

Right first time 24/7

Our evolving clinical and quality strategy –
a discussion document

with you  all the way

About the Trust

County Durham and Darlington NHS Foundation Trust is the largest provider of integrated health services in the North East with **over 1 million patient contacts** per year.

Our **8,000 staff** serve around **600,000 people** across County Durham, Darlington, North Yorkshire, the Tees Valley and South Tyneside.

The Trust is an organisation with a **track record of success** in meeting its financial and performance obligations.

In 2011, we became an **integrated care organisation**, bringing together hospital services with community and health and wellbeing services.

For more information about County Durham and Darlington NHS Foundation Trust log on at:
www.cddft.nhs.uk

Foreword

During 2012 and 2013 we have discussed with staff and stakeholders our shared aspirations and ambitions for the future of the health services we provide.

In all of these discussions it has been clear that we share an ambition for excellence that delivers the right care, in the right place, at the right time, 24/7.

We want to provide:

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

The Trust and our commissioners recognise that getting care right for the emergency patient must be prioritised – in hospital and in the community, with a particular focus on older people. This is our core business.

We also know that work needs to be done to strengthen some of our key services in centres of excellence, to ensure they are sustainable at a time of increased specialisation. We have seen the benefits of this in stroke, and in vascular surgery. This is key to emergency acute care being sustainable within County Durham and Darlington.

This document builds on discussions we have had with staff and stakeholders and work we have done to date with our clinical teams. It considers why we need to do more to provide a truly integrated service which meets the needs and expectations of local people.

Early in 2014, we will be sharing outline proposals about how we can deliver on these priority areas.

In the meantime, this document sets out some of the key issues identified as the “case for change” by Professor Chris Gray, our executive medical director, and Mike Wright, our executive director of nursing and the membership of the clinical strategy steering group.

Tony Waites

Chairman

On behalf of the Board of Directors

Sue Jacques

Chief Executive



Tony Waites



Sue Jacques

“The Trust and our commissioners recognise that getting care right for the emergency patient must be prioritised – in hospital and in the community, with a particular focus on older people. This is our core business.”





Chris Gray



Mike Wright

“We need to stop thinking of ourselves as a group of small acute hospitals, merged with community services, and really create a vision of one large progressive integrated provider.”

Introduction

2013 has been a year of challenges for the NHS.

Sir Bruce Keogh has challenged emergency care, proposing a major shake-up of accident and emergency services, pointing out that the country’s A&E departments provide varying levels of service.

The NHS has been challenged on service quality: in the Francis report into failures at Mid Staffordshire Trust; Sir Bruce Keogh’s review of 14 trusts with higher than expected death rates; and in Don Berwick’s report.

These are challenges to the NHS nationally, but they are also a call to action for County Durham and Darlington Foundation Trust.

We know our performance in A&E is inconsistent. On average we achieve our target to assess, treat and discharge patients within four hours, but when we are under pressure we fail to do so.

We know that there are too many of our patients, usually frail elderly, who are admitted to hospital unnecessarily, at risk of infection, at risk of becoming institutionalised and losing their independence, because services are not organised to respond appropriately to their needs at an early stage.

We know this can mean wasted effort, duplication of effort, sub-optimal decisions, lost time and lost opportunities to achieve the best care and the best outcome for the patient.

Over 10 years after the merger of acute services, the Trust continues to operate two acute sites at UHND and DMH, often working in isolation with duplication of services. There is evidence from HSMR data, highlighted in the 2013 Dr Foster report, that mortality outcomes differ between sites, when by now we should be working to the same policies and processes and the same standards across the Trust.

We know that if the Trust wishes to sustain itself as the main emergency provider for County Durham and Darlington, it must be able to deliver the majority of acute specialties to a consistently high standard on a 24/7 basis.

To achieve this, there needs to be a clear cultural shift.

We need to stop thinking of ourselves as a group of small acute hospitals, merged with community services, and really create a vision of one large progressive integrated provider.

