AUDIT AND GOVERNANCE COMMITTEE AGENDA

HARTLEPOOL BOROUGH COUNCIL

Thursday 20 February 2014

at 2.00 pm

in Committee Room B,
Civic Centre, Hartlepool.

MEMBERS: AUDIT AND GOVERNANCE COMMITTEE

Councillors Ainslie, S Akers-Belcher, Brash, Fisher, Loynes, Robinson and Shields

Standards Co-opted Members; Mr Norman Rollo and Ms Clare Wilson.

1. **APOLOGIES FOR ABSENCE**

2. **TO RECEIVE ANY DECLARATIONS OF INTEREST BY MEMBERS**

3. **MINUTES**

   3.1 To confirm the minutes of the meeting held on 23 January 2014 (to follow).

4. **AUDIT ITEMS**

   No items.

5. **STANDARDS ITEMS**

   No items.

6. **STATUTORY SCRUTINY ITEMS**

HEALTH ISSUES

Investigation into Chronic Obstructive Pulmonary Disease (COPD) – Awareness

6.1 Second Evidence Gathering Session – Covering Report - *Scrutiny Manager*

(a) Evidence from the British Lung Foundation – Presentation by Bev Wears, Service Development Manager

(b) Smoking Cessation Service – Evidence from the Smoking Cessation Service

(c) Evidence from Tees Valley Public Health Shared Service – Written evidence and presentation by Victoria Ononeze, Public Health Specialist

(d) Feedback from COPD Focus Group held on 10 December 2013 - Andy Graham, Public Health Registrar

NTHFT Quality Account

6.2 North Tees and Hartlepool NHS Foundation Trust (NTHFT) – Quality Account 2014/15:-

(a) Covering Report – *Scrutiny Manager*

(b) Presentation – Assistant *Director of Nursing and Patient Safety, North Tees and Hartlepool NHS Foundation Trust*

Healthwatch Hartlepool Work Programme

6.3 Local HealthWatch Work Plan 2013/14- *HealthWatch Representatives*

Care Quality Commission

6.4 Care Quality Commission Update – Presentation by Christine Wharton, Compliance Manager, Care Quality Commission

Requested Information

6.5 Requested Information:-

(a) Floor plan of University Hospital of Hartlepool

(b) Car parking charges and the length of stay and cost whilst visiting North Tees and Hartlepool NHS Foundation Trust

(c) Access to One Life Centre - *Assistant Director (Neighbourhoods)*

Monitoring of Scrutiny Recommendations

6.6 Six Monthly Monitoring of Agreed Scrutiny Recommendations – *Scrutiny Manager*

7. **MINUTES FROM THE RECENT MEETING OF THE HEALTH AND WELLBEING BOARD**

No items.

8. **MINUTES FROM THE RECENT MEETING OF THE FINANCE AND POLICY COMMITTEE RELATING TO PUBLIC HEALTH**

8.1 Extract from the minutes of the meeting held on 19 December 2013

9. **MINUTES FROM RECENT MEETING OF TEES VALLEY HEALTH SCRUTINY JOINT COMMITTEE**

9.1 Minutes of the meeting held on 9 December 2013

10. **MINUTES FROM RECENT MEETING OF SAFER HARTLEPOOL PARTNERSHIP**

10.1 Minutes of the meeting held on 13 December 2013

11. **REGIONAL HEALTH SCRUTINY UPDATE**

No items.

12. **ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS URGENT**

FOR INFORMATION

Date of next meeting – 6 March 2014 at 9.30 am in the Civic Centre, Hartlepool.

Audit and Governance Committee

20 February 2014

Report of: Scrutiny Support Officer

Subject: COPD INVESTIGATION - SECOND EVIDENCE GATHERING SESSION - COVERING REPORT

1. PURPOSE OF REPORT

1.1 To set the scene for the second evidence gathering session as part of the Chronic Obstructive Pulmonary Disease (COPD) investigation and introduce evidence from a variety of sources to inform the Committees consideration of the issue.

2. BACKGROUND INFORMATION

2.1 The Committee at its meeting on the 22 August 2013 agreed the Scope and Terms of Reference for its investigation into COPD.

2.2 In line with the agreed process the Committee, at its meeting on the 3 October 2013, received a very informative 'setting the scene' presentation which highlighted the causes, signs and symptoms and prevention and treatment of COPD.

2.3 As part of today's evidence gathering session, the Committee agreed that evidence / input would focus on awareness of COPD and early detection. Therefore, the following organisations have been invited to attend:-

- British Lung Foundation
- Smoking Cessation Service
- Tees Valley Public Health Shared Service

2.4 To assist the Committee, and inform discussion at today's meeting, the following questions have been put forward to representatives from each body.

(a) What are the benefits of early detection and what are the resource implications?

(b) What information is available to the public to raise awareness of COPD?

(c) What advertising campaigns / methods of advertising have been utilised to raise awareness of COPD? What work has been undertaken with Hartlepool BME communities to raise awareness of COPD?

(d) What good practice examples are available from the Smoking Cessation Service in relation to how to reach out to those people / communities who are 'seldom heard, seldom seen'?

(e) What are the difficulties faced when trying to raise awareness?

2.5 Members are asked to receive and consider the following evidence:

(a) Evidence from the British Lung Foundation – Presentation by Bev Wears, Service Development Manager

(b) Evidence from the Smoking Cessation Service – verbal evidence from representatives from the Smoking Cessation Service

(c) Evidence from Tees Valley Public Health Shared Service – Written evidence and presentation by Victoria Ononeze, Public Health Specialist

2.6 The former Health Scrutiny Forum carried out an investigation into Cancer Awareness and Early Diagnosis which details evidence from the Smoking Cessation Service and also highlights advertising campaigns. The report can be viewed at http://www.hartlepool.gov.uk/meetings/meeting/2664/cabinet. If you require a hard copy of the report, this is available by contacting Laura Stones on 01429 523087.

2.7 A COPD focus group was held on 10 December 2013 with COPD patients. The feedback from this group is attached as item 6.1(d) for the Committees information and discussion.

3. RECOMMENDATION

3.1 It is recommended that the Members of the Audit and Governance Committee consider the evidence presented and formulate views for either further consideration or inclusion in the Committee final report.

Contact Officer:- Laura Stones – Scrutiny Support Officer
Chief Executive's Department – Legal Services
Hartlepool Borough Council
Tel: 01429 523087
Email: laura.stones@hartlepool.gov.uk

BACKGROUND PAPERS

The following background papers were used in the preparation of this report:-

(i) Report of the Scrutiny Support Officer entitled 'Scrutiny Investigation into Chronic Obstructive Pulmonary Disease (COPD) – Scoping report presented to the Audit and Governance Committee on 22 August 2013.

(ii) Report of the Health Scrutiny Forum entitled Cancer Awareness and Early Diagnosis available at http://www.hartlepool.gov.uk/meetings/meeting/2664/cabinet.

(iii) Minutes of the Audit and Governance Committee held on 22 August 2013.

Hartlepool Borough Council Health Scrutiny COPD Investigation

Progress Report on Tees COPD Screening Programme (Lung Health Check)

1. Introduction

A screening/case finding programme for Chronic Obstructive Pulmonary Disease (COPD), the *Lung Health Check*, was introduced on Teesside on 1st January 2013.

The aim is to adopt a systematic approach to identifying and screening patients who are considered at risk of developing COPD. The strategic objective of the programme is to ensure that more people are diagnosed at an early stage of disease and supported with the effective management of the condition in order to slow down the progression of disease.

The programme was introduced as a Local Enhanced Service and 87 of 89 GP practices on Teesside have signed up to the programme. All GP practices in Hartlepool have signed up to the programme.

2. National context

Chronic Obstructive Pulmonary Disease describes lung damage that is gradual in onset which results in progressive airflow limitation. This lung damage, when fully established, is irreversible and if it is not identified and treated early leads to disability and eventually death.

The principal cause of COPD is smoking. Other factors include workplace exposure, genetic make-up and general environmental pollution.

COPD causes around 23,000 deaths in England each year, with one person dying from the condition every 20 minutes. COPD is the fifth biggest killer in the UK, the second most common cause of emergency admissions to hospital and one of the most costly inpatient conditions treated by the NHS. A large number of people with COPD do not know that they have the disease and remain undiagnosed.

3. Local Context

People living on Teesside experience some of the lowest life expectancies in the country and have remained substantially below the England average, and the gap is widening. Ward level life expectancy analysis reveals stark inequalities within local authority areas with up to a 13 year gap in life expectancy between the best and worst wards. COPD, together with cardiovascular disease and cancer contribute to 60% of the health inequalities in life expectancy gap.

The investment in COPD screening/ case finding and effective management of the condition is an important component of a Teeswide strategy (Clinical Commissioning Groups' Clear and Credible Plans and Local Authorities' Health and Wellbeing Strategies) to address health inequalities, reduce avoidable deaths and ill health and longer term health care costs associated with COPD.

4. The evidence for COPD screening/case finding

A large number of people in the UK live with undiagnosed COPD. It is estimated that about 14,600 people on Teesside are not aware that they have COPD. Nationally about 10% of emergency COPD admissions are in people whose COPD has not previously been diagnosed. This is estimated to be about 20% on Teesside.

If people remain undiagnosed until they are severely disabled by the condition or are admitted to hospital as an emergency, the benefits of treatment to the individual are greatly reduced and the costs to the healthcare system greatly increased.

COPD is incurable. National policies therefore recommend earlier and accurate diagnosis of COPD through quality-assured spirometry, to help slow down the rate of progression of disease and improve quality of life in people living with the condition.

5. The Tees Lung Health Check programme

Aims and objectives

The Tees Lung Health Check (LHC) is a face-to-face risk assessment aimed at people aged 35 years and over who are current smokers, and who are considered to be at risk of COPD but have not already received a *diagnosis* confirmed by quality-assured diagnostic spirometry.

Programme structure

The programme has the following elements:

- Practices sign up to deliver screening through a Local Enhanced Service
- Practices are provided with a list of eligible screening target population aged 35 years and over who are current smokers, including a sub population of those from the most deprived communities. The lists exclude patients who have already been diagnosed with COPD or asthma.
- Practices are expected to screen the eligible population over 5 years, with 20% screened each year.
- Practices send invites to the eligible population to attend screening (may be opportunistically as patients attend surgery for other reasons).
- Patients are assessed and spirometry tests performed by appropriately trained practice staff. Practices are expected to prioritise for assessment those from the top 20% most deprived communities who are at greatest risk.
- Payment is made to practices for each patient screened and an additional fee if patient live in the top 20% most deprived communities.
- Practices are provided with clinical templates to help with accurate recording and reporting of screening processes and activities.

Support to practices

- Spirometers purchased for practices, both to help ensure accurate spirometry tests and results, and recording and reporting.

- COPD Nurse Facilitators provide onsite support to practices and coordinate training for practice staff.

Public awareness

- The programme was launched in March 2013 with a Teeswide campaign in local media
- Posters and leaflets distributed to community venues including pharmacies, libraries, appropriate community centres and workplaces

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Monitoring and evaluation

- Quarterly reports on screening activities - numbers screened and diagnosed, including I those who live in deprived communities
- Programme is being evaluated to assess the impact on a range of outcomes.

6. Progress to date

Practice sign up

Eighty-seven out of 89 GP practices on Teesside have signed up to the LES. All GP practices in Hartlepool have signed up to the programme.

However, a significant number started screening in the past few months or are yet to start.

Uptake of LHC

The uptake of LHC from 1 January to 31 December 2013 is summarised below.

About a quarter of the eligible target population have been screened across Tees practices, with 70% of those screened from the top 20% most deprived communities. A total of 393 new COPD diagnoses have been made, 14% of those assessed to date.

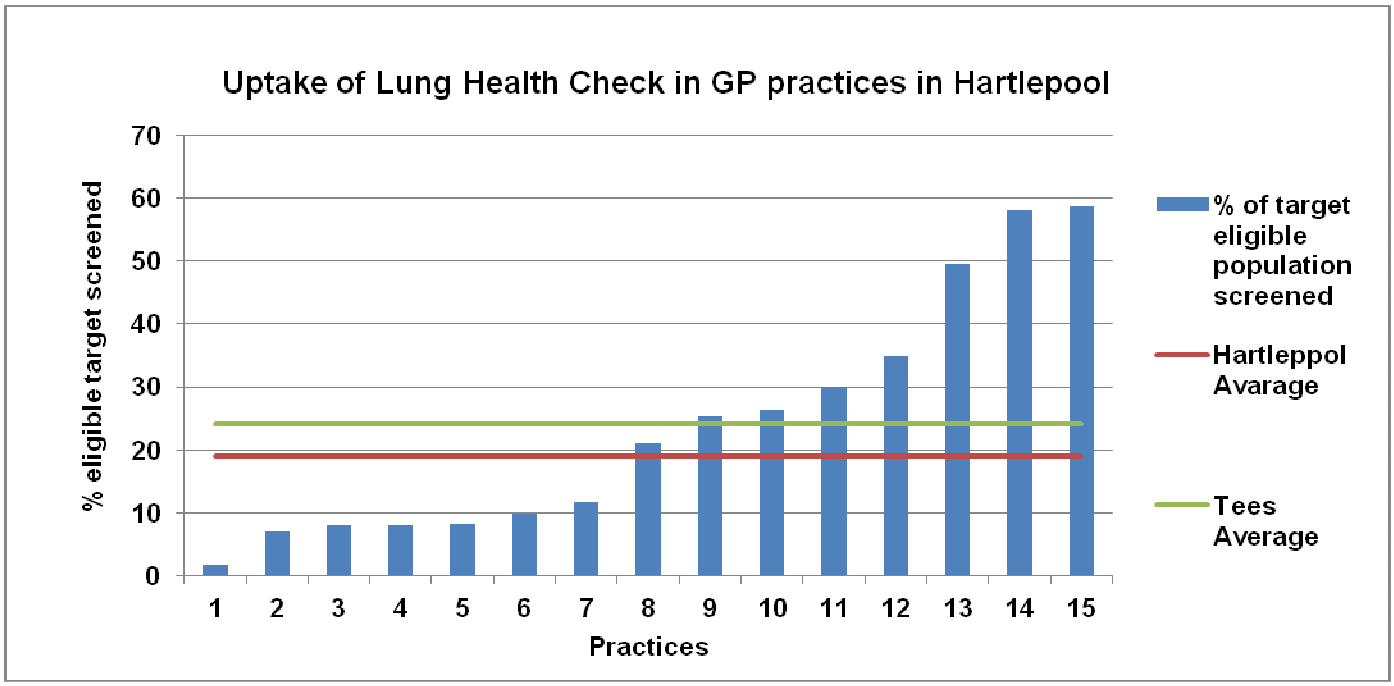
The uptake in the four local authorities are summarised in Figure 1 below.

Figure 1: Number screened and subsequently diagnosed with COPD: Jan - Dec 2013

	Annual target of eligible population	Eligible number screened	Eligible number screened from Quintile 1 area (most deprived)	Number diagnosed following screening	Number diagnosed following screening from Quintile 1 (most deprived)
Hartlepool	2,140	410 (19%)	**296 (72%)**	89 (22%)	**65 (21%)**
Middlesbrough	3,336	774 (23%)	**602 (78%)**	147 (19%)	**73 (12%)**
Redcar & Cleveland	2,768	526 (19%)	**385 (73%)**	61 (12%)	**37 (10%)**
Stockton-on-Tees	3,710	1189 (32%)	**731 (61%)**	96 (8%)	**80 (14%)**
Tees Total	11,954	2,899 (24%)	**2,014 (70%)**	393 (14%)	**255 (13%)**

As expected there are huge variations in the uptake of LHCs across Hartlepool GP practices (Figure 2 below). The uptake of screening in about half of practices is below the Hartlepool average. There are a variety of reasons for the variations in uptake including late sign up to and start of programme and patients not attending screening.

Figure 2: Proportion of eligible target population screened in Hartlepool by GP practices

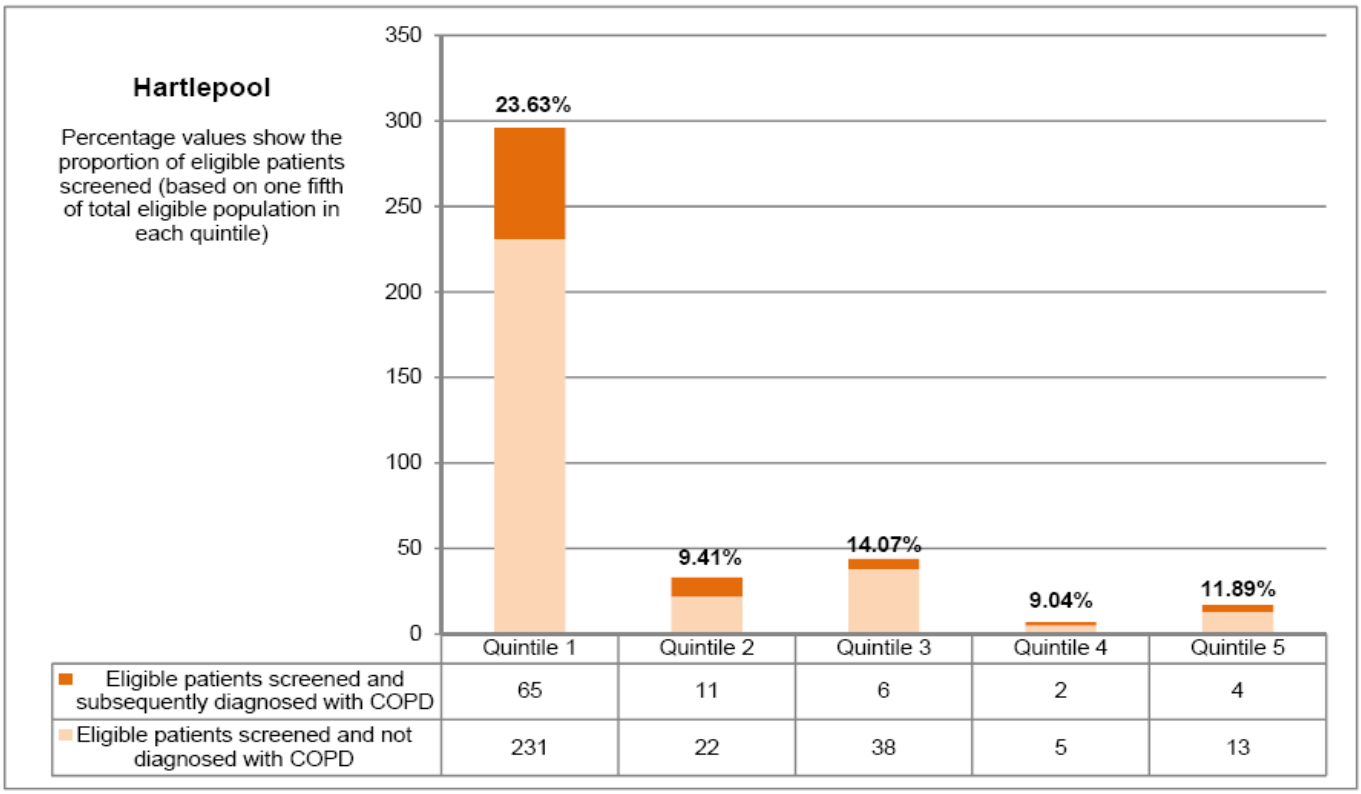


Addressing inequalities in LHC uptake

One of the objectives of the LHC is to reduce health inequalities. One of the ways we are doing this is through providing practices with an incentive to be more proactive in inviting and screening patients from the most deprived communities.

