to the daily Bed Meetings to ensure all parts of the whole health and social care system are responding effectively to pressures.

The Trust has developed a joint ambulance handovers action plan with NEAS as well as its own Standard Operating Procedure.

In addition, estates work is progressing at both sites to enable full implementation of primary care screening. Meanwhile, CCGs have indicated an intention to shift the focus of their demand management initiatives onto non-elective care in 2017/2018, although the precise schemes are not yet agreed. Active planning for the coming winter is now being undertaken.

7 Day Service Standards

CDDFT are committed to delivering high quality care for patients. The Transforming Emergency Care (TEC) programme has been established to drive service improvements in emergency care, ensure timely assessment and treatment for patients. This programme of work is a key to the delivery of the 4 national priority standards; ensuring patients;

- don't wait longer than 14 hours to initial consultant review.
- get access to diagnostic tests.
- get access to specialist, consultant-directed interventions.
- with high-dependency care needs receive twice-daily specialist consultant review, and those patients admitted to hospital in an emergency will experience daily consultant-directed ward rounds.

As part of our plan continue to drive improvements, the trust participates in national audits. The last audit conducted in

September 2017, reported;

- 100% patients with high dependence care needs receiving twice daily review.
- 80% of patients were seen within 14 hours by the consultant.

To increase patient satisfaction as measured Patient Reported Outcome Measures (PROMs)

⊖ Improvement demonstrated but ambition not achieved

What are they? PROMs measure quality from the patient perspective by using questionnaires. They cover four clinical procedures – hip replacements, knee replacements, hernia and varicose veins. PROMs calculate the health gain after treatment using surveys carried out before and after the operation. PROMs are a measure of the patient's health status or health related quality of life at a single point in time. They provide an indication of the outcome or quality of care. They comprise of the patient being provided with two questionnaires (one before surgery - given at pre-assessment and one after surgery – usually after a minimum of 3 months).

All patients irrespective of their symptoms are asked to participate by completing a common set of questions about their health status.

The post-operative questionnaires also contain additional questions about the surgery, such as patient perception in respect of the outcome of surgery and whether they experienced any post-operative complications.

Our aim

We want to increase participation so that we can gain a good understanding of patient's view of their care and outcomes. We want to see an improvement in participation rates for all PROMs. During 2017/2018, the care group and provider have worked collaboratively to work to improve participation with the completion and compliance with questionnaire 1, that which is provided during the pre-operative assessment. Since the commencement of this work, which involved training and education in respect to the benefits and realisation of the significance of collecting PROMs data our monthly compliance has significantly improved. Care Group representatives from the Trust have presented improvement in compliance at National PROMs Summit in London in December 2017. Due to the increased uptake in the participation rates for questionnaire 1 and having an identified clinical lead to review the specific outcome data at patient level it is anticipated that we will have greater understanding of our PROMs outcomes in summer 2018 as this is presented via NHS digital 18 months in arrears. NHS England have indicated that PROMs data will not be required to collect data for reporting for Varicose Veins and Groin Hernia moving forward.

County Durham & Darlington NHS Foundation Trust considers that the outcome scores are as described for the following reasons:

- The data is collected by a dedicated team within the organisation.
- The data collected is made available by the Health and Social Care Information Centre as stated above.

STATEMENTS OF ASSURANCE FROM THE BOARD

During 2017/2018 County Durham & Darlington NHS Foundation Trust provided and/or sub-contracted 125 relevant services.

The County Durham & Darlington NHS Foundation Trust has reviewed all of the data available to them on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2017/2018 represents 100 per cent of the total income generated from the provision of relevant health services by the County Durham & Darlington NHS Foundation Trust for 2017/2018.

Review of Services

The Trust's performance against national priorities is shown in Part 3 of this report.

At each of its meetings, the Trust Board receives an Integrated Board report covering the four key Touchstones: best experience, best outcomes, best efficiency and best employer. The report includes an integrated performance scorecard.

The Trust has reviewed its Performance Management Framework which continues to involve a monthly review of each Care Group's objectives and performance on all the key metrics affecting the four Trust Touchstones. It also includes a quarterly Executive-led Review and an annual opportunity for Care Groups to review the performance of corporate Departments.

In addition to reports to the Board, the key performance risks and the outcomes of the Performance Reviews are reported monthly to the Executive team and to the Integrated Quality and Assurance sub-committee of the Board.

Participation in Clinical Audits and National Confidential Enquiries

During 2017/2018 47 national clinical audits and 6 national confidential enquiries covered NHS services that County Durham & Darlington NHS Foundation Trust provides.

During 2017/2018 County Durham & Darlington NHS Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that County Durham & Darlington NHS Foundation Trust was eligible to participate, participated in, participated in and for which data collection was completed during 2017/2018 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 Audit/National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 17– Mar 18	% cases submitted
Women's and Children's Health				
Maternal, infant and newborn programme (MBRRACE-UK)* (Also known as Maternal, Newborn and Infant Clinical Outcome review Programme)	☑	☑	On-going	100.00%
Neonatal intensive and special care(NNAP) -	☑	☑	☑	☑
National Maternity and Perinatal Audit (	☑	☑	☑	N/A Organisational Audit
Paediatric intensive care (PICANet)	☒			

National Audit/National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 17– Mar 18	% cases submitted
Acute Care				
Adult critical care (Case Mix Programme) –	☑	☑	On-going data collection. Final quarter to be submitted May 18	100% April – Sep 17
National emergency laparotomy audit (NELA)	☑	☑	☑	*DMH 81% UHND 82%
Hip, knee ankle, shoulder elbow replacements (National Joint Registry)	☑	☑	On-going	88%
Major Trauma Audit (Trauma and Audit Research Network TARN)	☑	☑	On-going. Data still being collected	27th Jan 2018 UHND 72 - 83% DMH 100+%
Fractured Neck of Femur (Royal College of Emergency Medicine)	☑	☑	☑	**100.0%
Procedural Sedation in Adults (care in emergency departments) (Royal College of Emergency Medicine)	☑	☑	☑	**100.0%
Pain in Children (Royal College of Emergency Medicine)	☑	☑	☑	**100.0%
National Clinical Audit of Specialist Rehabilitation for patients with complex needs following Major Injury (NCASRI)	☒			

* Case ascertainment required is >80% of expected cases between 1/12/16 and 30/11/2017
** Sample required by the Royal College of Emergency Medicine has been submitted.

National Audit/National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 17– Mar 18	% cases submitted
Long Term Conditions				
Chronic Obstructive Pulmonary Disease (COPD) Audit Programme Chronic Obstructive Pulmonary Disease Rehabilitation audit . Chronic Obstructive Pulmonary Disease Secondary Care Audit	☑	☑	☑	*100% N/A
Diabetes (National Adult Diabetes Audit)	☑	☑	☑	100% of cases on System One and databases
Diabetes (RCPH National Paediatric Diabetes Audit)	☑	☑	☑	100% cases on database sent
National Pregnancy in Diabetes (NPID)	☑	☑	☑	100%
National Diabetes Footcare Audit (NDFA)	☑	☑	☑	*100%
Inflammatory Bowl Disease (IBD) Programme (IBD Registry) National Clinical Audit of Biological Therapies	☑	☑	☑	N/A

* Data entered for all patients that consented to participate in the audit.

National Audit/National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 17– Mar 18	% cases submitted
Mental Health Conditions				
Prescribing in mental health services (POMH)	☒			
Mental Health programme: National Confidential Inquiry into Suicide and Homicide for people with mental illness(NCISH)	☒			

National Audit/National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 17– Mar 18	% cases submitted
Older People				
Falls and Fragility Fractures Audit Programme (FFFAP): Fracture Liaison Service Database (FLS-DB) Hip fracture (National Hip Fracture Database) Inpatient falls (RCoP)	☑ ☑ ☑	☑ ☑ ☑	On-going Data to be extracted June 18	N/A 100% Validated up to Dec 17 *100%
Sentinel Stroke National Audit Programme (SSNAP)	☑	☑	On-going 17/18 final 4 months data to be submitted by 2/5/18	**100%
National Audit of Dementia Royal College of Psychiatrists	☑	☑	☑	>80% (A) case ascertainment Aug-Nov 17
UK Parkinson's Audit: Speech and Language Therapy Audit Physiotherapy Occupational Therapy Elderly Care	☑ ☑	☑ ☑	☑	***100% ***100% ***100% Iv 100%

* Snapshot audit of the care provided to a sample of up to 30 patients per acute site was achieved.
** A minimum of 50 patients for each hospital site was required (UHND = 59 and DMH= 52)
*** The minimum of 10 patients for each service was achieved.
Iv The minimum of 20 patients for each service was achieved

National Audit/National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 17– Mar 18	% cases submitted
Heart				
Acute Coronary Syndrome or Acute Myocardial Infarction & other ACS (MINAP)	☑	☑	On-going	Data to be submitted 30/06/2018
National Adult Cardiac Surgery Audit (Adult Cardiac Surgery)	☒			
Cardiac Arrhythmia (HRM)	☑	☑	On-going	100%
Congenital Heart Disease (Paediatric Cardiac Surgery) (CHD)	☒			
Coronary angioplasty (NICOR Adult cardiac interventions audit)	☒			
Heart failure (Heart Failure Audit)	☑	☑	On-going	Data to be submitted 0-30/06/2018
Cardiac arrest (National Cardiac Arrest Audit)	☑	☑	☑	100%
National Vascular Registry (elements will included CIA Carotid Interventions Audit, National Vascular Database, AAA, peripheral vascular surgery/VSGBI Vascular Surgery Database.	☑	☑	On-going	As of the 31/12/2017 Carotids = 100% AAA = 97% Amputations 69%

National Audit/National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 17– Mar 18	% cases submitted
Cancer				
Lung cancer (National Lung Cancer Audit)	☑	☑	*Now via COSD ☑	100%
Bowel cancer (National Bowel Cancer Audit Programme)	☑	☑	** ☑	100%
Oesophago-gastric cancer (National O-G Cancer Audit)	☑	☑	*** ☑	100%
Head and Neck Cancer (HANA)	☑	N/A	Audit ceased to be part of NCAPOP from May17	N/A
Prostate cancer (National Prostate Cancer Audit)	☑	☑	On-going monthly data submissions	100%
National Audit of Breast Cancer in Older Patients (NABCOP)	☑	☑	On-going monthly data submissions	100%

* Data collection deadline in 2017/2018 for patients covering period Jan – Dec 2016
** Data collection deadline in 2017/2018 for patients covering period 1st Apr 2016 – 31st Mar 2017
*** Data collection deadline in 2017/2018 for patients covering period 1st Apr 2016 – 31st Mar 2017

National Audit/National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 17– Mar 18	% cases submitted
Other				
Elective surgery (National PROMs Programme)	☑	☑	N/A	N/A
Learning Disability Mortality Review Programme (LeDeR Programme)	☑	☑	☑	N/A
National Ophthalmology Audit (NOD)	☑	☑	☑	100%
National Bariatric Surgery Registry (NBSR)	☑	☑	Prospective Ongoing data collection	100%
National Audit of Intermediate Care	☑	☑	☑	*N/A
Endocrine and Thyroid National Audit BAETS	☑	☑	Ongoing data collection by surgeons that joined BAETS in 2016 to participate	N/A
Serious Hazards of Transfusion (SHOT) :UK national haemovigilance scheme	☑	☑	No incidents for CDDFT	N/A
National Neurosurgery Audit Programme	☒			
BAUS Urology Audits: Nephrectomy Audit	☒			
BAUS Urology Audits: Percutaneous Nephrolithotomy	☒			
BAUS Urology Audits: Radical Prostatectomy Audit	☒			
BAUS Urology Audits: Cystectomy	☒			
BAUS Urology Audits: Urethroplasty	☒			
BAUS Urology Audits: Female stress urinary incontinence	☒			

* Trust only submitted In the Organisational Audit.

National Audit/National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 17– Mar 18	% cases submitted
Other				
Blood transfusion and Transplant				
TACO Audit (National Comparative Audit of Blood Transfusion)	☑	☑	☑	100%
2017 Audit of Red Cell and Platelet Transfusion in Adult Haematology Patients (National Comparative Audit of Blood Transfusion)	☑	☑	☑	100%
Audit of O negative red cells 17/18 (National Comparative Audit of Blood Transfusion)	☑	☑	On-going	N/A
National Confidential Enquiries – Medical and Surgical Clinical Outcome Review Programme				
Acute Heart Failure	☑	☑	☑	83%
Peri-operative management of surgical patients with diabetes	☑	☑	Still Ongoing	66% 16/4/18
Pulmonary Embolism	☑	☑	To begin in Feb 18	N/A
National Confidential Enquiries – Child Health Clinical Outcome Review Programme				
Chronic Neurodisability Study	☑	☑	☑	80%
Young Persons Mental Health Study	☑	☑	☑	75%
Cancer in Children, Teens and Young Adults	☑ Only the Organisational Audit	☑ Only the Organisational Audit	☑	N/A

- The reports of *25 national clinical audits were reviewed by the provider in 2017 and County Durham & Darlington NHS Foundation Trust intends to takethe following actions to improve the quality of healthcare provided.

  *For the National Cardiac Arrest Audit (NCAA) 16/17, Adult Critical Care (Case Mix Programme - ICNARC CMP 16/17, National Heart Rhythm Management Audit 15/16, National Joint Registry 16 (14th Annual Report) –, there was compliance with standards.

National Clinical Audits reviewed in 2017/2018	Action
National Audit of Dementia 2016/2017 care in hospital UHND/DMH.	Cognitive tests assessed on admission and again before discharge. (to be incorporated into the F1 training) and embedded into practice. Ward managers to promote the recording of factors which may cause distress and the action or actions which can help calm the patient. Clinical teams complete the "This is me" booklet and involves the patient and carer in this (if not already done in primary care). Ward managers to implement the use of personal patient information from "this is me/hospital passport" in to care plans. Results and sufficient information regarding the episode of delirium recorded on the electronic discharge summary. (to be incorporated into the F1 training) and embedded into practice. Implementation of carers passport to enable carers to be given the opportunity and support to spend as much time as necessary whenever they need to. Staff are trained in mental capacity, consent, best interest's decision making, lasting powers of attorney and supportive communication with family/carers on these topics. Site nurse practitioners and bed managers to develop expertise in dementia care to ensure support for staff 24 hours per day 7 days per week. Ensure staff receive training in delirium and its relationship with dementia, manifestations of pain, behavioural & psychological symptoms treatment, care. Further develop, implement and promote the finger food menu. Patients, families/carers are involved in discharge planning. Carers are identified at first contact or as soon as possible after this. Before a person is discharged, their physical, psychological and social needs must be assessed. The person with dementia and someone involved in their day-to-day care should be fully involved in this assessment. Plans about the date and time of discharge should be discussed with the person and their carer. Any organisations that will be providing services must be informed of the date and time of the person's discharge, and when they should start to provide the services.

National Clinical Audits reviewed in 2017/2018	Action
Royal College of Emergency Medicine – Asthma paediatrics and adults 2016 (Darlington Memorial Hospital).	To include in August Educational Programme for Nursing and Medical Staff to improve both treatment and documentation. A dedicated doctor will be allocated to paediatrics to ensure prompt assessment and treatment is initiated for children with asthma. Advanced Paediatric Nurse Practitioner (APNP) will deliver bespoke training to ED nurses and junior doctors on the assessment and management of paediatric asthma, including the administration of oxygen, assessment of inhaler technique. Also ensuring discharge advice is given and documented. All paediatric patients will have initial observations undertaken within 15 minutes of attendance, including oxygen saturation measurement. Vital signs will be repeated and recorded on a paper observation chart and PEWS calculated so that observations and trends can easily be observed, within 60 minutes of first set. Key messages will be developed to communicate to staff.
Royal College of Emergency Medicine – Asthma paediatrics and adults 2016 (University Hospital of North Durham).	Remainder of asthma management to be placed prominently in the Emergency Department . To discuss at senior staff meeting whether oxygen should be formally prescribed on a chart. Ensure sufficient Peak Flow meters are available in all clinical areas, and publicise need for use in prominent place. Key messages will be developed to communicate to staff. Reminder of asthma protocols to be placed in high traffic areas. As regards ensuring safe discharge planning liaise with respiratory paediatrician, with regard to action plans and discharge leaflets, and respiratory physician re: adult plans, and educate staff in key messages. When available, liaise with ward clerk to ensure discharge advice is readily accessible to clinical staff.

National Clinical Audits reviewed in 2017/2018	Action
Royal College of Emergency Medicine – Severe Sepsis and Septic Shock 2016 (Darlington Memorial Hospital).	To include in August Educational Programme for Nursing and Medical Staff to improve both treatment and documentation. Communicated to staff as a key message and included in nursing huddles at shift handover. All patients should have an initial assessment within 15 mins of attendance, GP primary care streaming will be initiated by 1st October 2017 which will improve time to initial assessment. Medical and Nursing sepsis leads have been nominated to promote sepsis training at departmental level. On-going training on sepsis recognition carried out in Emergency Department by Cardiac Arrest Prevention Team. Emergency Department Registered Nurses trained in taking blood cultures using a WASP framework assessment.
Royal College of Emergency Medicine – Severe Sepsis and Septic Shock 2016 (University Hospital of North Durham).	Reminder to perform blood sugar – laminated card placed in high traffic areas. In University Hospital of North Durham an ST3 is acceptable senior review. Encourage senior review and for this to be documented. Include in Key messages. Reminder of sepsis 6 – placed in high traffic areas. Sepsis form to be scanned into Emergency Department system - liaise with ward clerk. Ensure staff have access to Arterial Blood Gas machine login. Liaise with ward clerk re: scanning printouts Discuss with IT – is a computer link to the gas machine possible. Contact IV team- to enable nursing staff to be trained in taking blood cultures.
National Oesophago-Gastric Audit 2016.	Importance of accurate description will be re-enforced to all endoscopists. A nurse led Barretts Clinic has already been set up to standardise and improve complete data.

National Clinical Audits reviewed in 2017/2018	Action
National Diabetes Audit (Adult) 15/16.	To re-emphasise to data clerk to document serum creatinine. To re-emphasise to data clerk to document urine albumin Hba1c targets: These are worse than the England averages because we see poorly controlled diabetes in secondary care and by that nature to compare would be unfair. The number of patients with Hba1c less than 58 should decrease as the service have a drive to discharge more of the patients who have good control. The service would, however prefer to see the number of patients with Hba1c more than 86mmol/mol decrease and be closer to the national average.
National Diabetes in Pregnancy Audit 2015 Darlington Memorial Hospital.	Letter to be sent by Diabetic lead at DMH. To continue to education of Primary Care Trust on the use folic acid 5mg supplement prior to pregnancy. Continue to work on first trimester control and provide robust antenatal/ diabetic care.
National Diabetes in Pregnancy Audit 2015 University Hospital of North Durham.	Letter to be sent by Diabetic lead at UHND. To continue to education of Primary Care Trust on the use folic acid 5mg supplement prior to pregnancy. Continue to work on first trimester control and provide robust antenatal/ diabetic care.
National Diabetes Inpatient Day Audit 2016 Darlington Memorial Hospital.	To continue education of Primary Care about early referral to the Diabetes Foot Clinic. To continue to educate Junior Doctors and health care professionals to ensure that prescriptions are accurate To continue to educate Junior Doctors and health care professionals to ensure that insulin is administered accurately.

National Clinical Audits reviewed in 2017/2018	Action
National Diabetes Inpatient Day Audit 2016 University Hospital of North Durham.	New model of Diabetes Service to start in Oct 17. Seven day extended Diabetes Specialist Service reduce insulin infusion use. Plans to increase consultant recruitment and foot clinics in the next 24 mths. Aim to reduce severe hypoglycaemic episodes with the : New diabetes model service. Buddy ward education model. Diabetes Specialist Nurse Education model.
MINAP 14/15.	On-going review of admission criteria to acute cardiac wards (units).
MINAP 15/16.	On-going review of admission criteria to acute cardiac wards (units). Re-enforce use of MINAP data collection form to ensure accurate recording of secondary prevention.
National Diabetes Footcare Audit 14/16.	To continue to educate of primary care re the pathway and the need to refer immediately there is a footcare problem.
National Hip Fracture Database Audit 16/17.	Maintain the improvement in time to surgery through regular feedback to Consultant teams and bi-monthly reporting of outcomes. Audit the number of hip fractures performed on non-trauma list. Improve communication with Community Physiotherapy service. Audit compliance with trust guidance on screening for malnutrition. Expand the trust NHFD leadership to include Anaesthetist as well as Orthopaedic Surgeon and Ortho-geriatrician. Hospital Managers and clinicians should examine how ward environments contribute to the risk of inpatient falls. Discuss with Trust Falls Lead in relation to medical wards The trust should use the on-going Physiotherapy Hip Fracture Sprint Audit to improve their understanding of the patient flow through the relevant service

National Clinical Audits reviewed in 2017/2018	Action
National Emergency Laparotomy Audit (NELA) Dec 15-Nov 16 (Trustwide).	Develop elderly care model based on Orthopaedics Surgery. Increase recovery Nursing staffing to facilitate operating between 17.00 – 21.00pm. Increase the number of Level 1 Nursing beds in the wards. Governance Facilitators and/or Research Nurse to support data collection. Governance Facilitators to keep prospective diary of all Laparotomies undertaken.
BTS Adult Asthma 16/17.	Introduce an Asthma Care Bundle stamp across all wards to help ensure comprehensive data collection. Increase awareness of objective testing within Emergency Department and Acute Medical Unit at Darlington Memorial Hospital.
MBRRACE Surveillance of maternal deaths in the UK 2012-14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-14.	Care Pathway. Areas of assessment in the event of emergency at point of assessment. Guideline / pathway to be developed to ensure early referral to ECMO.
National Bowel Cancer Audit 14/15 (2016 Annual Report).	Encourage patient's in the clinic who are eligible for bowel screening. If no resection is offered these patients should have an alternate pathway plan. Starting enhanced recovery audit, approved by CSTC pending minor alterations. ERAS programme will identify any potential delays to discharge.

National Clinical Audits reviewed in 2017/2018	Action
SSNAP Organisational Audit 2016	Although physiotherapy is available at weekends, staffing issues and service configuration prevents the others. On-going business case development. Continue with business case to support ESD. SSNAP Audit 15/16.

Confidential Enquiries

County Durham and Darlington NHS Foundation Trust has participated/is still participating in 6 enquiries during the course of 2017/2018. The Trust has submitted/is submitting either patient or organisational data for all studies which were deemed relevant.

Confidential Enquiries reviewed in 2017/2018	Action
NCEPOD – Inspiring Change Acute Non Invasive Ventilation.	A structured plan for future treatment should be discussed with the patient and/or carer either at the point of discharge from hospital or at subsequent follow-up.

The reports of 24 local clinical audits were reviewed by provider in 2017/2018 and County Durham & Darlington NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

National Clinical Audits reviewed in 2017/2018	Action
A Quality Improvement Project To Improve Prescribing At The End Of Life At University Hospital North Durham.	Introduce training to Foundation doctors on end of life prescribing into their Foundation Programme teaching Introduce an 'end of life' anticipatory prescribing order set into ePMA through discussion with the ePMA and Palliative Care teams.
An audit of the investigation and management of rectal cancer within the CDDFT trust March 2014 - March 2015.	Liaise with radiology to decrease length of wait for staging examinations particularly with MRI. Earlier referral to specialists for downstaging chemo/ radiotherapy when results of imaging available.

National Clinical Audits reviewed in 2017/2018	Action
Neck Ultrasounds – are requests complaint with BMUS Guidelines	BMUS Guidelines to be shared with referrers. Disseminate results of audit among referrers
Neuromuscular Block Monitoring Before Extubation: Are We Following National Guidance?	To consider buying more nerve stimulators. To consider buying more quantitative monitors
Clinical Audit Inpatient Scales.	Clinical areas to record any weighing equipment they hold, when it was purchased, what calibration and or servicing is needed, when this is required and by whom and the frequency is this to be done. Consider a tender for on-going maintenance and calibration of patient weighing equipment. To explore equipment options and costs, to make available equipment fit for purpose and that staff are trained in using any new equipment acquired Care pathway embedded into practice. Role essential training for all ward based nurses.
Reversal of treatment for Glaucoma or Occular Hypertension.	All newly diagnosed patients to be seen by a senior doctor at least once to confirm the validity of the first diagnosis. Ideally, all glaucoma patients to be followed up by a team with special experience and expertise i.e. Glaucoma specialists Review all patients with Glaucoma or OH and assess the accuracy of the original diagnosis. Stop treatment in selected patients. This would help the patients with unnecessary hospital visits, thus saving expenses for all.
Impact of Papilloedema referrals on the Ophthalmology Department.	Pathway to be made available to all in Casualty. Prompt and correct referral when found to have papilloedema.