We need to consider our personal and team professional behaviours, consider how we work together effectively and how we ensure quality in every contact with patients.

The Clinical Strategy Steering Group, which includes executive directors and our senior clinicians, has established a vision and principles for the future of services to guide us.

Our evolving clinical and quality strategy, Right First Time, 24/7, is the part of the conversation about how we achieve this.

Professor Chris Gray

Executive Medical Director

Mike Wright

Executive Director of Nursing

On behalf of the Clinical Strategy Steering Group.



Right first time 24/7

Our vision

- Right person, right place, right time, *first time 24/7*

Principles

- Deliver core acute specialties across both acute sites
- Specialty departments delivering care across two acute sites and beyond
- Consultant delivered care
- Patients in homes not hospital, clinicians to patients
- Care closer to home where safe, effective and efficient
- Older person at the heart of service delivery, supported in the community



Why we need to change

Nationally and locally NHS services are under pressure. Organisations need to do more for less, and to a higher quality standard. 2013 has demonstrated how far the NHS has been adrift in some areas in terms of patient care, while new national standards and guidance have raised the bar for what organisations need to achieve.

Quality – the national picture

 Mike Wright

Experience elsewhere in the country and published nationally has shown what can go wrong when services are under severe pressure and there is a lack of focus on quality.

The Francis report looked into care at Mid Staffordshire and revealed a tolerance of poor standards and risks to patients, and the failure of stakeholders in the local system to share knowledge of their concerns.

Sir Bruce Keogh's review looked at 14 trusts with high mortality rates and identified themes relating to patient and staff engagement, poor use of data, problems with recruitment and over reliance on locums, support given to frontline staff to innovate, and transparency.

Don Berwick's report identified similar themes, and stressed the importance of continually seeking to reduce harm and of quality and safety as priority areas for investment.

We cannot take for granted that similar problems could not happen here. During our Francis listening events in 2013, staff shared the concerns they have about the quality of care they provide. It is important that we recognise the relationship between these issues and the pressures facing our own services.



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Guidance on 7 day working

■ Stuart Dabner

The Future Hospital Commission was established by the Royal College of Physicians. Its aim is to create change across hospitals and the wider health and social care economy in order to improve the care provided to patients. In September 2013 the Commission published Future Hospital: Caring for Medical Patients.

The Future Hospital Commission aims to develop a new model of care that delivers safe, high-quality care for patients across 7 days. There is an increased emphasis on continuity of care for all patients, including those with multiple and complex conditions.

The Commission’s overarching vision for the future hospital articulates key components of hospital services in the future. Hospitals will be responsible for delivering specialist medical services (including internal medicine) for patients across the health economy, not only for patients that present to the hospital.

Acutely ill patients in hospital will have the same access to medical care on Saturdays, Sundays and bank holidays as on a week day. Services will be organised so that consultant review, clinical staff (eg allied health professionals and specialist nurses), and diagnostic and support services are readily available on a 7-day basis.

Health and social care services in the community will be organised and integrated to enable patients to move out of hospital on the day they no longer require an acute hospital bed. Hospital procedures for transferring patient care to a new setting will operate on a 7-day basis, with 7-day support from services in the community.

Future Hospital: Caring for Medical Patients is available to download here:
http://www.rcplondon.ac.uk/sites/default/files/recommendations_0.pdf

In December 2013, Sir Bruce Keogh published proposals which set out 10 new clinical standards for hospitals. These include:

- All emergency admissions to be seen by a consultant within a maximum of 14 hours - although the Trust view is that to provide the best care patients should be seen more quickly - and where ever possible and appropriate, care should be consultant delivered
- Seven day access to diagnostic tests, such as X-rays, ultrasound, MRI scans and pathology
- Patients in intensive care and other high dependency units to be review by a consultant twice a day
- Weekend access to muti-disciplinary teams, which include expert nurses, physiotherapists and other support staff.