Figure 3 shows the number of patients screened and subsequently diagnosed with COPD in each of the five deprivation quintiles in Hartlepool. It shows that the largest proportion of patients screened and diagnosed are in Quintile 1, the most deprived communities. The results are encouraging.

Figure 2: Numbers screened and subsequently diagnosed by quintiles: Jan - Dec 2013



7. Issues

Good progress has been made in implementing the LHC. However, there are significant issues as expected from a general practice based programme including:

- Slow sign up and implementation in a large number of practices
- Patients not attending checks despite repeated invitations from practices
- Further work to improve data recording and reporting
- Issues with the spirometry used for LHCs and the software that transfers screening activity onto the practice computer
- Ongoing demand for training from practice staff

8. Future plan

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- Plan further public campaigns to raise awareness of LHCs...
- Explore how to implement LHCs in appropriate community venues in order to improve availability and increase access
- Work is in progress to develop a single GP Public Health Contract that will include all primary care based public health interventions. The aim is to help ensure a more sustainable approach to improving population coverage, with targeted initiatives and incentive to reduce inequalities in uptake. In addition, it is anticipated that practices would

see a single contract as long-term and that this may encourage them to invest in staff to deliver interventions.

9. Recommendations

The Audit and Governance Committee is asked to note:

- the progress made in implementing the Tees LHC programme
- some of the issues and challenges to improving uptake
- the plans to improve uptake and sustainability of programme

Dr Victoria Ononeze (PhD)
Public Health Specialist
Tees Valley Public Health Shared Service

4 February 2014

Feedback from the COPD Focus Group held on 10 December 2013

1) The majority of people who attended the focus group were aware of COPD as they had the condition or they were aware of someone who had the condition. One woman had symptoms and had attended to find out more about the condition;

2) Change in access to services has resulted in patients / families finding it difficult to contact respiratory nurses. Access to respiratory nurses used to be direct, for example patients could contact a respiratory nurse by calling him/her direct, and now access is via the 'single point of contact' number, who then passes on the message to the nurses. However, with COPD, it is more often than not, that an immediate response is required;

3) The system appears to be broken, the system has been changed and now it appears not to work and there was frustration and anger expressed;

4) It appears that the change in the system has resulted in a loss of expertise as people have been grouped together and now people cannot access the experts;

5) Patients are advised by the GP how best to manage their condition and if part of that management is direct access to a respiratory nurse then this should be available;

6) People who attended the focus group were finding it difficult to get appointments with their GP and often appointments were only available late afternoon or patients were having to wait for the GP to call them, which is hours later. Also, people would like appointments with their family doctor. Often people see locums who do not know them or their condition which means time is wasted on explanations, which affects the continuity of care.

7) Seems to be a great variation of how health professionals diagnose people who have COPD. People have been diagnosed with a different condition at first and then years later diagnosed with COPD. There needs to be a consistent approach to diagnosis. COPD needs clinical evaluation as there are a spectrum of conditions that fall within the term COPD;

8) People were of the view that there is a lack of information on COPD and said those people that are newly diagnosed would struggle to find information as information is not available;

9) The cost of emergency admissions needs to be compared with the cost of providing additional respiratory nurses. The changes to the services may have been as a result of cost saving, however, saving money in one place will more than likely result in additional cost in another, for example, an increase in emergency admissions;

10) People have produced their own exercises to manage their conditions, which includes cardboard breathing tubes;

11) GP practices should do two things:- 1) provide timely and appropriate access to care and 2) provide continuity of care. People with COPD are flagged on GP systems and care is tailored to the patient; and

12) GPs refer to the Community Respiratory Assessment and Management Service (CRAMS). All people at the focus group thought that the CRAMS service was an excellent service, which needs to be increased as it is under resourced.

A person who could not attend the Focus Group spoke to the Scrutiny Support Officer and said that she received a good service from her own GP and did not have trouble accessing nurses.

Audit and Governance Committee

20 February 2014

HARTLEPOOL BOROUGH COUNCIL

Report of: Scrutiny Manager

Subject: NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST – QUALITY ACCOUNT 2013/14 – COVERING REPORT

1. PURPOSE OF REPORT

1.1 To introduce representatives from North Tees and Hartlepool NHS Foundation Trust who will be in attendance at today's meeting to discuss the Trust's Quality Account for 2013/14.

2. BACKGROUND INFORMATION

2.1 In November 2009 the Government published the Health Bill which required all providers of NHS healthcare services to provide an annual Quality Account. The Department of Health made a legal requirement on all NHS healthcare providers to send their Quality Account to an Overview and Scrutiny Committee in the local authority area where the provider has a registered office.

2.2 Members of the Audit and Governance Committee met on 22 August 2013 where initial discussions were held in relation to the North Tees and Hartlepool NHS Foundation Trust's Quality Account for 2013/14 and 2014/15.

2.3 The Audit and Governance Committee at their meeting of 3 October 2013 discussed what they would like to see changed or added to the 2014-15 priorities. The Committee identified the following priorities for consideration in the Trust's Quality Account for 2014/15:-

(i) Discharge processes: co-ordination between the hospital, GPs, district nurses and the local authority still remains an area for improvement;

(ii) Dementia services: training needs: The improvements in services around dementia were welcomed. However, some concerns were raised around training provided to nursing staff in relation to dementia awareness; and

(iii) Patient experience: members welcomed the word bubble approach and asked for all comments to be reflected in the word bubbles.

2.4 Subsequently, representatives from North Tees and Hartlepool NHS Foundation Trust will be present at today's meeting to provide a presentation in relation to North Tees and Hartlepool NHS Foundation Trust's Quality Account.

2.5 A draft copy of the Quality Account is attached at **Appendix A** (Hard copies of this document have been circulated to Members of the Committee but an electronic copy can be viewed at http://www.hartlepool.gov.uk/meetings/meeting/2933/audit_and_governance_committee.)
The data within the document is accurate at the time of writing and will be further updated in April.

3. RECOMMENDATIONS

3.1 That Members:-

(i) Consider the contents of the draft Quality Account and the presentation, seeking clarification on any issues from the representatives from North Tees and Hartlepool NHS Foundation Trust present at today's meeting; and

(ii) Formulate a response from the Audit and Governance Committee to be included in the North Tees and Hartlepool NHS Foundation Trust's Quality Account for 2013/14.

Contact Officer:- Laura Stones – Scrutiny Support Officer
Chief Executive's Department – Legal Services
Hartlepool Borough Council
Tel: 01429 523087
Email: laura.stones@hartlepool.gov.uk

BACKGROUND PAPERS

The following background paper was used in the preparation of this report:-

(a) Minutes of the meetings of the Audit and Governance Committee held on 22 August 2013 and 3 October 2013.

ANNUAL QUALITY ACCOUNT 2013-14

Our approach to Quality: an Introduction to this Annual Quality Account from the Chief Executive

The Trust is pleased to present our annual Quality Account to demonstrate our continued commitment to delivering high quality patient care. Whilst there has been continued publicity about the quality of care provided to some patients in hospitals in England and Wales over the last year, I am always pleased to receive excellent feedback from our patients and their relatives across both the community and hospital services we deliver, which demonstrate to me that we strive to ensure that our patients receive high standards of clinical care, delivered by caring, compassionate staff.

University Hospital of North Tees is rated at 5.0 out of 5 star services on NHS choices and University Hospital of Hartlepool is rated at 5.0 out of 5.

Despite the challenging economic climate during 2013-2014, we remain committed to maintaining quality and protecting frontline teams. We have continued to invest in and expand our training and development opportunities to provide staff with the skills, technology and knowledge they need to meet the needs of patients and their families.

This, our third combined community and hospital service Quality Account, demonstrates some of the actions we have taken during 2013-2014, and highlights actions we will be taking over the forthcoming year to ensure our continued commitment to ensuring and continuing to monitor and improve quality of care and patient experience.

Our quality strategy and our Quality Account indicate our priorities for the coming year. These have been developed with patients, carers, staff, governors, commissioners and with key stakeholders including health scrutiny committees, local involvement networks (Healthwatch) and health care user group.

We believe and commit to Putting Patients First by making patient safety and experience our number one priority every day.

Contents:

PART 1: STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

Our quality pledge

In 2012, our Board and our staff pledged **patient safety and experience** as their **number one priority** supported by our corporate strategy. Our continued commitment to improving the quality of our care and service quality for our patients remains our number one priority. It is prevalent at every level of our organisation and is generating excellent performance results.

Our Board of Directors receive and discuss quality, performance and finance at every Board meeting. We use our **Patient Safety and Quality Standards** (PS & QS) Committee and our Audit Committee to assess and review our systems of internal control and to provide assurance in relation to patient safety, effectiveness of service, quality of patient experience and to ensure compliance with legal duties and requirements. The Patient Safety and Audit Committees are each chaired by non-executive directors with recent and relevant experience, these in turn report directly to the Board of Directors.

The Board of Directors seek assurance on the Trust's performance at all times and recognise that there is no better way to do this than by talking to patients and staff. During 2013-2014, members of the Board of Directors undertook reviews of services. These unannounced visits enable members of the Board to witness for themselves how well our staff manage the patient care and the environment/premises during the out-of-hours period. This approach of unannounced visits at varied times will continue during 2014-2015.

Moving forward the Trust will be rolling out Community service reviews following similar guidelines to the Acute service reviews.

Quality standards and goals

Values, standards and goals

The Trust greatly values the contributions made by all members of our organisation to ensure we can achieve the challenging standards and goals which we set ourselves in respect of delivering high quality patient care. The Trust also works closely with commissioners of the services we provide to set challenging quality targets. Achievement of these standards, goals and targets form part of the Trust's four strategic quality aims.

Listening to patients and meeting their needs

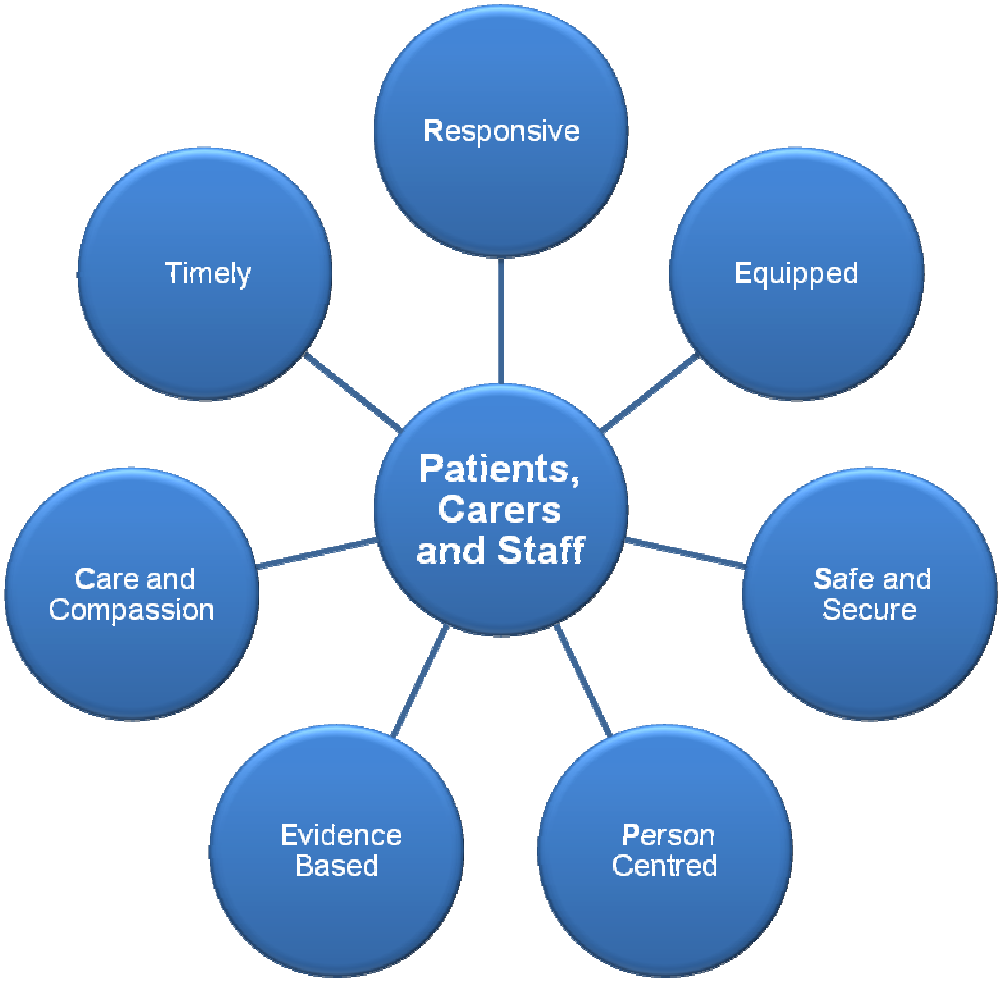
We recognise the importance of understanding patients' needs and reflecting these in our values and goals.

Our patients want and deserve excellent clinical care delivered with dignity, compassion, and professionalism and these remain our key quality goals.

Over the last year we have spoken with over 7,000 patients. We have spoken to them in their own homes, in community clinics and in our inpatient and outpatient hospital wards and departments. We always ask patients how we are doing and what we could do better.

We understand from patients that great healthcare is defined in the way that we treat patients, family members, carers and staff. As a result of this we continue to promote our RESPECT nursing and midwifery strategy which was developed by staff, patients, governors and stakeholders.

The strategy encompasses the fundamental elements of what we believe underpins great patient care. These are:



Achievements:

Unconditional CQC Registration

During 2013-2014 the Trust met all standards required for **successful and unconditional registration with the Care Quality Commission (CQC)** for services across all of our community and hospital services.

Awards:

Queen's Nurse Title honour for Dorothy Wood

Lead community respiratory nurse Dorothy Wood was awarded the title of Queen's Nurse by the Queen's Nursing Institute in April 2013

Head of pharmacy receives the title of honorary professor

Head of pharmacy and quality control laboratory services Philip Dean was awarded the title of Honorary Professor in the School of Medicine, Pharmacy and Health at the University of Durham in April 2013

Trust awarded bronze

The trust obtained the bronze award following the Investors in People assessment, which included a health and wellbeing assessment in May 2013

Gold award for healthy staff

The trust received the gold award in the North East Better Health at Work awards in March 2013

Trust short-listed for award in recognition in end of life care

The trust earned national recognition for a diary system it created which allows the families of patients on end of life care to leave feedback. The trust was nominated in the clinical leadership category of the Patient Safety Awards in April 2013 for the creation of the diary, known as the family's voice

Nurse and midwife of the year

Three members of our staff won this award:

- Geraldine Croft from the breast unit
- Midwife Michelle Crombie
- Midwife Karen Stevens

Team of the year

For the fourth year running the chemotherapy day unit at UHH won this award

Long term achievement award

Director of nursing Cath Siddle

Governance Ratings

All NHS Foundation Trusts are subject to assessment by Monitor against their compliance framework. During 2013-14 we continued to achieve high outcomes for our standards of clinical care; however the Clostridium difficile target remained a significant challenge and we did/did not achieve this. Section 3 describes actions we have taken to manage this.

Our positive patient safety culture, actions and behaviours have continued to deliver results by improving the safety and quality of care we deliver. Working in the spirit of shared learning, by communicating with our colleagues and stakeholders, the benefits of this work have been recognised nationally and internationally. Several of our clinicians and clinical teams have been featured in journals, conferences, or won prestigious awards over the last year.

Introduction to Parts 2 and 3 of our Quality Account

Part 2 of this Quality Account indicates it should be performance over the year and priorities for the future. Part 3 demonstrates and reviews additional performance over the past year. This Quality Account allows us to demonstrate our commitment to continuous, evidence-based quality improvement; to draw your attention to the standards achieved and the progress we have made; and to describe the approach we intend to continue improving. It enables you the opportunity to assess the quality of our performance across the healthcare services we offer.

The areas we have chosen as our quality improvement targets for 2013-2014 have once again been set following consultation with our Council of Governors, local health scrutiny committees, local involvement networks, healthcare user group, our commissioners and importantly, by talking to staff, patients and carers.

Progress described within this document is based on data and evidence collected locally and nationally, much of which is presented as part of our performance framework each month and in our public board meetings, in our Council of Governors meetings and to our commissioners.

To the best of my knowledge the information given in this document is accurate.

Alan Foster
pic

Alan Foster MBE

[Signature]

Chief Executive

PART 2: Priorities for improvement in our community and hospital services 2013-2014

2A Performance against quality improvement priorities for 2013-2014

Introducing our key priorities

In our 2012-2013 Quality Account, we identified a number of quality improvement priorities that patients, staff and stakeholders agreed we should focus on over the last year.

Priority 1, Patient safety: reduce deaths and prevent deterioration

Priority 2, Effectiveness of Care: clinical documentation and communication

Priority 3, Patient experience: care with compassion

Part 2A of the Quality Account provides an opportunity for the Trust to report on progress against quality priorities that were agreed with external stakeholders the previous year. We are very pleased to be able to report some significant achievements during the course of the year.

Our progress against the above and the action plans for each of them have been regularly monitored via key quality committees, the Board of Directors and the Council of Governors.

Progress is described in this section for each of the 2013-2014 priorities.

Stakeholder priorities 2013-2014

The quality indicators that our external stakeholders said they would like to be reported on in the 2013-2014 Quality Accounts were:

Patient Safety	Effectiveness of Care	Patient Experience
1. Dementia	1. Discharge Processes Information	1. End of Life Pathway & Family's Voice
2. Safeguarding Adults (Learning Disabilities)	2. Discharge Processes Medication	2. Is our care good? (Patient Experience Surveys)
3. Infection Control (C difficile)	3. Discharge Processes (Safe and Warm)	3. Friends and Family recommendation
	4. Nursing Dashboard	

The following pages details how the Trust has progressed against these indicators.