National Clinical Audits reviewed in 2017/2018	Action
Audit to compare the use of temperature monitoring and warming methods in adults undergoing surgery at UHND with recommended national guidelines.	Disseminate an email and discuss with theatre staff regarding changing the starting fluid volumes from 1000ml to 500ml. Any further fluid needed after this should be warmed. Discuss results at departmental meeting and explain NICE guidelines into temperature monitoring and warming methods.
Outcome of Cataract Surgery in Diabetic and Non Diabetic and compare with HbA1c level.	To ensure all the patients get their post-operative BCVA on each and every visit. To update contact details on each and every visit.
Audit of Anti-Vegf treatment in Age Related Macular Degeneration.	Create a new referral form with better placement. Contact Royal College of Ophthalmology to explain the issue with audit of their standards of care when using the urgent care referral form produced by them.
Audit into the management of perioperative hypothermia.	Commence a PDSA cycle. Consider question on the pre-induction checklist asking "Is this patient at risk of hypothermia?" This may prompt staff to think about using warming systems. Increased education and awareness for staff of the importance of avoiding POH and measures that can be done to do so. Revisit the PDSA cycle re: all IV fluids >500ml should be warmed.
Outcome of Scaphoid fracture non-union fixation.	Increase in the number of patients undergoing percutaneous fixation with bone grafting can potentially improve healing rate.
Ambulatory Emergency Care – Maintaining Quality and Safety.	Train nursing and medical staff to accurately record AMB scores and to complete the referral proforma.
An Audit of Appropriate Diagnosis and Management of UTI in Adults (non-pregnant).	Increasing awareness among medical staff about the importance of following the Hospital protocol through verbal communication to colleagues. Hanging a copy of the Protocol on the ward board for easy reference and a constant reminder.
MRSA Decolonisation in neck of femur fracture patients.	Guidance booklet re: prescribing MRSA prophylaxis being written for new foundation doctors starting surgical placements.

National Clinical Audits reviewed in 2017/2018	Action
Audit of TARN quality indicators for trauma CT.	Agreement with administrator on which data to be taken from Radiology systems. Detailed analysis of the cases which missed the targets to identify root cause. Agree a target time for CT to be sent to Medics for reporting e.g. 10 mins. Introduce a provisional trauma report template to aid swift reporting.
Hypopack Audit.	Paediatricians agreed to ensure urine samples are sent. Raising awareness amongst staff in A&E regarding the indications for and importance of sending Hypopacks when identifying hypoglycaemia in children.
VTE Risk Assessment and Prophylaxis.	Renew push to re-educate junior doctors about the importance of VTE risk assessment & prophylaxis. Encourage the T&O department to think about a move away from paper VTE assessment tools to electronic tools by incorporating VTE risk assessment as part of the EPMA electronic prescribing system on iSOFT such as that already practiced by the medical department.
Audit of consent forms in Trauma Orthopaedic Surgery in Darlington Memorial Hospital.	To discuss blood transfusions with all patients if this is applicable and to offer information leaflet. Write box of 'not applicable for this section' (special requirements). Consenting doctors should fill this in for all patients. All doctors should offer patients copy of consent forms and record this information. Designing patient friendly info leaflet for trauma patients.

National Clinical Audits reviewed in 2017/2018	Action
An audit of awareness of tools for diagnosing delirium.	Increase awareness of CAM as screening tool for delirium by: • Posters in ward offices. • Liaise with IT to have delirium screensavers and make the CAM proforma available on the intranet.. • Liaise with mental health to suggest a delirium awareness day. • Consider mandatory delirium screening on iSoft within 24 hrs of admission of any patient over the age of 65.
Are we complying with the Trust's Guidelines: Management of Venepuncture (Adults) and Management of Cannulation (Adult), In the specific steps to reduce the risk of haemolysis.	Clear standards/instruction will be developed to identify best practice in relation to skin preparation. Clear standards/instruction will be developed to identify best practice in relation to tourniquet time. Five venesection trays will be ordered Disseminate venesection tray instruction. During first week of introduction, venesection will only take place using a 'fresh stab' vacutainer system. Prior to introduction full instructions must be given to all staff relating to the above action. During introduction utilise every shift handover to reinforce details regarding the intervention.
Three year block dissection.	Add indication to proforma. Undertake a literature review re: Antibiotic protocol for groin dissection and discuss with Microbiology.

National Clinical Audits reviewed in 2017/2018	Action
An Audit of AMU performance against Society of Acute Medicine (SAM) clinical quality indicators regarding the time of initial clerking and senior review.	Reminding doctors of the importance of documentation on admission clerking documents. Sharing the information at the Junior Doctors Forum. Reminding the on-call team about the target of 100% od patients seen within 4hrs of admission. Discuss on ways to improve junior doctors cover especially during winter.
Compliance of AMTS documentation at admission of patient's >70 yrs.	To improve compliance with documentation of AMTS in >70 yrs present findings of audit an implement changes (presentations and education session and visual reminders. Constant reminder to juniors \nursing staff to document AMTS at admission for patients aged >70 yrs with Consultant support.
Audit of Acute Kidney Injury (AKI) Management .	Education on AKI aimed at junior and senior medical staff. AKI bundle to be trailed on AMU.

Research & Innovation

The number of patients receiving relevant health services provided or sub-contracted by County Durham & Darlington NHS Foundation Trust in 2017/2018 that were recruited during that period to participate in research approved by a Research Ethics Committee was 1874 participants. The table below shows the areas research has taken place within CDDFT. The complexity adjusted recruitment figures for 2017/2018 were 12259 showing a 63% increase in the complexity of the studies delivered as compared to 31% average for the Clinical Research Network North East & North Cumbria (CRN: NE&NC).

Managing Specialty	Total
Anaesthesia, Perioperative Medicine and Pain Management	2
Cancer	189
Cardiovascular Disease	58
Children	54
Critical Care	178
Dementias and Neurodegeneration	2
Dermatology	89
Diabetes	33
Ear, Nose and Throat	4
Gastroenterology	507
Genetics	1
Haematology	5
Health Services Research	53
Hepatology	16
Infection	95
Injuries and Emergencies	12
Mental Health	12
Metabolic and Endocrine Disorders	6
Musculoskeletal Disorders	31
Neurological Disorders	2
Primary Care	12
Renal Disorders	3
Reproductive Health	327
Respiratory Disorders	8
Stroke	76
Surgery	99
Total	**1874**

County Durham & Darlington NHS Foundation Trust is committed to participation in clinical research and innovation and our continued successful recruitment to clinical research studies demonstrates our desire to improving the quality of care we offer and to making our contribution to wider health improvement

locally, regionally and nationally. Through research our clinical staff remains informed of the latest possible treatment possibilities and it has been shown research-active institutions provide better care and have better patient outcomes than those NHS Trusts that conduct less clinical research.

During 2017/2018 County Durham & Darlington NHS Foundation Trust was involved in conducting National Institute for Health Research (NIHR) Portfolio clinical research studies in the following new areas of sexual health and ENT.

Areas in which non-NIHR clinical research studies were conducted by County Durham & Darlington NHS Foundation Trust in 2017/2018 include:

- Cardiovascular.
- Colorectal Disease.
- Dermatology.
- Gynaecology.
- Health Service & Delivery Research.

Building on national strategy, Research & Innovation have developed a Research & Innovation Strategy 2018-2021 with the aim of continuing to work towards developing:

- A culture that values and promotes research and to continue to provide opportunities for patients to be recruited to new studies.
- Increase the opportunities for all people across the region to participate in health research
- Provide researchers with the practical support they need to make clinical research studies happen in the NHS
- Improve the efficient delivery of high quality clinical research.
- Increase commercial clinical research investment and activity to support the Trust's growth
- Provide a coordinated and innovative approach to local and national research priorities.
- Assist CDDFT in retaining a high quality workforce through education and training, targeted strategic investment of both medical and nursing, midwifery and allied health professionals and creating opportunities for professional and leadership development and strategic contribution.

We have 90 Principal Investigators (PI's) across all specialties and disciplines with 38 currently leading multiple clinical research studies across the organisation demonstrating a good platform from which to build ensuring research is firmly embedded as core Trust business and have successfully increased the number of NMAHP PI's with two of the top five recruiting PI's for 2017/2018 being nurses. In 2018/2019 we aim to continue to develop more Chief Investigators within CDDFT therefore the number of Investigator Initiated studies in line with national priorities.

2017/2018 also saw the formal coming together of the Clinical Research Department and the Innovation team further embedding a fully integrated Research & Innovation Department within the Trust.

Information on the use of the Commissioning for Quality and Innovation (CQUIN) framework

A proportion of County Durham & Darlington NHS Foundation Trust's income in 2017/2018 was conditional on achieving quality improvement and innovation goals between County Durham & Darlington NHS Foundation Trust and anybody they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation framework.

The main CQUIN scheme covers two years (2017-19) and carries financial incentives to the value of 2.5% of the total Trust contract; of which 1% is contingent upon CDDFT participation in the regional Sustainability and Transformation Plans (STP) and achieving financial targets agreed with NHS Improvement (NHSI).

A further 1.5% is contingent upon quality improvements in several nationally defined indicators. In addition to its main CCG contract, CDDFT has small contracts with NHS Specialist Commissioners and with NHS Public Health, both of which include small CQUINs.

The CQUINs are:

Target	Q1	Q2	Q3	Q4
Staff Survey: 5% Improvement on responses to two questions from Staff Survey about the Trust's approach to staff health and well-being:				
Healthy Food: improve availability of healthy food at UHND, DMH, BAH, CLS, Shotley.				
Staff - Flu Vaccinations – 70% uptake				
Sepsis screening in ED – 90% screened				
Sepsis screening in In-patients – 90% screened				
Sepsis treatment within one hour in ED – 90% treated				
Sepsis treatment within one hour in IPs – 90% treated				
Antibiotic review within 72 hours (Acute) – 90%				
Reducing antibiotic usage (IP and OP): (Acute): 1. Total 2. Carbapenem 3. Piperacillin-tazobactam				
Improving services for MH patients in A&E (Acute) and reduce by 20% A&E attendances by a defined group of frequent attenders with mental health problems				
Offering Advice & Guidance (Acute)				
E-Referrals (Acute) 100% Consultant OP clinics on C&B and slot issues reducing to 4%.				
Proactive & Safe Discharge (Acute and Community) - 47.5% of >65 non-elective patients discharged to normal place of residence.				
Wound care (Community) - Number of wounds which have failed to heal after 4 weeks that receive a full wound assessment				
Personalised Care / Support Planning (Community)				
Preventing ill health alcohol & tobacco (Community Hospitals)				
SpecComm and Public Health CQUINs				
Chemotherapy Dose Banding				
Medicines Optimisation. Adoption of best value drugs				
Dental - Populate a quarterly Dashboard and contribute to development of a Managed Clinical Network				
Bowel Screening - Patient feedback				
Aycliffe Nursing - Patient feedback				

Key: Fully achieved | Partially achieved | Failed

Total CQUIN monies for 2017/2018 amount to approximately £8.6m. During 2016/17 this total was £8.56m. A local agreement was reached that CCGs would re-invest half of any monies CDDFT lost as a result of failure to achieve CQUIN targets. This was superseded by a year-end agreement covering all CDDFT income, including CQUIN payments.

Registration with Care Quality Commission

- County Durham & Darlington NHS Foundation Trust is required to register with the Care Quality Commission, the Trust's current registration status is described below under each specified location:

University Hospital of North Durham, Durham City

- Assessment or medical treatment for persons detained under the Mental Health Act 1983.
- Diagnostic and screening procedures.
- Family planning.
- Maternity and midwifery services.
- Surgical procedures.
- Termination of pregnancies.
- Treatment of disease, disorder or injury.
- Transport services, triage and advice provided remotely.

Chester-le-Street Community Hospital, Chester-le-Street

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures.
- Family planning.
- Treatment of disease, disorder or injury.

Shotley Bridge Community Hospital, Shotley Bridge

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures.
- Family planning.
- Maternity and midwifery services.
- Surgical procedures.
- Treatment of disease, disorder or injury.
- Transport services, triage and advice provided remotely.

Richardson Community Hospital, Barnard Castle

- Diagnostic and screening procedures.
- Treatment of disease, disorder or injury.

Weardale Community Hospital, Stanhope

- Diagnostic and screening procedures.
- Treatment of disease, disorder or injury.

Sedgefield Community Hospital, Sedgefield

- Diagnostic and screening procedures.
- Treatment of disease, disorder or injury.

Bishop Auckland Hospital, Bishop Auckland

- Assessment or medical treatment

for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures.
- Family planning.
- Maternity and midwifery services – service currently suspended due to workforce capacity
- Surgical procedures.
- Termination of pregnancies.
- Treatment of disease, disorder or injury.
- Transport services, triage and advice provided remotely

Darlington Memorial Hospital, Darlington

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures.
- Family planning.
- Maternity and midwifery services.
- Personal Care – registered as HQ for delivery in the community.
- Surgical procedures.
- Termination of pregnancies.
- Treatment of disease, disorder or injury.
- Transport services, triage and advice provided remotely.

Dr Piper House, Darlington

- Treatment of disease, disorder or injury.
- Diagnostic and screening procedures.
- Transport services, triage and advice provided remotely – The Trust made an application to the Care Quality Commission to remove this regulated activity from Dr Piper House. This is due to the relocation of the Urgent Care Centre to Darlington Memorial Hospital. All other regulated activity at Dr Piper House remains the same.

Peterlee Community Hospital, Peterlee

- Treatment of disease, disorder or injury.
- Diagnostic and screening procedures.
- Transport services, triage and advice provided remotely.

Seaham Primary Care Centre, Seaham

- Treatment of disease, disorder or injury.
- Diagnostic and screening procedures.
- Transport services, triage and advice provided remotely.

County Durham and Darlington NHS Foundation Trust has no conditions on registration. The Care Quality Commission has not taken enforcement action against County Durham and Darlington NHS Foundation Trust during 2017/2018.

County Durham & Darlington NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Care Quality Commission Ratings

The Trust is rated 'Requires Improvement' following the CQC's last inspection of the Trust, carried out in September and October 2017 and reported in March 2018. This inspection covered the following services at both Darlington Memorial Hospital (DMH) and University Hospital

North Durham (UHND): Urgent and Emergency Care; Medicine; Surgery and Maternity. Services were selected according to a risk assessment. CQC's report, published in March 2018, set out ratings tables which combined the outcomes of the latest inspection with ratings for those services not inspected, which were brought forward from the comprehensive inspection reported in September 2015.

Overall ratings by Domain are set out below:

Are services safe?	Requires Improvement (RI)
Are services effective?	Requires Improvement (RI)
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

CQC's inspection methodology now includes a three-day detailed assessment of Trust leadership arrangements against Key Lines of Enquiry for the Well-Led Domain. The rating for 'Well-Led' at the Trust level reflects the outcome of this detailed assessment. The rating for 'Well-Led' for services at each of the Trust's hospitals reflects the leadership of services and aggregates the ratings for the services provided at those locations. The aggregation methodology results in 'Requires Improvement' ratings for Well-Led for services at both DMH and UHND.

Ratings grids for each Hospital / Community Services are:

- **Darlington Memorial Hospital (DMH)**

Ratings for Darlington Memorial Hospital

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

- **University Hospital North Durham (UNHD)**

Ratings for University Hospital of North Durham

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

- **Community Services**

Ratings for community health services

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

Context and key issues

It is important to note that End of Life Care was not included in the inspection taking place in October 2017, at each hospital site. The Trust believes that it has made significant improvements in the safety, effectiveness and leadership of End of Life Care, based upon national audit data, surveys of those relying on the service and a review by NHS Improvement. The Trust looks forward to further inspection by CQC in due course.

CQC have acknowledged that actions from the 2015 inspection were, in the main, fully implemented and noted a number of improvements in their report, in particular:

- In most areas nurse staffing had improved.
- Staff investigated incidents quickly, and shared lessons learned.
- Wards and department areas were clean and equipment was well maintained. Staff followed infection control policies that managers monitored to improve practice.
- Staff provided care and treatment based on national guidance and evidence and used this to develop new policies and procedures.
- Staff cared for patients with compassion, treating them with dignity and respect.
- Patients, families and carers gave positive feedback about their care.
- The hospital escalation policy and procedural guidance was followed during busy times.

Requirements and recommendations included in CQC's final reports can be summarised by theme as follows:

- The need to further embed learning from never events, including further strengthening of the culture and staffing within operating theatres. CQC acknowledged the work undertaken by the Trust in response to a high number of never events reported in 2016/17, together with an active programme to improve staffing and culture in theatres but concluded that both work-streams needed to go further.
- The need to strengthen policies, training and education and systems with respect to the application of the Mental Capacity Act and Deprivation of Liberty Standards and related matters such as the administration of covert medications.
- The need to review and improve the safety of facilities within the Trust's Emergency Departments used to assess and treat patients with Mental Health conditions, in line with national best practice.
- Actions and recommendations in respect of specific findings concerning administration and security of medications and oxygen; nursing assessments and record-keeping.

Improvement Plans and Progress

The Trust submitted a 51 point action plan to CQC on 23rd March 2018. This captured both initial actions, which had been taken in response to verbal feedback and CQC's draft reports, and the further actions required to address 'Must Do' requirements and 'Should Do' recommendations included in the final reports. The majority of the actions identified are already being implemented. Governance arrangements

are in place to drive and assure delivery of the specific actions as follows:

- Actions are owned by Matrons and Heads of Service, or by relevant Heads of corporate departments in the case of Trust-wide policy and training issues concerning Mental Health conditions and the Mental Capacity Act.
- Accountability for service specific actions is included in annual operating plans agreed between the Executive Directors and the relevant Care Groups and these actions are to be monitored through the Care Group's Quality Governance forums and reported on, every month, to the Executive Patient Safety and Experience Committee. The Executive Director of Nursing will hold Executive accountability, through this meeting, for actions relating to nursing practice and staffing and the Executive Medical Director, or his delegate, will attend and be accountable for actions with respect to medical staffing and practice.
- Semi-independent monitoring checks will be undertaken by the Trust's Assurance and Compliance Team, and by Senior Nurses undertaking 'Back to Practice' visits to wards and Emergency Departments, to assess whether changes made are effective.
- The Board's Integrated Quality and Assurance Committee, chaired by a Non-Executive Director, will receive monthly reports to provide assurance of progress with respect to implementation of actions.

The Trust is seeking to enrol in NHS Improvement's 'Moving to Good' programme, which is designed to support Trusts with an overall 'Requires Improvement' rating in moving to a Good rating. Through this programme, alongside monthly meetings with NHS Improvement and bi-monthly meetings with the CQC team, the Trust will avail itself of a wide range of support both to implement the specific actions but also to ensure that our culture, management and oversight arrangements are sufficiently robust to sustain improvements and maintain good performance across all services. The Trust will seek to obtain insight from Trusts rated 'Outstanding' and will seek independent support to strengthen mock inspections and other monitoring checks as part of this process.

The tables below summarise the actions underway to address the requirements and recommendations from CQC:

Urgent and Emergency Care	• Rooms used to assess patients with Mental Health conditions are to be modified to comply with best practice guidance on minimising opportunities for patients to harm themselves and others. A wider piece of work is being undertaken with Tees, Esk and Wear Valleys NHS Foundation Trust to implement the good practice with respect to patients with Mental Health conditions, set out in the National Confidential Enquiry "Treat As One" in our acute hospitals. • A risk assessment has been completed with respect to other potential ligature risks within our Emergency Departments. Where appropriate, work will be undertaken to mitigate risks identified. • Record-keeping and reconciliation procedures for controlled drugs have been standardised and made subject to frequent spot checks and audits to confirm compliance. • Arrangements have been put in place to secure intravenous infusions for potassium separately from other drugs, and to provide lockable cupboards in short stay rooms to secure patients own medications. • Guidance on recording of blood sugar levels has been reiterated and will be subject to regular spot checks and audits. • The policy for prescribing of oxygen therapy is to be reviewed and reiterated Trust-wide.
	• Medical and nursing staffing rotas are to be reviewed with expert support and nursing staffing aligned to demand. Recruitment of consultants and Associate Specialists will continue with the aim of enabling the Trust to meet Royal College of Emergency Medicine staffing guidelines. • A review of pathways is underway to strengthen our capacity to take ambulance handovers, to provide access to Children's Nurses for Paediatrics patients, and to assess patients within 15 minutes of arrival within our Emergency Departments. The Trust already has a range of actions in place, working with NHS Improvement's Emergency Care Intensive Support Team and our Local Accident and Emergency Delivery Board to seek to meet the 95% target for patients attending our Emergency Department to be seen and treated in four hours. These will continue.

Medicine	• A Task and Finish Group has been established to update the Trust's policies for compliance with the Mental Capacity Act in line with best practice. The policy has been rewritten and is undergoing review with external specialists prior to approval. The Group is also reviewing the training needs of all staff and will develop training programmes to meet those needs. • Weekly monitoring is now in place with respect to the application of Deprivation of Liberty Standards (DOLS), where appropriate, for patients subject to supervision or cohorting due to the risk of falls. • Required changes to the nursing assessment documentation have been identified, to prompt due consideration of capacity and DOLS issues. These are to be made to the templates in our electronic observations system, Nervecentre and trialled over the next quarter, with a view to full implementation in the second quarter of the year. • Our Safeguarding Adults Lead is working closely with ward staff to raise their awareness and understanding of the above requirements and we will create and appoint a lead for the Mental Capacity Act. • Further actions are planned to address additional, specific recommendations.

Surgery	• We will continue the roll out of arrangements to reinforce patient safety in theatres and to mitigate the risk of never events. These include Local Safety Standards for Invasive Procedures and associated training and audit procedures, so that we are assured that these standards are followed in practice. Independent audits will also be undertaken to assure ourselves that teams are complying with protocols introduced in response to never events in 2016/17 and 2017/2018. • The Trust has an on-going programme of work in place to strengthen the culture within operating theatres, with some success. However, this has further to go and additional Organisation Development support will be provided to consolidate the positive changes experienced to date. • Theatre staffing has been reviewed against good practice guidance and recommendations. Further granularity is being sought prior to recommendations being made to the Board. Six monthly safe staffing reports to the Board will then be introduced as for other services. • Additional monitoring arrangements are to be put in place to ensure that time is protected for training for Theatre staff and that targets for training of staff in Safeguarding are met. • Spot checks are being put in place, reinforced by independent observational audits, to ensure that the difficult intubation trolley is checked in line with policy. • Further actions are planned to address additional, specific recommendations.

Conclusion

The Trust is committed to working with CQC, and with support from NHS Improvement, to address all requirements and recommendations and to sustain improvements in quality to achieve a "Good" rating at the next inspection.

Data Quality

Indicator	Target	2017/2018 Months 1 -12
Data completeness community services - RT	50%	100%
Data completeness community services - Referrals	50%	99.8%
Data completeness community services - Treatment activity	50%	99.7%
% of SUS data altered	10%	27.2%
Valid NHS number field submitted via SUS - Acute	99%	99.7%
Valid NHS number field submitted via SUS - A&E	95%	98.5%

County Durham & Darlington NHS Foundation Trust submitted records during 2017/2018 to the Secondary Uses services for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

Please note the latest available report for the following is M12

- which included the patients valid NHS number was:
  - 99.6% for Admitted Patient Care
  - 99.7% for Outpatient Care
  - 98.3% for Accident and Emergency Care
- which included the patient's valid General Medical Practice Code was:
  - 99.9% for Admitted Patient Care
  - 99.8% for Outpatient Care
  - 99.9% for Accident and Emergency Care

County Durham & Darlington NHS Foundation Trust's Information Governance Toolkit Assessment Report overall score for 2017/2018 was 93% Green and Satisfactory.

County Durham & Darlington NHS Foundation Trust was not subject to the Payment By Results clinical coding audit during 2017/2018 by the Audit Commission, however, internal audit carried out by our accredited audit yielded the following accuracy scores:-

- 98% Correct for Primary Diagnosis
- 94% Correct for Secondary Diagnosis
- 97% Correct for Primary Procedure
- 94% Correct for Secondary Procedure

The results should not be extrapolated further than the actual sample audited. The specified areas do not constitute a representative sample of overall Trust performance but are an indication of sound controls and processes. The programme included data testing of a random sample of episodes as there were no specific areas to be addressed or highlighted by commissioner input. These are well above national expectations. The sample size had a combined denominator of 1,411 clinical codes.

County Durham & Darlington NHS Foundation Trust is taking the following actions to improve data quality:-

- Communications and feedback process with the A&E department in relation to the accuracy of data recording on the Symphony system and completion of the new Emergency Care Dataset
- Readmission Within 30 Days daily validation to ensure accuracy of recording and allow for Care Group level internal audit to be carried out as and when required.
- Junior doctor training in relation to discharge summary completion and accuracy.
- Specialty specific Consultant/coding joint working to ensure correct documentation and wording is used in the correct locations to be picked up by Clinical Coding.
- Continued audits of individual coder accuracy with attention given to depth and relevance of coding.
- Co-morbidity validation reporting at record level, exception based.
- Improved clinical coding turnaround has resulted in a final quarter position that is under the 10% threshold.