These standards must be in place in hospitals by 2017, and will be enforced through a system of fines.

Urgent and Emergency Care Review

■ Chris Gray

In November 2013, Sir Bruce Keogh published a report on the first stage of his review of urgent and emergency care in England.

Sir Bruce advocates a system-wide transformation over the next three to five years, as “the only way to create a sustainable solution and ensure future generations can have peace of mind that, when the unexpected happens, the NHS will still provide a rapid, high quality and responsive service free at the point of need.”

The NHS will introduce two types of hospital emergency department with the current working titles of Emergency Centres and Major Emergency Centres.

Emergency Centres will be capable of assessing and initiating treatment for all patients and safely transferring them when necessary.

Major Emergency Centres will be much larger units, capable of not just assessing and initiating treatment for all patients but providing a range of highly specialist services. The NHS envisages around 40-70 Major Emergency Centres across the country. It expects the overall number of Emergency Centres - including Major Emergency Centres - carrying the red and white sign to be broadly equal to the current number of A&E departments.

The report can be downloaded here:

<http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf>

Pressure in our emergency departments

■ Stuart Dabner

The Trust’s accident and emergency services are the third busiest nationally, seeing and treating 122,000 patients last year. We admitted 138,000 patients as emergency admissions in 2012/13, with an increasing proportion of frail elderly patients. We estimate the average age of the patients we admit to be 84 years.

Although we achieve the 95% target for A&E 4 hour wait on average, there are days when the target is not achieved. Multiple ambulances can be waiting outside A&E to hand over patients, and patients are waiting in A&E for beds to become available for them to be admitted. Medical patients are regularly boarded onto surgical wards.

This pressure is experienced on both acute sites, but is particularly high at UHND where last year’s “winter beds” have remained open throughout the year.

We recognise the limitations of the existing A&E departments in terms of capacity and infrastructure. Both of these factors lead to an unsatisfactory experience for patients and staff especially at UHND where the physical space is inadequate.



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Workforce issues

■ Chris Lisle

Organisations across the NHS are grappling with a number of staffing pressures.

National changes in medical training mean that there will be fewer junior doctors available over the next few years. It is also becoming more difficult to recruit to non-consultant qualified posts (“middle grade doctors”). This will increase our reliance on consultant staff.

There are shortages of doctors in training in key specialties and areas of practice, which is particularly challenging for smaller hospitals.

Sir Bruce Keogh’s report identified that some hospital trusts are operating in geographical, professional or academic isolation. This, he said, can lead to difficulties in recruiting enough high quality staff, and an over-reliance on locums and agency staff.

In County Durham and Darlington, there are specialties where we have struggled to recruit to consultant posts, or attract a strong field of candidates for interview.

Recent surveys of medical trainees show that the Trust is not a placement of choice for junior doctors, who cite work intensity, availability of support and concerns regarding quality of care. They represent a large tranche of lost potential future consultants.

As a consequence, many of our rotas at both junior and senior level are supported by locum staff, which impacts on continuity of care and consistency of quality.

There are also pressures in the availability of nurses nationally. We are currently experiencing difficulties in recruiting to nursing vacancies, where we want to move forward to make ward managers and team leaders supernumerary and strengthen teams. However there is a limited pool of candidates.

We believe that, in future, clinical appointments should be made with the expectation that that the appointee will work across any service setting, hospital and community, as patients require.



Patient experience

■ Mike Wright

The Trust received 18,583 compliments in 2012/13 – 3,820 more than the previous year. The number of complaints fell from 651 to 585 in 2012/13.

Although comments we receive on Friends and Family cards are usually positive and constructive, our scores are poor.

We are also concerned about our staff's perceptions about the Trust as a place to be treated. Although this showed an improvement in 2012, there is much more to be done.

Patient experience data from across the Trust therefore presents a mixed picture, which points to us offering an inconsistent experience for patients.