Priority 1 patient safety:

- **Improving care for people with dementia**

Rationale: *There are currently 14,000 people with a diagnosis of dementia across Co Durham & Darlington and Tees. NHS Hartlepool/Stockton on Tees has the highest projected increase of dementia across the North East by 2025. All stakeholders identified dementia as a key priority.*

Healthcare	Overview of how we said we would do it	Overview of how we said we would measure it	Overview of how we said we would report it	Completed and reported?
Hospital	• We will use the Stirling Environmental Tool to adapt and audit the impact on our hospital environment. • We will ensure that all patients over 65 receive an Abbreviated Mental Test (AMT) and are, where appropriate referred for further assessment.	• The Stirling Environmental audit assessment tool will be used to monitor the difference pre and post adaptation. • The percentage of patients who receive the AMT and, where appropriate, further assessment will be reported quarterly.	• Dementia Strategy Group quarterly • Integrated Professional Nursing and Midwifery Board (IPNMB) and PS & QS Quarterly	• Reported to the Dementia and Strategy Group ✓ • Reported to IPNMB and PS & QS quarterly ✓

Part of the transitional move from University Hospital of Hartlepool to University Hospital of North Tees has enabled the estates team within the Trust to use limited principles from the Stirling audit tool in the refurbishment of west wing new ward areas.

Post transitional move audit of the areas will be completed through Datix reporting specifically related to falls, and re-audit using Stirling. HIA falls is no longer in place all data aspects will go as before through the organisational falls group chaired by a General Manager.

The Trust Dementia Strategy Group now meets monthly and continues to enhance patient experience and develop pathways of care.

Priority 1 patient safety:

1. Improving care for people with dementia

All hospital patients will have a named advocate and an individualised plan of care.

Rationale: *In 2012 the Trust signed up to the Right Care: Creating dementia friendly hospital. Along with key stakeholders the Trust believes that patients with dementia receive the right treatment in the right place.*

Healthcare	Overview of how we said we would do it	Overview of how we said we would measure it	Overview of how we said we would report it	How did we do?
Community	• Patients with Dementia will be appropriately assessed and referred on to specialist services	• We will audit the number of patients over 75 admitted as an emergency that are reported as having a known diagnosis of dementia, or have been asked the (Prime Ministers) dementia case finding question. • A monthly audit of the percent of patients who are screened, assessed and referred for specialist review.	• To the IPNMB • To the Board of Directors.	• Reported to IPNMB and PS & QS quarterly ✓ • Reported at every Public Board of Directors meetings ✓

How – all patients aged 75 and above who fit the criteria for screening according to the CQUIN guidance will receive an AMT assessment and referred on accordingly if the score requires.

Measure – This will be measured through a daily three month period and monthly outside of this via UNIFY.

Report – to the Board of Directors, CCG, UNIFY, Trust Dementia Strategy Group.

In addition to this all patients who have a formal diagnosis of dementia and an identified carer will be asked if the carer would appreciate a carer's assessment personal to them.

The prevalence study identified a number of measures which area reported in the table below:

Dementia Screening - Monthly Data Collection – April 2013 – March 2014

	Question	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
a	Number of patients 75 and above admitted as emergency inpatients, reported as having been asked the dementia case finding question within 72 hours of admission to hospital or who have a clinical diagnosis of delirium on initial assessment or known diagnosis of dementia.	420	391	377	379	349	348	378	299	383
b	Number of patients aged 75 and above, admitted as emergency inpatients, minus exclusions.	420	391	377	407	349	406	427	326	396
c	% of all patients aged 75 and above admitted as emergency inpatients who are asked the dementia case finding question within 72 hours of admission or who have a clinical diagnosis of delirium on initial assessment or known diagnosis of dementia.	100%	100%	100%	93.10%	100%	85.70%	88.50%	91.70%	96.70%
d	Number of admissions of patients aged 75 and above admitted as emergency, inpatients who have scored positively on the case finding question or who have a clinical diagnosis of delirium reported as having had a dementia diagnostic assessment including investigations.	101	182	84	105	60	81	52	54	101
e	Number of patients aged 75 and above admitted as emergency inpatients who have scored positively on the case finding question or who have a clinical diagnosis of delirium.	101	182	85	105	60	81	52	54	102
f	% of all patients aged 75 and above admitted as emergency inpatients who have scored positively on the case finding question, or who have a clinical diagnosis of delirium and who do not fall into the exemption categories reported as having had a dementia diagnostic assessment including investigations.	100%	100%	98.80%	100%	100%	100%	100%	100%	99.00%
g	Number of all patients aged 75 and above admitted as an emergency inpatient who have had a diagnostic assessment (in whom the outcome is either positive or inconclusive) who are referred for further diagnostic advice/follow up.	17	20	47	30	35	23	34	15	56
h	Number of patients aged 75 and above who were admitted as an emergency inpatient who underwent a diagnostic assessment (in whom the outcome is either positive or inconclusive)	17	20	49	30	35	23	34	15	58
i	% of all patients aged 75 and above, admitted as an emergency inpatient who have had a diagnostic assessment (in whom the outcome is either positive or inconclusive) who are referred for further diagnostic advice/follow up.	100%	100%	95.90%	100%	100%	100%	100%	100%	96.60%

Priority 1 patient safety:

2. Safeguarding Adults with Learning Disabilities (LD)

All hospital patients will have a named advocate and an individualised plan of care.

Rationale: *The Winterbourne View Review* identified a number of actions that service commissioners and providers could undertake to prevent the terrible outcome suffered by people with LD at Winterbourne View.*

The Trust and Commissioners believe that people with LD should not be in hospital unless absolutely necessary. When it is necessary to admit patients with LD, they must have an individualised plan of care and a named advocate.

Molly to Update rationale: - Sent 29 Jan 2013

Healthcare	Overview of how we said we would do it	Overview of how we said we would measure it	Overview of how we said we would report it	How did we do?
Hospital	• All patients with LD will be referred on admission to the LD specialist nurse. • The LD Specialist nurse will act as the named advocate and will ensure that an individualised plan of care is in place and reasonable adjustments documented.	• Audits will be carried out and results reported	• Audit results and Action Plans to be reported to IPNMB quarterly.	• Audit plans and results presented to IPNMB quarterly ✓ • Learning Disabilities steering group ✓

Safeguarding

Adult Safeguarding

In 2013 Adult Safeguarding has continued to make positive strides towards its objectives. In April of this Year PREVENT was incorporated into the adult safeguarding portfolio. This move from emergency preparedness reflects the national shift reflecting a closer collaboration between the Department of Health and the Home Office. Our workforce is currently undertaking training to ensure that this important aspect of adult safeguarding has the awareness it merits. The Lee Rigby case in 2013 brought this issue of counter terrorism to closer our agenda.

The greatest inroad achieved is in the way that the Trust has developed its data base since April 2013. This records the adult safeguarding activity on a level not previously seen.

Safeguarding adults

North Tees and Hartlepool NHS Foundation Trust continues to work to enhance and develop standards for safeguarding adults across the hospitals and community. During 2013/2014 the trust saw a change in the post holder of specialist nurse learning disabilities, the outgoing post holder left a visible legacy which will be incorporated into the successful applicant who took up the post in January 2014.

Provision of specialist advice relating to implementation of The Mental Capacity Act (MCA), Deprivation of Liberty Safeguards and the Human Rights Act provides added assurance that the Trust remains compliant with legislation.

Training activity 2013/ 2014

Tees-wide multi agency training is undertaken at level one via a workbook which is distributed through induction and following completion is marked & discussed with the line manager before sign off. Compliance with level 1 training across the Trust is **XX**%.

Tees-wide multi agency level 2 training is no longer undertaken via a two-day course. We are currently developing a level 2 workbook and anticipate this being distributed by April 2014.

Trust Reporting

For each quarter we produce the following Safeguarding report:

North Tees and Hartlepool NHS
NHS Foundation Trust

Safeguarding Vulnerable Adults
Quarterly Activity Report

Molly Taylor (Specialist Nurse Safeguarding Vulnerable Adults)

Quarter 1 to 4 2013/2014
North Tees and Hartlepool NHS Foundation Trust
Safeguarding Vulnerable Adults Steering Group

The purpose of this report is to provide the North Tees and Hartlepool NHS Foundation Trust Safeguarding Vulnerable Adults Steering Group members an overview of quarterly safeguarding activity within the previous quarter, with the objective that information relevant to their areas of representation may be disseminated through respective clinical governance frameworks.

Additionally, the importance of two way communications are recognised as vital to achieve safeguarding adult activity as embedded within practice across adult health and social care. Therefore this report will subsequently highlight areas of good practice within and across services and areas requiring development and provide actions agreed from discussion within the group.

The data contained in the report breaks down the following key themes:

- Alerts raised by Local Authority
- Number of referals
- Alerts raised by age and gender
- Number of alerts raised by Trust role
- Number of alerts raised by location
- Number of alerts raised by theme
- Incidents raised by type of abuse, Trust role and outcome
- Number and type of incident by age (18-60)
- Number and type of incident by age (61-80)
- Number and type of incident by age (81+)

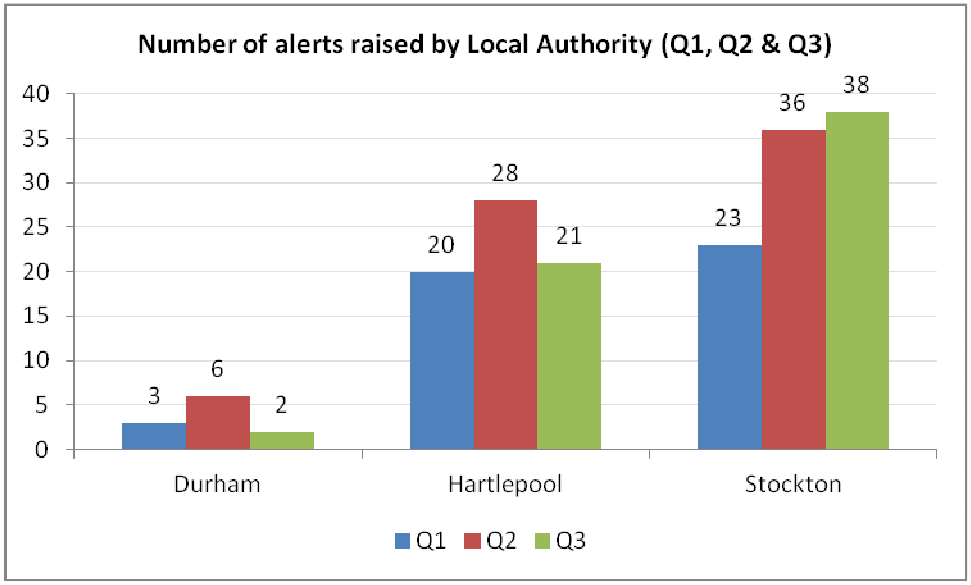
The report is presented internally and shared with our commissioners.

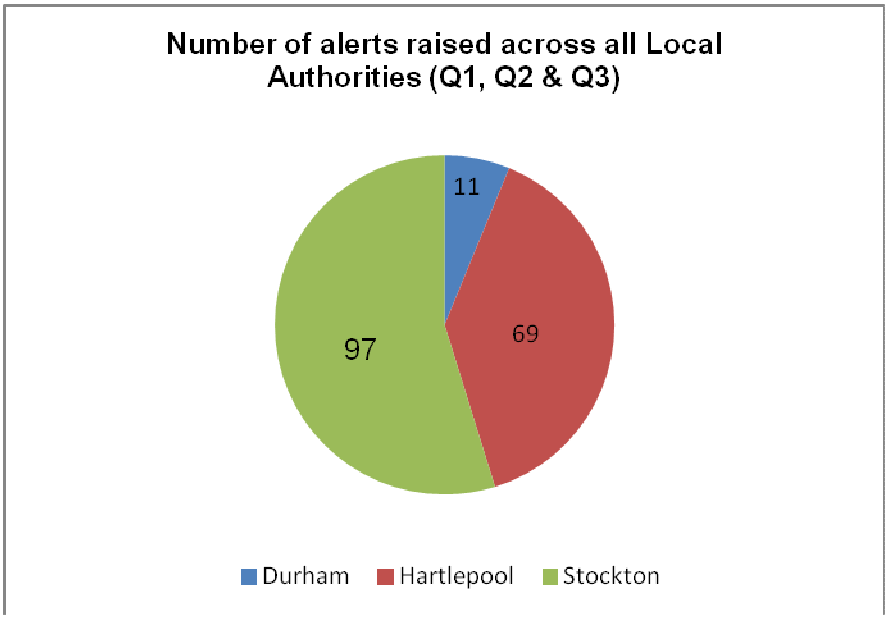
Please see the following for the data breakdown:

Location (Local Authority) – Data as of end of Quarter 3

Since April 2013 there have been **177** Adult Safeguarding incidents across the Local Authorities of Durham, Hartlepool and Stockton. Please see the following breakdown:

Local Authority	Q1	Q2	Q3
Durham	3	6	2
Hartlepool	20	28	21
Stockton	23	36	38





Trust Adult Safeguarding Governance Arrangements

The Director of Nursing and Patient Safety is the executive lead for safeguarding adults with the Deputy Director of Nursing has operational responsibility for safeguarding adults through the directorate leads.

Directorate management teams are responsible for practices within their own teams with individual clinicians are responsible for their own practice.

The Trust Adult Safeguarding Committee has been revised and includes representatives from key Trust clinical and non-clinical directorates and partners from Local Authority and Harbour who are experts in domestic abuse. The Trust Adult Safeguarding Committee reports to Patient Safety and Quality Standards Group (PS & QS).

Attendance and participation in adult safeguarding activity is positive and this prepares the Trust for the anticipated shift towards the Law Commission recommendation to bring Adult Safeguarding in line with Children's Safeguarding by making the Board function statutory. We await further confirmation of this development.

The Trust is represented at both Hartlepool and Stockton Local Authority Adult Safeguarding Boards and maintains strong links with Durham, the Trust is also represented at the Tees wide Adult safeguarding Board.

The Trust Strategy groups for adult safeguarding, learning disability and dementia all have reciprocal standard agenda items and membership. This supports sharing of information and lessons learnt so that they can be incorporated into relevant work streams relating to the most vulnerable groups.

Safeguarding Adult Achievements

The Trust has implementing a Single Point of Contact system (SPOC) and a reporting system for internal and external safeguarding alerts. Each alert is added to a central database and progress of the vulnerable adult can be tracked and managed towards an acceptable to outcome

Local authorities have agreed to inform the Trust of relevant alert strategy and review meeting to enable the Trust to participate, this change in system aims to provide a robust basis for developing reports on a regular basis to the Trust. The Adult Safeguarding Steering group now receives the report in respect of activity data each quarter.

The Trust is working with Local Authorities to understand trends in activity, referrals and complexity of cases across Hartlepool and Stockton.

Using Trust facilities to convene meetings supports widened participation from staff and in particular from medical colleagues.

Communication issues within discharge have been a focus of alerts across Hartlepool and Stockton.

Deprivation of Liberty Safeguard authorisations remain low but are in line with regional and national trends. The rationale for this is that staff appropriately using the least restrictive principle of The Mental Capacity Act.

The Trust has further developed its National reputation within adult safeguarding and hosted a national webinar for NHS England in late 2013. To date, the Trust has had no PREVENT referrals.

Looking ahead / key challenges

The key challenges for Adult Safeguarding in 2013 are;

- Reviewing and enhancing vulnerable patient's experience of safe discharge.
- Developing understanding of professional accountability within adult safeguarding.
- Improving links between practice and effective clinical supervision.
- Enhance the clinical documentation of Best Interest decisions by undertaking further audits using the recently Tees-wide adopted audit tool.
- Implement the principles of Deciding Right into practice.
- Significant progress is reported in terms of PREVENT. The Trust event held in August 2013 and to be repeated in February 2014 saw 88 Health workers accredited as trained to the national health wrap course standards. In January 2014 an event will see 30 plus staff trained as trainers. They will go onto deliver the health wrap course to their Directorates. A newly developed regional network for trainers is developed and our trainers will have access to this forum. We have strong links with this group.
- Improving Community pathways for people with learning disabilities in line with CQUIN requirements. 2014 will see the roll of Children pathways.
- Our Trust will take part in a national work stream which combines The Mental Capacity Act and young People with learning Disabilities.
- Our Trust anticipates that work undertaken with Public Health Commissioners and Harbour will lead to the pilot of working with an independent domestic violence worker within the Trust.

Children's safeguarding

The Trust has continued to deliver on all key performance indicators relating to children's safeguarding and has received **significant assurance** from external agencies including Audit North and multi agency OFSTED review in Hartlepool.

We have implemented a new in-house safeguarding children training programme which enables us to deliver targeted training to meet the needs of the organisation and maintain high levels of compliance with standards.

Our Trust has a seat all three Local Safeguarding Children's Boards (LSCB's) – Hartlepool, Stockton-on-Tees and County Durham and we continue to provide assurance through Section 11 that we are discharging our statutory responsibilities.

Section 11 of the Children's Act provides a statutory framework for arrangements to promote the welfare of children, the Trusts safeguarding for children operation group audits performance in relation to statutory guidance.

There are a number of examples of excellent development work being undertaken. One example is the development of an **adult risk behaviours assessment tool** which has been introduced in A&E/Urgent care. The purpose of this tool is to identify potential safeguarding concerns when an adult presents with a behaviour which may impact on their ability to parent (domestic abuse, substance misuse).

The Trust continues to ensure that safeguarding children and adults is a key priority and closely monitors standards.

Priority 1 patient safety:

3. Infection Control:

Rationale: *Key stakeholders asked us to continue to report on C diff in 2013-2014 as this remains high on the infection agenda. The Trust commissioners and clinicians also asked that we continue to report on E coli infections.*

Healthcare	Overview of how we said we would do it	Overview of how we said we would measure it	Overview of how we said we would report it	How did we do?
Hospital	• We will closely monitor testing regimes, antibiotic management and repeat cases and ensure we understand and manage the root cause wherever possible.	• We will monitor the number of hospital and community acquired cases • We will undertake a multi-disciplinary Root Cause Analysis (RCA) within 3 working days. • We will define avoidable and unavoidable for internal monitoring. • We will benchmark our progress against previous months and years. • We will benchmark our position against Trusts in the North East in relation to number of cases reported; number of samples sent for testing and age profile of patients.	• Public Board meetings • Council of Governor meetings (CoG) • Infection Control Committee (ICC) • Patient Safety and Quality Standards Committee (PS & QS) • To frontline staff through Chief Executive brief. • Nursing Dashboard • Clinical Quality Review Group (CQRG)	• Reported at every Public Board of Directors meetings ✓ • Reported at every Council of Governors meeting. ✓ • Discussed in detail at Audit Committee and Directorate meetings ✓ • Reported in detail to Monitor ✓ • Nursing and Midwifery Dashboard contains infection data ✓ • Unannounced Prevention Protection Control practices undertaken ✓ • **Did/Did not** achieve the 2013/14 C difficile target of **40** cases ✗✓

Clostridium difficile (C diff)

During 2013-2014 we did/did not achieve our clostridium difficile target achieving a ??% reduction on the previous year. We have continued to work hard to control and reduce opportunity for infections to spread when we treat people in our clinical premises or in their own homes. There is no one way in which clostridium difficile can be eliminated but a consistent approach across the important areas of cleanliness of the environment; appropriate antibiotic prescribing and strict hygiene at the point of care are vigorously pursued. We continue to invest in new equipment which is easier to clean and which is less likely to harbour infections, **use of technology** to improve our decontamination methods, review and improve our antibiotic stewardship and strive for high standards of hand hygiene.