Cyber-security

The Trust is committed to maintaining the security and integrity of data used to deliver healthcare and to drive the achievement of quality goals. To that end, the Trust continued to invest during 2017/2018 in the roll out of a bespoke cyber-security strategy approved by the Board in December 2016. The strategy includes: strengthening controls over physical access to servers and data; deployment of a suite of technology to monitor and protect our networks, working with a leading IT security provider; user education and awareness of risks such as phishing and commissioning period testing of our controls to ensure that they remain up-to-date. Thanks to this strategy the Trust's systems were not compromised by the Wannacry attack. Further technology has since been deployed and the Trust continues to work with NHS Digital to ensure that systems are patched on a timely basis and threats are recognised and planned for.

Learning from Deaths

During 2017/2018 2047 of County Durham and Darlington NHS Foundation Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 439 in the first quarter;
- 433 in the second quarter;
- 524 in the third quarter;
- 651 in the fourth quarter.

By 31/03/2018 191 case record reviews and 9 investigations have been carried out in relation to 2047 of the deaths included above.

In 9 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 79 in the first quarter;
- 60 in the second quarter;
- 37 in the third quarter;
- 15 in the fourth quarter.

Four, representing 0.19% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- 1 representing 0.23% for the first quarter;
- 1 representing 0.23% for the second quarter;
- 1 representing 0.19% for the third quarter;
- 1 representing 0.15% for the fourth quarter.

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

The key learning themes identified through both those deaths identified 2017/2018 have been in relation to adherence to policy, documentation, escalation of care and sepsis. Learning identified through case record review overall has included caring for patients with an acute kidney injury, advanced care planning and initiation of DNACPR forms.

Actions that County Durham and Darlington NHS Foundation Trust has taken in relation to the learning identified from those deaths in 2017/2018 form part of comprehensive SMART action plans monitored through the Trust governance processes. The key actions are in relation to ensuring robust application of policy and procedure and taking steps to improve communication pathways and documentation.

A detailed action plan is in development in relation to improving advance care planning. The Trust has also recently appointed to a falls lead post.

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

No case record reviews and no investigations were completed after 1st April 2017 which related to deaths which took place before the start of the reporting period.

No cases, representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the PRISM 2 mortality review methodology or the Co Durham and Darlington NHS Foundation Trust Serious Incident Investigation Process.

Seven, representing 0.35% of the patient deaths during 2016/17, are judged to be more likely than not to have been due to problems in the care provided to the patient.

Part 3: Additional Information

Financial Review

Despite a very challenging economic environment, the trust delivered an overall deficit of £1.14m in 2017/2018, which comprised an operational surplus of £7.1m (which was £3.4m ahead of plan) and an impairment of £8.07m resulting from a reduction in the value of the trust's land and buildings following a review by the trust's valuers, together with the trust's charity spending £0.324m in excess of the income it received in year.

Performance Framework

The Trust's operational scorecard is built upon the Four Touchstones. The latest figures available are for March 2018.

Month: March 2018. * One month in arrears ** Two months in arrears ***Three months in arrears

Experience	Target	2017/2018
RTT - % Incompletes waiting <18wks	92%	92.60%
RTT waits over 52 weeks	0	0
A&E % seen in 4hrs - Trust Total	95%	91.40%
A&E % seen in 4hrs - All UCC 'Walk-ins' Type 3	95%	100%
Ambulance handovers >15-30mins	0	7156
Ambulance handovers >30-60mins	0	2202
Ambulance handovers >60mins	0	890
Ambulance Handovers - no. >120 minutes	0	160
12 Hour Trolley Waits	0	0
% Diagnostic Tests <6wks	99%	99.78%
Cancer 2WW*	93%	93.90%
Cancer 2WW Breast Symptoms*	93%	95.60%
Cancer 31 Days Diagnosis to Treatment*	96%	99.70%
Cancer 31 Days Subsequent Treatment - Surgery*	94%	98.80%
Cancer 31 Days Subsequent Treatment - Anti Cancer Drug*	98%	100%
Cancer 62 Days to First Treatment*	85%	86.70%
Cancer 62 Days Screening*	90%	87.50%
Cancer 62 Days Consultant Upgrade*	85%	100%
A&E % Seen in 4hrs - DMH	95%	88.90%
A&E % Seen in 4hrs - UHND	95%	83.60%
A&E CI - Unplanned Re-attendance rate	<=5%	1.50%

Experience	Target	2017/2018
A&E CI - Time to treatment (median)	<=01:00	00:43:00
6 hour wait in Urgent Care Centres	95%	99.30%
Maternity 12 week bookings	90%	90.90%
Maternity Breast Feeding at Delivery	60%	58.70%
Maternity Smoking at Delivery	22.40%	17.60%
Stroke - 90% of time on a stroke unit**	90%	93.10%
Stroke - CT scan within 24 hours**	90%	96.10%
Stroke - Scan within 1 hour**	50%	38.10%
Sleeping Accommodation Breach	0	3
ERS - ASI % of DBS Bookings *	4%	21.20%
Cancelled Operations - Breaches of 28 Days	0	22
Urgent Operations cancelled for 2nd time	0	0
Delayed transfers of care*	3.50%	0.06%
Community nursing - urgent and OOH referral waiting times* (72 hr target)	93%	93%

Month: March 2018 * One month in arrears ** Two months in arrears ***Three months in arrears

Outcome	Target	2017/2018
Clostridium difficile cases	19	21
MRSA Bacteraemia	0	4
MSSA		23
Ecoli		358
VTE	95.00%	96.50%
Sepsis Screening AE (Quarterly)*		
Sepsis Screening IP (Quarterly)*		
Duty of candour	Compliance	
Never events	0	4
Serious Incidents reported within 2 working days of identification		100.00%
Total number of incidents reported (Monitoring trends)*		18279
Serious Incidents Interim reports within 72 hours		97.00%
SUIs reported via STEIS as a proportion of all incidents involving severe injury or death within a Trust		78
Serious Incident RCAs submitted within 60 working days***		96.00%
Readmissions within 30 days of previous discharge following elective*		995

Outcome	Target	2017/2018
Readmissions within 30 days of previous discharge following emergency*		6410
Crude Mortality***		4.30%
HSMR***		96.05
SHMI***		102.32
Dementia - eligible admissions screened*	90.00%	90.50%
Dementia - AMTS compliance*	90.00%	86.70%
Dementia - onward referrals*	90.00%	33.20%
Quality Account Indicators not elsewhere reported		
Falls - Acute (Incident Report)		1689
Falls - Community (Incident Report)		205
Reduction in Falls - Acute (per 1000 beddays) (Cumulative)	5.6	6.0
Reduction in Falls - Community (per 1000 beddays) (Cumulative)	8	5.9
Continuation of Sensory Training into staff education programmes	180 per Q	
Falls & Fragility fractures - patients screened*		826
Falls & Fragility fractures - % eligible patient receiving follow up assessment for osteoporosis*	50.00%	37.60%
Falls & Fragility fractures - % patients with appropriate referral for axial scan (as a proportion of eligible patients)*		91.10%
Falls & Fragility fractures - % patients commenced on bone sparing drugs (as a proportion of eligible patients)*		
Grade 3 & 4 newly acquired avoidable pressure ulcers - Acute*	0	1
Grade 3 & 4 newly acquired avoidable pressure ulcers - Community*	0	4
Grade 2 newly acquired avoidable pressure ulcers - Acute	Monitor	0
Grade 2 newly acquired avoidable pressure ulcers - Community	Monitor	0
% adult patients that are correctly screened for undernutrition within 4 hours	85.00%	
% adult patients re-screened weekly for undernutrition	89.00%	
% adult patient identified at moderate or high risk of undernutrition have evidence that a nutrition care plan has been implemented, which fulfils recommendation on the 'MUST' nutritional tool	79.00%	
% adult patients identified at moderate or high risk of undernutrition have evidence of well completed food and fluid record charts	89.00%	

Outcome	Target	2017/2018
Rate of patient safety incidents resulting in severe injury or death	Within national average	
Rate of patient safety incident reporting	75th %ile	
Did you feel involved enough in decisions about your care and treatment?		86.00%
Were you given enough privacy when discussing your condition or treatment?		91.00%
Did you find a member of staff to discuss any worries or fears you had?		84.00%
Did a member of staff tell you about any medication side effects that you should watch out for after you got home in a way that you could understand?		69.00%
Did hospital staff tell you who you should contact if you were worried about your condition or treatment after you left hospital?		82.00%
% of staff who would recommend the trust to family and friends needing care (Staff Survey) Annual		
Friends and Family Test - increased response rate in In patients		32.10%
Friends and Family Test - increased response rate in A&E		15.90%
Summary Hospital Mortality Indicator (SHMI) ***		102.32
Hospital Standardised Mortality Ratio (HSMR) ***		96.05
Crude Mortality***		4.30%
Deaths with a palliative care code (Z515)***		33.50%
Readmissions within 28 days*	7.00%	12.50%

Efficiency	Target	2017/2018
Data completeness community services - RTT*	50%	100%
Data completeness community services - Referrals*	50%	99.8%
Data completeness community services - Treatment activity*	50%	99.7%
% of SUS data altered*	10%	27.2%
Discharge summaries within 24 hours	95%	91.9%
Valid NHS number field submitted via SUS - Acute*	99%	99.7%
Valid NHS number field submitted via SUS - A&E*	95%	98.5%
GP referrals		97146
Non GP referrals		70909
Outpatient attendances		554364

Efficiency	Target	2017/2018
Elective day-case admissions		44153
Elective inpatient admissions		7248
Theatres (utilisation)	85%%	80%
Non-elective admissions		68945
Digital Dictation - upload to approve		6.75
Summary Income and Expenditure (£000s) (cumulative)		-2214
Agency cap (£000s) (cumulative)		-9006
Cost Reduction (£000s) (cumulative)		-6870

Workforce	Target	2017/2018
Trust Sickness	<4%	4.57%
Agency Spend*	Decrease	£11,007,605
Bank Spend*	Increase	£10,944,420
Appraisal Figures - All staff	95.0%	95.33%
Essential Training - All staff	95.0%	95.85%
Voluntary Turnover	9.0%	7.39%
Total Turnover	Information	13.91%
Vacancy Rates -Effective shortfall	<5%	3.88%

Performance Risks

Non-elective pressures

The Trust's main operational and performance risk remains the non-elective pathway. Growth in A&E attendances and non-elective admissions, particularly at the Trust's busiest site, UHND, continues to put pressure on all services.

As described earlier, growth in non-elective medical admissions across the full year was 5% Trust-wide and at UHND 7.2%.

- In Q3/Q4 alone, all specialty non-electives grew by 2.8%; whilst Medicine grew by 7.9% (9.9% at UHND).
- Medical occupied bed-days. Throughout much of the winter, medical patients have occupied more in-patient beds on acute wards than in 2016-17. UHND has been particularly affected: bed-days occupied by medical patients were 9% higher in October, 15.5% in December, 10% higher in January, and 13.4% in March.

Elective pressures

The Trust is achieving the NHSI trajectory by a small margin each month.

18 weeks RTT	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
NHSI Trajectory	92.50%	92.50%	92.50%	92.50%	92.50%	92.50%	92.50%	92.50%	92.50%	92.50%	92.50%	92.50%
Performance	92.83%	93.44%	93.50%	92.93%	92.61%	92.11%	92.52%	92.84%	92.12%	92.10%	92.30%	92.00%

Key: Green = achieved both NHSI trajectory and 92% national standard; Amber = failed either NHSI or 92% national standard; Red = failed both NHSI and the 92% national standard

The undershooting of the trajectory in December was due to escalating winter pressures which peaked in Q4. January was particularly difficult with NHS England advising Trusts to stand down elective activity in order to accommodate non-elective demand. Transfer of work to the independent sector has been used for breast surgery, surveillance endoscopy, and orthopaedics patients scheduled for treatment at BAH who cannot be treated within 18 weeks.

This performance has taken place in the context of a significant fall in referrals. During 2017/2018 (compared to the 2016-17), referrals fell by 7.6% (GP referrals by 10.5% and non-GP referrals by 2.8%) across all major Specialties with the exception of breast surgery, plastics and obstetrics. The largest falls in GP referrals into the major specialties are orthopaedics (20%), urology (51%) and rheumatology (26%), but many other Specialties have seen falls of more than 10%, including general surgery, ophthalmology, gastroenterology, dermatology, and respiratory medicine. The Surgery Care Group, which is the one principally affected, is developing a recovery plan with the support and supervision of the Director of Operations.

North Durham CCG has commissioned a Referral Management company to filter referrals to CDDFT (in key specialties) from GPs. Darlington CCG is considering doing the same. Durham Dales, Sedgefield and Easington has its own internal peer review system.

Patient access is reviewed every week in the Referral to Treatment (RTT) Assurance Group. Operational Plans incorporating demand and capacity analyses for 2018/2019 are being finalised by all Care Groups.

In response to workforce and financial pressures, CDDFT and their main CCG commissioners have worked to re-configure services and reduce costs in several Specialties, the main ones being: ophthalmology (particularly the glaucoma pathway), A&E out-patient clinics; rheumatology, gastroenterology, occupational therapy, podiatry, dietetics, MSK physio and gynaecology. Most of these work-streams will continue into 2018/2019.

Cancer

The main cancer targets are for two week waits (2ww), 31 days and 62 days. The 31-day target is not normally problematic because the entire pathway is under the control of the Trust. The 62-days to first treatment target is the subject of an NHSI trajectory, although no financial incentives/ penalties are involved.

During 2017/2018, the number of two week wait cancer referrals fell by 3.9%.

Cancer performance against national standards

	Target	2017/2018
Cancer 2WW	93.00%	93.50%
Cancer 2WW Breast Symptoms	93.00%	95.60%
Cancer 31 Days Diagnosis to Treatment	96.00%	99.70%
Cancer 31 Days Subsequent Treatment - Surgery	94.00%	98.90%
Cancer 31 Days Subsequent Treatment - Anti Cancer Drug	98.00%	100.00%
Cancer 62 Days to First Treatment	85.00%	87.00%
Cancer 62 Days Screening	90.00%	88.00%

Breast symptomatic 2ww referrals continue at historically high levels due to the continuing absence of a comprehensive service in Sunderland. The Trust continues to play a valuable role in supporting the regional position albeit the Trust has to send considerable amounts of activity to the independent sector to achieve the targets.

The 62-day screening target is always at risk due to the very small numbers of patients using this pathway, so a single patient can make a significant difference to the % performance.

Other key performance risks:

Staffing: in common with many Trusts, CDDFT continues to rely heavily on locum and Agency nursing and medical staff in some Specialties. Some successful recruitments has taken place but some services remain fragile, notably ophthalmology and rheumatology. The region-wide STP process will have a crucial role in creating sustainable services region-wide.

Health Care Infections. the Trust has had four cases of MRSA in 2017/2018 against a target of 0; and 21 cases of Clostridium difficile compared to an end-of-year target of 19.

Never Events: the Trust has had four never events during 2017/2018. All such events are subject to a rigorous root cause analysis and the lessons learned are publicised throughout the Trust.

Priorities for 2017/2018

The table below illustrates the results for the organisation against the national mandated indicators. The national average, national high and national low results are stated as available. Where gaps are shown this is because data is not available but updates for some will be available prior to publication. The source of the data is stated below the table.

YEAR	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/2018 (provisional)
Readmission within 28 days of discharge1								12.50%
CDDFT Age 0-15 years	10.4	10.3		11.2	11.8	11.3	12.6	11.8
National high	14.1	14.9				17.1	14.5	18.2
National low	0	0				0	0	0
CDDFT Age 16 + years	12	12.1		11.2	11.8	10.8	10.8	12.7
National high	14.1	13.8				18.3	20.3	18.5
National low	0	0				0	0	0
CDDFT MRSA per 100,000 bed days3	1.4	1.1	0.9	0.6	1.8	0.7	1.7	1
North East	2	2	1	1	1	0.8	1.1	1
England	3	2	1	1	0.8	0.9	0.9	0.9
National high	9	9	10	11	3.2	6.5	2.7	4.6
National low	0	0	0	0	0	0	0	0.0
CDDFT - Post 72 hour cases of Clostridium difficile per 100,000 bed days (aged 2 years and over)3		24.5	16.5	20.3	8.4	7.4	5.3	6.9
England	29.7	222.3	17.4	14.7	15	14.9	13.2	13.5
National high		71.2	58.2	30.8	37.1	58.11	28.4	28.9
National low		0	0	0	0	0	2.8	4
Patient Reported Outcome measures (PROM) – case mix adjusted health gain1	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17 (provisional)	2017/2018 (provisional)
CDDFT PROM Groin Hernia	0.1	0.12	0.1	0.1	0.06	0.08	0.07	0.09
England	0.08	0.09	0.09	0.09	0.08	0.09	0.09	0.09
National high	0.14	0.12	0.14	0.15	0.14	0.16	0.14	0.14

YEAR	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/2018 (provisional)
National low	0.01	0.03	0.03	0.01	0.01	0.02	0.01	0.06
CDDFT PROM Hip	0.43	0.38	0.38					
England	0.41	0.41	0.41					
National high	0.48	0.47	0.47					
National low	0.29	0.26	0.32					
CDDFT PROM Hip Replacement				0.45	0.44	0.39	0.44	
England				0.44	0.44	0.44	0.44	
National high				0.54	0.54	0.51	0.53	
National low				0.32	0.31	0.32	0.33	
CDDFT PROM Hip Revision				NA	NA	NA	NA	
England				0.27	0.28	0.28	0.29	
National high				0.35	0.37	0.37	0.36	
National low				0.17	0.16	0.22	0.24	
CDDFT PROM Knee	0.32	0.29	0.3					
England	0.3	0.3	0.3					
National high	0.37	0.38	0.37					
National low	0.17	0.2	0.18					
CDDFT PROM Knee Replacement				0.31	0.3	0.32	0.32	
England				0.32	0.32	0.32	0.32	
National high				0.42	0.43	0.4	0.4	
National low				0.21	0.22	0.2	0.24	
CDDFT PROM Knee Revision				NA	NA	NA	NA	
England				0.25	0.26	0.26	0.27	
National high				0.37	0.32	0.34	0.3	
National low				0.2	0.12	0.19	0.16	
CDDFT VTE assessment Trust				95.10%	95.65%	95.99%	96.83%	96.45%
National Low				82.10%	92%	79.93%	76.68%	87.02%
National High				100%	100%	99.76%	99.88%	99.45%

YEAR	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/2018 (provisional)
CDDFT Responsiveness to personal needs of the patient1	71.5	67.9	68.5	73.3	65.3	68.8	66	
England	67.3	67.4	68.1	68.7	68.9	69.6	68.1	
National high	82.6	85	84.4	84.2	86.1	86.2	86.2	
National low	56.7	56.5	57.4	54.4	59.1	58.9	54.4	
CDDFT Percentage of staff who would recommend the trust to their family or friends1	49%	50%	57%	53%	57%	57%	61%	54%
England					68%	70%	71%	72%
National high		94%	94%	93%	92%	91%	90%	97%
National low		35%	40%	35%	31%	43%	43%	40%

	Reporting Period	Highest	Lowest	CDDFT Trust	Peer	Comments
SHMI	Jan 12 - Dec 12	119.2	70.3	104.1	102.2	
	Apr 12 - Mar 13	117	65.2	104.5	101.9	
	Jul 12 - Jun 13	115.6	62.6	104.3	101.9	
	Octr 12 - Sep13	118.6	63	103.8	101.1	
	Jan - Dec 13	117.6	62.4	102.4	100.8	
	Ap 13 - Mar 14	119.7	53.9	101.9	100.9	
	Jul 13 - Jun 14	119.8	54.1	102.5	101	
	Oct 13 - Sep 14	119.8	59.7	103.1	101.3	
	Jan – Dec 14	124.3	65.5	100.9		Peer was via CHKS
	Apr 14 – Mar 15	121	67	101		Peer was via CHKS
	Jul 14 – Jun 15	120.9	66.1	100.7		Peer was via CHKS
	Oct14 – Sep 15	117.7	65.2	99.6		Peer was via CHKS
	Jan 15 - Dec 15	117.3	66.9	102.3	102.1	
	Apr 15 - Mar 16	117.8	67.8	103.2	103.7	
	Jul 15 - Jun 16	117.1	69.4	104.7	103.2	
	Oct 15 - Sep 16	116.4	69	106.7	103.1	
	Jan 16 - Dec 16	119.8	69.2	106.1	104.2	
	Apr 16 - Mar 17	122.6	71.5	105.2	103.8	
	Jul 16 - Jun 17	122.8	73	104.9	105.3	
	Oct 16 - Sep 17	124.7	72.7	104.6	101.9	
	Jan17-Dec17 (provisional HED data)	119.5	71.4	102.3	100.6	

	Reporting Period	Highest	Lowest	CDDFT Trust	Peer	Comments
The banding of the summary hospital-level indicator	Apr 12 - Mar 13			2 (As Expected)		7 Trusts higher than expected
	Jul 12 - Jun 13			2 (As Expected)		9 Trusts higher than expected
	Octr 12 - Sep13			2 (As Expected)		8 Trusts higher than expected
	Jan - Dec 13			2 (As Expected)		7 Trusts higher than expected
	Ap 13 - Mar 14			2 (As Expected)		9 Trusts higher than expected
	Jul 13 - Jun 14			2 (As Expected)		9 Trusts higher than expected
	Oct 13 - Sep 14			2 (As Expected)		9 Trusts higher than expected
	Jan – Dec 14			2 (As Expected)		11 Trusts higher than expected
	Apr 14 – Mar 15			2 (As Expected)		16 Trusts higher than expected
	Jul 14 – Jun 15			2 (As Expected)		14 Trusts higher than expected
	Oct14 – Sep 15			2 (As Expected)		18 Trusts higher than expected
	Jan 15 - Dec 15			2 (As Expected)		14 Trusts higher than expected
	Apr 15 - Mar 16			2 (As Expected)		16 Trusts higher than expected
	Jul 15 - Jun 16			2 (As Expected)		11 Trusts higher than expected
	Oct 15 - Sep 16			2 (As Expected)		10 Trusts higher than expected
	Jan 16 - Dec 16			2 (As Expected)		10 Trusts higher than expected
	Apr 16 - Mar 17			2 (As Expected)		10 Trusts higher than expected
	Jul 16 - Jun 17			2 (As Expected)		12 Trusts higher than expected
	Oct 16 - Sep 17			2 (As Expected)		12 Trusts higher than expected
	Jan17-Dec17 (provisional HED data)			2 (As Expected)		

	Reporting Period	Highest	Lowest	CDDFT Trust	Peer
The percentage of patient deaths with palliative care coded	Apr 12 - Mar 13	44.00%	0.10%	12.80%	
	Jul 12 - Jun 13	44.10%	0.00%	14.00%	
	Octr 12 - Sep13	44.90%	0.00%	14.10%	
	Jan - Dec 13	46.90%	1.30%	15.90%	
	Ap 13 - Mar 14	48.50%	0.00%	17.80%	
	Jul 13 - Jun 14	49.00%	0.00%	18.70%	
	Oct 13 - Sep 14	49.40%	0.00%	19.00%	
	Jan – Dec 14	48.30%	0.00%	17.70%	
	Apr 14 – Mar 15	50.85%	0.00%	17.18%	
	Jul 14 – Jun 15	52.90%	0.00%	17.39%	
	Oct14 – Sep 15	53.53%	0.20%	18.59%	
	Jan 15 - Dec 15	54.75%	0.19%	21.12%	26.14%
	Apr 15 - Mar 16	54.60%	0.58%	24.22%	27.55%
	Jul 15 - Jun 16	54.83%	0.57%	26.58%	27.84%
	Oct 15 - Sep 16	56.27%	0.39%	28.19%	28.06%
	Jan 16 - Dec 16	55.90%	7.30%	30.20%	28.30%
	Apr 16 - Mar 17	56.90%	11.10%	31.40%	28.17%
	Jul 16 - Jun 17	58.60%	11.20%	31.90%	28.84%
	Oct 16 - Sep 17	59.80%	11.50%	36.20%	29.14%
	Jan17-Dec17 (provisional HED data)			38.66%	
Data from NHS Digital quarterly SHMI publications					

Local Priorities for the Trust

The information below indicates the progression of these priorities, where appropriate.

SAFETY

Falls and falls resulting in injury

Why is this a priority?
Nationally falls are the most frequently reported patient safety incidents

Our aim
We have seen a reduction in falls resulting in injury but need to work harder to reduce this further. We want to see a reduction in falls to within or below the national average, and a continued reduction in falls resulting in fractured neck of femur. We aim to reduce falls to 5.6 per 1000 bed days for acute wards and 8 per 1000 bed days for community based wards.