Health and wellbeing

■ Lee Mack

There is more we can do to capitalise on the huge potential of embedding health and wellbeing services into every aspect of clinical service delivery. We have made a promising start over the past three years, building the prevention first hub and making every contact count by offering brief advice to our patients.

Patients coming into hospital for planned care can now benefit from our "getting better sooner" campaign and website, ensuring that people are aware of how lifestyle changes can contribute to a speedier recovery.

We want to build on these foundations to extend life expectancy, improve quality of life and tackle health inequalities.



"Patient experience data from across the Trust presents a mixed picture, which points to us offering an inconsistent experience for patients."





“Our reserves can only be spent once, so it is important that we do so wisely, on investments and capital schemes in hospital and in the community, that will help us achieve our vision.”

Improving efficiency

 Peter Dawson

NHS England has set out the challenges facing the NHS in its document “The NHS belongs to the people – A Call to Action”.

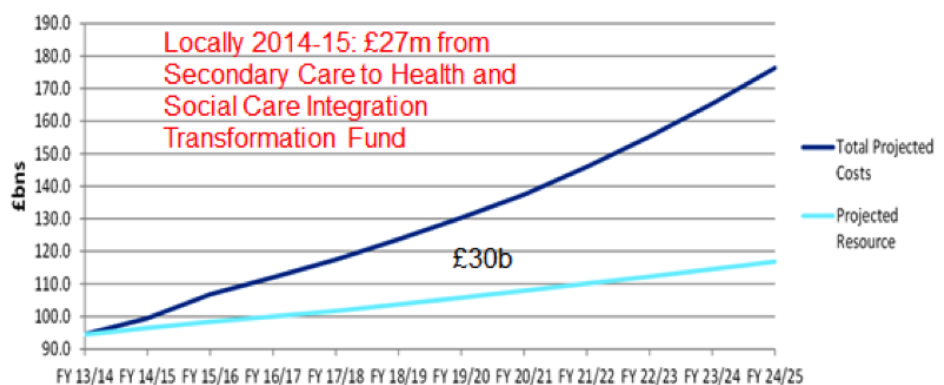
If we don’t change the way we provide health services, by 2021, there will be a £30 billion gap between the cost of running the NHS and the funding available. In addition, the Government plans to shift £3.8 billion from the NHS to local government to fund integrated health and social care services and move services out of hospitals and into community and primary care settings.

We can no longer continue to provide services the way we do, and we need to respond to the challenge to improve service quality and outcome. This will require new models of care that are more efficient than those we currently operate. We are fortunate that, thanks to prudent financial management over the last seven years, we have strong reserves to invest in developing our services.

However, current pressures on services means that some of those reserves that we had hoped to put aside for investment this year are being eroded.

Our reserves can only be spent once, so it is important that we do so wisely, on investments and capital schemes in hospital and in the community, that will help us achieve our vision of right person, right place, right time, first time 24/7.

Projected Resource vs. Projected Spending Requirements



Our evolving clinical strategy

In 2012 we published 'with you, all the way', our clinical strategy to 2015. This identified four areas where we need to change the way we provide services. These are driven by national policy, best practice guidance on quality and safety, the requirements of commissioners and our aspirations to provide the best services to local people:

- Unscheduled care
- Integration and care closer to home
- Women's and children's services
- Centres of excellence.

We focused on each of these areas at a series of stakeholder events.

Unscheduled care

 Chris Gray

The current pressure on our services means that getting care right for the emergency patient must be our first priority. In particular, we need to focus on the needs of our frail elderly patient population. This is our core business.

This will mean redesigning some services so that we can continue to deliver the majority of acute specialties on a 24/7 basis across County Durham and Darlington.

This will include more weekend working in some professions and services, including support services, and opportunities for different patterns of working, such as fewer but extended days for some staff.

We are already taking this work forward as part of the "towards midnight" programme.