An action plan was developed following an independent review in 2012 and this has continued to be reviewed and updated throughout 2013/14. It is presented regularly to the Infection Control Committee, Board of Directors, Council of Governors and our commissioners.

The comprehensive review of governance, performance and practices in relation to C difficile, first produced in January 2013 has been enhanced in 2013/14 and is utilised to update the Board of Directors on a quarterly basis.

How did we do?

In 2013-2014, we had a challenging C diff target set by our commissioners of no more than 40 cases, which we did/did not achieve. Over the last few months of the year we were able to bring our rate down however the larger numbers in the second quarter of the year resulted in our breaching the end of year target. The following table identifies the numbers of hospital acquired cases of C diff cases reported by the Trust against the target for that period. The table also identifies the number of community acquired cases of clostridium difficile reported by our laboratory.

Quarter	Q1	Q2	Q3	Q4
Target for hospital acquired cases	**10**	**10**	**10**	**10**
Number of hospital acquired cases	10	11	6	2*
Number of community acquired cases (acquired in people's own homes)	27	44	14	xx

***data currently up to 16 January 2013**

North East Trusts stool specimens examined and tested for C difficile.

		2012 - 2013				2013 - 2014			
		2012	2012	2012	2013	2013	2013	2013	2014
		Apr-Jun	Jul-Sept	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec	Jan-Mar
Trust 1	Total No. stool specimens examined	1,582	1,718	1,730	1,478	No data	No data		
	C difficile toxin tests	896	857	969	916	No data	No data		
	% of C.diff toxin tests V examined	56.64	49.88	56.01	61.97	- -	- -		
Trust 2	Total No. stool specimens examined	5,530	5,342	5,563	4,927	4,707	4,747		
	C difficile toxin tests	1,547	1,276	1,602	1,499	1,208	1,126		
	% of C.diff toxin tests V examined	27.97	23.89	28.80	30.42	25.66	23.72		
Trust 3	Total No. stool specimens examined	1,230	1,237	1,518	1,171	1,279	1,258		
	C difficile toxin tests	109	91	92	98	68	60		
	% of C.diff toxin tests V examined	8.86	7.36	6.06	8.36	5.32	4.77		
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	Total No. stool specimens examined	2,386	2,627	2,664	2,160	2,131	2,194	2,080	
	C difficile toxin tests	1,108	1,395	1,349	1,148	1,153	1,620	1,410	
	% of C.diff toxin tests V examined	46.44	53.10	50.64	53.14	54.10	73.84	67.79	
Trust 5	Total No. stool specimens examined	2,638	2,659	2,862	2,391	2,422	2,658		
	C difficile toxin tests	1,268	1,030	1,271	1,091	981	1,025		
	% of C.diff toxin tests V examined	48.07	38.74	44.41	45.62	40.50	38.56		
Trust 6	Total No. stool specimens examined	3,169	3,132	3,241	3,221	3,227	3,291		
	C difficile toxin tests	737	585	664	845	695	650		
	% of C.diff toxin tests V examined	23.26	18.68	20.49	26.33	21.53	19.75		
Trust 7	Total No. stool specimens examined	1,973	No data	No data	No data	No data	No data		
	C difficile toxin tests	255	No data	No data	No data	No data	No data		
	% of C.diff toxin tests V examined	12.92	- -	- -	- -	- -	- -		
Trust 8	Total No. stool specimens examined	4,224	3,792	4,472	4,086	4,190	4,180		
	C difficile toxin tests	1,498	1,210	1,526	1,372	1,450	1,361		
	% of C.diff toxin tests V examined	35.46	31.91	34.12	33.57	34.61	32.56		

6.2 (a)

The following table shows the number of C difficile cases that have been confirmed each month for each North East Trust.

	2013/14																
	Apr	May	Jun	Quarter	Jul	Aug	Sep	Quarter	Oct	Nov	Dec	Quarter	Jan	Feb	Mar	Quarter	Year
	Q1			Total	Q2			Total	Q3			Total	Q4			Total	Total
Trust 1	4	1	7	12	3	4	7	14	3	2	0	5					**31**
Trust 2	5	2	1	8	2	1	2	5	3	2	0	5					**18**
Trust 3	1	2	1	4	2	1	2	5	6	0	1	7					**16**
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	3	6	1	10	3	4	4	11	5	1	0	6	1*				**28**
Trust 5	2	2	1	5	4	1	3	8	4	3	0	7					**20**
Trust 6	3	10	3	16	4	2	8	14	3	4	10	17					**47**
Trust 7	1	1	1	3	1	0	1	2	3	3	1	7					**12**
Trust 8	9	9	3	21	3	14	7	24	7	10	1	18					**63**

***January data not fully validated**

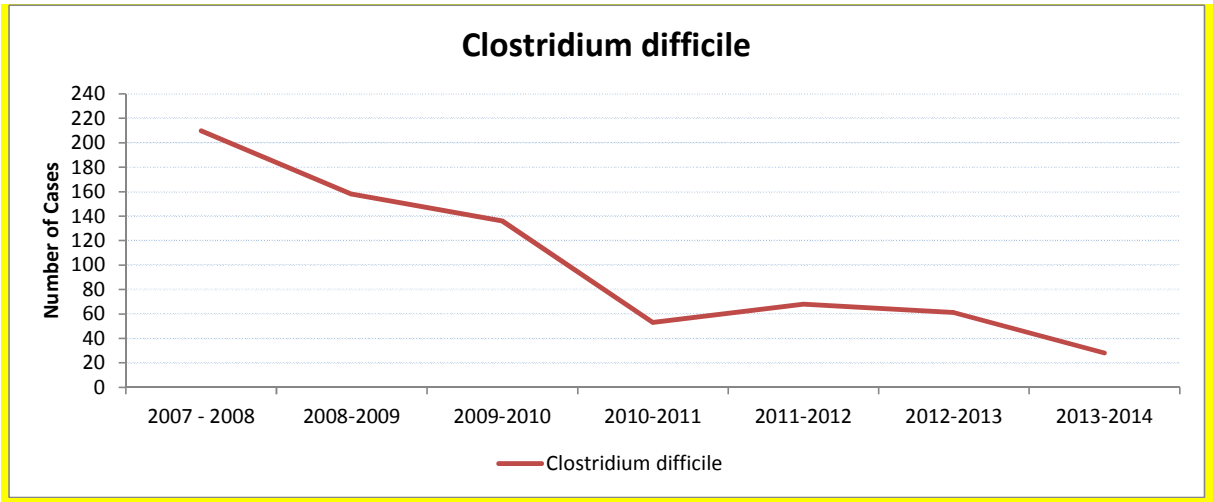
Against Monitors set maximum amount of C difficile cases

Trust	2013/2014 Total	Monitor Target	% towards Monitor target	
Trust 1	**31**	**36**	**86.11%**	**Approaching Trajectory**
Trust 2	**18**	**40**	**45.00%**	**Under Trajectory**
Trust 3	**16**	**17**	**94.12%**	**Approaching Trajectory**
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	**28**	**40**	**70.00%**	**Under Trajectory**
Trust 5	**20**	**37**	**54.05%**	**Under Trajectory**
Trust 6	**47**	**37**	**127.03%**	**Over Trajectory**
Trust 7	**12**	**8**	**150.00%**	**Over Trajectory**
Trust 8	**63**	**66**	**95.45%**	**Approaching Trajectory**

Monitor, our regulator and our commissioners has reviewed actions taken by the Trust and both are satisfied that the Trust has done and continues to do all that we can to reduce opportunity for patients to acquire C diff whilst in hospital. Monitor continues to review the position.

The trend in hospital acquired C diff over 7-years can be seen in the following table below:

Year	2007 - 2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014
Clostridium difficile	210	158	136	53	68	61	28*

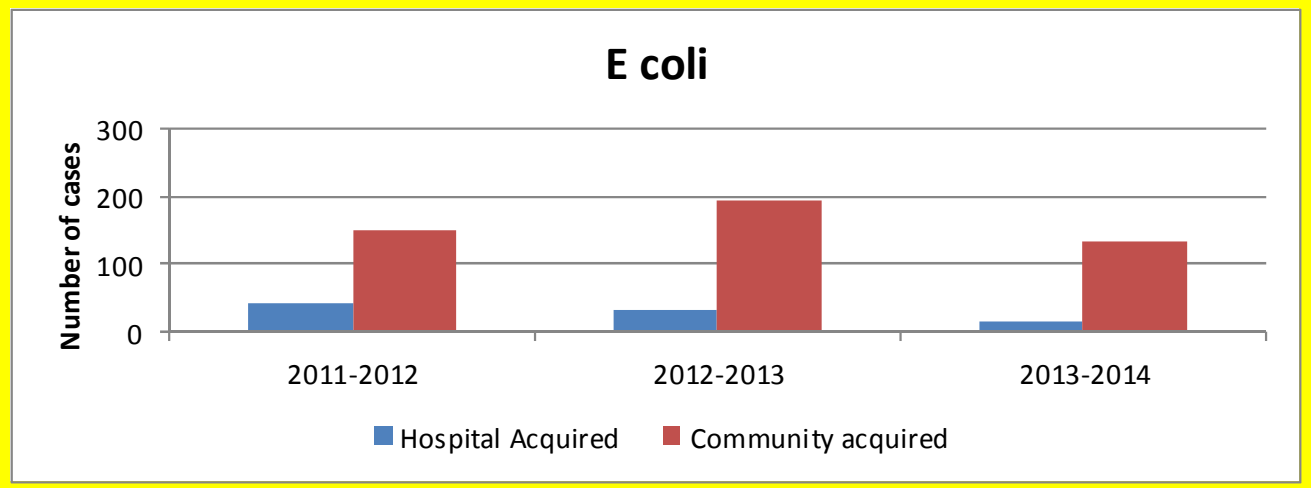


*data currently up to 15 January 2013

E coli

The numbers of E coli reported across community and hospital during the year follow. When compared against the previous year(s) it is clear that there needs to be a health care economy approach to reducing infection.

E coli	2011-2012	2012-2013	2013-2014
Hospital Acquired	41	31	16*
Community acquired	149	194	132*



*data currently up to 15 January 2013

Priority 2 effectiveness of care; clinical documentation and communication

Patients and stakeholders said that they would like us to listen to patients and to provide opportunities for concerns to be heard and acted on in a timely way.

B Carr -

In the past year there have been a number of high-profile reports that have drawn attention to examples of poor standards of healthcare. One such report is the Mid-Staffordshire Inquiry, outlining the poor provision in attending to patients' needs. A copy of the Francis report can be found on:

www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/en/@ps/documents/digitalasset/dh_113447.pdf

The most recent report which includes 290 recommendations can be found at:

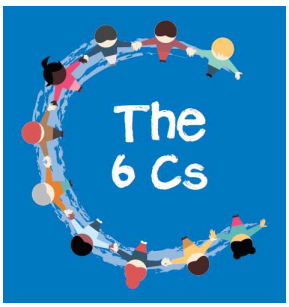
www.midstaffspublicinquiry.com/report

In order to challenge and prevent poor practice, North Tees and Hartlepool NHS Foundation Trust have implemented Intentional rounding.

Intentional rounding provides an opportunity for our nurses to pick up and address any issues or concerns our patients and visitors have in a timely way.

Through communicating with patients and relatives Intentional rounding should provide confidence and reassurance in a calm and orderly environment. This is in line with both our Trust RESPECT strategy and the national 6c's nursing and midwifery strategy.

The 6 c's - Our culture of compassionate Care – D blackwood sent 27 01 2014



The 6 c's are

- Care
- Compassion
- Competence
- Communication
- Courage and
- Commitment

Priority 2 - Effectiveness of Care

1. **Discharge processes – Information/Communication**

Rationale: *Although quality of discharge information has improved considerably over the years, this remains a priority with further improvements recommended by stakeholders.*

Healthcare	Overview of how we said we would do it	Overview of how we said we would measure it	Overview of how we said we would report it	How did we do?
Hospital & Community	• All patients discharged to a nursing or care home requiring district nurse review, will receive a written summary of care provided and of ongoing care required. A copy will be provided to the home or district nurse.	• Audit a number of patients discharged with a letter.	• To the IPNMB **BC to check with Nicola D'North**	• Reported to IPNMB ✓

A sub group of the discharge steering group have undertaken a review of the discharge summary to identify if the current form provides the right information and amount. Work is continuing to identify the appropriate means by which to alter the electronic discharge summary.

Priority 2 - Effectiveness of Care

2. Discharge processes – Medication

P.Dean to provide more detail

Rationale: *The latest national patient experience survey identified that the percentage of patients told about medication side-effects to watch out for at home had reduced by 5%.*

Healthcare	Overview of how we said we would do it	Overview of how we said we would measure it	Overview of how we said we would report it	How did we do?
Hospital & Community	• All patients will receive information about medication side-effects to watch out for at home.	• Via national and local patient surveys	• Local audit reports twice yearly to IPNMB and PS & QS • National audit report to PS & QS	• Reported to IPNMB and PS & QS ✓ • Reported to the Drug and Therapeutic committee ✓

Dispensed medication has patient information leaflets that inform of any possible side effects that the medication may cause. However, there may be a current gap still in this area for any patient who either cannot read the leaflet or those where leaflets do not come with the pre packed medication.

Further discussion and work will need to be undertaken with the Head of Pharmacy to ensure that this is rectified for all patients.

Priority 2 - Effectiveness of Care

3. Discharge and transfer processes – Safe and warm

B Carr to Check

Rationale: *Following receipt of a complaint in December 2012, the Trust has included Safe and Warm discharge and transfer as an additional measure for 2013-2014.*

Healthcare	Overview of how we said we would do it	Overview of how we said we would measure it	Overview of how we said we would report it	How did we do?
Hospital & Community	• We will deliver a 'Safe and Warm' campaign • We will review our protocols for transferring and discharging patients to ensure that blankets are always provided and are adequate to maintain warmth throughout the patient journey. • We will liaise with the ambulance services and staff to ensure patients are kept warm until they arrive at their destination.	• Referrals to the 'Stay Safe and Warm campaign scheme' will be monitored	• Annual report to IPNMB from Tees wide Vulnerable Adults Patient Experience Group	•

Priority 2 - Effectiveness of Care

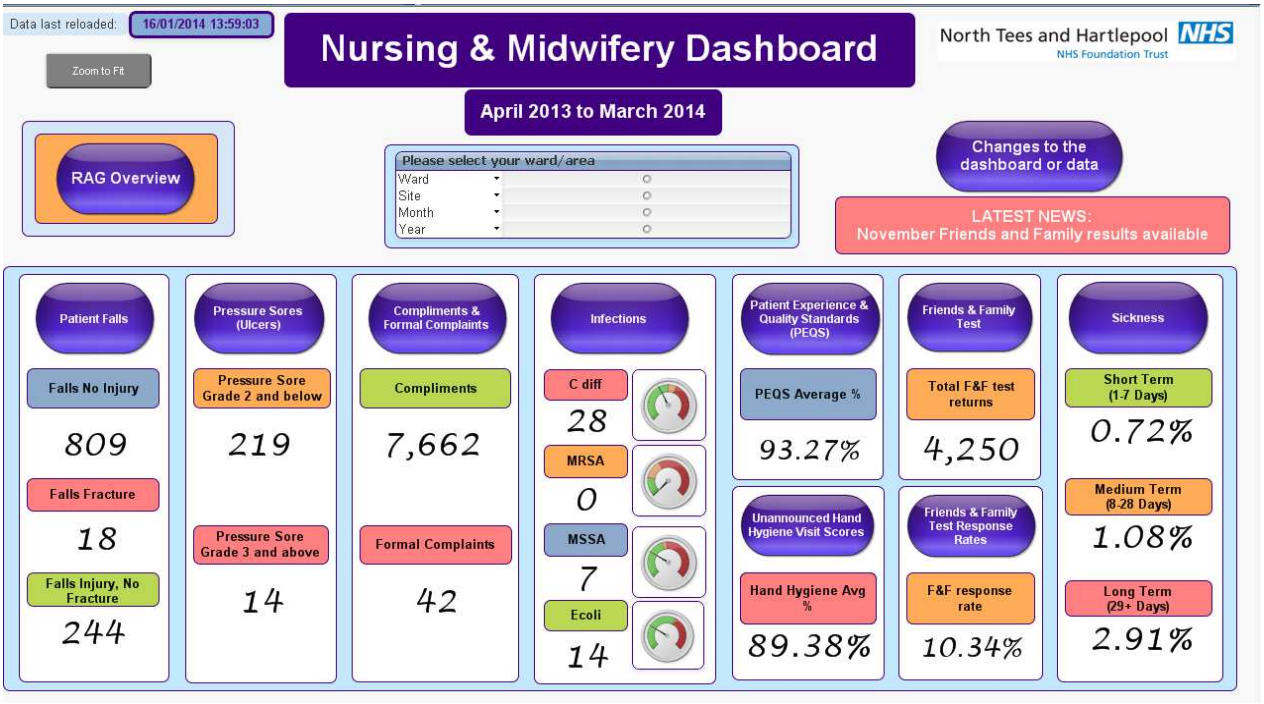
4. Nursing Dashboard

Rationale: *The nursing Dashboard will support close monitoring of nurse sensitive patient outcomes on a day-to-day basis. It will support sharing of best practice and speedy review of any potential areas of concern.*

Healthcare	Overview of how we said we would do it	Overview of how we said we would measure it	Overview of how we said we would report it	How did we do?
Hospital	• Training will be completed and each department will evidence that their results have been disseminated and acted upon. • Ward matrons will present their analysis on a public area of the ward for patients and staff to see. The results will be discussed and minuted.	• SCMs will monitor ward areas to ensure that data is up to date, accurate and displayed in a public area.	• Monthly dashboard analysis to the Director of Nursing • Quarterly to Senior Matron and General Manager meeting and IPNMB	• Dashboard analysis report presented to Director of Nursing on a monthly basis ✓ • Reported to IPNMB and SCM quarterly ✓

Nursing and Midwifery Dashboard

In 2013 the Trust rolled out a comprehensive Nursing and Midwifery Dashboard to all in-patient ward areas, this was also made available to all ward matrons, managers and Directors of the Trust.