Our actions
We will implement actions from the published National Falls Audit

We will formulate an action plan and begin embedding the priorities identified from the Falls Strategy

We will introduce improvement cycles in relation to falls reduction

Measuring and monitoring
We will continue to collect information on all patient falls and review this with our clinical teams at Falls Group.

This information is collected internally using data retrieved from the Safeguard incident reporting system and contained within the monthly trust Incident Report. This data is not governed by standard national definition.

Care of patients with dementia

Why is this a priority?
Hospitals have seen an increase in patients requiring care in their services for patients who have a background of dementia. These patients are particularly vulnerable and we want to ensure that they are receiving a high standard of care.

Our aim
We want to ensure that patients who have dementia have a positive experience when under our care and that all needs are considered.

Our actions
We will continue to roll out key elements of the dementia strategy and introduce monitoring tools to measure compliance against this

Measuring and monitoring
Key metrics will be introduced to monitor implementation of the strategy

This data is not governed by standard national definition.

MRSA Bacteraemia

Why is this a priority?
MRSA can cause serious illness and this is a mandatory indicator.

Our aim
We aim to have zero patients with hospital acquired MRSA bacteraemia as set by as set by NHS England guidance.

Our actions
We will continue to regular meetings with

senior staff to ensure that any actions identified are monitored and implemented. The action plan can be accessed via the infection prevention and control team.

Measuring and monitoring
All hospital acquired bacteraemia cases identified within the trust will be reported onto the Mandatory Enhanced Surveillance System. This data is governed by standard national definitions. Any reported cases will be discussed at Infection Control Committee and reported to Trust Board. Reported cases will be subject to full root cause analysis to ensure that any remedial actions are addressed.

Clostridium difficile

Why is this a priority?
Clostridium difficile can be a serious illness that mainly affects the elderly and vulnerable population and this is a mandatory indicator.

Our aim
To have no more than 18 patients identified with Clostridium difficile infection that are attributed to the trust, as set by NHS England guidance.

Our actions
We will continue with regular meetings with senior staff to ensure that any actions identified are monitored and implemented. The action plan can be accessed via the infection prevention and control team.

Measuring and monitoring
Reports of Clostridium difficile will be reviewed at HCAI reduction group meeting, the Infection Control Committee and reported to Trust Board.

This data is governed by standard national definitions.

Pressure ulcers

Why is this a priority?
Pressure ulcers are distressing for patients and can be a source of further illness and infection. This can prolong the treatment that patients need and increase the need for antibiotic therapy.

Our aim
To continue with the programme of monitoring of patients with pressure ulcers and carry out a full review of all pressure ulcers graded 3 or above to ascertain whether avoidable or unavoidable, and take remedial action where necessary to ensure learning within the Trust. We aim to have zero avoidable grade 3 and 4 pressure ulcers and see a decrease in grade 2 avoidable pressure ulcers.

Our actions
We will ensure that all of our hospital inpatients continue to be risk assessed for their risk of pressure ulcers and that this is regularly reviewed during the admission period. We will ensure timely provision of pressure relieving mattresses if required, and access to specialist tissue viability advice as indicated.

Measuring and monitoring
We will continue to monitor that all patients are assessed for their risk of developing pressure ulcers and report this through the ward performance framework. All grades of pressure ulcers will continue to be reported and reported to Trust Board via the performance scorecard.

Whilst this indicator is not governed by national standard definitions, the assessment of grade of pressure ulcer is

used using national definitions.

Discharge summaries

Why is this a priority?
It is important that communication is of a high standard when patients are discharged back to the care of their own GP. If not, the GP does not know what prescription or other changes have taken place or are recommended by the discharging Consultant. In addition, if a patient has died in hospital, it is important for the GP to be advised quickly in case the Practice tries to contact the patient or relatives for some reason, unaware of the patient's death.

Over a three year horizon progress has been excellent, but in 2017/2018 the national 95% target has never been achieved at Trust level, although performance has fluctuated within a fairly narrow range just short of target: 89.2%-93.9%.

Our aim
To complete and send 95% of discharge summaries within 24 hours of a patient discharge.

Our actions
The Care Groups will continue to review, develop and implement improvement plans.

Measuring and monitoring
This will continue to be monitored by Directors in the monthly Performance Review meetings and thence to the Board and its IQAC sub-committee. This standard is governed by a national definition.

Rate of patient safety incidents resulting in severe injury or death

Why is this a priority?
We want to improve our incident reporting to ensure that we capture all incidents and near misses that occur. This will allow us to understand how safe our care is and take remedial action to reduce incidents resulting in harm.

Our aim
To ensure that accurate and timely data is uploaded to the national reporting system and that incidents are reviewed in a timely fashion so that lessons can be identified for learning. To remain within the national average for both incident reporting and the rate of incidents resulting in severe injury of death.

Our actions
To ensure that our staff are fully educated in the importance of reporting incidents and near misses. We will do this by continuing with an educational programme. We will ensure that serious incidents are fully reviewed so that lessons can be learned and cascaded across the trust.

Measuring and monitoring
We will continue to monitor compliance with timeliness of report completion via Safety Committee. A monthly report will give detail on incidents reported and reviews undertaken and will be submitted to Safety Committee and Care Groups. We will monitor our relative position against the national reporting system.

Whilst this data is not governed by standard national definition, the trust uses the reporting grade as recommended by Department of Health.

Local safety standards for invasive procedures (LOCSSIPS)

Why is this a priority?
Never Events persist on a national level with CDDFT reporting an unprecedented number during 2016/1718. Existing processes built upon the Surgical Safety Checklist only capture invasive procedures undertaken in theatres whereas procedures that may be associated with Never Events are conducted in multiple procedural areas. Without reviewing, updating and embedding Local Safety Standards in all relevant clinical areas, risk of further never events will persist.

Our aim
We wish to ensure full implementation of national guidance embedding Local Safety Standards into all areas conducting Invasive Procedures trust-wide.

- Our actions
  The Trust has formed a LocSSIP Implementation and Governance Group (LIGG) which brings together members of the Corporate Governance body with Care Group representatives in order to develop LocSSIPs.
- The LIGG will work with procedural teams to support the implementation of developed LocSSIPs ensuring all individuals understand why the programme is required and how the additional steps are to be conducted.
- The LIGG will co-ordinate both quantitative and qualitative audits to ensure procedural LocSSIPs are being conducted to a high standard providing reports to IQAC and the Trust Board.

Measuring and monitoring

- Quantitative and qualitative (observational) audit evidence of successful implementation.
- An elimination of Never Events and a reduction in patient safety incidents related to the Invasive Procedures covered by the LocSSIP programme.
- Continued Care Group engagement with further development to capture areas not associated with 'never events' but where the LocSSIP approach would be of clinical benefit.

Whilst this indicator is not governed by national standard definitions, the production of LocSSIP is decided using national definitions.

EXPERIENCE

Nutrition and hydration in hospital

Why is this a priority?
Many of our patients are elderly and frail and require assistance to ensure that their nutritional needs are met to aid recovery and prevent further illness. Therapeutic dietetic advice can aid their treatment and recovery for specific conditions and we ensure that these patients dietetic requirements are assessed.

Our aim
To ensure that nutritional and hydration needs are met for patients who use our services.

Our actions
We will continue to use already established systems and documentation to record that patients who have been assessed as

being at risk are continually monitored and corrective actions taken as required.

Measuring and monitoring
We will continue to monitor compliance using the newly produced ward quality metrics. We did not reach full compliance against our goals last year but there were improvements in all outcome measures; there was a mid-year decrease in the nutritional indicators, as a result of this the nutrition and dietetic department have worked closely with all ward sisters to ensure that the rational for nutritional screening, re-screening and care planning is understood. The indicators were revised at ward level, after discussion between senior nurses and dietetics as a result of trends seen within the metrics.

This data is not governed by standard national definition but is based on the nationally recognised MUST score.

End of life and palliative care

Why is this a priority?
Palliative Care has been recognised as an area for improvement by the trust, the CQC inspection and the Health and Wellbeing Board.

Our aim
Each patient to be able to say "I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including my carer(s)."

- Our actions
  Further improvement to personalised care planning through education, incident monitoring and cultural change
- Work with regional partners to develop ePaCCS
- Support and monitor new out of hours advice service
- Deliver palliative care mandatory training for all staff
- Deliver local repeat of postal questionnaire of bereaved relatives (VOICES)
- Continue the successful training fellow programme to develop palliative care consultants for the future

Measuring and monitoring

- Audit action plans for palliative care 100% complete
- Deliver all key milestones in strategic plan for end of life and palliative care
- Responses to VOICES survey should be as good or better than 2012 benchmark
- Continuing improvement in palliative care coding and ''death in usual place of residence"

This data is not governed by standard national definition but is based on the nationally recognised end of life national documents...

Responding to patients personal needs

Why is this a priority?
Responding to patients needs is essential to provide a better patient experience. Ensuring that we are aware of patients views using 5 key questions allows us to target and monitor for improvement. This is a mandated priority as set by the Department of Health.

Our aim
This priority contains 5 question areas related to patient experience, and the results of these show improvement in all of the questions asked. Once we have the results we will reach agreement on the percentage improvement to ensure that we aim to be at or above national average.

Our actions
Quarterly in house measurement of the 5 questions will continue to ensure that we are aware of any emerging themes for action.

Measuring and monitoring
Quarterly results will be reported to Quality & Healthcare Governance Committee and emerging themes discussed so that actions can be taken. Results of the national survey will be published to allow benchmarking against other organisations.

This data is governed by standard national definition as outlined in the national inpatient survey questions.

Percentage of staff who would recommend the provider to family or friends needing care

Why is this a priority?
The annual national survey of NHS staff provides the most comprehensive source of national and local data on how staff feel about working in the NHS. All NHS trusts take part in the survey and this is a mandated priority as set by the Department of Health.

Our aim
To achieve average national performance against the staff survey.

Our actions
To continue with a programme of staff engagement and development to build on current successes and improve areas where our performance is below average.

Measuring and monitoring
Results will be measured by the annual staff survey. Results are reviewed by sub committees of the Board and Trust Board and shared with staff and leaders so that actions and emerging themes can be considered as part of staff engagement work.

This data is governed by standard national definition as outlined in the national staff survey.

EFFECTIVENESS

Mortality monitoring

Why is this a priority?
We want to measure a range of clinical outcomes to provide assurance on the effectiveness of healthcare that we provide and this is a mandatory indicator as set by the Department of Health.

Our aim
To remain at or below the national average for the mandated indicator.

Our actions
We will continue to monitor the Trust's mortality indices to understand how we compare regionally and nationally. We will continue to undertake patient specific mortality reviews in line with any agreed national process that is mandated and to share the themes from these reviews with clinicians and colleagues in primary care. In addition, we will continue to use multiple sources of information to ensure we understand where any failings in care may

have occurred and to use this information to inform the process of pathway review to improve patient care. This process will continue to be reviewed by the Mortality Reduction Committee, chaired by the Medical Director, to ensure that mortality is fully reviewed and any actions highlighted implemented and monitored.

Measuring and monitoring
We will continue to benchmark ourselves against the North East hospitals and other organisations of a similar size and type. We will publicise our results through the Quality Accounts. We will provide a monthly update of crude and risk adjusted mortality to Trust Board via the performance scorecard. We will measure compliance against "Learning from Deaths" policy. These data are governed by standard national definition.

Reduction in readmissions to hospital

Why is this a priority?
It is not possible to prevent all re-admissions but they can be distressing for patients and carers, and can be an indicator of a lack of care and ineffective use of resources. This is a mandated indicator by the Department of Health.

Our aim
The Trust aims to deliver the best and most effective care to patients by eliminating unnecessary re-admissions to hospital.

Our actions
Together with partners in Primary and Social Care, the voluntary sector and others the Trust has developed a range of intensive short-term intervention services to prevent avoidable admissions and re-admissions, and to improve the support available to patients being discharged from hospital.

Measuring and monitoring
The Trust and local partners recently held an audit to establish the threshold beyond which CDDFT will only receive a reduced tariff payment for re-admissions. The effectiveness of the re-admissions avoidance schemes in which commissioners have invested the monies saved from reduced tariff payments is also subject to review. This data is governed by standard national definition

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

Why is this a priority?
Patients want to be treated in a timely manner. If this does not happen, cubicles in A&E become blocked slowing the process of care for everyone and creating additional risk and inconvenience for all patients.

Our aim
We aim to assess and treat 95% of patients within four hours in line with national standards.

Our actions
Pressures in A&E rise are an indicator of pressures in the wider health system. The Trust's Transforming Emergency Care Programme is the main improvement vehicle with progress monitored through the multi-agency Local A&E Delivery Board (see section in Review of Performance against priorities 2017/2018).

Measuring and monitoring
This issue is governed by standard national definitions and reporting arrangements. In addition to internal monitoring, monthly reports are provided to the Local A&E

Delivery Board, chaired by the Trust's Chief Executive and, where performance falls short of the agreed NHSI trajectory, to NHSI. This data is governed by standard national definition.

To reduce the length of time that ambulance services have to wait to hand over the care of the patient in the Emergency Department (ED)

Why is this a priority?
Ambulances waiting at A&E to hand over patients to the care of the Trust are not available to respond to emergencies in the community. Delays are also potentially dangerous and distressing for patients and carers.

Our aim
We aim to take over the care of ambulance patients as soon as possible following their arrival at A&E.

Our actions
We continue to work with partners in the local A&E Delivery Board to implement the Transforming Emergency Care Programme and Perfect Month initiatives as described earlier.

Measuring and monitoring
We review all instances in which an ambulance cannot hand over care within 2 hours. Ambulance handover performance is governed by standard national definition, national and local quality requirements. This data is governed by standard national definition.

Patient Reported Outcome Measures

Why is this a priority?
PROMs measure the quality of care received from their perspective so providing rich data and this is a mandated priority as set by the Department of Health.

Our aim
Last year we monitored ourselves for improvement in participation rates but for the coming year we will focus on the rates for health gain and hope to see that this is within national average.

Our actions
We will continue to drive the agenda for encouraging participation through identified staff. We will continue to educate staff on the importance of this priority and the benefits of using this alternative care as an indicator of the care we provide. We will continue to monitor ourselves against national benchmarking data to assess the impact for the patient in terms of health gain.

Measuring and monitoring
Results of the PROMs health gain data will be monitored on the Care Group performance scorecard and reviewed at performance meetings. Results will be included in scorecards presented to Trust Board.

This data is governed by standard national definitions.

Maternity Care

Why is this a priority?
Nationally the five year forward plan and the national maternity review place maternity care as a priority. NHS England have also produced a report "Saving Babies Lives" and this reports on standards required to ensure safe, effective care in this area.

Our aim

We want to ensure that patients who receive care have a positive experience when under our care and that all needs are considered.

Our actions
We will complete a gap analysis against the report and agree any actions that result from this.

Measuring and monitoring
Key metrics will be introduced to monitor implementation of any identified actions

This data is not governed by standard national definition.

Care of patients requiring paediatric care

Why is this a priority?
The care of children in emergency/ urgent care settings will be delivered using bespoke pathways for that care and it is important that pathways are enhanced to ensure that practice continues to be evidence based and triangulates all areas of speciality.

Our aim
We want to ensure that children continue to receive care which is evidence based using pathways to inform decision making. This will also have the aim of enhancing the child's experience and ensuring that care between primary and secondary settings is streamlined by the provision of increased education and improved accessibility to GPs.

Our actions
We will continue to introduce pathways of care for paediatric patients.

Measuring and monitoring

With the introduction of paediatric pathways.

This data is not governed by standard national definition.

ANNEX 1

Feedback from Darlington, Durham Dales, Easington and Sedgefield and North Durham Clinical Commissioning Groups

NHS Darlington Clinical Commissioning Group

NHS Darlington CCG
Dr Piper House
King Street
Darlington
DL3 6JL

NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group

NHS Durham Dales Easington and Sedgefield CCG
Sedgefield Community Hospital
Salters Lane
Sedgefield
Stockton-on-Tees
TS21 3EE

NHS North Durham Clinical Commissioning Group

NHS North Durham CCG
The Rivergreen Centre
Aykley Heads
Durham
DH1 5TS

Mr Noel Scanlon
Executive Director of Nursing and Patient Experience
County Durham and Darlington NHS Foundation Trust
Darlington Memorial Hospital
Hollyhurst Road
Darlington
DL3 6HX

24th April 2018

Re: County Durham and Darlington NHS Foundation Trust (CDDFT) Quality Account 2017/2018.

Corroborative statement from North Durham, Durham Dales, Easington, Sedgefield and Darlington Clinical Commissioning Groups, for County Durham and Darlington NHS Foundation Trust (CDDFT) Quality Account 2017/2018.

North Durham, Durham Dales, Easington and Sedgefield and Darlington Clinical Commissioning Groups welcome the opportunity to review and comment on the Quality Account for County Durham and Darlington NHS Foundation Trust for 2017/2018 and would like to offer the following commentary:

As commissioners, North Durham, Durham Dales, Easington and Sedgefield and Darlington Clinical Commissioning Groups (CCGs) are committed to commissioning high quality services from County Durham and Darlington NHS Foundation Trust and take seriously their responsibility to ensure that patients' needs are met by the provision of safe, high quality services and that the views and expectations of patients and the public are listened to and acted upon.

The CCGs continue to hold regular clinical quality review group meetings with the Trust

which are well attended and provide positive engagement for the monitoring, review and discussion of quality issues. The CCGs have also continued throughout 2017/2018 to conduct commissioner led inspection visits to CDDFT sites to gain assurances and an insight into the quality of care being delivered to patients. Therefore the CCGs feel that the quality account is an accurate representation of the services provided during 2017/2018 within the Trust.

The report provides a comprehensive description of the quality priorities which have been the Trust focus during 2017/2018. The report provides an open account of where improvements in priorities have been made.

The CCGs would like to congratulate the Trust on the work that has been carried out in reducing pressure sores and the effort that has gone into the prevalence of falls across the hospitals.

Encouraging work has been undertaken by the Trust alongside NHS Improvement regarding Never Events and the Trusts ambition to ensure Never Events do not happen within the Organisation. The roll out and implementation of the national and local safety standards (LocSSIPs) has been monitored by the CCGs through the year and the CCGs acknowledge the work that has gone into this project.

Following the CQC inspection and subsequent action plan the CCGs would like to offer support to the Trust whenever possible and will continue to monitor the Trust's action plans to ensure progress is made and the recommendations highlighted by the CQC are carried out.

The CCGs note that the quality accounts do not make reference to the Trust's participation in the LEDER process. We would expect this to be integrated within the learning from deaths programme and for the trust to work in collaboration with other providers and the CCGs to implement the learning from these reviews.

The CCGs would like to recognise the good work that the trust has undertaken in relation to Gram negative bacteraemia. We would expect to see a continued reduction in cases next year

Following the award of the contract for community services we look forward to working with the trust to identify quality improvement targets that are pertinent to community services.

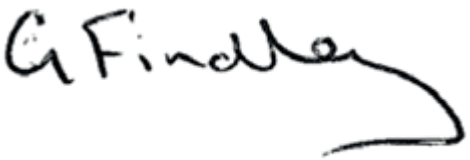
North Durham, Durham Dales, Easington and Sedgefield and Darlington Clinical Commissioning Groups welcome the specific quality priorities for 2018/2019 highlighted in the report and feel that they are appropriate areas to target for continued improvement which link in with CCG commissioning priorities. CCGs would expect to see an increased focus on learning from never events and cultural changes within the organisation in line with the actions planned.

North Durham, Durham Dales, Easington and Sedgefield and Darlington Clinical Commissioning Groups can confirm that to the best of their ability, the information provided within the Annual Quality Account is an accurate and fair reflection of the Trust's performance

for 2017/2018. It is clearly presented in the format required and the information it contains accurately represents the Trust's quality profile.

It is felt that overall the report is well written and presented and is reflective of quality activity and aspirations across the organisation for the forthcoming year.

The CCGs look forward to continuing to work in partnership with the Trust to assure the quality of services commissioned in 2018/2019.



Gillian Findley
Director of Nursing/Nurse Advisor
NHS North Durham and DDES CCGs

Feedback from Darlington Borough Council Health and Partnerships Scrutiny Committee

County Durham and Darlington NHS Foundation Trust – Draft Quality Account 2017/2018

The Health and Partnerships Scrutiny Committee remit covers the Governance arrangements of the Trust and it has the responsibility to comment on the Quality Accounts, in line with its Health Scrutiny Powers. The Members of the Scrutiny Committee are committed to being involved, at an early stage with the Foundation Trusts Quality Accounts and received regular updates on performance information from the Trust.

Members of the Health and Partnerships Scrutiny Committee have considered the draft Quality Accounts 2017/2018 for County Durham and Darlington NHS Foundation Trust and have attended Stakeholder events over the past year.

Members believe this has enabled them to have a better understanding and more detailed knowledge of performance to evidence their commentary on this year's Quality Accounts. Members maintain that this process has been successful and are certain that it has also benefited the Foundation Trust. Members wish to place on record their thanks to the Associate Director of Nursing (Patient Safety and Governance) for her attendance at the meetings.

In respect of the Quality Improvement Priorities for 2017/2018 Members have the following comments to make:-

Patient falls – The Scrutiny Committee was pleased to note the Trust's commitment to continued improvement and that it was aiming for a further reduction in falls in line with the national averages of 5.6 per 1000 beds for acute hospitals and 8.0 per 1000 bed days for community hospitals. Members noted that sensory awareness training had continued this year, focusing on the vulnerability of people with sensory impairments and their risk of falls, and welcomed the mandatory training for all registered nurses which included multifactorial risk assessments, intervention and previous Root Cause Analysis. Members were pleased to note that all stakeholders in the region had agreed to follow the Falls Strategy which had been developed and that as a result focused work would be undertaken in the next year.

Care of Patients with dementia – The Scrutiny Committee welcomed the Dementia Pathway which was now in place and development of the Action Plan to monitor its implementation. Members were pleased to note that the finger food menu had been further developed, the environment was constantly being reviewed to ensure it remained dementia friendly and that patients, families and carers were involved in discharge planning.

Healthcare Associated Infections – Members were concerned to note that, although the Trust had a zero tolerance for MRSA, there had been four reported cases. However, a full

post infection review had been undertaken to ascertain the reason for each case. Members were also concerned that the number of cases of clostridium difficile had exceeded the target set and of those cases two were referred to appeal and subsequently upheld. The comprehensive action plan for all hospital acquired infection improvement goals was welcomed.

Venous Thromboembolism (VTE) – The Scrutiny Committee was pleased to note that the targets of this mandatory Priority had been achieved, that the VTE Task and Finish Group had been re-established and the policy and information leaflets had been reviewed throughout 2017/2018.

Pressure Ulcers – The aim of the Trust was to have no avoidable grade 3 or above pressure ulcers for patients in its care so it is disappointing to note that there have been instances during the year. Members were, however, pleased that a Root Cause Analysis would be undertaken for all grade 3 and above pressure ulcers so that any remedial actions can be identified and addressed. Training and education is also to continue. Members were pleased to note that this is to remain a primary objective for 2018/2019.

Discharge Summaries – Members are again concerned that although there has been some improvement here the target of completing 95 per cent of all discharge letters within 24 hours of discharge had not been met. We do, however, acknowledge the proactive approach which has been taken by the Trust including analysis and monitoring of incomplete discharge letters, training and education, reinforcement of the process, prompt cards, posters and so forth.

Rate of Patient Safety Incidents Resulting in Severe Injury or Death – Members carefully considered all the data and information relating to this Priority and in particular would like to express concerns about the four 'Never Incidents'. Members noted details of the actions that have been taken which should hopefully prevent such incidents occurring again.

Management of Patients with Sepsis – Members were very pleased to note the progress in dealing with Sepsis and that the Trust had integrated its Regional Sepsis Screening Tool within Nervecentre for inpatients and Symphony for Emergency Department patients thus ensuring all patients within The Trust were automatically screened for sepsis.

Duty of Candour – Members were pleased to note that the Trust had achieved this statutory indicator which ensured providers were open and transparent with the relevant people should an incident resulting in harm occur.

Local Safety Standards for Invasive Procedures (LocSSIPs) – Members noted the Trust had achieved its aim to deliver a programme of work across the Trust to review local standards for invasive procedures and ensure that current practice was harmonised with the National Safety Standards for Invasive Procedures. It was noted that the LocSSIP programme scope was extended in August 2018 to review existing World Health Organisation Surgical

Safety Checklist which required revision following a never event. All 25 procedural LocSSIPs (checklists) within phase one were fully approved and ready to commence deployment within Care Groups by 31 March 2018.