In November, the Trust was chosen to be part of a national pilot for sharing good practice around 7 day working, and we want to maximise this opportunity for innovation locally.

Data collected by the Care Quality Commission showed 530,000 over-65s were admitted in England as an emergency for a preventable cause last year. This represents an increase of more than 40% since 2007-8. These were caused by conditions such as dehydration or infections which could have been prevented with better care.

"In November, the Trust was chosen to be part of a national pilot for sharing good practice around 7 day working, and we want to maximise this opportunity for innovation locally."





“For Winter 2013/14, the Care Co-ordination Centre is being piloted in North Durham, initially for patients who are being transferred from hospital into community based services.”

Avoiding admissions requires alternative pathways for the rapid assessment of medical and surgical patients. We want patients to be seen in the right place at the right time by the right professional. This will mean more care delivered directly by consultants, working closely with clinical colleagues in hospital and community.

It will also mean developing new roles for nurses and other clinical professionals to carry out roles previously carried out by doctors.

Our ambition should be to host one of the major emergency care centres, envisaged in Sir Bruce Keogh’s report, within the Trust, and upgrade the level of acute and emergency care available within County Durham and Darlington.

Integration and care closer to home

 Linda Templey

We want to offer patient pathways that are integrated across providers. Where improvements might adversely affect a partner, we will work together to manage that impact, not lose the benefits of that improvement.

We want to work in an environment where good practice and examples of best care and support are shared for the benefit of all.

We are changing the way we organise our services, particularly in the community. In future, we will be organising many of our services on a locality basis, to ensure that they reflect local need, and that clinicians and managers are effectively engaged with their partners.

An important step we have taken is to establish a “Care Co-ordination Centre”. This will eventually offer a single point of access to our services for health and social care professionals across the whole health economy.

For Winter 2013/14, the Care Co-ordination Centre is being piloted in North Durham, initially for patients who are being transferred from hospital into community based services.

We need to ensure that steps to keep patients out of hospital and support them in the community are clinically effective and cost efficient at a time when there are pressures on budgets, and deliver the improvements in care we all want to achieve.

We want to work together across County Durham and Darlington as a collaboration of commissioners and providers to achieve this.



Women's and children's services

Stephen Cronin

We are committed to sustainable high quality women's and children's services within County Durham and Darlington.

The recent consultation on maternity and children's services at the Friarage demonstrates the challenges that exist in sustaining these services to a safe standard 24/7 in district general hospitals.

Following changes at the Friarage, we expect an increase in paediatric referrals and obstetric deliveries at Darlington Memorial Hospital.

This year, reflecting our aim of right person, right place, right time, our child health team has been piloting a paediatric "front of house" service. This aims to ensure that children are seen and assessed promptly by a senior clinician. This has resulted in 40% fewer hospital admissions for children.

Our clinical teams are developing a business case to improve maternity services in the Trust. If approved, this would see a new pregnancy assessment unit and upgraded labour rooms in Darlington, and midwife led units being co-located with the obstetric units at Durham and Darlington.

Earlier this year, we opened the first birthing pool at University Hospital of North Durham.

The Trust is a major provider of women's and children's care in the North East. We need to do more make sure that we are offering services to women and families that make us their first choice of provider, and that the service we provide is clinically of high quality.



"The Trust is a major provider of women's and children's care in the North East. We need to do more make sure that we are offering services to women and families that make us their first choice of provider."





“Some of the most specialist services and interventions will need to be centralised on one site, in order to ensure we have the critical mass of specialist staff and patients to ensure we meet nationally recognised quality standards.”

Centres of excellence

 Iain Bain

We want to offer services that are evidence based, accessible, safe and effective.

Where this will deliver an improved service, specialist services should be delivered from a lead site within the Trust, with patients moving between sites, rather than staff, only if there is a clinical need to do so.

This will be essential if we are to maintain specialist care within County Durham and Darlington in the medium to long term.