***Data as of 16 January 2013**

The dashboard consists of the following indicators:

- Patient Falls
- Pressure Sores
- Compliments and Formal Complaints
- Infections
- Patient Experience and Quality Standards (PEQS)
- Friends and Family Test
- Unannounced Hand Hygiene
- Sickness rates

The purpose of the dashboard is for the Trust to have an overview of what is going on at ward level and to see if there are any issues/trends identified by having all the data located in one place.

The dashboard data is presented in numerous meetings highlighting any issues or wards that are outliers, thus ensuring that the Senior Clinical Matrons/Ward Matrons in charge of the wards can act upon the issues quickly, or at least provide a response to the Director of Nursing and Patient Safety as to why they are outliers.

The dashboard is printed of each month and displayed on each wards 'Productive Ward' boards for public display.

Also to note, In November 2013 the dashboard was audited by Audit North achieving Limited Assurance. The Trust will continue to work with Audit North to improve the Assurance level in the future**.**

Priority 3 - Patient Experience

1. **End of Life Pathway and Family's Voice**

Rationale: *The Trust has made excellent progress in rolling out use of the Family's Voice. Stakeholders and the Trust believe that this needs to remain a priority in 2013-2014 both in hospital and in the community.*

Healthcare	Overview of how we said we would do it	Overview of how we said we would measure it	Overview of how we said we would report it	How did we do?
Hospital	• We will continue to embed use of the Family's Voice in hospital and continue to roll its use out in the community.	• We will evaluate feedback in relation to pain, nausea, breathlessness restlessness, care for the patient and care for the family.	• Quarterly to IPNMB • Annually to PS & QS	• Reported to IPNMB and quarterly ✓ • Reported to PS & QS annually ✓

Spiritual and emotional care of patients at the end of their life

In November 2011, the National Institute of Health and Clinical Excellence (NICE) published guidance describing the importance of spiritual and religious support to patients approaching end of life. The guidance specifically referred to role of chaplains in end of life care. We were very pleased to read the guidance because it promotes the approach that our Trust has taken since July 2009 to meet the needs of patients and families when faced with the knowledge that end of life is near.

Actions taken by the Trust:

Since July 2009, this Trust has routinely referred patients on the end of life care pathway to the chaplaincy team. During 2013-2014, **713** patients were referred by our staff to this pioneering service provided by the Trust chaplains. They provide **spiritual, pastoral and emotional support** to patients, families and staff. Only **3** patients declined their support during the year. **153** patients welcomed and received **multiple visits**. This service offers added value to the quality of overall care provided to patients and their loved ones and has highlighted the importance of this aspect of support to the dying patient.

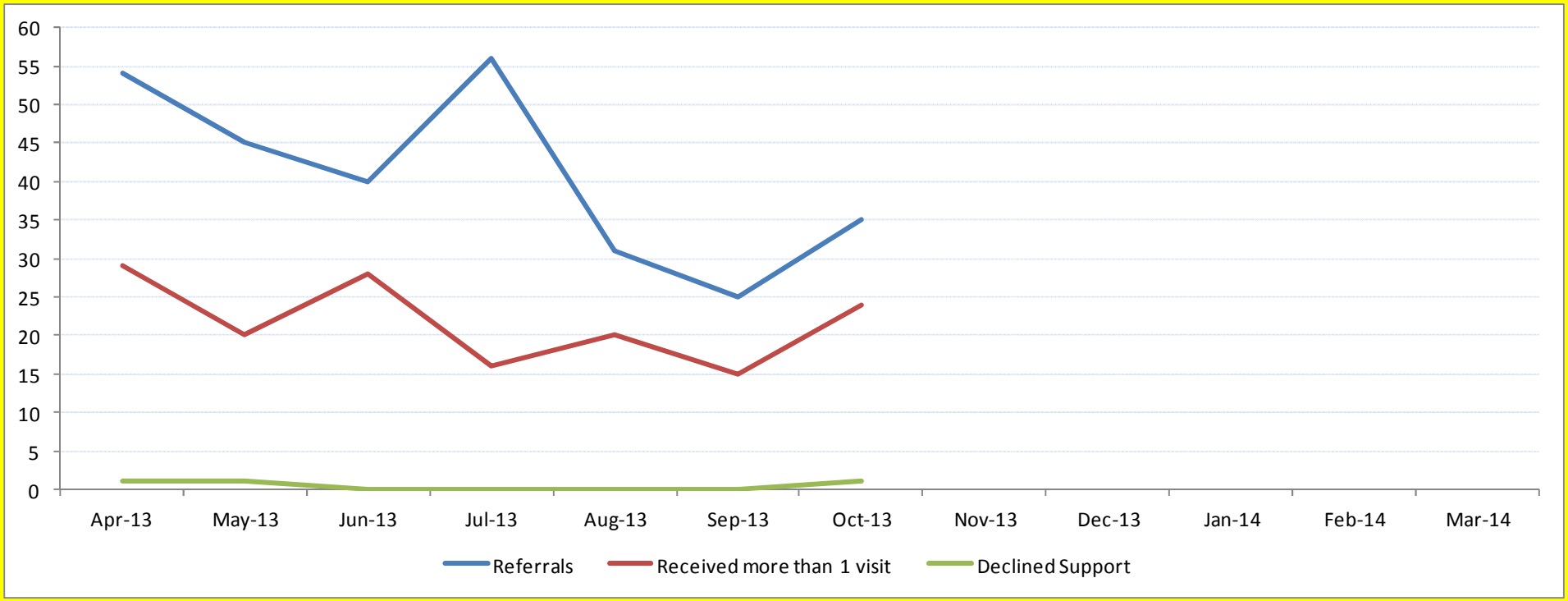
This innovative and groundbreaking approach has been recorded for national television and featured in publications.

This initiative has been so successful that in August 2012, the service was extended into the community. We received funding to run a pilot over 18 months to address the spiritual and pastoral needs of patients in the community. Initially, this was for patients on or near the end of life, but practice has indicated that the service needs to be offered to patients earlier in the palliative care stage, in order to build up a relationship with the patient and offer a meaningful service. Perhaps because of management restructuring in the community, referrals have been less frequent than in the acute trust, but they are now beginning to gather momentum.

When this service is allied to the use of the Family's Voice (carers diary), we believe that our philosophy of care results in a **better experience** for patients, relatives and carers as well as better job satisfaction for clinical staff and chaplains.

Please see the following chart and table below for additional detail:

Chaplain Referrals, Received more than 1 visit and Declined Support

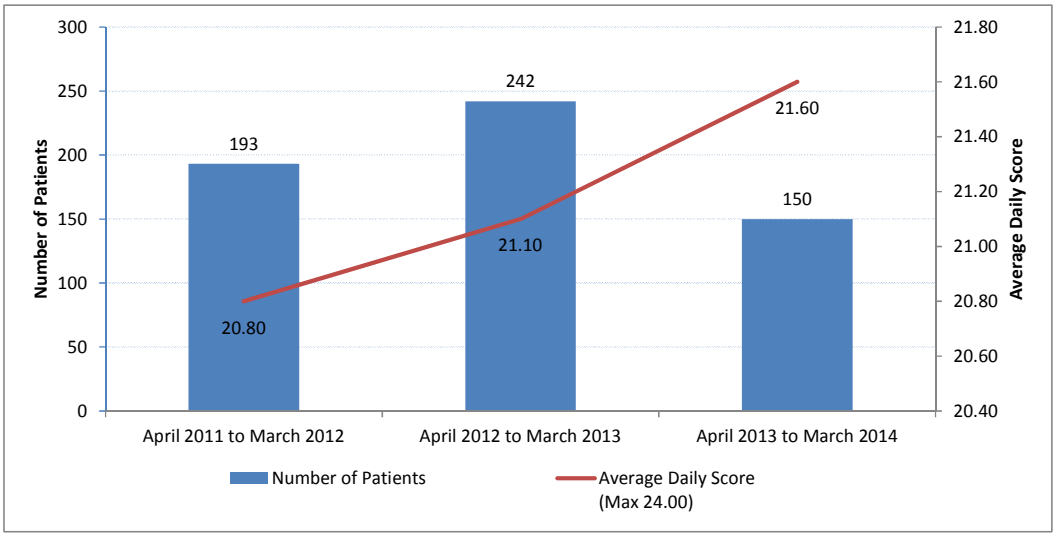


Insert Line Chart, to be updated with 2013-2014 data

	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Referrals	54	45	40	56	31	25	35					
Received more than 1 visit	29	20	28	16	20	15	25					
Declined Support	1	1	0	0	0	0	1					

The Family's Voice **(previously known as the carer's diary)**

At time of writing, 598 diaries have been given out. 146* have been given out between April 2013 – March 2014, an increase of xx diaries (xx.xx%) from the previous reporting year. These results have demonstrated that a **high standard of care continues** to be provided. The following table demonstrates the overall marks afforded to each ward/department across the Trust.



Reporting Period	Number of Patients	Average Daily Score (Max 24.00)
April 2011 to March 2012	193	20.80
April 2012 to March 2013	242	21.10
April 2013 to March 2014	146*	21.60

***data currently up to 16 January 2013**

Marks are awarded on a scale of 0 (poor) to 4 (excellent) for each of **6 key quality indicators**, these being; pain, nausea, breathlessness, restlessness, how the nurse is with the patient and how the nurse is with the family or carer. The maximum score that can be achieved is 24.

	Ward	Average score
1	28/29	23.27
2	Ward 24	23.00
3	Ward 40	23.00
4	Ward 11	22.89
5	ITU	22.83
6	Ward 42	22.30
7	Ward 26	22.25
8	EAU	22.09
9	Ward 41	22.00
10	Ward 7	21.75

	Ward	Average score
11	Ward 38	21.73
12	Ward 9	21.57
13	Ward 8	21.50
14	ACU	21.00
15	Ward 27	21.17
16	SSU	20.29
17	Ward 31	20.00
18	Ward 25	19.08
20	Ward 5	18.00
21	Ward 2	-

Understanding this data helps the Trust to understand how we are doing and to develop and target training in end of life care for wards where scores are lower. In 2013 we will, once again, send our trainers to work with and support staff in developing knowledge and skill to bring all scores up to match or exceed the best.

In November 2013 the Trust has started to introduce guidance on how to introduce the Family's Voice to patient's relatives and/or carers. This would hopefully increase the completion rate and uptake of the Family's Voice.

The guidance is as follows:

North Tees and Hartlepool NHS

Guidance for giving out the Family's Voice

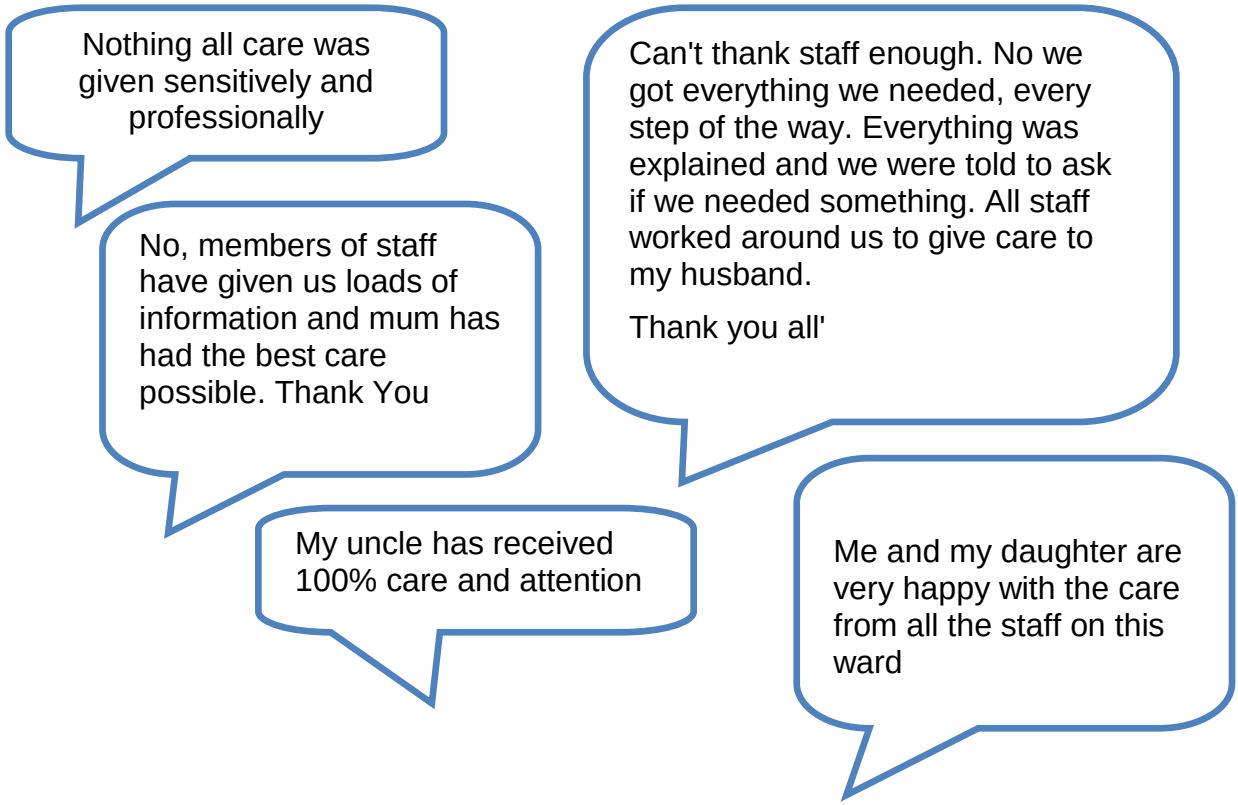
10 Steps to giving out the Family's Voice

We should offer the Family's Voice and Information Leaflet to all families and friends of dying patients, and offer the following guidance:

1. On all wards, the Family's Voice diary and Information Leaflet should be attached to the End of Life Care Pathway document or End of Life Care Plan document. It should be kept in a familiar place known to all relevant staff.
2. **The Family's Voice will only be offered** when the Consultant (in consultation with the clinical team) makes the decision that the patient is not for any further active intervention due to the futility of the patient's clinical condition, i.e. when it is believed the patient is dying.
3. **Assess the appropriateness of introducing the diary.** It may not be appropriate to offer the diary if the patient is dying imminently, or within the next hour or two, or if there is not enough time to explain the diary. There will always be a degree of distress when someone is dying, but if the family are distraught, it may not be appropriate to discuss using the diary with them.
4. Assuming it is appropriate, please offer the Family's Voice by identifying the main carer and/or the spokesperson for the family, and requesting to talk with them privately for a few minutes.
5. **Find a quiet place** and ask a broad question acknowledging the difficulty of the situation and ask whether they have any questions, worries or concerns about the patient's care. Address anything that is highlighted.
6. **Use the following passage as a guide for explanation:** "We want to give the best care possible for your relative or friend. You know the patient better than we do. We have developed a way we can work together and it is called the Family's Voice. We offer it to all families who are in the same situation as you. There are six questions about care that we ask you to answer once a day, or more if you wish. It will help us to work together to ensure that the patient is free of pain, feels calm, does not feel sick, and is breathing comfortably. We want to ensure we provide good, sensitive care to both you and the patient. We will check it on a daily basis when we are in the room. Have a look at the diary and the information sheet and use it if you wish."
7. **Fill in the patient's details:** either use a sticker or write their details on the inside page.
8. **Every time a nurse enters the room** of a dying patient please ask: "Are there any worries or concerns? Can I look in the diary? We want to address any difficulties immediately".
9. **After the patient has died,** even if the diary is empty, make sure of patient details and please send it to the Specialist Palliative Care Team at the University Hospital of North Tees.
10. The Senior Clinical Matron in collaboration with Ward Matrons and their staff are responsible for giving out the Family's Voice.

Between 01/3/2011 and 19/11/2013, 580 Family's Voice diaries were given out to relatives, of which 403 were used. This means there was a completion rate (whether partial or full) of 67%.

Comments from the diaries chosen at random:



Community Healthcare – evidence in practice

The roll out and use of The Family's Voice in the community commenced in November 2011. Following feedback from the community nursing teams they were re-designed to meet the needs of patients in the community. The Family's Voice has been produced and printed in a larger format making it easier for relatives and friends to complete.

The new documentation was launched in November 2012, and the intention is to raise the awareness of General Practitioners and their practice teams to the benefits of The Family's Voice. In addition commissioners have supported the appointment of a nurse none recurrently to take this work forward.

Quotes from the (community) Family's Voice

Priority 3 - Patient Experience

2. Is our care good

Rationale: *Trust and key stakeholders believe that it is important to ask this question through internal and external reviews.*

Healthcare	Overview of how we said we would do it	Overview of how we said we would measure it	Overview of how we said we would report it	How did we do?
Hospital	• We will ask the question to every patient interviewed in the Patient Experience and Quality Standards (PEQS) reviews. • We will ask the question in all Trust patient experience surveys. • We will monitor patient feedback from national surveys.	• We will analyse feedback from PEQS and patient experience/national surveys.	• Six monthly reports to IPNMB and to PS & QS.	• Reported to IPNMB and PS & QS ✓

Patient Experience Surveys – *Data as of end of November 2013

Below are a list of the surveys that the Trust carried out between April 2013 and March 2014. Number of patients surveyed against number available to survey.