Patient Experience - The Trust is committed to listening to the views of patients, carers and families and any feedback acted upon to ensure safe, effective practice, service improvement and enhanced patient experience. Members welcomed The Patient Experience and Community Engagement Strategy, developed during 2017/2018 which provided an overarching strategy underpinned by the principles of Dignity for All, 'Think Like a Patient'.

Members noted the aim of The Trust to create an environment in which delivering excellence in patient experience was seen as essential to the management and delivery of health services with patients being at the centre of everything the Trust did.

Nutrition and Hydration – The Scrutiny Committee noted that although this indicator had not been achieved, improvements had been made to ensure screening of patients for under nutrition and dehydration and that they had an onward referral as appropriate.

It was also noted that the Nutrition and Dietetic Department and Catering Service continued to work closely together on hospital menu development and nutritional analysis.

End of Life Care – Members were disappointed to note that this indicator had not been met but acknowledged that the service continues to improve and deliver more care whilst providing a key role in supporting other specialities and services with training and service improvement. The Trust aims to ensure that patients approaching the end of life will be confident in receiving high quality care in accordance with their wishes

Responsiveness to Patient Personal Needs – Members were pleased to note that targets had been met.

Percentage of Staff who would Recommend the Trust to Family and Friends Needing Care – Members noted that this Priority had not been achieved although improvements had been made. It was reported that the Trust had seen an improvement of 0.4 per cent on its score last year however the national average had increased to 3.75. The Trust is disappointed with this performance result but Members welcomed the actions in place to try and achieve national performance.

Percentage of staff who have experienced harassment, bullying or abuse from staff in the last twelve months – Although results for this indicator had increased since last year it was in line with the national average, however Black and Minority Ethnic staff reporting had gone down from 35 per cent to 32 per cent, improving the Trust's performance, in contrast to the national average which had deteriorated since 2016.

Percentage of staff believing that the Trust provided equal opportunities for career progression or promotion – Members welcomed the overall score of 90 per cent for the Trust which was better than the national average of 85 per cent.

Friends and Family Test – Members noted The Trust's aim to increase Friends and Family response rates by raising staff awareness and continuing to capture data to advise Care Groups of their compliance rates and of areas where actions were required for improvement. It was noted that the Patient Experience Team provided all Wards and Departments with monthly individual Ward reports and Trust reports to develop improvements in service based on patient feedback.

Reduction in risk adjusted mortality – Members noted that the Trust had achieved this indicator and its aim was to remain at or below the national average.

Reduction in 28 day readmissions to hospital – Members noted that, although this ambition had not been met, improvements had been made despite readmissions rising between April and November 2017 by 0.9 per cent. Members welcomed the ongoing discussions with Commissioners regarding a further audit of re-admissions which are much higher than those achieved by other Trusts in the region.

Reduction of the length of time to assess and treat patients in Accident and Emergency Departments – Members were pleased that the Trust was working towards achieving this priority with its main targets being 95 per cent of patients assessed, treated, admitted or discharged within four hours of arrival at Accident and Emergency and Ambulance Crews handing over the care of patients to CDDFT staff within 30 minutes of arrival. Members acknowledge the pressures on the Trust in Emergency Departments and that, although the ambitions have not been achieved, there are improvements.

To increase patient satisfaction as measured Patient Reported Outcome Measures (PROMS) – Although the Trust's ambition had not been met there have been improvements and Members were pleased to note that the Trust wanted to increase patient participation to get a better understanding of their views on their care and outcome.

Maternity Standards

The Scrutiny Committee was particularly pleased to note that the smoking in pregnancy, 'Saving Babies Lives' and twelve week booking targets had been met. It was rather disappointing that the Trust had narrowly missed the target for breast feeding. Members welcomed the further actions to be taken to promote breast feeding as part of the next steps to improve this priority.

Members were pleased that improved paediatric pathways for urgent and emergency care were another new indicator, following stakeholder events, which the Trust had achieved.

Quality Priorities for 2017/2018

Members are pleased with the number of Priorities being carried over from 2017/2018 and note the introduction of different methods for monitoring where the priority has changed or the service objectives have changed.

Conclusion

Overall, Members welcome the Quality Accounts and are pleased with the Trusts progress against the chosen priorities, in a challenging year for all NHS organisations. Moving forward, Members are particularly interested in care of patients with dementia, maternity and paediatric services, discharge summaries, A&E/Urgent Care Services and the Stroke Pathway and will continue to monitor progress in these areas.

Members wish to place on record their admiration for all The Trust's employees who worked over and above requirements during a very challenging Winter period.

Members raised concerns around communication difficulties and whilst understanding the time pressures on Trust staff it is always very useful to have Trust representation at Scrutiny Committee meetings.

Having gained a detailed understanding of the process of the Quality Accounts this year, Members would like to receive six monthly reports to monitor progress being made against the priorities during 2018/2019.

Councillor Wendy Newall

Chair, Health and Partnerships Scrutiny Committee

Feedback from Healthwatch Darlington

County Durham and Darlington Foundation Trust (CDDFT) Quality Accounts 2017-2018.

These comments are on behalf of Healthwatch Darlington Limited.

Healthwatch Darlington have again welcomed the opportunity to be involved in the County Durham and Darlington Foundation Trust (CDDFT) Quality Accounts this year.

We would like to congratulate the Trust on all areas of their Quality Accounts where actions have been achieved and rated Green. We recognise that some work is still to be done in those not achieved and appreciate the Trusts open and honest responses around those areas.

Healthwatch Darlington recognise the work the Trust is putting into reducing Healthcare Associated Infection and acknowledge the Trust target was not achieved but we recognise that they do remain one of the best nationally in Clostridium Difficile, we are pleased to see that the MRSA Bacteraemia is slightly down from the previous year.

It is disappointing to see that the Trust had four Never Events, we are pleased and confident that the Trust are working with NHS Improvements to co-ordinate an improvement programme. Healthwatch Darlington are also encouraged to see staff continue to be supported to report all incidents and that all serious incidents have a full root cause analysis review and themes are identified.

We are pleased to see the commitment and development of the Patient Experience and Community Engagement Strategy underpinned by the principles of Dignity for All "Think Like a Patient". It is positive to see the Trusts commitment to the training of staff along with the reduction in complaints around staff attitude.

Healthwatch Darlington are encouraged to see that work to improve access to and waiting times for the Emergency Department continues to be a priority and acknowledges that the unanticipated high levels of activity which was seen throughout the country.

Following the recent CQC inspection, it is disappointing to find that the Trust still requires improvements. We acknowledge the new fifty-one-point action plan that the Trust agreed with the CQC in March 2017. Healthwatch Darlington are encouraged that the majority of action identified are already being actioned.

Healthwatch Darlington agree with the priorities set out by the Trust for 2018/2019 and thank you for involving Healthwatch Darlington in the stakeholder events and the feedback sessions. Healthwatch Darlington have enjoyed the opportunity to work with County Durham and Darlington Foundation Trust. We look forward to working with the Trust in 2018-2019.

Feedback from Durham County Council Adults Wellbeing and Health Overview and Scrutiny Committee

DURHAM COUNTY COUNCIL ADULTS WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

COMMENTS ON COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST QUALITY ACCOUNT FOR 2017/2018

The Committee welcomes County Durham and Darlington NHS Foundation Trust's Quality Account and the opportunity to provide comment on it. The Committee are mindful of their statutory health scrutiny role and the need to demonstrate a robust mechanism for providing assurance to the residents of County Durham that health service provision is efficient and effective. The quality account process provides the Committee with one such mechanism.

The Committee has engaged with the Trust on a number of issues during the course of 2017/2018 including maternity services at Darlington Memorial Hospital; inpatient bed reductions at Richardson Hospital, Barnard Castle, Weardale Hospital, Stanhope and Sedgefield Community Hospital; community health services; winter pressures and the work of the local A&E Delivery board; the review of stroke rehabilitation services; the Trust's CQC Re-inspection report and action plan and the County Durham Integrated Care Partnership and the development of teams around patients.

The Quality Account is clearly set out and the Committee noted the positive performance set out within the document in respect of care of patients with dementia; patient safety incidents resulting in severe injury or death; the introduction of new local patient safety standards; end of life care and the proposed introduction of consultant paediatric clinics in GP surgeries.

During previous years, the Committee has considered the improvements identified within the Trust's CQC Inspection Improvement plan and commended the actions planned by the Trust to improve quality and performance within the organisation. Members are therefore concerned that the recent re-inspection report from the Care Quality Commission reaffirmed a "requires improvement" judgement. To this end, the Committee would seek assurances that the Trust continues to place the highest importance on delivering the required levels of improvements across its services and that this is reflected within ongoing priorities for the Trust for 2018/2019 and beyond.

The Committee has also requested further information to be brought back to future meetings in respect of the work being done by the Trust regarding the treatment of Sepsis as well as the numbers of planned/elective surgery procedures that were cancelled due to pressures within the Trust in respect of urgent and emergency care.

In summary, it is considered from the information received from the Trust that the identified priorities for 2018/2019 are a fair reflection of healthcare services provided by the Trust and

the Committee note the progress made against the 2017/2018 priorities.

Finally, in order to ensure that it continues to provide a robust Health scrutiny function and assurances in this respect to the residents of County Durham, the Committee would request a six monthly progress report on delivery of 2018/2019 priorities and performance targets as well as the CQC Re-inspection action plan in November 2018.

Cllr John Robinson
Chair of the Adults, Wellbeing and Health Overview and Scrutiny Committee

Feedback from Health and Wellbeing Board

Contact: Cllr Lucy Hovvels
Direct Tel: 03000 268 801
email: lucy.hovvels@durham.gov.uk
Your ref:
Our ref:

Joanne Todd
Associate Director of Nursing (Patient Safety & Governance)
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Darlington
DL3 6HX

15 May 2018

Dear Joanne

Re: County Durham and Darlington NHS Foundation Trust Quality Account 2017/2018

Thank you for the opportunity to comment on the County Durham and Darlington NHS Foundation Trust (CDDFT) Quality Account 2017/2018. The County Durham Health and Wellbeing Board appreciates this opportunity and would like to provide comments on the document.

It is important that the Quality Account aligns, where appropriate, to the County Durham Joint Health and Wellbeing Strategy, Clinical Commissioning Group Commissioning Plans and the Better Care Fund Plan which have been agreed through the County Durham Health and Wellbeing Board.

A great deal of positive partnership working exists within County Durham between County Durham and Darlington NHS Foundation Trust (CDDFT) and other partners, including Durham County Council and Clinical Commissioning Groups to ensure a holistic approach is provided for users of services. It is important that the Quality Account continues to evidence this joint work to recognise the contributions partners make to service users.

The Health and Wellbeing Board (HWB) acknowledge your performance against your three priority areas for improvement over the 2017/2018 period, which were:

- Safety
- Patient Experience
- Clinical Effectiveness

The Health and Wellbeing board notes the recommendations following the CQC's last inspection of the Trust carried out in September and October 2017 and reported in March 2018. Following a "requires Improvement" rating the HWB notes the areas of concern within the hospital services but also the positive progress across community services. We support the Trust submission of 51 actions plan and note your continued commitment to delivering stakeholder priorities alongside recommendations from the CQC.

The HWB supports your ''with you all the way" strategic direction which concentrates on putting the patient first, a strategy which links strongly to the HWB vision to ''Improve the health and wellbeing of the people of County Durham and reduce health inequalities". Central to this vision is the principle that decisions about the services provided to service users, carers and patients, are made as locally as possible, involving the people who use them.

We also welcome your continued focus through 2017/2018 to further embed good practice in line with the Trust's 'Quality Matters' strategy launched in 2017. The County Durham Health & Wellbeing Board recognise the quality priority areas and support the drive in these areas where the greatest difference can be made.

This aligns to the HWB's Health and Social Care Integration work. In February 2018, the NHS England 2018/2019 planning guidance was clear in articulating the expectation that Integrated Care Systems would need to develop to enhance the quality of health and social care. In County Durham, there is a strong track record of integrated working based on effective partnerships. Successful outcomes have been achieved through the continued application of a multi-disciplinary team (MDT) approach, the introduction of Teams Around Patients (TAPs) and the Primary Care Home joint programme, to provide comprehensive and personalised care to individuals, based on needs.

The Board recognises the additional pressure placed on the Emergency Department of the Trust and the continued increasing demand against the challenging environmental and financial climate during 2017/2018. Despite these pressures the board recognises the continued intention alongside some positive indicators towards reducing the length of time taken to assess and treat patients in A&E departments is still to be advocated by the Board.

The Health and Wellbeing Board supports the Trust's three priority areas for 2017/2018:

- Safety
- Experience
- Effectiveness

From the priorities which you have identified, there are a number which we believe specifically align to the strategic objectives in the Joint Health and Wellbeing Strategy, they are:

	CDD FT - Priorities for 2017/2018	Joint Health and Wellbeing Strategy 2016-19 – Strategic Objectives
1	Patient Falls (continuation)	Improve the quality of life, independence and care and support for people with long term conditions
2	Care of patients with dementia (continuation)	Improve the mental and physical wellbeing of the population
3	End of life and palliative care (continuation)	Support people to die in the place of their choice with the care and support that they need
4	Maternity standards (new indicator)	Children and young people make healthy choices and have the best start in life
5	Paediatric care (new indicator)	Children and young people make healthy choices and have the best start in life

We acknowledge the progress you have made to reduce patient falls in community hospital settings through ongoing staff training, and your continued focus on technology to help with falls prevention is welcomed. However, we have also noted your continued increase in falls in acute hospital settings, combined with a continued trend above the national benchmark; which is an area of concern. We note that you are focusing work in high risk areas to tackle this issue and ensure that falls prevention remains high on clinical agendas. We would suggest implementation of your recently agreed falls strategy should be a key priority. We also recognise that your falls strategy emphases the need to work with stakeholders in both a workforce and community.

The board recognises the achievement of the trust ambition in regard to care of patients with Dementia. Continued development of the dementia pathway and the focus on making the hospital estate ''dementia friendly" is welcome, as this is something that was advocated by the Health and Wellbeing Board. The board have supported a number of projects that have been delivered in partnership, focussed on supporting older people, reducing social isolation and improving mental health. Housing staff have been trained in 'Making Every Contact Count' which might trigger them to consider making changes to their lifestyle to improve their health and wellbeing. This has led to funding to support a community housing led dementia coordinator to progress this work. We welcome this area as a continued priority.

We acknowledge your aim and steps taken to improve end of life and palliative care, through the End of Life Strategy and completion of all key recommendations from the 2015 CQC inspection. We welcome your acknowledgement of feedback from last year's quality accounts and stakeholder's feedback and have placed workforce development at the core of your work by establishing mandatory care education for all staff.

We note your admission that there is still work to do to make improvements in people's care at the end of their lives; but we would also like to recognise your achievement in your local measure. An increase from 57% to 88% (over the year) in preferred place of death is

a notable achievement which aligns with the HWB priority to ''support people to die in the place of their choice with the care and support they need".

The HWB acknowledge the overall improvement and delivery of performance targets of overall maternity standards. We welcome the new standards that allow for further in depth understanding of performance and ensuring monitoring against the standards identified in "Saving Babies Lives". The HWB also notes that while the Trust progress towards your ambition for this year is positive, core areas for improvement in smoking in pregnancy continue with inconsistencies in approach and contract delivery across different geographies. We would welcome a partnership approach to better align activities in this area.

We welcome the work you have been doing to introduce the standards identified in ''Saving Babies Lives" and your aim to continue to embed these standards during the forthcoming year. We are also pleased to note that you are going to be developing stronger, more personal relationships with individuals within primary and secondary care settings, to improve the levels of paediatric care. These improvements link directly to the HWB priority to give children the best start in life.

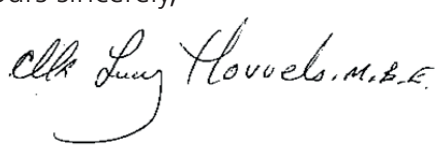
The Health and Wellbeing Board welcomes the continued focus on improving indicators linked to the Board's areas of work. The Board, however have noted a continued number of Never Events in 2017/2018 and, in the interests of safe and effective services for the people of County Durham, will look to see improvements outlined by the Trust in the next Quality Account. We note that the CQC have also identified this area which is particularly disappointing considering this was further highlighted in last year's accounts. As per the CQCs recommendations the HWB will look to see how both your implementation work-streams will look to go further in implementation.

We would like to acknowledge the positive outcomes you have achieved in your three priority areas, whilst recognising that there are some areas which need improvement.

We note that you are committed to working with CQC, and with support from NHS Improvement, to address all requirements and recommendations and to sustain improvements in quality to achieve an improved rating at the next inspection, we would wish the Trust a future positive outcome.

If you require further information please contact Andrea Petty, Strategic Manager – Partnerships on 03000 267312 or by email at andrea.petty@durham.gov.uk.

Yours sincerely,



Councillor Lucy Hovvels MBE
Cabinet Portfolio Holder for Adult and Health Services

Statement of Directors' Responsibility in Respect of 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.

Monitor 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

- 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 2017 to May 2018;
  - papers relating to quality reported to the board over the period April 2017 to May 2018;
  - feedback from commissioners dated 24th April 2018.
  - views of governors shared at meetings of the Council of Governors Quality and Healthcare Governance Committee during 2017/2018 and the joint Trust Board and Council of Governors meeting held on 23rd May 2018;
  - feedback from local Healthwatch organisation dated 16th May 2018;
  - feedback from Durham County Council Adults Wellbeing and Health Overview and Scrutiny Committee dated 16th May 2018;
  - feedback from Durham County Council Health and Wellbeing Board dated 15th May 2018.
  - feedback from Darlington Borough Council Health and Partnership Scrutiny Committee dated 17th May 2018;
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
  - the 2016 national patient survey;
  - the 2017 national staff survey;
  - the 2017/2018 Head of Internal Audit's annual opinion over the trust's control environment; and
- 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, confirms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual).

The directors confirm to the best of their knowledge and belief they have complied with the requirements in preparing the Quality Report.

By Order of the Board:

NB: Sign and date in any colour ink except black

Date: 24/05/18  .....Chairman

Date: 24/05/18  .....Chief Executive

5.2 INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of County Durham and Darlington NHS Foundation Trust to perform an independent assurance engagement in respect of County Durham and Darlington NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following two national priority indicators (the indicators):

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge;

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed requirements for quality reports for foundation trusts 2017/18 ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Requirements for external assurance for quality reports for foundation trusts 2017/18.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes and papers for the period April 2017 to May 2018;
- papers relating to quality reported to the board over the period April 2017 to May 2018;
- feedback from commissioners, dated May 2018;
- feedback from governors, dated May 2018;
- feedback from local Healthwatch organisations, dated May 2018;
- feedback from Overview and Scrutiny Committee, dated May 2018;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the latest national patient survey, dated July 2017;
- the 2017 national staff survey;
- Care Quality Commission Inspection, dated 1 March 2018;
- the 2017/18 Head of Internal Audit's annual opinion over the trust's control environment, dated 24 May 2018; and
- any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of County Durham and Darlington NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and County Durham and Darlington NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by County Durham and Darlington NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to

believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicator in the Quality Report subject to limited assurance has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP
Chartered Accountants
Quayside House
110 Quayside
Newcastle Upon Tyne
NE1 3DX

25 May 2018

6. Annual Accounts

6.1 Annual Accounts for the year ended 31 March 2018

Foreword to the accounts

County Durham and Darlington NHS Foundation Trust

These accounts, for the year ended 31 March 2018, have been prepared by County Durham and Darlington NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed: 

Sue Jacques
Chief Executive
24/5/18

Statement of Comprehensive Income

		Group	
		2017/18	2016/17
	Note	£000	£000
Operating income from patient care activities	3	430,879	436,035
Other operating income	4	43,992	45,700
Operating expenses	6, 8	(460,979)	(468,869)
Operating surplus from continuing operations		**13,892**	**12,866**
Finance income	11	174	261
Finance expenses	12	(13,583)	(14,336)
PDC dividends payable		(1,400)	(965)
Net finance costs		**(14,809)**	**(15,040)**
Other (losses) / gains	13	(10)	14
Corporation tax expense		(214)	-
Deficit for the year		**(1,141)**	**(2,160)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	-	(38)
Revaluations	16	-	634
Other reserve movements		-	(29)
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains on available-for-sale financial investments	17	47	409
Total comprehensive expense for the period		**(1,094)**	**(1,184)**
Deficit for the period attributable to:			
non-controlling interest, and			
County Durham and Darlington NHS Foundation Trust		(1,141)	(2,160)
TOTAL		**(1,141)**	**(2,160)**
Total comprehensive expense for the period attributable to:			
non-controlling interest, and			
County Durham and Darlington NHS Foundation Trust		(1,094)	(1,184)
TOTAL		**(1,094)**	**(1,184)**

The results in these accounts are for the group of organisations which comprise County Durham and Darlington NHS Foundation Trust, its wholly owned subsidiary Synchronicity Care Ltd and its associated charity County Durham and Darlington NHS Foundation Trust Charity. The 'Group' columns relate to the results of all three organisations consolidated into one, the columns marked 'Trust' only show the results relating to the foundation trust.

The deficit attributable to the Trust only is £1.298m (£1.914m 2016/17) prior to consolidation adjustments.

As permitted by the NHS GAM no separate statement of comprehensive income is presented in respect of the trust.

Impact of Property, Plant & Equipment revaluations	2017/18	2016/17
Surplus before Property Plant & Equipment valuation adjustments	6,932	11,303
Net reduction in the value of trust property, plant & equipment	(8,073)	(13,463)
Deficit for the year	(1,141)	(2,160)

Statement of Financial Position

	Note	Group 31 March 2018 £000	Group 31 March 2017 £000	Trust 31 March 2018 £000	Trust 31 March 2017 £000
Non-current assets					
Intangible assets	15	1,807	2,588	1,807	2,588
Property, plant and equipment	16	173,086	169,606	173,086	169,606
Investments in Subsidiaries	18	-	-	17,803	-
Other investments / financial assets	17	3,429	3,709	-	-
Trade and other receivables	21	-	-	37,993	92
Total non-current assets		**178,322**	**175,903**	**230,689**	**172,286**
Current assets					
Inventories	20	8,602	7,233	7,162	7,233
Trade and other receivables	21	32,015	28,826	34,125	28,972
Non-current assets for sale and assets in disposal	22	-	405	-	405
Cash and cash equivalents	23	3,778	10,927	3,586	10,700
Total current assets		**44,395**	**47,391**	**44,873**	**47,310**
Current liabilities					
Trade and other payables	24	(53,834)	(49,292)	(54,187)	(49,284)
Borrowings	26	(4,906)	(4,203)	(7,522)	(4,203)
Provisions	28	(477)	(1,825)	(477)	(1,825)
Other liabilities	25	(2,521)	(3,162)	(2,521)	(3,162)
Total current liabilities		**(61,738)**	**(58,482)**	**(64,707)**	**(58,474)**
Total assets less current liabilities		**160,979**	**164,812**	**210,855**	**161,122**
Non-current liabilities					
Borrowings	26	(84,602)	(89,432)	(138,372)	(89,432)
Provisions	28	(3,152)	(3,457)	(3,152)	(3,457)
Total non-current liabilities		**(87,754)**	**(92,889)**	**(141,524)**	**(92,889)**
Total assets employed		**73,225**	**71,923**	**69,331**	**68,233**
Financed by					
Public dividend capital		115,078	112,682	115,078	112,682
Revaluation reserve		681	681	681	681
Merger reserve		541	541	541	541
Income and expenditure reserve		(46,538)	(45,722)	(46,969)	(45,671)
Charitable fund reserves	19	3,463	3,741	-	-
Total taxpayers' equity		**73,225**	**71,923**	**69,331**	**68,233**

The notes on pages 8 to 53 form part of these accounts.