Some of the most specialist services and interventions will need to be centralised on one site, in order to ensure we have the critical mass of specialist staff and patients to ensure we meet nationally recognised quality standards.

Maintaining specialist skills locally has been the principle behind the centralisation of stroke and vascular services at UHND, and the concentration of rehabilitation and planned joint replacement at Bishop Auckland.

We must design our future configuration to make sure that we make the best use of our hospital sites and that each site has a strong portfolio of services.



Quality first - investing in quality, disinvesting in harm

Delivering high quality patient care and services is the Trust's ultimate priority.

Patients, families and carers have the right to the best care possible. They should feel confident that, if their condition deteriorates and when they are at their most vulnerable, they are in the best place.

We should make the best and most informed decisions so that patients receive prompt, effective treatment and an overall positive experience.

The delivery of healthcare carries risks, and sometimes accidents and errors occur. We must do everything we can to ensure our systems, processes and services are as safe and effective as they can be, and that every reasonable effort is made to learn from errors and prevent a recurrence.

All staff, clinical and non-clinical, carry personal accountability for contributing to a quality service, and all staff have a responsibility to ensure that risks to the effective delivery of quality care are reported, recorded and managed and mitigated.

The Trust's Quality Strategy was approved by the Board in October. It sits alongside the evolving Clinical Strategy to help determine how the Trust is discharging key responsibilities in relation to patient care safely and effectively.

Our quality strategy reflects the three nationally recognised domains of quality:

- **Safety** - reducing mortality and harm
- **Effectiveness** - improving care outcomes and the use of best practice and evidence based care
- **Experience** - improving the experiences of patient, service users and our staff.

Although not exhaustive, the three domains and the associated themes represent the key quality areas for improvement for the Trust.

Priorities in these three domains are included in the strategy, and in the Trust's quality account, which is included in the Trust's Annual Report and Accounts.

<http://www.cddft.nhs.uk/media/251977/co%20durham%20darlington%20-%20parliament%20copy.pdf>



Mike Wright

“All staff, clinical and non-clinical, carry personal accountability for contributing to a quality service, and all staff have a responsibility to ensure that risks to the effective delivery of quality care are reported, recorded and managed and mitigated.”



Supporting the change

Our senior clinicians are working closely with clinical teams on developing our evolving clinical strategy. Other key areas of work are being taken forward to support the strategy.



The right information to support the right clinical decisions

 Tom Hunt

The Board has agreed a prioritised series of clinical informatics developments that build on previous investments, to support better decision making and deliver safer care for patients.

During 2013, we have launched electronic clinical document management – ECDM – to digitise the Trust’s 900 thousand patient records. This is resulting in safer and more secure storage of records, and immediate access to records for clinicians from whichever location they are working. ECDM is a key step towards a paperless system and full electronic records.

We have also introduced digital dictation to make the process of producing all clinical correspondence, both to GPs and patients, swifter and more secure.

A new electronic patient record system in our two accident and emergency departments is helping clinicians on the frontline by providing a live clinical record. This gives them access to real time information on the care of individual patients.

We are now commissioning a clinical “portal” that will bring together information from key clinical information systems onto one screen, in a meaningful view that is accessible and understandable to hospital services, community services, general practices and patients themselves. The “portal” will also enable clinicians to interact with the patient records, enabling automated alerts and improvements in both the clinical workflow and patient pathway.

We are also exploring how we can provide remote access to systems and information for community staff who spend most of their working days in patients’ homes.

“We are now commissioning a clinical portal that will bring together information from key clinical information systems onto one screen.”



Using technology to improve care

■ Tom Hunt

We are working with technology providers to develop innovative solutions to patient centred care.

200 patients now no longer need to attend hospital for regular warfarin tests, as a result of a telehealth pilot. These patients are now carrying out their own tests and are able to report on the results remotely, allowing them to live more independently.

Our Focus on Under Nutrition team have developed a digital health based planning tool for nutritional planning which is to be used in care homes.