Survey	Month Survey published	Number of Patients Surveyed		
National Cancer Patient Experience Survey 2012	August 2013	397/646 patients		
National Chemotherapy Patient Experience Survey 2013	Dec 2013	51/83 patients		
National Maternity Survey 2013	Dec 2013	105/294 patients		
National Inpatient Survey 2013	April 2014	850 patients (fieldwork still in progress)		
National Care of the Dying Survey 2013	Nov 2013	15/30 relatives		
Friends and Family Test – Inpatients, Accident and Emergency and Maternity (commenced Oct)	April – November 13	IP 3,139	A&E 1,154	MAT 296
	TOTAL	4,600 patients		
Specialist Cancer Survey	Jan 2014	119/202 patients		
Learning Disability Survey	Sept 13	18/64 patients		
Discharge Outreach Support Service Survey	Jan 14	47/169 patients *(still ongoing)*		
You're Welcome Project - Young People's Survey	Oct 13	66/120 patients		
Community Dental Health Survey	Sept 13	58/164 patients		
Oocyte Retrieval under Sedation – Patient Survey	Nov 13	33/74 patients		
Assisted Reproduction Unit – Client Survey (up to June 13)	Expected Dec 13	47 patients		
Local Food and Cleanliness Survey	Jan – Sept 13	226/263 patients		
Medical Rehabilitation Day Unit Patient / Carer Survey 2013	May 2013	87 patients/Carers		
Acute Oncology Survey (commenced Nov 13)	April 2014	9/17 *(still ongoing)*		
Sexual Dysfunction and incontinence survey in colorectal cancer patients – patient survey	Nov 13	34/71 patients		
Local Outpatient Survey 2013	May 13	185/345 patients		
NESHA Patient Experience Survey 2012/13	Sept 12 - August 13	385 patients		
MRSA Surveys	April 13	20 patients		

(community/inpatient/maternity)		

Priority 3 - Patient Experience

3. *Friends and Family recommendation*

Rationale: *The Department of Health require Trusts to ask the Friends and Family recommendation questions from April 2013. Stakeholders agree that this should be implemented and reported in the 2013-2014 Quality Account.*

Healthcare	Overview of how we said we would do it	Overview of how we said we would measure it	Overview of how we said we would report it	How did we do?
Hospital	• We will incorporate the Friends and Family test wording into PEQS and patient surveys. • We will ask patients to complete a questionnaire on discharge from hospital.	• We will analyse feedback from PEQS and patient surveys and discharge questionnaires.	• Quarterly to IPNMB and to PS & QS.	• Reported to IPNMB and PS & QS quarterly 

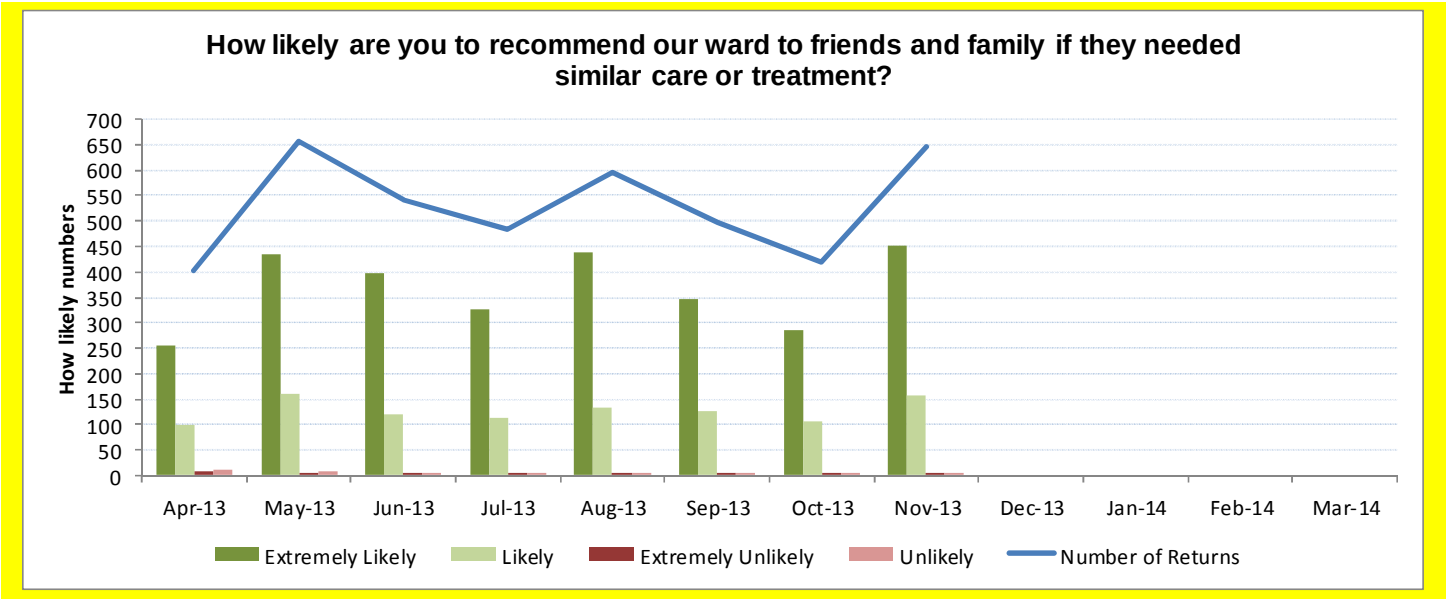
The Test was first announced by the Prime Minister in January 2012 and means that patients will now have a real voice in deciding whether their care is good enough or not – and hospitals will be able to take swift action to make any necessary improvements.

The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. It is initially for providers of NHS funded acute services for inpatients (including independent sector organisations that provide acute NHS services) and patients discharged from A&E (type 1 & 2) from April 2013.

The Friends and family data can be found at: http://www.england.nhs.uk/statistics/statistical-work-areas/friends-and-family-test/friends-and-family-test-data/

North Tees and Hartlepool NHS Foundation Trust - Returns for April 2013 to March 2014

		How likely are you to recommend our ward to friends and family if they needed similar care or treatment?							
Month of Return	Number of Returns	Extremely Likely	% of returns	Likely	% of returns	Extremely Unlikely	% of returns	Unlikely	% of returns
Apr-13	404	256	63.37%	101	25.00%	9	2.23%	12	2.97%
May-13	655	434	66.26%	160	24.43%	4	0.61%	7	1.07%
Jun-13	542	397	73.25%	121	22.32%	4	0.74%	6	1.11%
Jul-13	485	325	67.01%	114	23.51%	4	0.82%	2	0.41%
Aug-13	596	438	73.49%	134	22.48%	2	0.34%	2	0.34%
Sep-13	497	346	69.62%	127	25.55%	1	0.20%	1	0.20%
Oct-13	419	285	68.02%	107	25.54%	2	0.48%	3	0.72%
Nov-13	646	452	69.97%	157	24.30%	6	0.93%	4	0.62%
Dec-13									
Jan-14									
Feb-14									
Mar-14									
Total	4,244	2,933	69.11%	1,021	24.06%	32	0.75%	37	0.87%



***Includes November F&F data**

Friends and Famliy Test - Comments:

It was important for the Trust to monitor the type and number of comments made on the Friends and Family Test returns.

To date the Trust has had **4,244** Friends and Family returned questionaires of which there have been **4,140** positive comments and **311** negative comments made (It is possible to have more than one comment on a returned questionnaire).

The Trust is pleased to show that by far the most common **positive** comment is in regards to our staff followed by the service that we provide. To date from the **4,140** positive comments ,**2,573 (62.15%)** were made in regards to staff and **620 (14.98%)** in regards to our service.

The Trust is pleased to show that from the **4,244** returns there were only **311 (7.33%)** were **negative**. The category with the highest negative comments is our communication to patients with **102 (32.80%)** of the **311** negative comments.

The Trust monitors the 'negative comments' on a weekly basis to ensure that any issues or concerns can be acted upon to ensure similar negative comments are not received in the future or to provide an explanation where necessary.

Please see the following tables for the detailed breakdown on the positive and negative comments.

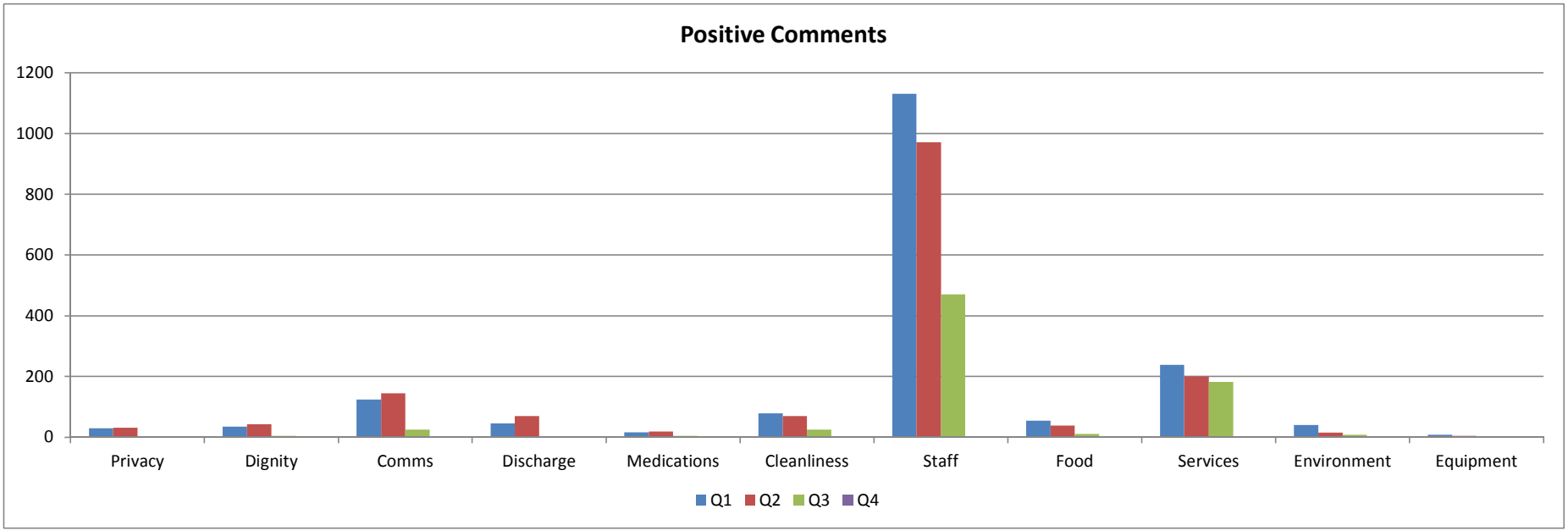
Friends and Famliy Test - Positive Comments:

Positive Monthly returns

	Positive Comments										
Month of Return	**Privacy**	**Dignity**	**Communications**	**Discharge**	**Medications**	**Cleanliness**	**Staff**	**Food**	**Services**	**Environment**	**Equipment**
Apr-13	4	6	12	0	4	18	336	12	0	0	0
May-13	16	18	60	28	10	27	419	24	128	34	2
Jun-13	10	11	52	18	2	34	376	19	110	6	6
Jul-13	15	18	49	30	11	27	301	21	66	4	1
Aug-13	8	21	56	31	4	25	374	10	99	5	3
Sep-13	8	4	40	8	4	17	296	8	35	6	0
Oct-13	0	3	13	0	2	13	269	6	95	3	0
Nov-13	1	2	12	0	3	12	202	5	87	5	0
Dec-13											
Jan-14											
Feb-14											
Mar-14											
Total	**62**	**83**	**294**	**115**	**40**	**173**	**2,573**	**105**	**620**	**63**	**12**
Grand Total	**4,140**										

Positive Quarterly returns

Quarter	Privacy	Dignity	Communications	Discharge	Medications	Cleanliness	Staff	Food	Services	Environment	Equipment
Q1	30	35	124	46	16	79	1131	55	238	40	8
Q2	31	43	145	69	19	69	971	39	200	15	4
Q3	1	5	25	0	5	25	471	11	182	8	0
Q4	0	0	0	0	0	0	0	0	0	0	0



***Includes November F&F data**

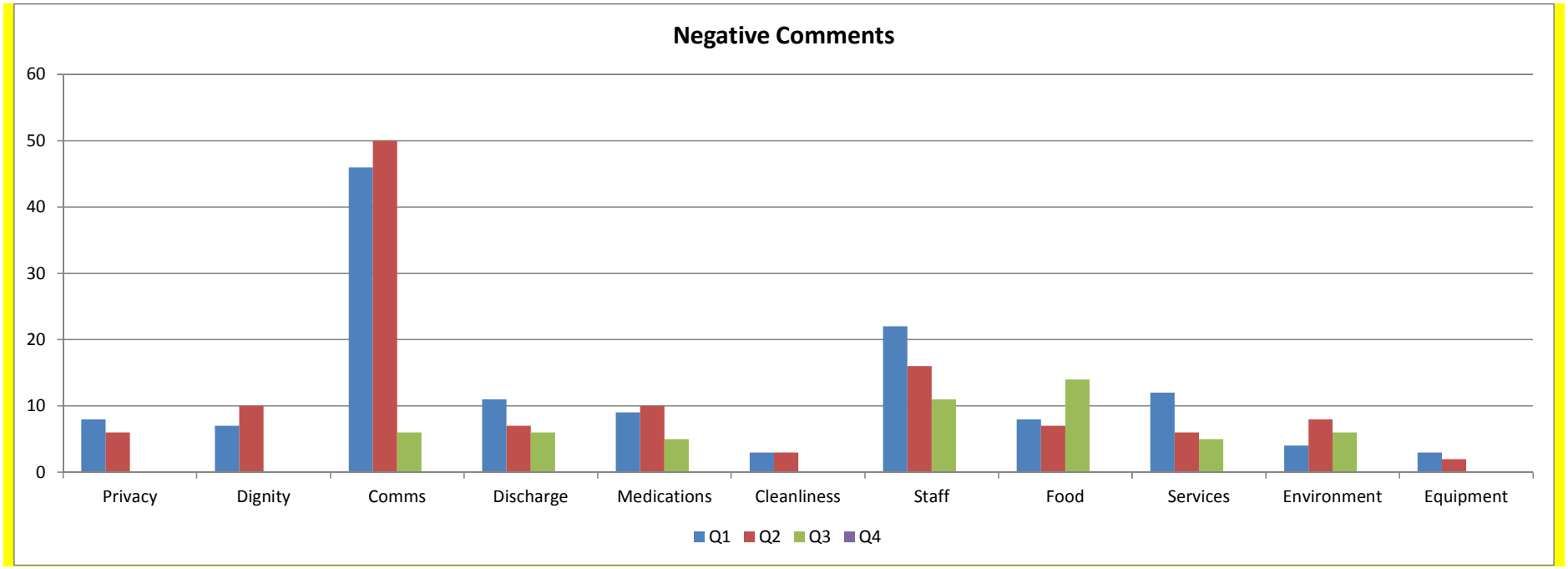
Friends and Famliy Test - Negative Comments:

Negative Monthly returns

	Negative Comments										
Month of Return	**Privacy**	**Dignity**	**Communications**	**Discharge**	**Medications**	**Cleanliness**	**Staff**	**Food**	**Services**	**Environment**	**Equipment**
Apr-13	1	2	4	4	3	0	12	2	0	0	0
May-13	5	3	25	6	5	1	6	4	7	3	3
Jun-13	2	2	17	1	1	2	4	2	5	1	0
Jul-13	5	9	23	5	4	2	9	2	4	3	0
Aug-13	0	0	21	1	1	0	3	3	1	4	2
Sep-13	1	1	6	1	5	1	4	2	1	1	0
Oct-13	0	0	1	2	3	0	6	7	0	4	0
Nov-13	0	0	5	4	2	0	5	7	5	2	0
Dec-13											
Jan-14											
Feb-14											
Mar-14											
Total	**14**	**17**	**102**	**24**	**24**	**6**	**49**	**29**	**23**	**18**	**5**
Grand Total	**311**										

Negative Quarterly returns

Quarter	Privacy	Dignity	Communications	Discharge	Medications	Cleanliness	Staff	Food	Services	Environment	Equipment
Q1	8	7	46	11	9	3	22	8	12	4	3
Q2	6	10	50	7	10	3	16	7	6	8	2
Q3	0	0	6	6	5	0	11	14	5	6	0
Q4	0	0	0	0	0	0	0	0	0	0	0



*Includes November F&F data

North Tees and Hartlepool NHS Foundation Friends and Family word bubble

The word bubble is displayed on each ward with the positive and negative comments made for that specific ward, this enable the public to see what is being said about those wards.

The Trust also produces a Trust version incorporating the negative and positive comments, please see the following word bubble for the Trust during April 2013 to March 2014.

Word bubble requires updating for 2013-2014

Friends and Family – Maternity Services

PART 2B: Quality improvement priorities for 2014-15

Introduction to 2014-2015 Priorities

Key priorities for improvement for 2014-2015 have been agreed through consultation with patients, staff, governors, local involvement networks, commissioners, health scrutiny committees and other key stakeholders. We started the consultation period at the end of August 2013 which allowed us to consult widely and provide stakeholders with a significant opportunity to consider and suggest the priorities that they would like to see us address.

Feedback and third party declarations have been invited from formal stakeholders. Full details of stakeholder feedback can be found in Section 3B. Our governors have also been actively involved in assisting us in setting our priorities.

The trust continues to develop quality improvement capacity and capability to deliver our priorities as demonstrated throughout this Quality Account.

We would like to thank all of those involved in setting priorities for 2014-15 which are linked to patient safety, effectiveness of care and patient experience. We all agree that our priorities for improvement should continue to reflect three key principles, namely:

Stakeholder priorities for 2014-2015

The quality indicators that our external stakeholders said they would like to see included in next year's Quality Accounts were:

Patient Safety	Effectiveness of Care	Patient Experience
1. Dementia	1. Discharge Processes Information	1. End of Life Pathway & Family's Voice
2. Safeguarding Adults (Learning Disabilities)	2. Discharge Processes Medication	2. Is our care good? (Patient Experience Surveys)
3. Infection Control (C difficile)	3. Discharge Processes (Safe and Warm)	3. Friends and Family recommendation
	4. Nursing Dashboard	

Rationale for the selection of priorities for 2014-2015

The Trust recommended to the stakeholders that a continuity of priorities would be beneficial in reporting, this proposal was welcomed by all stakeholders.

Therefore the same priorities that are included in the 2013-2014 Quality Accounts will be in the 2014-2015 Accounts.

Part 2C: Statements of Assurance from the Board

Review of Services – Pam Gretton – Sent 23 Jan 2014

During 2012-2013 North Tees and Hartlepool NHS Foundation Trust provided and/or subcontracted 64 NHS services. The majority of our services were provided on a direct basis, with a small number under sub-contracting or joint arrangements with others.

We have reviewed all of the data available to us on the quality of care in all of these NHS services. The income generated by the NHS services reviewed in 2012-2013 represents 100% of the total income generated from the provision of NHS services by the Trust for 2012-2013.

Transformation – Katie Dixon/Peter Tindal

The data reviewed aims to cover the three dimensions of quality; patient safety, clinical effectiveness and patient experience. In a number of areas there has been no benchmark data available. Where benchmark data has been available, it has been included.

Participation in clinical audits

All NHS Trusts are audited on the standards of care that they deliver and our Trust participates in all mandatory national audits and national confidential enquiries.

The Healthcare Quality Improvement Partnership (HQIP) provides a comprehensive list of national audits which collected audit data during 2013-2014 and this can be found on the following link:

http://www.hqip.org.uk/assets/National-Team-Uploads/Quality-Accounts/Quality-Accounts-Resource-2010-15-updated-20.12.2013.xls

During 2013-2014, 37 national clinical audits and 5 national confidential enquiries covered the NHS services that we provide. During that period we participated in all 37 national clinical audits and all 5 national confidential enquiries of the national clinical audits and national confidential enquiries which we were eligible to participate in.