Sue Jacques
Chief Executive
24/5/18

Statement of Changes in Equity for the year ended 31 March 2018

Group	Public dividend capital £000	Revaluation reserve £000	Merger reserve £000	Income and expenditure reserve £000	Charitable fund reserves £000	Total £000
Taxpayers' and others' equity at 1 April 2017 - brought forward	**112,682**	**681**	**541**	**(45,722)**	**3,741**	**71,923**
Surplus/(deficit) for the year	-	-	-	(1,251)	110	**(1,141)**
Fair value gains on available-for-sale financial investments	-	-	-	-	47	**47**
Public dividend capital received	2,396	-	-	-	-	**2,396**
Other reserve movements	-	-	-	435	(435)	**-**
Taxpayers' and others' equity at 31 March 2018	**115,078**	**681**	**541**	**(46,538)**	**3,463**	**73,225**

Statement of Changes in Equity for the year ended 31 March 2017

Group	Public dividend capital £000	Revaluation reserve £000	Merger reserve £000	Income and expenditure reserve £000	Charitable fund reserves £000	Total £000
Taxpayers' and others' equity at 1 April 2016 - brought forward	**112,682**	**85**	**541**	**(43,757)**	**3,556**	**73,107**
Surplus/(deficit) for the year				(2,289)	129	**(2,160)**
Impairments		(38)				**(38)**
Revaluations		634				**634**
Fair value gains on available-for-sale financial investments					409	**409**
Other reserve movements				324	(353)	**(29)**
Taxpayers' and others' equity at 31 March 2017	**112,682**	**681**	**541**	**(45,722)**	**3,741**	**71,923**

Statement of Changes in Equity for the year ended 31 March 2018

Trust	Public dividend capital	Revaluation reserve	Merger reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2017 - brought forward	**112,682**	**681**	**541**	**(45,671)**	**68,233**
Surplus/(deficit) for the year	-	-	-	(1,298)	**(1,298)**
Public dividend capital received	2,396	-	-	-	**2,396**
Taxpayers' and others' equity at 31 March 2018	**115,078**	**681**	**541**	**(46,969)**	**69,331**

Statement of Changes in Equity for the year ended 31 March 2017

Trust	Public dividend capital	Revaluation reserve	Merger reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2016 - brought forward	**112,682**	**85**	**541**	**(43,757)**	**69,551**
Surplus/(deficit) for the year				(1,914)	**(1,914)**
Impairments		(38)			**(38)**
Revaluations		634			**634**
Taxpayers' and others' equity at 31 March 2017	**112,682**	**681**	**541**	**(45,671)**	**68,233**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Available-for-sale investment reserve
This reserve comprises changes in the fair value of available-for-sale financial instruments. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure.

Merger reserve
This reserve reflects balances formed on merger of NHS bodies.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the Group or Trust.

Charitable funds reserve
This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as restricted or unrestricted; a breakdown is provided in note 19

Statement of Cash Flows

	Note	Group 2017/18 £000	Group 2016/17 £000	Trust 2017/18 £000	Trust 2016/17 £000
Cash flows from operating activities					
Operating surplus		13,892	12,866	14,035	13,113
Non-cash income and expense:					
Depreciation and amortisation	6	9,361	8,778	9,361	8,778
Net impairments	7	8,073	13,463	8,073	13,463
Income recognised in respect of capital donations	4	-	(88)	(39)	(88)
(Increase)/decrease in receivables and other assets		(3,031)	(1,031)	(2,578)	(1,276)
(Increase)/decrease in inventories		(1,369)	(4,010)	71	(4,010)
Increase/(decrease) in payables and other liabilities		3,404	(2,778)	4,114	(2,588)
(Decrease)/ increase in provisions		(1,737)	204	(1,737)	204
Movements in charitable fund working capital		103	(89)	-	-
Net cash flows from operating activities		**28,696**	**27,315**	**31,300**	**27,596**
Cash flows from investing activities					
Interest received		44	163	1,461	163
Investment in subsidiary		-	-	(17,803)	-
Purchase of intangible assets		(120)	(110)	(120)	(110)
Purchase of PPE		(19,951)	(18,856)	(19,951)	(18,856)
Sales of PPE		504	14	56,908	14
Receipt of cash donations to purchase assets		-	88	-	88
Prepayment of PFI capital contributions		-	(3,799)	-	(3,799)
Net cash flows from charitable fund investing activities		463	466	-	-
Movement on loans to subsidiary		-	-	(40,382)	-
Net cash flows used in investing activities		**(19,060)**	**(22,034)**	**(19,887)**	**(22,500)**
Cash flows from financing activities					
Public dividend capital received		2,396	-	2,396	-
Capital element of finance lease rental payments		(319)	(391)	(315)	(391)
Capital element of PFI, LIFT and other service concession payments		(3,811)	(4,937)	(3,811)	(4,937)
Interest paid on finance lease liabilities		(104)	(155)	(1,850)	(155)
Interest paid on PFI, LIFT and other service concession obligations		(13,392)	(14,173)	(13,392)	(14,173)
PDC dividend paid		(1,555)	(648)	(1,555)	(648)
Net cash flows used in financing activities		**(16,785)**	**(20,304)**	**(18,527)**	**(20,304)**
Decrease in cash and cash equivalents		**(7,149)**	**(15,023)**	**(7,114)**	**(15,208)**
Cash and cash equivalents at 1 April - b/f		**10,927**	**25,950**	**10,700**	**25,908**
Cash and cash equivalents at 31 March	23	**3,778**	**10,927**	**3,586**	**10,700**

Notes to the Accounts
Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment and certain financial assets and financial liabilities.

Note 1.1.2 Going concern
These accounts have been prepared on a going concern basis.

The Group delivered a £25.5m Cost Improvement Program (CIP) for 2017/18 and achieved a surplus of £7.1m (after adjusting for impairments) against its 2017/18 £3.7m surplus Control Total. Control Totals are set by NHS Improvement to measure Group financial performance and exclude items such as revaluations, impairments, gains/losses on disposal and donations. The Group has a planned surplus of £8.1m in 2018/19 and this agrees to the 2018/19 Control Total. The financial plan for 2018/19 is dependent upon whole "system" transformation programmes as well as internal CIP's to achieve the control total. The Board is focussed on the risks within the 2018/19 plan, in particular those relating to the significant system benefits assumed therein. NHS Improvement continues to support the Trust to work closely with local stakeholders and partner organisations to mitigate the system based risks to the plan.

The 2018/19 plan submitted to, and accepted by NHS Improvement, includes a requirement for a revenue loan support of £22.5m as a result of the sudden move towards activity income being received from its clinical commissioning groups in twelfths, rather than the longstanding agreed payment profile, which allowed the Trust to be able to meet its liabilities when they fell due. This loan was agreed and drawn down in April 2018 and provides an uncommitted loan facility for a period of 3 years as detailed in note 36. Whilst the terms of the loan do allow the facility to be withdrawn by the Secretary of State for Health the Trust consider the likelihood of this happening to be remote.

After making enquiries, and as a result of the revenue loan support received in April 2018, the Directors have adopted a going concern basis in preparing these accounts as they do not intend to apply to the Secretary of State for the dissolution of the NHS Foundation Trust without the transfer of services to another entity nor do they believe there is no realistic alternative but to do so.

Note 1.2 Critical judgements in applying accounting policies
The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Valuation of Property Plant and Equipment

The trust's buildings are valued on a 'modern equivalent asset value' basis. An alternative site has been identified and a revised specification has been identified that would better fit with the current services provided at the trust's hospitals.

A desk top valuation was carried out during the final quarter of the year by Cushman & Wakefield, who are qualified surveyors, registered with the Royal Institute of Chartered Surveyors. This valuation reflects the current economic conditions within County Durham.

These assets have been valued net of VAT. MEA valuations require the inclusion of VAT only to the extent that it is an irrecoverable cost. It is assumed that all future building costs will be incurred in such a way that VAT will be recoverable. This may be through a PFI scheme as the majority of the trust's assets were built through PFI, or through the use of the trust's commercial subsidiary.

Embedded Lease
The Trust has identified embedded leases within the Operated Healthcare Facility Agreement with its subsidiary, Synchronicity Care Limited (see note 27).

At inception of an arrangement, the Trust determines whether such an arrangement is, or contains, a lease. This is determined to be the case through a judgemental assessment of whether the following 2 criteria are met:

The fulfilment of the arrangement is dependent on the use of a specific asset or assets; and
The arrangement contains the right to use the asset(s).

At inception or on reassessment of the arrangement, the Trust separates payments and other consideration required by an arrangement into those for the lease and those for other elements (generally services) on the basis of their relative fair values. If the Trust identifies a finance lease arrangement an asset and a liability are recognised at an amount equal to the lower of the fair value of the underlying asset and the present value of the minimum lease payments, discounted using the rate implicit in the lease.

Subsequently the liability is reduced as payments are made and an imputed finance cost on the liability is recognised using the Trust's incremental borrowing rate.
Income Recognition
The trust recognises income when it is due and revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial period on the basis of bed occupancy as at 31 March 2018, compared to expected length of stay.

Note 1.2.1 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Valuation of Property Plant & Equipment

The trust's buildings are valued on a 'modern equivalent asset value' basis. An alternative site has been identified and a revised specification has been identified that would better fit with the current services provided at the trust's hospitals.

A valuation was carried out on 31st March 2018 by Cushman & Wakefield, who are qualified surveyors, registered with the Royal Institute of Chartered Surveyors. This valuation reflects the current economic conditions within County Durham.

The Group's valuation as at 31 March 2018 has been produced through indexing the full valuation supported by inspection that was carried out as at 1 April 2016. Indexing the valuation requires judgement as to the choice of indices, whether averaging is used and the appropriateness of regional factors. The Trust has determined that the most reliable method of valuation is to adopt the BCIS all in tender price index as at the balance sheet date and to adopt a ten-year average for the regional factor applied in order to reduce volatility.

These assets have been valued net of VAT. MEAV valuations require the inclusion of VAT only to the extent that it is an irrecoverable cost. It is assumed that all future building costs will be incurred in such a way that VAT will be recoverable. This may be through PFI, as the majority of the trust's assets were built under PFI, or through the use of the trust's commercial subsidiary.

Provisions
The amount recognised for pensions and injury benefits are the best estimate of the expenditure required to settle the obligation at the end of the year.

The period over which future cashflows will be paid is estimated using the England life expectancy tables published by the office of national statistics, updated by the Public Health England marmot indicators for County Durham which shows the difference between English life expectancy and that in County Durham.

Note 1.3 Consolidation

NHS Charitable Fund
The trust is the corporate trustee to County Durham and Darlington NHS charitable fund. The trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the trust's accounting policies and
- eliminate intra-group transactions, balances, gains and losses.

Other subsidiaries

In addition to the Charitable Funds, County Durham and Darlington NHS Foundation Trust has a 100% owned subsidiary: Synchronicity Healthcare Ltd.

Subsidiary entities are those over which the trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year 2017/18.

Note 1.4 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of health care services. At the year end, the trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Revenue grants and other contributions to expenditure
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. There, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Note 1.7.2 Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All land and buildings are revalued every year using professional valuations in accordance with IAS 16 and the Group Accounting Manual.

The valuations are carried out primarily on the basis of a modern equivalent asset basis for specialised operational property and existing use value for non-specialised operational property. The value of land for existing use purposes is assessed at existing use value.

Non-operational properties, including any surplus land are valued at open market value.

Assets under construction are valued at cost and are valued by professional valuers during the annual revaluation or when they are brought into use.

Subsequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value.

Where subsequent expenditure is simply restoring the asset to the specification assumed by its economic useful life, then the expenditure is charged to operating expenses.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which have been reclassified as 'held for sale' ceases to be depreciated upon the reclassification.

Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as assessed by the NHS foundation trust's professional valuers. Leaseholds are depreciated over the primary lease term.

Equipment is depreciated on current cost evenly over the estimated life. Each piece of new equipment has its useful economic life assessed prior to capitalisation, however the range of useful lives are shown below:

- Medical equipment is depreciated between five and fifteen years
- IT equipment is depreciated over the following :
  - PCs depreciated over six years
  - Laptops depreciated over four years
  - Other items depreciated between five and fifteen years.
- Fittings are depreciated by aligning with the life of the building
- All other categories are depreciated between five and seven years.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.7.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable ie:
  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.7.5 Private Finance Initiative (PFI) transactions

PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Where the PFI contract includes an element of lifecycle replacement, this is capitalised as the payments are made.

Note 1.8 Intangible assets

Note 1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the trust intends to complete the asset and sell or use it
- the trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
- the trust can measure reliably the expenses attributable to the asset during development.

Software
Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.8.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell". Software Licences are measured at the equivalent current cost of the licence.

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method other than Pharmacy Stocks which are valued at average cost.

Note 1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

Note 1.11 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Note 1.12 Financial instruments and financial liabilities

Note 1.12.1 Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described above/below.

Regular way purchases or sales are recognised and de-recognised, as applicable, using the Trade date.

All other financial assets and financial liabilities are recognised when the trust becomes a party to the contractual provisions of the instrument.

Note 1.12.2 De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.12.3 Classification and measurement

Financial assets are categorised as loans and receivables.

Financial liabilities are classified as other financial liabilities".

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS receivables, accrued income and "other receivables".

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Financial liabilities

All financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs.

Impairment of financial assets

At the Statement of Financial Position date, the trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced.

The trust creates a doubtful debt provision for the value of any NHS debtor invoices identified as 'not agreed' during the annual NHS agreement of Balances exercise, and provides for Non NHS Debtors in the following bandings :

31 – 60 Days: 10% Provision
61 – 90 Days : 50% Provision
91 days+: 100% Provision

The trust also provides a 22.84% doubtful debt provision for income due from the Compensation recovery Unit for outstanding claims in line with the nationally recommended percentage.

Note 1.13 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.13.1 The trust as lessee

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.13.2 The trust as lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the trust net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.14 Provisions

The trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the trust is disclosed at note 30 but is not recognised in the trust's accounts.

Non-clinical risk pooling
The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 31 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 29, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.16 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for

(i) donated assets (including lottery funded assets),

(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and

(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.17 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.18 Corporation tax

Synchronicity Care Limited is a wholly owned subsidiary of County Durham & Darlington NHS Foundation Trust and is subject to corporation tax on its profits.

Tax on the profit or loss for the year comprises current and deferred tax. Tax is recognised in the profit and loss account except to the extent that it relates to items recognised directly in equity or other comprehensive income, in which case it is recognised directly in equity or other comprehensive income. Current tax is the expected tax payable or receivable on the taxable income or loss for the year using tax rates enacted or subsequently enacted at the balance sheet date, and any adjustments to tax payable in respect of previous years. Deferred tax is provided on provided on temporary differences between the carrying amounts of assets and liabilities, for financial reporting purposes and the amounts used for taxation purposes. The amount of assets and liabilities, using tax rates enacted or substantively enacted on the balance sheet date. A deferred tax asset is recognised only to the extent that it is probable that future taxable profits will be available against which the temporary difference can be utilised.

Note 1.19 Foreign exchange

The functional and presentational currency of the trust is sterling.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Note 1.20 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.21 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.22 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.24 Standards, amendments and interpretations in issue but not yet effective or adopted

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1st January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

- IRFS 14 Regulatory Deferral Accounts – Not applicable to DH group bodies.

- IRFS 15 Revenue from contracts with customers - Application required for accounting periods beginning on or after 1st January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

- IFRS 16 Leases – Application required for accounting bodies beginning on or after 1st January 2019, but not yet adopted by the FReM and early adoption is not therefore permitted.

- IFRS 17 Insurance contracts - Application required for accounting bodies beginning on or after 1st January 2021, but not yet adopted by the FReM and early adoption is not therefore permitted.

- IFRIC 22 Foreign Currency Transactions - Application required for accounting bodies beginning on or after 1st January 2018.

- IFRIC 23 Uncertainty over Income tax treatments - Application required for accounting bodies beginning on or after 1st January 2019.

Note 2 Operating Segments

The Trust has identified the 'chief operating decision maker' as being the Trust Board and attributes all of its income to one segment : Healthcare

Note 3 Operating income from patient care activities (Group)

Note 3.1 Income from patient care activities (by nature)	2017/18 £000	2016/17 £000
Acute services		
Elective income	47,916	57,656
Non elective income	121,193	96,792
First outpatient income	33,001	26,811
Follow up outpatient income	28,486	32,687
A & E income	17,760	15,903
High cost drugs income from commissioners (excluding pass-through costs)	31,695	31,204
Other NHS clinical income	57,592	78,551
Community services		
Community services income from CCGs and NHS England	82,490	88,210
Income from other sources (e.g. local authorities)	6,832	6,500
All services		
Private patient income	50	58
Other clinical income *	3,864	1,663
Total income from activities	**430,879**	**436,035**

* Includes £1.657m relating to CRU income

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18 £000	2016/17 £000
NHS England	31,314	26,091
Clinical commissioning groups	387,021	396,946
Department of Health and Social Care	36	-
Other NHS providers	486	558
NHS other	90	213
Local authorities	9,987	10,592
Non-NHS: private patients	51	58
Non-NHS: overseas patients (chargeable to patient)	126	123
NHS injury scheme	1,657	1,286
Non NHS: other	111	168
Total income from activities	**430,879**	**436,035**
Of which:		
Related to continuing operations	430,879	436,035
Related to discontinued operations	-	-

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2017/18	2016/17
	£000	£000
Income recognised this year	126	123
Cash payments received in-year	42	63
Amounts added to provision for impairment of receivables	10	40
Amounts written off in-year	14	15

Note 4 Other operating income (Group)

	2017/18	2016/17
	£000	£000
Research and development	175	197
Education and training	12,771	12,579
Receipt of capital grants and donations	-	88
Non-patient care services to other bodies	11,394	10,881
Sustainability and transformation fund income	16,371	19,040
Rental revenue from operating leases	165	165
Income in respect of staff costs where accounted on gross basis	13	13
Charitable fund incoming resources	283	190
Other income	2,820	2,547
Total other operating income	**43,992**	**45,700**
Of which:		
Related to continuing operations	43,992	45,700
Related to discontinued operations	-	-

* Material figures within 'Other' other operating income
£1,265,000 (2016/17 £1,340,000) arises from catering services
£1,073,000 (2016/17 £829,000) arises from car parking
£285,000 (2016/17 £75,000) arises from accommodation charges
£218,000 (2016/17 £243,000) arises from sponsorship income

Note 5.1 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	Group and Trust	
	2017/18	2016/17
	£000	£000
Income from services designated as commissioner requested services	430,879	436,035
Income from services not designated as commissioner requested services	-	-
Total	**430,879**	**436,035**

The proportion of income which relates to the provision of goods and services for the purposes of health services in England is 90.7% (90.5% in 2016/17) of its total income.

Note 5.2 Profits and losses on disposal of property, plant and equipment

Profits and losses on sale all relate to disposals of plant & machinery therefore do not relate to protected assets.

Note 6 Operating expenses (Group)

	2017/18 £000	2016/17 £000
Purchase of healthcare from NHS and DHSC bodies	1,340	873
Purchase of healthcare from non-NHS and non-DHSC bodies	7,185	9,455
Staff and executive directors costs	298,450	301,163
Remuneration of non-executive directors	176	161
Supplies and services - clinical (excluding drugs costs)	38,056	33,528
Supplies and services - general	8,389	8,117
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	36,145	36,952
Consultancy costs	767	866
Establishment	4,506	3,680
Premises	11,611	14,152
Transport (including patient travel)	2,598	2,774
Depreciation on property, plant and equipment	8,452	7,748
Amortisation on intangible assets	909	1,030
Net impairments	8,073	13,463
Increase in provision for impairment of receivables	787	1,703
Change in provisions discount rate(s)	8	355
Audit fees payable to the external auditor		
audit services- statutory audit	71	55
other auditor remuneration (external auditor only)	8	43
Internal audit costs	-	265
Clinical negligence	12,211	8,722
Legal fees	75	844
Insurance	603	495
Research and development	24	51
Education and training *	1,410	1,422
Rentals under operating leases	1,699	2,120
Early retirements	1	-
Redundancy	88	1,001
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	17,658	16,932
Losses, ex gratia & special payments	8	5
Other NHS charitable fund resources expended	304	247
Other **	(633)	647
Total	**460,979**	**468,869**
Of which:		
Related to continuing operations	460,979	468,869
Related to discontinued operations	-	-

* Education and Training includes £0.7m (£0.6m in 2016/17) of training provided by the North East Leadership Academy, which has been hosted by the trust since 2010.

** Material items included within 'Other operating expenses' :

£332,000 (£246,000 in 2016/17) relates to National Quality Control and accreditation fees
£271,000 (£265,000 in 2016/17) relates to Internal Audit Fees
£132,000 (£153,000 in 2016/17) relates to professional fees

Note 6.1 Auditor remuneration (Group)

The remuneration to the trust's external auditors was all in relation to the audit of the trust, subsidiary and charity annual financial statements.

The audit of the trust's statements (£53.9k)
The audit of the Subsidiary's statements (£12.5k)
The audit of the charity accounts (£4k)

Non Audit Services in 2017/18 included:
The review of the trust's quality report (£8.4k)

Note 6.2 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £2m (2016/17: £2m).

Note 7 Impairment of assets (Group)

	2017/18 £000	2016/17 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	8,073	13,463
Total net impairments charged to operating surplus / deficit	**8,073**	**13,463**
Impairments charged to the revaluation reserve	-	38
Total net impairments	**8,073**	**13,501**

Impairments (and their reversals) are primarily due to the change in fair value identified as a result of the annual revaluation undertaken.

Accounting Standards require all reductions in the value of assets to be charged to the revaluation reserve where one exists for that asset. Where no revaluation reserve exists for a specific asset, the drop in value is charged straight to the Statement of Comprehensive Income.

In addition to the impairments and reversal of impairments shown in the table above, in 16/17 the trust also had revaluation gains of £634,000 (2017/18 £nil).

Note 8 Employee benefits (Group)

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	237,507	234,011
Social security costs	22,077	22,170
Apprenticeship levy	1,061	-
Employer's contributions to NHS pensions	26,969	27,179
Termination benefits	88	1,001
Temporary staff (including agency)	11,690	18,224
Total gross staff costs	**299,392**	**302,585**
Recoveries in respect of seconded staff	(189)	-
Total staff costs	**299,203**	**302,585**
Of which		
Costs capitalised as part of assets	665	421

Note 8.1 Retirements due to ill-health (Group)

During 2017/18 there were 3 early retirements from the trust agreed on the grounds of ill-health (5 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £181k (£543k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 8.2 Directors remuneration

The aggregate amounts payable to directors were :

	Group	
	2017/18 £000s	2016/17 £000s
Salary	1,161	1,350
Taxable benefits	2	1
Employer's pension contributions	746	313
	1,909	**1,664**

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Note 10 Operating leases (Group)

Note 10.1 County Durham and Darlington NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where County Durham and Darlington NHS Foundation Trust is the lessor.

	Group and Trust	
	2017/18	2016/17
	£000	£000
Operating lease revenue		
Minimum lease receipts	165	165
Total	**165**	**165**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	103	103
- later than one year and not later than five years;	169	169
- later than five years.	334	334
Total	**606**	**606**

The operating lease income relates to :
WRVS Shop at Bishop Auckland Hospital
WH Smith shop at Darlington Memorial Hospital
North East Ambulance Service lease of the ambulance station at Chester-le-Street Hospital

Note 10.2 County Durham and Darlington NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where County Durham and Darlington NHS Foundation Trust is the lessee.

	2017/18	2016/17
	£000	£000
Operating lease expense		
Minimum lease payments	1,699	2,120
Total	**1,699**	**2,120**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease payments due:		
- not later than one year;	1,691	1,892
- later than one year and not later than five years;	1,777	1,916
- later than five years.	112	223
Total	**3,580**	**4,031**
Future minimum sublease payments to be received		

The trust's leasing arrangements relate to building leases, car leases and photocopying and other minor equipment leases.

Note 11 Finance income (Group)

Finance income represents interest received on assets and investments in the period.

	2017/18	2016/17
	£000	£000
Interest on bank accounts	47	151
NHS charitable fund investment income	127	110
Total	**174**	**261**

Note 12.1 Finance expenditure (Group)

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2017/18	2016/17
	£000	£000
Interest expense:		
Finance leases	104	155
Interest on late payment of commercial debt	3	-
Main finance costs on PFI and LIFT schemes obligations	7,554	7,850
Contingent finance costs on PFI and LIFT scheme obligations	5,838	6,323
Total interest expense	**13,499**	**14,328**
Unwinding of discount on provisions	84	8
Total finance costs	**13,583**	**14,336**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2017/18	2016/17
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	689	-
Amounts included within interest payable arising from claims made under this legislation	3	-

Note 13 Other gains / (losses) (Group)

	2017/18	2016/17
	£000	£000
Gains on disposal of assets	19	13
Losses on disposal of assets	(37)	(79)
Gains / losses on disposal of charitable fund assets	8	80
Total (losses) / gains on disposal of assets	(10)	14
Total other (losses) / gains	**(10)**	**14**

Note 14 Trust income statement and statement of comprehensive income

In accordance with Section 408 of the Companies Act 2006, the trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The trust's deficit for the period was £1.3 million (2016/17: £1.9 million). The trust's total comprehensive expense for the period was £1.3m million (2016/17: £1.3 million).