We have also developed a surgical outcome tracker. After discharge post day surgery, patients phone in and answer a series of questions, which helps staff decide who requires follow up.

Clinical and corporate teams are working together on these and other projects, which make care more convenient for patients, fit in with their lifestyles, and help us provide better services.

Improving our estate

■ Bill Headley

£26m of investment in the engineering infrastructure at Darlington Memorial Hospital was completed in March 2012, future proofing the site and providing a platform for the progressive and incremental development of services there.

2013/14 sees the development of major estates projects which contribute to the Trust's strategic plan.

The surgical theatre and enhanced mortuary project, for which the business case is currently in production, will deliver the improved theatre capacity necessary to meet the demands on the service.

The Trust has constructed the region's first **endovascular theatre** at UHND, so key hole and conventional surgery can take place in one theatre.

We are also planning a new **learning centre for UHND** which will support the Trust's objective to be the best employer by providing modern state of the art learning facilities for its staff.

Working with the Clinical Strategy Steering Group, the estates team is working up initial plans for a new fit for purpose **emergency care centre at Durham**. This would allow us to provide a better experience for our patients, increase our capacity for ambulatory care and reduce unnecessary hospital admission, prolonged waits for patients and ambulance handover delays.



“£26m of investment in the engineering infrastructure at Darlington Memorial Hospital was completed in March 2012, future proofing the site and providing a platform for the progressive and incremental development of services there.”



A call to action

Our clinical and quality strategy is not just a job for the Board or clinical leads and senior managers.

We need to work with our commissioners, with primary care, with other providers, and with our local authorities to provide a truly integrated service which meets the needs and expectations of patients. We also want to work with our staff.

We want to discuss with you these questions:

- What is your vision for the future of services
- What do quality metrics and patient outcomes tell us about services now and in the future?
- Are services financially viable? Where should we invest and where should we disinvest?
- What are the priorities for change?
- What should be the pace of change to secure quality?
- Will there be different long term and interim solutions?

You can share your views in the following ways:

Staff

Email your comments to: rightfirsttime@cddft.nhs.uk

At your team meetings. We have asked all heads of department and meeting chairs to include the clinical and quality strategy at their next meeting, and feed back.

At a series of meetings with directors to be held across the Trust – details will be available shortly.

A major staff workshop will be held on 14 February 2014 - details will be available shortly.

Stakeholders

Email your comments to: rightfirsttime@cddft.nhs.uk

We would be delighted to come and talk to you or your organisation. Please request via the email above.

We will also be holding a stakeholder workshop on the 6 February 2014, details will be available shortly.



Clinical Strategy Steering Group

The Clinical Strategy Steering Group meets weekly and reports to the Board via the Executive and Clinical Leadership Group. Key clinical membership includes:

- Professor Chris Gray –** Chris is a specialist in elderly care and joined the Foundation Trust in 2013. He is executive medical director on the Trust Board and is chair of the Steering Group.
- Mike Wright –** Mike is executive director of nursing on the Trust Board.
- Stuart Dabner –** Stuart is a consultant anaesthetist and care group clinical director for acute and long term conditions.
- Iain Bain –** Iain is a consultant in colorectal surgery and care group clinical director for surgery and diagnostics and health improvement.
- Linda Templey –** Linda is a nurse and care group clinical director for care closer to home.
- Stephen Cronin –** Stephen is a consultant paediatrician and clinical director of women's and children's services.
- Diane Murphy –** Diane is a nurse and clinical director of service transformation.

The Group is supported by programme director **Tracey Hardy**.

The Group also includes other executive directors, including the chief executive, and senior managers with key roles in the care groups and corporate services.



Chris Gray



Mike Wright



Stuart Dabner



Iain Bain



Linda Templey



Stephen Cronin



Diane Murphy



Tracey Hardy



County Durham and Darlington 
NHS Foundation Trust

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