This represents 100% of all mandatory national clinical audits and 100% of all mandatory national confidential enquiries. We did not participate in all non-mandatory audits as we have a small audit team.

The national clinical audits and national confidential enquiries that we were eligible to participate in during 2013-2014 are listed below. This list also identifies those national clinical audits and national confidential enquiries that the Trust participated in during this period.

The national clinical audits and national confidential enquires that the Trust participated in, and for which data collection was completed during 2013-2014, are listed 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.

6.2 (a)

Audit title	Participation M = Mandatory N = Non-Mandatory	% cases submitted
Adult community acquired pneumonia (British Thoracic Society)	Yes (N)	100%
Adult critical care (Case Mix Programme – ICNARC CMP)	Yes (N)	Data collection ongoing
National Emergency Laparotomy Audit (NELA) (Royal College of Anaesthetists)	Yes (M)	Data collection ongoing
Emergency use of oxygen (British Thoracic Society)	Yes (N)	100%
National Joint Registry (NJR)	Yes (M)	Data collection ongoing
National Audit of Seizure Management in Hospitals (2nd round)	Yes (N)	100%
Paracetamol Overdose (College of Emergency Medicine)	Yes (N)	Data collection ongoing
Severe Sepsis and Septic Shock (College of Emergency Medicine)	Yes (N)	Data collection ongoing
Moderate or Severe Asthma in Children (College of Emergency Medicine)	Yes (N)	Data collection ongoing
Severe trauma (TARN) (Trauma Audit & Research Network)	Yes (N)	Data collection ongoing
National Comparative Audit of Blood Transfusion programme: i. Use of Anti-D ii. Patient information and consent	 Yes (N) Yes (N)	 100% Data collection ongoing
Bowel cancer (NBOCAP)	Yes (M)	100%
Lung cancer (NLCA)	Yes (M)	100%
Oesophago-gastric cancer (NAOGC)	Yes (M)	100%
Care of the Dying in Hospital (NCDAH)	Yes (N)	100%
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes (M)	Data collection ongoing
Heart failure (HF)	Yes (M)	Data collection ongoing
National Cardiac Arrest Audit (NCAA)	Yes (N)	Data collection ongoing
Paediatric Bronchiectasis (British Thoracic Society)	Yes (N)	Data collection ongoing

Pilot COPD Audit (Royal College of Physicians/BTS)	Yes (M)	100%
National Diabetes Inpatient Audit (NADIA): i. Hospital-wide clinical audit ii. Survey of current inpatients iii. Pregnancy in Diabetes audit	 Yes (M) Yes (M) Yes (M)	 100% 100% 100%
Diabetes (Paediatric) (NPDA)	Yes (M)	Data collection ongoing
UK Inflammatory bowel disease: i. Audit of adult patients ii. Audit of paediatric patients	 Yes (M) Yes (M)	 100% 100%
Hip fracture database (NHFD)	Yes (M)	Data collection ongoing
Sentinel Stroke National Audit Programme (SSNAP)	Yes (M)	Data collection ongoing
Elective surgery (National PROMs Programme): i. Hip replacement ii. Knee replacement iii. Varicose Vein surgery iv. Groin Hernia surgery	 Yes (N) Yes (N) Yes (N) Yes (N)	Based on return rate of the pre-operative questionnaire: i. 96% ii. 94% iii. 93% iv. 61%
Child Health (CHR-UK)	Yes (M)	100%
Epilepsy 12 audit (Childhood Epilepsy)	Yes (M)	Data collection ongoing
Maternal infant and perinatal (MBRRACE-UK)	Yes (M)	100%
Neonatal intensive and special care (NNAP)	Yes (M)	100%
Paediatric asthma (British Thoracic Society)	Yes (N)	Data collection ongoing
Paediatric intensive care (PICANet)	Yes (M)	100%
Rheumatoid and early inflammatory arthritis (British Society for Rheumatology)	Yes (M)	Data collection ongoing
National Confidential Enquiry into Patient Outcome and Death (NCEPOD): i. Alcohol Related Liver Disease Study ii. Subarachnoid Haemorrhage Study iii. Tracheostomy Study iv. Lower Limb Amputation Study v. Gastrointestinal Haemorrhage Study	 Yes (M) Yes (M) Yes (M) Yes (M) Yes (M)	 100% 100% 100% 100% Data collection ongoing

Confidential Maternal and Child Health Enquiries (CMACE) (Update Pending) Elaine Gouk – Sent 23 Jan 2014

The Trust provides information to these national enquiries for all maternal, perinatal (the period shortly before and after birth) and child deaths through the Regional Maternity Survey Office (RMSO) and the North East Public Health Observatory (NEPHO). Participation in this audit provides useful benchmarking data across the North East

MBRRACE-UK has been appointed by the Healthcare Quality Improvement Partnership (HQIP) to continue the national programme of work investigating maternal deaths, stillbirths and infant deaths, including the Confidential Enquiry into Maternal Deaths. The aims of MBRRACE-UK are to provide robust information to support the delivery of safe, equitable, high quality, patient-centered maternal, newborn and infant health services. Nationally there are future plans to include a new programme of audit for maternal deaths, late fetal losses, still births and infant deaths, the Trust intends to participate.

The maternity, neonatal and paediatric teams will continue to provide information relating to all child deaths from birth to 18 years of age to the RMSO office and the Child Death Overview Panels that review all child deaths on behalf of the Local Safeguarding Children's Boards. This allows for a multidisciplinary review of data and analysis for any trends and shared learning relating to these deaths.

The Trust also provides details to the North East Public Health Observatory (NEPHO) to help collate data including diagnosis and incidences of congenital abnormalities; management and outcome data from multiple pregnancies; and diabetes in pregnancy. This data is analysed regionally and included in national analysis.

Terry – Sent 23 Jan 2014

The Trust participated in all five national confidential enquiries (100%) that it was eligible to participate in, namely:

National Confidential Enquiries (NCEPOD)
NCEPOD Cardiac Arrest Procedures (Time to Intervene?)
NCEPOD Bariatric Surgery Study (Too Lean a Service?)
NCEPOD Alcohol Related Liver Disease Study (data collection ongoing)
NCEPOD Subarachnoid Haemorrhage Study (data collection ongoing)
NCEPOD Tracheostomy Care Study (study just commenced)

Commendations on our participation and performance

In the latest National Cancer Patient Experience Survey (received 2012), the Trust was rated in the top 20% nationally for over 60% of all responses, with the Trust achieving the highest responses in the country for two questions:

- Patients being told to bring a friend when they were first told they had cancer
- Providing GPs with enough information about diagnosis and treatment.

The Trust was invited to present its work on (NICE50 guideline; reducing deterioration) at the **national NICE conference** in 2012.

National Clinical Audits

The reports of 9 national clinical audits were reviewed by the Trust in 2013-2014 resulting in the following actions to improve the quality of healthcare provided:

Audit title	Actions taken
National Stroke Organisational Audit	Results confirmed that Trust performance remained in the top quartile nationally. This service has also been reconciled onto one hospital site, which allows daily consultant led ward rounds. Direct paramedic admissions have also begun which reduce delays for patient requiring thrombolysis.
CEM Feverish Children Audit	Audit results highlighted a lack of written advice on discharge. An information leaflet is now available to address this.
CEM Renal Colic Audit	Recording of initial pain score had improved to 82% (compared to 51% in the previous audit). Improvement was required for re-evaluation of pain and the need to undertake an ultrasound scan to exclude abdominal aortic aneurysm (AAA) in patients over 60 years of age. It was also noted that blood results in A&E were not being filed on the ICE system. Actions currently in progress.
CEM Fractured Neck of Femur Audit	It was noted that, in contrast to the above audit, documentation of pain score was poor: 36%, compared to the national median of 72%. A local audit of pain management in the elderly was then undertaken in order to look at this in more detail and results of this audit showed a much improved figure of 96%
National Inpatient Survey 2012	Local actions include increased pain assessments on wards to ensure adequate pain control is in place, additional support for patients who require assistance with eating and reminders to staff to ensure relevant patient information leaflets are given out to patients.
National Cancer Patient Experience Survey 2012	Many of the criteria in the survey showed an improvement with 'finding out what was wrong with you' results being significantly higher. Areas around ward nursing questions were lower than last year. Scoring for hospital care and treatment were also lower. The nursing actions raised by the survey are currently being dealt with by the appropriate Senior Clinical Matrons with dissemination via the ward newsletters and debrief sessions.
National Audit of Acute Kidney Injury (AKI) Stage 3 incidence and outcome	Identification and management of AKI has been shown to be poor across the NHS. A local task and finish group has been established in the Trust to look at ways of incorporating appropriate investigations into current documentation to remind staff of the need for early identification of such patients.
BTS Emergency Oxygen Audit	Results showed that the Trust performed well in relation to taking observations, however there was a lack of space on current Trust documentation to record the actual prescribing of oxygen. Further local audits have been planned.

National Dementia Audit	Results highlighted the need for improvement in the identification of patients with dementia and also in the information shared with Community Services on discharge. This work continues as part of the Dementia Collaborative.

Local Clinical Audits

The reports of 75 local clinical audits were reviewed by the Trust in 2013-2014 and the Trust intends to or has commenced the following actions to improve the quality of healthcare provided as follows:

Local audit title	Actions taken/in progress
Consent Audit - Regional anaesthetic blocks for shoulder surgery	New forms will be developed to improve documentation.
Fascia Iliac Block Audit	Audit identified the need for more staff to be trained. This will act as a training opportunity for anaesthetic trainees on the regional anaesthesia module.
Fluid Balance Management in Theatres	Improvements, particularly in documentation of urine output but still some areas requiring improvement.
Adult Community MUST Tool (NICE CG 32)	Scales for each District Nurse TAPS have been ordered to allow accurate weighing of patients who are able to stand.
First Fit Pathway	.A new leaflet is currently in development and the team will continue to make trainees aware of A&E guidance in induction.
Chest pain of recent onset: A&E aspects	Emergency Department pathway will be updated. Joint audit with Medicine to be undertaken
National Health Promotion in Hospital Audit	The audit drew attention to the need for more information stands, leaflets and resources. There is also a need to identify champions and specialist nurses to deliver brief interventions around health promotion topics. Health promotion lending library and Change 4 life literature will be used in future to improve our health promotion resource.

Role of Health Psychologist in mood assessment and intervention for stroke patients	All patients will have informal mood discussion at least once during admission
Audit of Management of Children with Downs Syndrome	A multi-disciplinary protocol will be developed with a checklist of age appropriate referrals and investigations. This will improve documentation and give a visual reminder of care needs.
Audit of the Management of Post Partum Haemorrhage (PPH)	Improvements evident in documentation but still a need to ensure completion of all required forms and the drugs card.

The Trust continues to perform well in audit activity and positive points to note include:

Local audit title	Good practice
Suction Audit	Good practice continues to embed within the Trust and improvements continue to be made.
Community Consent Audits - Hand & Wrist Surgery	Good compliance in most categories.
Anaphylaxis in Adults	Good practice in documenting salient points relating to features, triggers and timings of symptoms.
Neutropenic Sepsis Audit	Microbiology and infection control support is available for appropriate use of antibiotics in suspected neutropenic sepsis.
'MUST Tool'	Continued improvement and compliance with overall MUST assessment.
Chronic Pelvic Pain	There is thorough history taking to identify causative factors.
Community Consent Audits - Podiatric Surgery	Almost all categories showing 100% compliance.
Antibiotic Kardex Audit (Orthopaedics)	Improvements in many areas.

Paediatric Jobs List	The Jobs List will be included in the paediatric introduction for new staff including a handout with common problems and practical demonstration of the system used.
Audit of Consent (Paediatrics)	Good improvement in almost all areas that had low scores in previous audit.

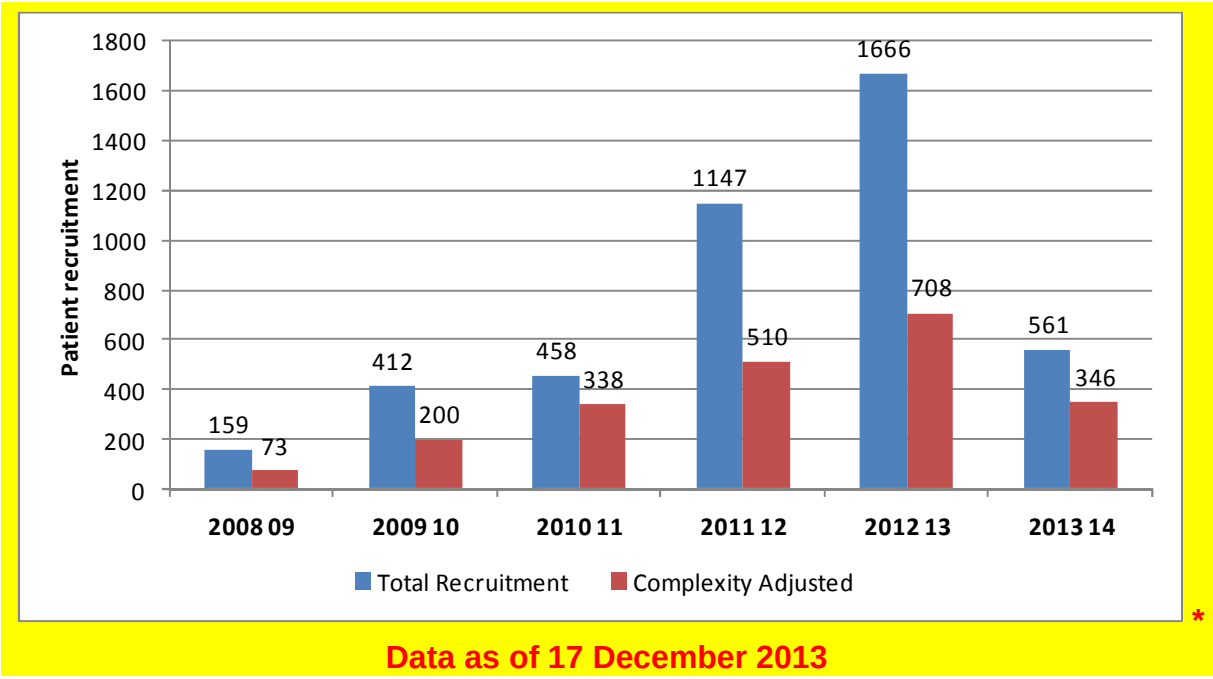
All national audit reports are considered by the Audit and Clinical Effectiveness (ACE) Committee which reports to the Patient Safety and Quality Standards (PS & QS) committee, PS & QS reports directly to the Board of Directors.

Patients recruited into NIHR portfolio research

Recruitment for 2012/13 saw an unprecedented 1666 patients being recruited into NIHR portfolio studies. This was due in part to two large observational studies active within that financial year.

Total year on year NIHR portfolio recruitment is shown in the table and graph below:

	2009/09	2009/10	2010/11	2011/12	2012/13	2013/14
Total Recruitment	159	412	458	1,147	1,666	561*
Complexity adjusted	73	200	338	510	708	346*



Data as of 17 December 2013

Recruitment for 2012/13 saw an unprecedented 1,666 patients being recruited into NIHR portfolio studies. This was due in part to two large observational studies active within that financial year.

This financial year our overall figure is lower as a higher proportion of our work is in more complex interventional studies which require higher input for lower overall recruitment figures.

The total number of patients receiving NHS services provided or subcontracted by the Trust in 2013/14 who were recruited during that period to participate in research approved by a research ethics committee was 572 (portfolio and non-portfolio studies).

2013/14 Study participation – number of studies

NIHR portfolio studies		Non-portfolio Studies		**Total**	
Observational	Interventional	Observational	Interventional	**Observational**	**interventional**
21	29	34	7	**55**	**36**

We have continued to streamline our research governance processes and consistently perform well within the NIHR performance metrics of providing R&D approval for portfolio studies within 30 days of receipt of valid SSI submission pack for CSP portfolio studies (average for our Trust 4 days).

There remain specialisms within the Trust where activity is low, however we are continually working with these areas and have introduced directorate level quarterly performance reporting metrics to ensure a higher profile is afforded to the increasing requirements to deliver on our research targets.

In The Guardian Research League tables for 2013 our Trust ranked 98th best nationally in the "All Trusts" category (148th the previous year out of a total 390 Trusts). In the "Acute Trusts- medium sized" category we ranked 9th best in the country 2011/12 (16th last year out of a total 48 Trusts in this category).

The research and development (R&D) team have worked with departments across the Trust to promote the importance of healthcare professionals being involved in research. Through the Trust's provision of an R&D **Incentive fund of £50,000** we have been able to help to develop staff knowledge and skills to enable them to lead and/or be involved in research studies through provision of:

- Bi-annual Good Clinical Practice (GCP) training – n attended this year
- R&D fellowship and small grant scheme (£41,461 awarded in small grants)
- R&D Conference - attended by 67 members of staff

We currently have 204 members of staff with valid Good Clinical Practice (GCP) training. Five staff members are enrolled to undertake Master of Science (MSc) degrees in health service research funded from successful applications to the R&D Incentive Fund. Two MD students have been provided with help for course fees for their research related MD thesis.

The range of specialisms now participating in research is notable, encompassing paediatrics and family health, respiratory medicine, gastroenterology, diabetes, stroke medicine, rheumatology, surgery, orthopaedics, anaesthetics and critical care, cardiology, Urology, rheumatology, dermatology and accident and emergency. Reproductive health has grown enormously in its portfolio research activity in the last six months.

There are fifty two members of staff acting as principal investigators/local collaborators in research approved by a research ethics committee within the Trust, some of whom have up to ten studies in their research portfolio. We have fourteen CLRN (comprehensive local research network) funded research nurses/midwifes within the Trust and two nurses/research practitioners funded from commercial income. Our bi-monthly **research nurses working group** continues to be well attended and provides professional support and mentorship.

To demonstrate the Trust's commitment to providing a more stable and flexible research nurse workforce, we have recently appointed five cross-specialty research nurses from the CLRN funded nurses previously working through secondment or on fixed term contracts.

Trust Consultant Neonatologist Professor Samir Gupta has been awarded a £3 million grant from the Health Technology assessment programme and will be Chief Investigator for the study collaborating with University of Oxford and the National Perinatal Epidemiology Unit in Oxford.

We continue to work with colleagues from cardiology, radiology, assisted reproduction and podiatry to develop further Trust initiated projects and this is a key priority for the R&D department over the next 12 months.

<u>Commercially sponsored Studies</u>

We continue to increase our participation in commercially sponsored studies.