Note 15.1 Intangible assets - 2017/18

Group and Trust	Software licences £000	Total £000
Valuation / gross cost at 1 April 2017 - brought forward	**6,026**	**6,026**
Additions - purchased / internally generated	101	**101**
Additions - assets purchased from cash donations/grants	27	**27**
Valuation / gross cost at 31 March 2018	**6,154**	**6,154**
Amortisation at 1 April 2017 - brought forward	**3,438**	**3,438**
Provided during the year	909	**909**
Amortisation at 31 March 2018	**4,347**	**4,347**
Net book value at 31 March 2018	**1,807**	**1,807**
Net book value at 1 April 2017	**2,588**	**2,588**

Note 15.2 Intangible assets - 2016/17

Group and Trust	Software licences £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2016 - as previously stated	**5,064**	**826**	**5,890**
Additions	68	71	**139**
Reclassifications	897	(897)	**-**
Disposals / derecognition	(3)	-	**(3)**
Valuation / gross cost at 31 March 2017	**6,026**	**-**	**6,026**
Amortisation at 1 April 2016 - as previously stated	**2,411**	**-**	**2,411**
Provided during the year	1,030	-	**1,030**
Disposals / derecognition	(3)	-	**(3)**
Amortisation at 31 March 2017	**3,438**	**-**	**3,438**
Net book value at 31 March 2017	**2,588**	**-**	**2,588**
Net book value at 1 April 2016	**2,653**	**826**	**3,479**

Note 16.1 Property, plant and equipment - 2017/18

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**6,300**	**120,343**	**707**	**18,895**	**29,045**	**54**	**21,047**	**196,391**
Additions	-	6,386	-	9,937	2,354	-	1,445	**20,122**
Impairments	-	(10,065)	-	-	-	-	-	**(10,065)**
Reversals of impairments	-	(54)	49	-	-	-	-	**(5)**
Reclassifications	-	18,300	-	(18,385)	81	4	-	**-**
Disposals / derecognition	(30)	(70)	-	-	(354)	-	-	**(454)**
Valuation/gross cost at 31 March 2018	**6,270**	**134,840**	**756**	**10,447**	**31,126**	**58**	**22,492**	**205,989**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**124**	**-**	**-**	**14,625**	**53**	**11,983**	**26,785**
Provided during the year	-	2,048	11	-	2,925	2	3,466	**8,452**
Impairments	-	(706)	-	-	-	-	-	**(706)**
Reversals of impairments	-	(1,280)	(11)	-	-	-	-	**(1,291)**
Disposals / derecognition	-	-	-	-	(337)	-	-	**(337)**
Accumulated depreciation at 31 March 2018	**-**	**186**	**-**	**-**	**17,213**	**55**	**15,449**	**32,903**
Net book value at 31 March 2018	**6,270**	**134,654**	**756**	**10,447**	**13,913**	**3**	**7,043**	**173,086**
Net book value at 1 April 2017	**6,300**	**120,219**	**707**	**18,895**	**14,420**	**1**	**9,064**	**169,606**

Note 16.2 Property, plant and equipment - 2016/17

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**9,560**	**125,544**	**1,037**	**9,815**	**27,248**	**54**	**19,148**	**192,406**
Additions	-	3,885	-	17,148	2,581	-	409	**24,023**
Impairments	(4,060)	(12,606)	(330)	-	-	-	-	**(16,996)**
Reversals of impairments	166	1,340	-	-	-	-	-	**1,506**
Revaluations	634	-	-	-	-	-	-	**634**
Reclassifications	-	2,180	-	(8,068)	81	-	5,807	**-**
Disposals / derecognition	-	-	-	-	(865)	-	(4,317)	**(5,182)**
Valuation/gross cost at 31 March 2017	**6,300**	**120,343**	**707**	**18,895**	**29,045**	**54**	**21,047**	**196,391**
Accumulated depreciation at 1 April 2016 - as previously stated	**-**	**62**	**-**	**-**	**12,336**	**50**	**13,680**	**26,128**
Provided during the year	-	2,040	11	-	3,118	3	2,576	**7,748**
Impairments	-	(1,978)	(11)	-	-	-	-	**(1,989)**
Disposals/ derecognition	-	-	-	-	(829)	-	(4,273)	**(5,102)**
Accumulated depreciation at 31 March 2017	**-**	**124**	**-**	**-**	**14,625**	**53**	**11,983**	**26,785**
Net book value at 31 March 2017	**6,300**	**120,219**	**707**	**18,895**	**14,420**	**1**	**9,064**	**169,606**
Net book value at 1 April 2016	**9,560**	**125,482**	**1,037**	**9,815**	**14,912**	**4**	**5,468**	**166,278**

Note 16.3 Property, plant and equipment - 2017/18

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**6,300**	**120,343**	**707**	**18,895**	**29,045**	**54**	**21,047**	**196,391**
Additions	1,670	41,863		25,391	8,662	5	1,445	**79,036**
Impairments		(10,065)						**(10,065)**
Reversals of impairments		(54)	49					**(5)**
Reclassifications		18,300		(18,385)	81	4		**0**
Disposals / derecognition	(1,700)	(35,547)		(15,454)	(6,662)	(5)		**(59,368)**
Valuation/gross cost at 31 March 2018	**6,270**	**134,840**	**756**	**10,447**	**31,126**	**58**	**22,492**	**205,989**
Accumulated depreciation at 1 April 2017 - brought forward		**124**			**14,625**	**53**	**11,983**	**26,785**
Provided during the year		2,048	11		2,925	2	3,466	**8,452**
Impairments		(706)						**(706)**
Reversals of impairments		(1,280)	(11)					**(1,291)**
Disposals / derecognition					(337)			**(337)**
Accumulated depreciation at 31 March 2018		**186**			**17,213**	**55**	**15,449**	**32,903**
Net book value at 31 March 2018	**6,270**	**134,654**	**756**	**10,447**	**13,913**	**3**	**7,043**	**173,086**
Net book value at 1 April 2017	**6,300**	**120,219**	**707**	**18,895**	**14,420**	**1**	**9,064**	**169,606**

Note 16.4 Property, plant and equipment - 2016/17

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**9,560**	**125,544**	**1,037**	**9,815**	**27,248**	**54**	**19,148**	**192,406**
Additions	-	3,885	-	17,148	2,581	-	409	**24,023**
Impairments	(4,060)	(12,606)	(330)	-	-	-	-	**(16,996)**
Reversals of impairments	166	1,340	-	-	-	-	-	**1,506**
Revaluations	634	-	-	-	-	-	-	**634**
Reclassifications	-	2,180	-	(8,068)	81	-	5,807	**-**
Disposals / derecognition	-		-	-	(865)	-	(4,317)	**(5,182)**
Valuation/gross cost at 31 March 2017	**6,300**	**120,343**	**707**	**18,895**	**29,045**	**54**	**21,047**	**196,391**
Accumulated depreciation at 1 April 2016 - as previously stated	**-**	**62**	**-**	**-**	**12,336**	**50**	**13,680**	**26,128**
Provided during the year	-	2,040	11	-	3,118	3	2,576	**7,748**
Impairments	-	(1,978)	(11)	-	-	-	-	**(1,989)**
Disposals/ derecognition	-	-	-	-	(829)	-	(4,273)	**(5,102)**
Accumulated depreciation at 31 March 2017	**-**	**124**	**-**	**-**	**14,625**	**53**	**11,983**	**26,785**
Net book value at 31 March 2017	**6,300**	**120,219**	**707**	**18,895**	**14,420**	**1**	**9,064**	**169,606**
Net book value at 1 April 2016	**9,560**	**125,482**	**1,037**	**9,815**	**14,912**	**4**	**5,468**	**166,278**

The additions and disposals in 2017/18 include £58,914,000 which relate to the sale and lease back arrangement with Synchronicity Care Ltd for Darlington Memorial Hospital, and certain plant and machinery.

Note 16.4 Property, plant and equipment financing - 2017/18

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018								
Owned - purchased	6,270	46,039	-	10,447	13,391	3	7,043	**83,193**
Finance leased	-	-	-	-	277	-	-	**277**
On-SoFP PFI contracts and other service concession arrangements	-	88,615	756	-	-	-	-	**89,371**
Owned - donated	-	-	-	-	245	-	-	**245**
NBV total at 31 March 2018	**6,270**	**134,654**	**756**	**10,447**	**13,913**	**3**	**7,043**	**173,086**

Note 16.5 Property, plant and equipment financing - 2016/17

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017								
Owned - purchased	6,300	36,795	-	18,895	13,711	1	9,064	**84,766**
Finance leased	-	-	-	-	397	-	-	**397**
On-SoFP PFI contracts and other service concession arrangements	-	83,424	707	-	-	-	-	**84,131**
Owned - donated	-	-	-	-	312	-	-	**312**
NBV total at 31 March 2017	**6,300**	**120,219**	**707**	**18,895**	**14,420**	**1**	**9,064**	**169,606**

Note 16.6 Donations of property, plant and equipment

The trust received grants of cash of £38,809 (2016/17: £87,699) from the County Durham and Darlington NHS Foundation Trust charity to purchase equipment.

Note 16.7 Revaluations of property, plant and equipment

During 2017/18 an annual revaluation was carried out that reduced the value of assets by £8.1m (£12.9m reduction in 2016/17). This revaluation adjustment has been charged to the income statement. The revaluations were performed in line with the valuation approach set out in the trust's accounting policies. For specialised operational property, in selecting the site on which the modern equivalent asset would be situated, the valuer considered, in discussion with the trust, whether the actual site remains appropriate. For certain assets it was determined that alternative sites would be appropriate.

Note 17 Other investments / financial assets (non-current)

	Group		Trust	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
Carrying value at 1 April - brought forward	**3,709**	**3,605**	**-**	**-**
Acquisitions in year	-	388	17,803	-
Movement in fair value	47	409	-	-
Disposals	(327)	(693)	-	-
Carrying value at 31 March	**3,429**	**3,709**	**17,803**	**-**

Charitable funds 'other investments' relate to the funds invested in shares on behalf of the Charity

These have been classified as fixed assets on the basis that they are likely to be held for more than twelve months.

The trust invested in shares in its subsidiary Synchronicity Care Ltd

Note 18 Disclosure of interests in other entities

The accounts of Synchroncity Care Ltd, a wholly owned subsidiary of the trust, are consolidated into these accounts.

	2017/18 £000s	2016/17 £000s
Operating Income	37,897	-
Operating Expenditure	(37,723)	(52)
Operating Surplus	174	(52)
Interest Receivable	1,990	-
Interest Payable	(1,414)	-
Corporation Tax	(214)	-
Net surplus / (deficit) for the year	536	(52)

As at 31st March 2018 the trust also holds a 15% holding in HealthCall Solutions Ltd, which has net assets of £0.5k, and which broke even in 2017/18.

Note 19 Analysis of charitable fund reserves

The accounts of County Durham and Darlington NHS Foundation Trust Charity have been consolidated within these accounts.

	31 March 2018 £000	**31 March 2017 £000**
Unrestricted funds:		
Unrestricted income funds	3,319	3,179
Restricted funds:		
Endowment funds	1	499
Other restricted income funds	143	63
	3,463	**3,741**

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

Note 20 Inventories

	Group		**Trust**	
	31 March 2018 £000	**31 March 2017 £000**	**31 March 2018 £000**	**31 March 2017 £000**
Drugs	2,120	1,422	2,120	1,422
Consumables	6,301	5,601	4,898	5,601
Energy	181	210	144	210
Total inventories	**8,602**	**7,233**	**7,162**	**7,233**

Inventories recognised in expenses for the year were £35,389k (2016/17: £46,991k). Write-down of inventories recognised as expenses for the year were £nil (2016/17: £nil).

Note 21.1 Trade receivables and other receivables

	Group		Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Current				
Trade receivables	19,649	21,918	24,987	21,918
Accrued income	6,138	554	1,566	554
Provision for impaired receivables	(2,167)	(4,002)	(2,090)	(4,002)
Prepayments (non-PFI)	2,507	2,945	2,353	2,945
Interest receivable	6	3	-	3
PDC dividend receivable	600	445	600	445
VAT receivable	1,656	2,122	609	2,122
Other receivables ****	3,621	4,836	6,100	4,987
NHS charitable funds: trade and other receivables	5	5	-	-
Total current trade and other receivables	**32,015**	**28,826**	**34,125**	**28,972**
Non-current				
Trade receivables	-	-	-	92
Other receivables****	-	-	37,993	
Total non-current trade and other receivables	**-**	**-**	**37,993**	**92**
Of which receivables from NHS and DHSC group bodies:				
Current	24,777	22,368	20,831	22,368
Non-current	-	-	-	-

* The trust provides fully for invoiced NHS debt that is not formally agreed by the debtor during the Department of Health's agreement of balances exercise. The trust continues to pursue all outstanding charges irrespective of the provision.

** Material items within 'Other receivables' ;

£3.3m relates to outstanding claims with the Compensation Recovery Unit (31st March 2017 £3.1m)

*** The long term debtor in the trust's accounts in 2016-17 relates to the initial cash advance made to its subsidiary Synchronicity Care ltd.

**** A current and long term debtor in the trust's accounts in 2017-18 relates to a loan made to its subsidiary Synchronicity Care ltd.
The loan is repayable over 25 years at 3.5% interest.

Note 21.2 Provision for impairment of receivables

	Group		Trust	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
At 1 April as previously stated	**4,002**	**2,747**	**4,002**	**2,747**
Increase in provision	787	3,108	710	3,108
Amounts utilised	(2,622)	(448)	(2,622)	(448)
Unused amounts reversed	-	(1,405)	-	(1,405)
At 31 March	**2,167**	**4,002**	**2,090**	**4,002**

The trust provides for 100% of NHS invoices that have not been formally agreed during the national agreement of balances exercise.
The trust provides for 22.84% of Compensation recovery Unit claims, in line with national levels.

The provision for impairment of receivables is split as follows :

	2017/18	2016-17
Inter NHS Debt	£0.9m	£2.8m
Local Authority Debt	£0.0m	£0.0m
Non NHS Debt	£0.6m	£0.5m
Compensation Recovery Unit claims	£0.7m	£0.7m

Note 21.3 Credit quality of financial assets

Group	**31 March 2018**		**31 March 2017**	
	Trade and other receivables	**Investments & Other financial assets**	**Trade and other receivables**	**Investments & Other financial assets**
Ageing of impaired financial assets	**£000**	**£000**	**£000**	**£000**
0 - 30 days	256	-	525	-
30-60 Days	36	-	1,767	-
60-90 days	38	-	37	-
90- 180 days	182	-	252	-
Over 180 days	1,655	-	1,421	-
Total	**2,167**	**-**	**4,002**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	4,336	-	17,801	-
30-60 Days	477	-	7,401	-
60-90 days	236	-	(1,612)	-
90- 180 days	1,030	-	(1,132)	-
Over 180 days	3,611	-	(2,346)	-
Total	**9,690**	**-**	**20,112**	**-**

Trust	**31 March 2018**		**31 March 2017**	
	Trade and other receivables	**Investments & Other financial assets**	**Trade and other receivables**	**Investments & Other financial assets**
Ageing of impaired financial assets	**£000**	**£000**	**£000**	**£000**
0 - 30 days	256	-	525	-
30-60 Days	36	-	1,767	-
60-90 days	38	-	37	-
90- 180 days	182	-	252	-
Over 180 days	1,579	-	1,421	-
Total	**2,091**	**-**	**4,002**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	2,118	-	17,801	-
30-60 Days	408	-	7,401	-
60-90 days *	236	-	(1,612)	-
90- 180 days *	1,012	-	(1,132)	-
Over 180 days *	3,534	-	(2,346)	-
Total	**7,308**	**-**	**20,112**	**-**

*Negative figures in the split of non impaired assets as at 31st March 2017 relate to outstanding credits which have now been taken. These were offset by outstanding charges within the 0-30 days period relating to the same customer, therefore they have not been reclassified as outstanding liabilities.

Note 22 Non-current assets held for sale and assets in disposal groups

	Group and Trust	
	2017/18	2016/17
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**405**	**405**
Assets sold in year	(405)	-
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**405**

South Moor was identified as surplus to requirements when clinical services moved to other NHS facilities close by. An offer was accepted on the land in 2015/16 and the land was revalued down to this offer value at that time. The property was sold on 13th September 2017.

Note 23.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
At 1 April	**10,927**	**25,950**	**10,700**	**25,908**
Net change in year	(7,149)	(15,023)	(7,114)	(15,208)
At 31 March	**3,778**	**10,927**	**3,586**	**10,700**
Broken down into:				
Cash at commercial banks and in hand	288	245	96	153
Cash with the Government Banking Service	3,490	10,682	3,490	10,547
Total cash and cash equivalents as in SoFP	**3,778**	**10,927**	**3,586**	**10,700**
Total cash and cash equivalents as in SoCF	**3,778**	**10,927**	**3,586**	**10,700**

Note 23.2 Third party assets held by the trust

County Durham and Darlington NHS Foundation Trust held cash and cash equivalents which relate to monies held by the the foundation trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	Group and Trust	
	31 March 2018	31 March 2017
	£000	£000
Bank balances	3	1
Total third party assets	**3**	**1**

Note 24.1 Trade and other payables

	Group		Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Current				
Trade payables	20,400	19,446	21,707	19,446
Capital payables	4,550	4,371	5,451	4,371
Accruals	9,789	9,622	8,729	9,621
Other taxes payable	8,496	8,912	8,320	8,912
Other payables	10,488	6,934	9,980	6,934
NHS charitable funds: trade and other payables	111	7	-	-
Total current trade and other payables	**53,834**	**49,292**	**54,187**	**49,284**
Of which payables from NHS and DHSC group bodies:				
Current	9,930	6,798	9632	6,798
Non-current	-	-	-	-

Note 25 Other liabilities

	Group		Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Current				
Deferred income	2,521	3,162	2,521	3,162
Total other current liabilities	**2,521**	**3,162**	**2,521**	**3,162**

Note 26 Borrowings

	Group		Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Current				
Obligations under finance leases	183	392	2,799	392
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	4,723	3,811	4,723	3,811
Total current borrowings	**4,906**	**4,203**	**7,522**	**4,203**
Non-current				
Obligations under finance leases	-	107	53,770	107
Obligations under PFI, LIFT or other service concession contracts	84,602	89,325	84,602	89,325
Total non-current borrowings	**84,602**	**89,432**	**138,372**	**89,432**

Note 27 Finance leases

Note 27.1 County Durham and Darlington NHS Foundation Trust as a lessor

The Trust has no Finance Lease receivables

Note 27.2 County Durham and Darlington NHS Foundation Trust as a lessee

Obligations under finance leases where the trust is the lessee.

	Group		Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Gross lease liabilities	**230**	**650**	**81,129**	**650**
of which liabilities are due:				
- not later than one year;	230	496	4,747	496
- later than one year and not later than five years;	-	154	11,979	154
- later than five years.	-	-	64,403	-
Finance charges allocated to future periods	(47)	(151)	(24,560)	(151)
Net lease liabilities	**183**	**499**	**56,569**	**499**
of which payable:				
- not later than one year;	183	392	2,799	392
- later than one year and not later than five years;	-	107	5,511	107
- later than five years.	-	-	48,259	-
Total of future minimum sublease payments to be received at the reporting date	-	-		-

Obligations under finance leases relate to the following non PFI leases.

	Group		Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Lease of pathology equipment within a managed service contract	183	867	183	867
Lease of Darlington Memorial Hospital Site *	-	-	56,386	-
Lease of a robot drug dispenser in Pharmacy	-	23	-	23
	183	**890**	**56,569**	**890**

* The Trust has entered into an arrangement with its subsidiary company Synchronicity Care Limited to provide an Operated Healthcare Facility on the Darlington Memorial Hospital site with effect from 1 April 2017. The land, buildings and equipment on this site have been sold to Synchronicity Care Limited as part of the Asset Transfer Agreement. The finance lease included within the accounts of the Trust relates to the embedded lease of these assets back to the Trust under the operated heathcare facility agreement.

Note 28.1 Provisions for liabilities and charges analysis (Group)

Group and Trust	Pensions - early departure costs	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2017	**3,803**	**190**	**527**	**762**	**5,282**
Change in the discount rate	8	-	-	-	**8**
Arising during the year	46	103	153	-	**302**
Utilised during the year	(336)	(91)	(392)	(145)	**(964)**
Reversed unused	(117)	(61)	(288)	(617)	**(1,083)**
Unwinding of discount	84	-	-	-	**84**
At 31 March 2018	**3,488**	**141**	**0**	**0**	**3,629**
Expected timing of cash flows:					
- not later than one year;	336	141	-	-	**477**
- later than one year and not later than five years;	1,344	-	-	-	**1,344**
- later than five years.	1,808	-	-	-	**1,808**
Total	**3,488**	**141**	**-**	**-**	**3,629**

The provisions all relate to the Trust therefore a separate note is not shown.

(a) Pensions Provisions are anticipated to be released evenly over the remaining years.

(b) Legal Claims relating to Public and Employers liability cases should all be settled within twelve months.

* The Trust has recalculated its outstanding pensions provisions using a discount factor of 0.10% provided by HM Treasury (from 0.24% in 2016/17) in order to more accurately reflect the ongoing liability.

Note 28.2 Clinical negligence liabilities

At 31 March 2018, £298,657k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of County Durham and Darlington NHS Foundation Trust (31 March 2017: £241,220k).

Note 29 Contingent assets and liabilities

	Group		Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Value of contingent liabilities				
NHS Resolution legal claims	(94)	(100)	(94)	(100)
Gross value of contingent liabilities	**(94)**	**(100)**	**(94)**	**(100)**
Amounts recoverable against liabilities				
Net value of contingent liabilities	**(94)**	**(100)**	**(94)**	**(100)**
Net value of contingent assets				

Note 30 Contractual capital commitments

	Group		Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	6,345	12,459	6,345	12,459
Total	**6,345**	**12,459**	**6,345**	**12,459**

Capital Commitments include £3.8m (2016-17 £9.3m) relating to the contract with Integrated Health Projects for the design and construction of the Surgical Theatres and Enhanced Mortuary (STEM) project at Darlington Memorial Hospital

Note 31 Other financial commitments

The group / trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	Group		Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
not later than 1 year	492	976	22,574	976
after 1 year and not later than 5 years	321	683	89,280	683
paid thereafter	-	78	423,553	78
Total	**813**	**1,737**	**535,407**	**1,737**

Other Group financial commitments relate to payments for the trust's patient record system, and procurement system.

The Trust financial commitments includes the commitments with its subsidiary Synchronicity Care Ltd for an operated healthcare facility.

Note 32 On-SoFP PFI, LIFT or other service concession arrangements

County Durham and Darlington NHS Foundation Trust currently has three PFI Schemes

	£000
PFI 1 : University of North Durham Hospital	
Estimated capital value of the PFI Scheme at 1st April 1998	113,693
Contract Start date:	01/04/1998
Contract End date:	31/03/2028

Our Partner from the Private sector, Consort Healthcare, designed and built the three storey acute hospital and run non-clinical services in the new hospital whilst the Trust continues to run all clinical services.

PFI 2 : Bishop Auckland General Hospital	**£000**
Estimated capital value of the PFI scheme at 28th June 2002	48,514
Contract Start date:	28/06/2002
Contract End date:	27/06/2032

Criterion are the PFI partners for this scheme which redeveloped Bishop Auckland General Hospital on the old site. It included the re-provision of all existing clinical services into new buildings plus the refurbishment of the existing administration block.

	£000
PFI 3 : Chester le Street Hospital	
Estimated capital value of the PFI Scheme at 1st May 2002	10,000
Contract Start date:	01/05/2002
Contract End date:	20/04/2032

Robertsons Group are the PFI partners for this scheme. They have designed and built the new two storey building on the site of the former Chester le Street General Hospital.

In July 2015, the trust set up a wholly owned subsidiary which would allow any modern equivalent assets to be built net of VAT, reducing their value.

Note 32.1 Imputed finance lease obligations

The following are obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Gross PFI, LIFT or other service concession liabilities	**268,635**	**284,688**	**268,635**	**284,688**
Of which liabilities are due				
- not later than one year;	18,701	17,257	18,701	17,257
- later than one year and not later than five years;	77,777	74,027	77,777	74,027
- later than five years.	172,157	193,404	172,157	193,404
Finance charges allocated to future periods	(179,310)	(191,552)	(179,310)	(191,552)
Net PFI, LIFT or other service concession arrangement obligation	**89,325**	**93,136**	**89,325**	**93,136**
- not later than one year;	4,723	3,811	4,723	3,811
- later than one year and not later than five years;	20,912	18,729	20,912	18,729
- later than five years.	63,690	70,596	63,690	70,596

Note 32.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future obligations under these on-SoFP schemes are as follows:

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	539,799	576,181	539,799	576,181
Of which liabilities are due:				
- not later than one year;	39,824	38,624	39,824	38,624
- later than one year and not later than five years;	170,475	165,341	170,475	165,341
- later than five years.	329,500	372,216	329,500	372,216

Note 32.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	Group		Trust	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
Unitary payment payable to service concession operator	38,765	37,597	38,765	37,597
Consisting of:				
- Interest charge	7,554	7,850	7,554	7,850
- Repayment of finance lease liability	3,811	4,937	3,811	4,937
- Service element and other charges to operating expenditure	16,094	15,568	16,094	15,568
- Capital lifecycle maintenance	5,468	2,919	5,468	2,919
- Contingent rent	5,838	6,323	5,838	6,323
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	1,564	1,364	1,564	1,364
Total amount paid to service concession operator	**40,329**	**38,961**	**40,329**	**38,961**

Note 33 Financial instruments

Note 33.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2017 are in receivables from customers, as disclosed in the Trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament . The Trust identified a cash shortage in April 2018 and successfully applied to the Secretary of State for a £22.5m three year revenue support loan, to assist with its short term cashflow issues. The Trust is not now, therefore, exposed to significant liquidity risks, however it must now generate an operating surplus in order to generate sufficient cash to repay this loan in 2021.

Note 33.2 Carrying values of financial assets

Group	Loans and receivables £000	Available-for-sale £000	Total book value £000
Assets as per SoFP as at 31 March 2018			
Trade and other receivables excluding non financial assets	23,217	-	**23,217**
Cash and cash equivalents	3,638	-	**3,638**
Consolidated NHS Charitable fund financial assets	140	3,429	**3,569**
Total at 31 March 2018	**26,995**	**3,429**	**30,424**

Group	Loans and receivables £000	Available-for-sale £000	Total book value £000
Assets as per SoFP as at 31 March 2017			
Trade and other receivables excluding non financial assets	23,252	-	**23,252**
Cash and cash equivalents	10,792	-	**10,792**
Consolidated NHS Charitable fund financial assets	135	3,709	**3,844**
Total at 31 March 2017	**34,179**	**3,709**	**37,888**

Trust	Loans and receivables £000	Total book value £000
Assets as per SoFP as at 31 March 2018		
Trade and other receivables excluding non financial assets	62,135	**62,135**
Cash and cash equivalents	3,586	**3,586**
Total at 31 March 2018	**65,721**	**65,721**

Trust	Loans and receivables £000	Total book value £000
Assets as per SoFP as at 31 March 2017		
Trade and other receivables excluding non financial assets	23,252	**23,252**
Cash and cash equivalents	10,700	**10,700**
Total at 31 March 2017	**33,952**	**33,952**

Note 33.3 Carrying values of financial liabilities

Group	Other financial liabilities £000	Total book value £000
Liabilities as per SoFP as at 31 March 2018		
Obligations under finance leases	183	**183**
Obligations under PFI, LIFT and other service concession contracts	89,325	**89,325**
Trade and other payables excluding non financial liabilities	41,812	**41,812**
Provisions under contract	3,629	**3,629**
Consolidated NHS charitable fund financial liabilities	111	**111**
Total at 31 March 2018	**135,060**	**135,060**

Group	Other financial liabilities £000	Total book value £000
Liabilities as per SoFP as at 31 March 2017		
Obligations under finance leases	499	**499**
Obligations under PFI, LIFT and other service concession contracts	93,136	**93,136**
Trade and other payables excluding non financial liabilities	40,051	**40,051**
Provisions under contract	5,282	**5,282**
Total at 31 March 2017	**138,968**	**138,968**

Trust	Other financial liabilities £000	Total book value £000
Liabilities as per SoFP as at 31 March 2018		
Obligations under finance leases	56,569	**56,569**
Obligations under PFI, LIFT and other service concession contracts	89,325	**89,325**
Trade and other payables excluding non financial liabilities	35,740	**35,740**
Provisions under contract	3,629	**3,629**
Total at 31 March 2018	**185,263**	**185,263**

Trust	Other financial liabilities £000	Total book value £000
Liabilities as per SoFP as at 31 March 2017		
Obligations under finance leases	499	**499**
Obligations under PFI, LIFT and other service concession contracts	93,136	**93,136**
Trade and other payables excluding non financial liabilities	43,165	**43,165**
Provisions under contract	5,282	**5,282**
Total at 31 March 2017	**142,082**	**142,082**

Note 33.4 Fair values of financial assets and liabilities

Note 33.5 Maturity of financial liabilities

	Group		Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
In one year or less	47,306	45,687	43739	45,687
In more than one year but not more	5,276	5,461	7,984	5,461
In more than two years but not more	16,980	15,151	19,783	15,151
In more than five years	65,498	72,669	113,757	72,669
Total	**135,060**	**138,968**	**185,263**	**138,968**

Note 34 Losses and special payments

Group and trust	2017/18 Total number of cases Number	2017/18 Total value of cases £000	2016/17 Total number of cases Number	2016/17 Total value of cases £000
Losses				
Fruitless payments	-	-	1	1
Bad debts and claims abandoned *	314	28	913	58
Stores losses and damage to property	6	17	7	80
Total losses	**320**	**45**	**921**	**139**
Special payments				
Compensation under court order or legally binding arbitration award	1	114	-	-
Ex-gratia payments	24	5	17	6
Total special payments	**25**	**119**	**17**	**6**
Total losses and special payments	**345**	**164**	**938**	**145**
Compensation payments received				

* The individual cases mainly relate to small value invoices for prescription charges that proved uneconomical to pursue further.

Note 35 Gifts

The trust made no gifts in 2016/17

Note 36 Events after the reporting date

On 15th April the Trust applied for, and received, a £22.5m interim cash support loan from Department of Health. The loan is a three year loan at 1.5% interest, to be repaid in April 2021. This cash support will ensure that the trust has positive cash balances going forward.

In 2017/18 the local CCGs retendered the contract for providing community services within County Durham and Darlington. In April 2018 it was announced that County Durham and Darlington had retained the contract which extends the scope of the current service.

Note 37 Related parties

County Durham and Darlington NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

During the year there were transactions between parties related to three of the Board Members of County Durham and Darlington NHS Foundation Trust, and to seven of the Governors of the trust the values of which are listed below :

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party *
	£000s	£000s	£000s	£000s
Board Members				
Mrs S Jacques - Chief Executive and Mr P Dawson - Director of Finance (to 30th June 2017)	8	-	2	-
J Flynn *	121		-	-
Governors				
Mrs B Sarker	-	2	-	1
Dr J Chandy	-	5	-	-
	129	**7**	**2**	**-**

Mrs S Jacques is a director of the Healthcare Financial Management Association and Mr P Dawson was Chairman of the Healthcare Financial Management Association (Northern Branch) until his retirement.

Mrs J Flynn has declared interests in Durham Constabulary, Tow Law Community Association, and Durham Community Action.

Mrs B Sarker declared an interest in BMI Woodland.

Dr J Chandy declared an interest in Caradoc Surgery and Shinwell Medical Practice.

Mr O Colling declared an interest in HC- One Ltd, but the transaction is less than £500

Mr R Scothan declared an interest in Durham University, but the transaction is less than £500

Mr J Sloss declared an interest in Relate North East, but the transaction is less than £500

Mr D Robertson declared an interest in Barnard Castle GP Surgery and Durham Dales Health Foundation but the transaction is less than £500

Mr D Smart declared an interest in Dunelm Medical Practice, but the transaction is less than £500

All payments and receipts relate to the declared organisations, other than where the interest is with an NHS or other Whole Government Accounting Body organisation.

Staff costs

	Group			
	Permanent	Other	2017/18 Total	2016/17 Total
	£000	£000	£000	£000
Salaries and wages	235,797	1,710	**237,507**	234,011
Social security costs	22,077	-	**22,077**	22,170
Apprenticeship levy	1,061	-	**1,061**	
Employer's contributions to NHS pensions	26,969	-	**26,969**	27,179
Pension cost - other	-	-	**-**	-
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	88	-	**88**	1,001
Temporary staff		11,690	**11,690**	18,224
NHS charitable funds staff	-	-	**-**	-
Total gross staff costs	**285,992**	**13,400**	**299,392**	**302,585**
Recoveries in respect of seconded staff	(189)	-	**(189)**	-
Total staff costs	**285,803**	**13,400**	**299,203**	**302,585**
Of which				
Costs capitalised as part of assets	665	-	**665**	421

Average number of employees (WTE basis)

	Group			
	Permanent	Other	2017/18 Total	2016/17 Total
	Number	Number	Number	Number
Medical and dental	664	56	**720**	761
Ambulance staff	-	-	**-**	-
Administration and estates	1,310	7	**1,317**	1,304
Healthcare assistants and other support staff	1,264	180	**1,444**	1,486
Nursing, midwifery and health visiting staff	2,164	215	**2,379**	2,465
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	962	16	**978**	1,006
Healthcare science staff	-	-	**-**	-
Social care staff	-	-	**-**	-
Other	-	-	**-**	-
Total average numbers	**6,364**	**474**	**6,838**	**7,022**
Of which:				
Number of employees (WTE) engaged on capital projects	5	-	**5**	5

Reporting of compensation schemes - exit packages 2017/18

[A narrative description of any exit packages agreed in the period should be provided]

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	5	32	**37**
£10,001 - £25,000	3	5	**8**
£25,001 - 50,000	4	-	**4**
£50,001 - £100,000	2	-	**2**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	1	-	**1**
>£200,000	-	-	**-**
Total number of exit packages by type	**15**	**37**	**52**
Total resource cost (£)	£490,000	£164,000	**£654,000**

Reporting of compensation schemes - exit packages 2016/17

[A narrative description of any exit packages agreed in the comparative period should be provided]

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	10	51	**61**
£10,001 - £25,000	7	3	**10**
£25,001 - 50,000	3	3	**6**
£50,001 - £100,000	3	1	**4**
£100,001 - £150,000	-	1	**1**
£150,001 - £200,000	1	-	**1**
>£200,000	-	-	**-**
Total number of exit packages by type	**24**	**59**	**83**
Total resource cost (£)	£676,000	£527,000	**£1,203,000**

Exit packages: other (non-compulsory) departure payments

	2017/18		2016/17	
	Payments agreed Number	Total value of agreements £000	Payments agreed Number	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	-	-	3	185
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	37	164	57	342
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**37**	**164**	**60**	**527**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

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Independent auditor's report

to the Council of Governors of County Durham and Darlington NHS Foundation Trust

. REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

1. Our opinion is unmodified

We have audited the financial statements of County Durham and Darlington NHS Foundation Trust ("the Trust") for the year ended 31 March 2018 which comprise the Group Statement of Comprehensive Income, the Group and Trust Statements of Financial Position, the Group and Trust Statements of Changes in Equity, the Group and Trust Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion:

- the financial statements give a true and fair view of the state of the Group and the Trust's affairs as at 31 March 2018 and of the Group's income and expenditure for the year then ended; and
- the Group and the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2017/18 and the Department of Health Group Accounting Manual 2017/18.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Group in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Overview	
Materiality: Group financial statements as a whole	£5.75m (2017:£5.75m) 1.2% (2017: 1.2%) of total income from operations
Coverage	100% (2017:100%) of group income

Risks of material misstatement		vs 2017
Recurring risks	Valuation of land and buildings and accounting for impairments	◆

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2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on:the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. We summarise below the key audit matter (unchanged from 2017), in arriving at our audit opinion above, together with our key audit procedures to address this matter and our findings ("our results") from those procedures in order that the Trust's Council of Governors as a body may better understand the process by which we arrived at our audit opinion. The matter was addressed, and our results are based on procedures undertaken, in the context of, and solely for the purpose of, our audit of the financial statements as a whole, and in forming our opinion thereon, and consequently is incidental to that opinion, and we do not provide a separate opinion on these matters.

The key audit matter relates to the Group and the parent Trust.

	The risk	Our response
Valuation of land and buildings and accounting for impairments (£140.9 million; 2016/17: £126.5 million) *Refer to Annual Report section 2.12 (Audit Committee Report) and Annual Accounts pages 8, 9 and 12 (accounting policy) and pages 33-35 (financial disclosures).*	**Subjective valuation** Land and buildings are required to be maintained at up to date estimates of current value in existing use (EUV). For specialised assets where no market value is readily ascertainable, EUV is the depreciated replacement cost of a modern equivalent asset that has the same service potential as the existing property (DRC). The DRC basis requires an assumption as to whether the replacement asset with the same level of service provision would be situated on the existing site or, if more appropriate, on an alternative site, with a potentially significant effect on the valuation. The Trust has assumed that, if replaced, the four current sites would be amalgamated into two sites which remains a significant judgement in determining the valuation. Determining whether VAT should be included in DRC valuations is dependent on a judgement as to whether VAT could be recovered on a new capital development and has a material impact on the valuation. The Group's external valuers produced a valuation as at 31 March 2018 through indexing their full valuation supported by inspection as at 1 April 2016. The valuers inspected significant capital additions in the period. The valuation is underpinned by data, including floor areas, compiled by the Group which can be inherently difficult to measure and compile. Indexing the valuation requires judgement as to the choice of indices, whether averaging is used and the appropriateness of regional factors. **Accounting treatment** Consideration is also required as to whether revaluation gains and impairment losses are processed through other operating income/ expense, or recognised in other comprehensive income. This treatment could have significant impact on the reported surplus or deficit for the year.	Our procedures included: — **Assessing the valuer's credentials:** We assessed the competence, capability, objectivity and independence of the Trust's external valuer and considered the terms of engagement of, and the instructions issued to, the valuer for consistency with the requirements of the NHS Group Accounting Manual; — **Methodology choice:** We assessed the appropriateness of the basis of the full valuation at 1 April 2016 and of the method used to index the valuation to the current year end; — **Our sector experience:** We challenged the assumptions relating to what a replacement asset would comprise and how equivalent service provision could be achieved with reference to our knowledge of the Group and of the local NHS Health economy; — **Historical comparisons:** We considered the Group's history of VAT recovery through its PFI arrangements and commercial subsidiary and critically assessed the consistency of this judgement with the evidence presented; — **Data comparisons and sensitivity analysis:** We critically assessed the source of the data used by the valuers with reference to our experience from previous years' audits and carried out sensitivity analysis to determine the potential impact on the valuation of changes in key inputs; — **Benchmarking assumptions:** We challenged the appropriateness of the factors used to index the valuation with reference to third party indices and sector practice; — **Accounting analysis:** We re-performed the gain or loss on revaluation for all applicable assets and checked whether the accounting entries are consistent with the NHS Group Accounting Manual; and — **Assessing transparency:** We considered the adequacy of the disclosures about the key judgements and degree of estimation involved in arriving at the valuation and the related sensitivities. **Our results** — We found the estimated valuation of land and buildings, and the accounting for impairments, to be acceptable.

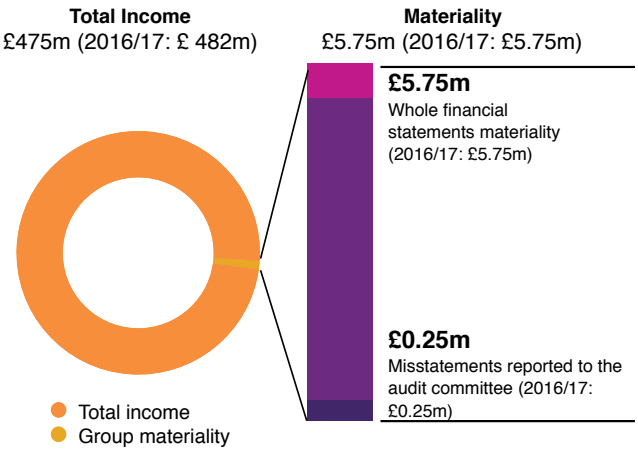
3. Our application of materiality and an overview of the scope of our audit

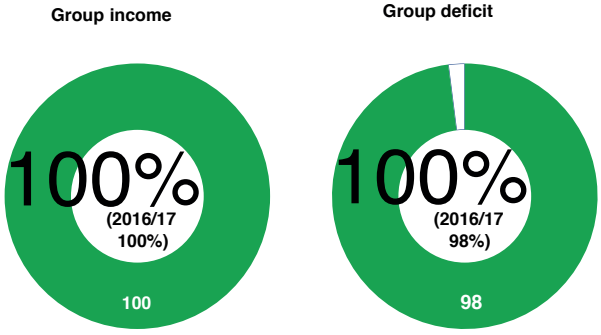
Materiality for the Group financial statements as a whole was set at £5.75 million (2016/17: £5.75 million), determined with reference to a benchmark of total income from operations of which it represents approximately 1.2% (2016/17: 1.2%). We consider operating income to be more stable than a surplus or deficit related benchmark.

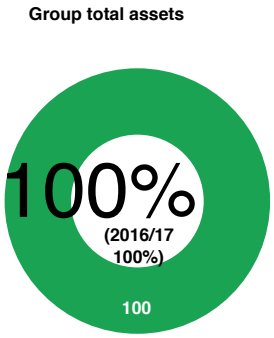
Materiality for the parent Trust's financial statements as a whole was set at £5.75 million (2016/17: £5.70 million), determined with reference to a benchmark of income from operations of which it represents approximately 1.2% (2016/17: 1.2%).

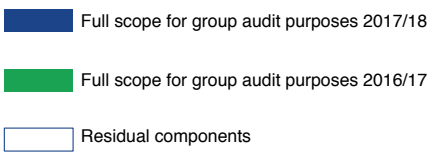
We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.25 million (2016/17:(£0.25 million), in addition to other identified misstatements that warranted reporting on qualitative grounds.

The Group team performed the audit of the Group as if it was a single aggregated set of financial information. The audit was performed using the materiality set out above and covered 100% of total Group income, Group deficit and total Group assets (2017: 100% of Group income, 98% Group deficit, 100% Group total assets).









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4. We have nothing to report on going concern

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least twelve months from the date of approval of the financial statements. We have nothing to report in these respects.

5. We have nothing to report on the other information in the Annual Report

The directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2017/18.

Corporate governance disclosures

We are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Group's position and performance, business model and strategy; or
- the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or
- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18, is misleading or is not consistent with our knowledge of the Group and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

6. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 78, the Accounting Officer is responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Group and parent Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Group and parent Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.
- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

We have nothing to report in respect of our work on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources..

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

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Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

The significant risks identified during our risk assessment are set out below together with the findings from the work we carried out on each area.

Significant Risk	Description	Work carried out and judgements
Delivery of Cost Improvement Programme (CIP)	The Trust should be able to demonstrate delivery against a CIP at the planned level of improvement and have delivered planned savings. The Trust had an original CIP target of £33m for 2017/18 compared to forecast of £21m. The Trust achieved £27m which is £6m behind the original target. There is therefore a risk that this indicates that the Trust does not have proper arrangements in place to deliver recurrent cost improvements.	Our work included: - We held discussions with the Programme Management Office and obtained documentation supporting the Trust's approach to meeting the targets agreed with NHSI; - We viewed evidence of the Trust having planned for the target set by NHSI and assessed why targets had not been achieved; and - We considered NHSI's review of the Trust's CIP and their observations in relation to cost improvements. **Our findings on this risk area:** - We concluded that the Trust had adequate arrangements in place to plan its finances effectively to support the sustainable delivery of strategic priorities and maintain its statutory functions.
Management of the Trust's cash position	In order to meet its working capital requirements the Trust has, subsequent to the year end, agreed and drawn down on an interim revenue support facility agreement with the Secretary of State for Health. There is therefore a risk that this indicates that the Trust does not have proper arrangements in place for managing working capital and monitoring cash flows.	Our work included: - We assessed the process in place for forecasting and monitoring cash levels and the associated financial controls; - We viewed correspondence with the main Clinical Commission Groups from which the Trust receives income; and - We made an assessment of the Trust's funding arrangements and consideration of borrowing facilities put in place. **Our findings on this risk area:** - We concluded that the Trust had adequate arrangements in place to plan its finances effectively to support the sustainable delivery of strategic priorities and maintain its statutory functions.
Results of external inspections	The VFM framework requires that we consider the outcomes of regulatory reviews in reaching our conclusion. During the year, the Trust was inspected by the Care Quality Commission (CQC). The overall rating in CQC's report, published in March 2018, was "Requires Improvement". This follows an inspection with the same overall result in 2015/16.	Our work included: - We reviewed the CQC inspection findings and considered whether the report demonstrated improvement on the results of 2015/16. We also considered the results of the Well-Led element of the review carried out by the CQC; and - We carried out inquiries with senior management in relation to the results of the inspection and progress made against recommendations; **Our findings on this risk area:** - We concluded that the Trust had adequate arrangements in place in relation to working with third parties and informed decision making to achieve its planned outcomes.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006 and the terms of our engagement by the Trust. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report, and the further matters we are required to state to them in accordance with the terms agreed with the Trust, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of County Durham and Darlington NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Rachel Fleming
for and on behalf of KPMG LLP (Statutory Auditor)

Chartered Accountants
Quayside House,
110 Quayside,
Newcastle Upon Tyne

25 May 2018

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7. 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.

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

BAH - Abbreviation used to refer to 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 Acute and Emergency Care, Surgery, Clinical Specialist Services, Integrated Adult Care and Family Health.

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

CDDFT – Abbreviation used to refer to County Durham and Darlington NHS Foundation Trust

CHP – Abbreviation used to refer to Combined Heat and Power

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

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

CoG - Abbreviation used to refer to a Council of Governors.

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

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

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

Cost Improvement Programme – an on-going cycle of work to improve processes to enhance quality and improve productivity and efficiency, subject to annual targets within our annual operating plans agreed with NHS Improvement.

DDES – Durham Dales, Easington and Sedgefield Clinical Commissioning Group

DMH – Abbreviation used to refer to Darlington Memorial Hospital

ED – Abbreviation used to refer to Emergency Department

FFT – Abbreviation used to refer to the Friends and Family Test

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

Francis Report – Reports produced by the Independent Enquiry into failings in care at Mid-Staffordshire Hospitals NHS Trust led by Robert Francis QC.

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 – Abbreviation used to refer to a General Practitioner

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

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

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

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

Methicillin-Resistant Staphyloccus Aureus (MRSA) – bacterium responsible for several difficult to treat infections.

MUST - Abbreviation used to refer to Malnutrition Universal Screening Tool

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

NCEPOD - Abbreviation used to refer to National Confidential Enquiry into Patient Outcome and Death

NEQOS - Abbreviation used to refer to the North East Quality Observatory System

NEST – A workplace pensions scheme established by the Government

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.

NHS – Abbreviation used to refer to National Health Service

NHS Improvement (NHSI) – the national body which awards the Trust its provider licence and regulates the Trust against it.

NHSFT – Abbreviation used to refer to NHS Foundation Trust

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

NHS Providers – a national association representing Trusts and Foundation Trusts

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

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

NRLS - Abbreviation used to refer to National Reporting and Learning System

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

OSC - Abbreviation used to refer to an Overview and Scrutiny Committee

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

PPI - Abbreviation used to refer to Patient and Public Involvement

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.

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

Provider Sector – Trusts and Foundation Trusts

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

Secondary care – care provided in hospitals.

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

Sustainability and Transformation Fund A national fund administered by NHS England which makes funding available to providers in line with the achievement of key financial and performance targets; the aim is to create headroom to enable providers to transform and improve services, including their productivity and efficiency.

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

UHND - Abbreviation used to refer to University Hospital of North Durham

UTI - Abbreviation for Urinary Tract Infection

VTE - Abbreviation for Venous Thromboembolism

8. How to find out more

For further information about County Durham and Darlington NHS Foundation Trust, including details of all our public meetings please visit the Trust's website: www.cddft.nhs.uk

In addition, please feel free to contact the Trust Secretary or a member of the Foundation Trust (FT) office team, if you would like more information about:

- becoming a member or Governor of the County Durham and Darlington NHS Foundation Trust;
- where to view the register of Directors' or Governors' interests;
- how to contact the Chairman or a member of the Board Directors or Council of Governors;
- to find detailed information about our Board of Directors' or Council of Governors' meetings which are open to the public; and
- how to obtain further copies of this report.

Write to: Foundation Trust Office
County Durham and Darlington NHS Foundation Trust
Executive Corridor
Darlington Memorial Hospital
Hollyhurst Road
Darlington
DL3 6HX

FT Office (Membership) Telephone: 01325 743 625
FT Office (Membership) Email: cdda-tr.foundation@nhs.net

Useful Contacts

Below is a list of useful contacts for enquiries of a more general nature than that listed above:

- Darlington Memorial Hospital Telephone Number: 01325 380100;
- University of Hospital of North Durham Hospital Telephone Number: 0191 333 2333;
- Bishop Auckland Hospital Telephone Number: 01388 455000;
- Chester-le-Street Community Hospital Telephone Number: 0191 387 6301;
- Richardson Hospital Telephone Number: 01833 696500;
- Shotley Bridge Community Hospital Telephone Number: 0191 333 2333;
- for communications, press office and media enquiries EMAIL: cdda-tr.communications@nhs.net
- for Freedom of Information requests EMAIL: cdda-tr.cddftFOI@nhs.net
- for general enquiries EMAIL: cdda-tr.generalenquiries@nhs.net
- for compliments, concerns, comments or complaints please contact County Durham and Darlington NHS Foundation Trust's Patient Experience Team: Telephone: 0800 783 5774 or EMAIL: cdda-tr.patientexperienceCDDFT@nhs.net

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

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