For the last three years our Respiratory Research team have continued to grow their commercially sponsored research activity resulting in their ability to fund a part –time research assistant and part-time research nurse. We were the third site globally to recruit into a highly competitive drug trial for patients with moderate to severe Chronic Obstructive Pulmonary Disease (COPD).

Additionally this year has seen an expansion of commercially sponsored research into other specialisms. We have opened our first commercial study within Paediatrics and are currently the second highest recruiter nationally into this. We also opened a cardiology commercial study and will be opening our second cardiology study before the end of the year.

Consultant Surgeon Dr Pud Bhaskar and Research Scientist Dr Liz Baker are leading a multi-centre study in collaboration with a commercial sponsor to determine the safety and efficacy of harvesting a larger volume of fat under the initial liposuction procedure for breast reconstruction following breast cancer and then storing the fat in a dedicated tissue bank for reinjection back into the patient over time using local anaesthetic rather than general anaesthetic.

Commissioning for quality and innovation (CQUIN) (Update Pending)

As for all Trusts, a proportion of the Trust income in 2013-2014 was conditional on achieving quality improvement and innovation goals agreed through contract negotiations with our commissioners and administered through the CQUIN payment framework. The total income received through achievement of CQUIN goals in 2013-2014 is £4,279,015.45 which includes £3,678,332.75 for acute and £600,682.71 for community services.

The total income received through achievement of CQUIN goals in 2012-2013 was £4,279,015.45 which included £3,678,332.75 for acute and £600,682.71 for community services.

Further details of agreed goals for 2013-2014 and the following 12-months CQUIN schemes are available electronically at: http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html

North Tees and Hartlepool and Community CQUIN Scheme

Indicator No.	Indicator	Expected Financial Value	Total Paid
1a	Friends and Family Test - Phased Expansion	£57,210.00	
1b	Friends and Family Test - Increased Response	£76,280.00	
1c	Friends and Family Test 0 Improved Performance on the Staff Friends and Family	£57,210.00	
2a	VTE - Risk Assessment	£190,699.00	
2b	VTE - Root Cause Analysis		
3a	Dementia - Find, Assess, Investigate and Refer	£95,350.00	
3b	Dementia - Clinical Leadership	£38,140.00	
3c	Dementia - Supporting Carers of People with Dementia	£57,210.00	
4a	NHS Safety Thermometer - Date Collection	£95,350.00	
4b	NHS Safety Thermometer - Improvement	£95,350.00	
5a	3 million lives	£381,399.00	
5b	Digital first	£381,399.00	
6a	Local programme to include FFT stretch and EOL Families' Voices. Dementia carers	£572,099.00	
6b	You're Welcome	£152,560.00	
7a	Surviving sepsis (Y2)	£114,420.00	
8a	Heart Failure Bundle	£114,420.00	
8b	Learning Disability	£152,560.00	
8c	Mental Capacity - Best Interest decisions	£152,560.00	
9a	Discharge - Medical	£114,420.00	
9b	Discharge Nursing	£114,420.00	
9c	Discharge Community services	£114,420.00	
9d	MUST Nutritional screening - To review	£114,420.00	
9e	STAMP - Nutritional screening for children - To review	£114,420.00	
9f	Catheter Care Passport	£114,420.00	
10a	EOL Quality Assessment	£190,700.00	
10b	EOL Improving delivery of preferred place of death	£152,560.00	
	Total	**£3,813,996.00**	

NHS County Durham & Darlington and NTHFT Draft acute CQUIN scheme 2013/14

Indicator Number	Indicator	Financial value	Total Paid
1a	Friends and family test - phased expansion (NM 1.1 New)	**£18,320.00**	
1b	Friends and family test - increased response rate (NM 1.2 New)	**£27,480.00**	
1c	Friends and family test - improved performance on the staff friends and family test (NM 1.3 New)	**£27,480.00**	
1d	i) Q1 to capture patient experience of agreed targeted groups e.g.. to capture patient experience of patients with more than 1 long term condition & high intensity users (>3/year) with know LTCs. (COPD, Diabetes, CHD) ii) Q2 Analyse information, agree performance improvement & actions plan for each areas iii) Q3 implement improvement plans iv) evidence changes are in place - plan to remeasure (new)	**£36,640.00**	
2a	NHS Safety Thermometer - data collection (NM2.1) - **NOT applicable**		
2b	NHS Safety Thermometer - improvement. Reduction in the prevalence of pressure ulcers (NM 2.2 New) *Reducing goal to be set*	**£45,800.00**	
3a	Dementia - Find, Asses, Investigate and Refer (NM 3.1)	**£18,320.00**	
3b	Dementia - Clinical Leadership (NM 3.2 New)	**£18,320.00**	
3c	Dementia - Supporting Carers of People with Dementia (NM 3.3 New)	**£27,480.00**	
3d	Implementation of an improvement plan linked to national dementia audit outcomes and to reduce length of stay (or DEMENTIA STRATEGY?) (L 12/13) (Reference D Nicholson letter and Alzheimers society guidance. significant gains if reduce LOS by one week) i) Q1 to determine the average LOS for patients admitted with hospital with a diagnosis of dementia ii) Q2 identify aread for improvement and commence delivery iii) remeasure Q4 - to decrease the average LOS in hospital for patients with a diagnosis of dementia; all causes.	**£73,280.00**	
4a	VTE risk assessment - % of all adult inpatients who have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool (NM 4.1) = 95%	**£27,480.00**	
4b	VTE root cause analyses- number of root cause analyses carried out on cases of hospital associated thrombosis (NM 4.2 New)	**£18,320.00**	

5a	(No Decision About Me Without Me)To introduce shared decision making (SDM) within 3 clinical areas (COPD; CVD; Diabetes) where there are choices to be made between treatment options. (new) i) Identify appropriate clinical pathways and teams. Ii) Develop and disseminate the SDM materials. iii) Implement SDM and raise awareness among the patient population. iiii) Evaluation including a survey of patients regarding the experience of their involvement and perception of the decision process, with audit and out patient letters. (New)	**£54,960.00**	
6a	Discharge bundle for dementia patients over 65/75 (L, New)	**£45,800.00**	
6b	Implementation of discharge communication improvement plan to improve quality of content with focus on prescribing information	**£36,640.00**	
7	Implementation on an improvement plan over 12/13 and 13/14 to: i) reduce the number of Trust initiated cancellations (goal TBC) - cancellation of appointments <6weeks for non-clinical reasons ii) improve the timeliness of review appointments	**£64,120.00**	
8a	i) Percentage of inpatients with a primary diagnosis of heart failure receiving all 7 indicators from the **heart failure** bundle (RS1, L 12/13) (New) ii) Potential to add new indicator for target dosage (L, New)	**£36,640.00**	
8b	**COPD** - proportion of patients receiving all elements of discharge bundle (RS3c, L12/13) (Amended to reflect local pathways if necessary) *Target to be 75% by year-end*	**£36,640.00**	
9a	Understanding of unobserved falls within Trust that result in fracture of the neck of femur and how they can be reduced	**£64,120.00**	
10a	Develop a code of practice with regard to 'every health contact counts' for smoking cessation, alcohol misuse and obesity. (New)	**£27,480.00**	
10b	Develop an action plan and measured implementation of 'the code' in practice (New)	**£27,480.00**	
11a	To register for the End of Life Quality Assessment Tool; ELCQua.nhs.uk (New)	**£18,320.00**	
11b	To measure the number of patients dying in hospital within 8 days of admission, known tro be in their last year of life, identifying areas for improved support of preferred place of care and deciding right	**£27,480.00**	
12a	Compliance with regional learning disabilities pathways (L 12/13) (RS4 11/12)	**£27,480.00**	
13a	To develop recommendations for 'the right test first time" to include radiology & pathology referrals (new)	**£109,920.00**	
	Total	**£916,000.00**	**£0.00**

Specialist Commissioning

Indicator	Financial Value	Total Paid
Friends and Family Test	£9,459	£2,364.84
NHS Safety Thermometer	£9,459	£2,364.84
Dementia	£9,459	£1,664.84
VTE	£9,459	£2,364.84
Quality dashboards for specialised services	£18,919	£4,729.68
Access to and impact of clinical nurse specialist (CNS) support on patient experience	£33,108	£8,276.93
Improved access to breast milk in preterm infants	£37,837	£9,459.35
Timely administration of total parenteral nutrition (TPN) for preterm infants	£28,378	£7,094.51
Simple discharge pathway	£33,108	£4,139.00
Total	£189,187	£42,458.82

Data as of end of Q1*

Care Quality Commission (CQC)

Like all NHS Trusts, North Tees and Hartlepool NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is **registered without conditions for all services provided**.

During this year the Director of Nursing has introduced quarterly meetings with the Regional officers for the CQC. These meetings has allowed the Trust to share details of innovations and changes in services; as well as allowing the opportunity to discuss any issues that either party may wish to raise for discussion. This supports the Trusts strategic aim to maintain full transparency with all partners.

Following the publication of its 3 year strategy in April 2013 the CQC launched a consultation "A new start" in order to review the way it regulates, inspects and monitors care. Over the summer the Trust has participated in the consultation. Currently the Essential Standards set in 2010 are still in place and the Trust is assessed against these during inspections; according to the consultation the standards will be replaced in April 2014. The suggested examples of the new standards appear to be very much based on the findings of the Francis II Report. Information on the progress of the CQC review, all inspection reports and monitoring can be found on the following link: www.cqc.org.uk

Change to CQC monitoring reports

In October 2013 the CQC replaced the Quality Risk Profile for all NHS Trusts with the Intelligent Monitoring Report (IMR).

The Intelligent Monitoring Report includes only the Trusts applicable indicators, for North Tees and Hartlepool this equates to 86 indicators. The indicators are made up of a variety of clinical and safety statistics (quantitative) and also patient experience measures (qualitative). The patient experience information comes from direct contacts with the CQC through their website, complaints or whistleblowing direct to the CQC, NHS Choices and also from numbers of complaints reported by the Trust. Specific areas of the staff survey and human resources data are also included.

These indicators relate to the five key questions the CQC will ask of all services are they:

- Safe
- Effective
- Caring
- Responsive and
- Well-led

Each of the indicators are then categorised into one of the following three groups as:

- No Evidence of Risk
- Risk
- Elevated Risk

The CQC use the IMRs to band hospital Trusts into six bands based on the risk that people may not be receiving safe, effective, high quality care with band 1 being the highest risk and band 6 the lowest.

North Tees and Hartlepool NHS Foundation Trust were pleased into Band 4 for the first report. Please see the following table for additional data.

Reporting Month	No Evidence of Risk	Risk	Elevated Risk	Trust Banding
October-13	81	3	2	4
January-14	xx	xx	xx	xx
April-14	xx	xx	xx	xx

The IMR reports can be located at www.cqc.org.uk/public/hospital-intelligent-monitoring.

Inspection Regime

Over the last since months the CQC have introduced a new inspection regime which involves larger teams, led by the Chief Inspector of Hospitals, reviewing services within Trusts. The Trusts identified through the Keogh Report (DoH, 2013) as having high mortality rates and also those identified through inspections prompted following incidents/ complaints; have been included in the first waves of a new style inspection regime. This new style of inspection involve large teams looking a wider range of services over a two week period. The CQC has advised that all NHS Acute Trusts will have hosted one of the new style inspections by 2015 and that rating will be applied; at this time there are no details on the overall rating system to be used.

The Trust, however, will, at this time, continue to be inspected within the current regime. One of these inspections was undertaken on 25th May 2013; this involved the Minor Injuries Unit within the One Life at Hartlepool.

Outcome	Regulation	Description
1	17	Respecting and involving people who use services
4	9	Care and welfare of people who use services
10	15	Safety & suitability of services
13	22	Staffing
15	10	Assessing and monitoring the quality of service provision

The Trust holds a repository of evidence to support compliance with current Essential Standards; this is available if required. Following the visit, which took place on a Bank Holiday weekend, the Trust was asked to provide evidence to support the inspection findings; this included details of the safety and governance arrangements for the unit.

Following the inspection and a review of the supporting evidence provided the CQC advised that the Trust had been successful in meeting the reviewed standards. Some minor issues relating to the waiting area and the signage were highlighted and these have been in turn relayed to the owners of the building. The report also provided excellent feedback for the staff working within this service.

Is there an update for the above highlighted area. (insert if amended)

Janet Alderton

CQC children safeguarding and looked after children and engagement with the Governors

Confirmation of no enforcement action

We are happy to confirm that the Care Quality Commission (CQC) has not taken enforcement action against the Trust during 2013/14.

National Surveys

CQC National Inpatient Survey data for 2010 to 2012

This survey is a Care Quality Commission (CQC) requirement for all Acute NHS Trusts. Each Trust randomly selected adult inpatient admissions during August 2012 (age over 16 years).

Within the report we identify if the Trust performs ***"better"***, ***"worse"*** or ***"about the same"*** as other trusts. Each of the indicators are scored out of 10, the higher the score the better the reported patient experience.

There were **381** returns from the **794** patients that received a survey, this equates to a response rate of **48%** against a national average of **51%**.

Below are a few of the questions and responses included in the survey:

Overall Domain/section scores

Domain	Overall score 2010	Overall score 2011	Overall score 2012
The Emergency/A&E Department	8.0	8.4	8.6
Waiting list and planned admissions	6.7	6.5	9.2
Waiting to get to a bed on a ward	8.6	8.5	8.4
The hospital and ward	8.3	8.3	8.1
Nurses	8.5	8.3	8.2
Care and treatment	7.6	7.5	7.5
Leaving hospital	7.4	7.2	7.3
10. Overall views & experiences	6.7	6.0	4.9

The Emergency/A&E Department (answered by emergency pts only)

Question	2010	2011	2012
How much information about your condition did you get in the A&E Department?	8.0	8.6	8.4
Were you given enough privacy when being examined or treated in the A&E Department?	9.1	9.0	8.9

Waiting list and planned admissions (answered by those referred to hospital)

Question	2010	2011	2012
How do you feel about the length of time you were on the waiting list?	8.3	7.6	8.5
Was your admission date changed by the hospital?	9.4	9.3	9.3
Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?	*Not asked*	*Not asked*	9.8

Waiting to get to a bed on a ward

Question	2010	2011	2012
Upon arrival, did you feel that you had to wait a long time to get to a bed on a ward?	8.6	8.5	8.4

The Hospital & Ward

6.2 (a)

Question	2010	2011	2012
Did you ever share a sleeping area with patients of the opposite sex?	9.5	9.7	9.5
Did you ever use the same bathroom or shower area as patients of the opposite sex?	8.9	8.7	8.9
Were you ever bothered by noise at night from other patients?	6.8	7.1	6.6
Were you ever bothered by noise at night from hospital staff?	7.9	7.9	7.5
In your opinion, how clean was the hospital room or ward that you were in?	8.8	8.8	8.6
How clean were the toilets and bathrooms that you used in hospital?	8.6	8.4	8.4
Did you feel threatened during your stay in hospital by other patients or visitors?	9.8	9.9	9.6 ↓
Were hand-wash gels available for patients and visitors to use?	9.7	9.6	9.4
How would you rate the hospital food?	5.5	5.3	5.2
Were you offered a choice of food?	8.7	9.0	8.9
Did you get enough help from staff to eat your meals?	6.8	7.5	6.8

Nurses

Question	2010	2011	2012
When you had important questions to ask a nurse, did you get answers that you could understand?	8.4	8.2	8.1
Did you have confidence and trust in the nurses treating you?	8.7	8.5	8.7
Did nurses talk in front of you as if you weren't there?	8.9	8.7	8.9
In your opinion, were there enough nurses on duty to care for you in hospital?	7.9	7.4	7.1

Your care and treatment

Question	2010	2011	2012
Did a member of staff say one thing & another say something different?	7.8	7.9	7.9
Were you involved as much as you wanted to be in decisions about your care?	7.1	7.4	7.1
How much information about your condition or treatment was given to you?	8.1	8.0	7.7
Did you find someone on the hospital staff to talk to about your worries or fears?	5.9	6.4	5.9
Do you feel you got enough emotional support from hospital staff during your stay?	*Not asked*	7.3	7.3
Were you given enough privacy when discussing your condition or treatment?	8.3	8.3	8.4
Were you given enough privacy when being examined or treated?	9.4	9.5	9.4
Do you think the hospital staff did everything they could to help control your pain?	8.5	8.0	7.8
After you used the call button, how long did it usually take before you got help?	7.0	6.3	6.1

Overall impression

6.2 (a)

Question	2010	2011	2012
Did you feel you were treated with respect and dignity while you were in the hospital?	**8.8**	**8.8**	**8.8**
Overall, how would you rate the care you received?	**7.8**	**7.7**	***Not asked***
Overall… (0 - I had a very poor experience to 10 - I had a very good experience)	***Not asked***	***Not asked***	**7.8**
While in hospital, were you ever asked to give your views on the quality of your care?	**1.0**	**0.6**	**0.9**
Did you see any posters or leaflets explaining how to complain about the care you received?	**5.5**	**4.9**	**2.2**

Department of Health National Cancer Survey 2013

Background:

Part of the NHS Cancer Patient Experience Survey Programme

Designed to monitor national progress on cancer care & to help drive local quality improvements

155 Acute hospital NHS Trusts took part

All adult patients with a primary diagnosis of cancer admitted as an inpatient or as a day case patient, and had been discharged btw 1st September and 30th November 2011

646 patients were sent a National Cancer questionnaire with the Trust response rate being **66%** against a National response rate of **64%**.

Below are a selection of the questions that were asked in the survey

Diagnostic tests

Question	2010	2011	2012
Staff gave complete explanation of purpose of test (s)	**85%**	**86%**	**88%**
Staff explained completely what would be done during test	**88%**	**87%**	**92% ***
Given easy to understand written information about test	**86%**	**89%**	**93%**
Given complete explanation of test results in understandable way	**85%**	**85%**	**85%**

The 2012 score is significantly higher than in 2011

Finding out what was wrong with you

Question	2010	2011	2012
Patient told they could bring a friend when first told they had cancer	**86%** ***(highest performing score)***	**88%** ***(highest performing score)***	**89%** ***(highest performing score)***
Patient felt they were told sensitively that they had cancer	**87%**	**88%**	**91%**
Patient completely understood the explanation of what was wrong	**79%**	**76%**	**82%**
Patient given written information about the type of cancer they had	**71%**	**73%**	**80% ***

The 2012 score is significantly higher than in 2011

Deciding the best treatment for you

Question	2010	2011	2012
Patient given a choice of different types of treatment	**87%**	**85%**	**88%**
Patient's views definitely taken into account by doctors & nurses discussing	**-**	**74%**	**76%**

treatment			
Possible side effects explained in an understandable way	79%	81%	82%
Patient given written information about side effects	90% *(highest performing score)*	88%	87%
Patient definitely told about treatment side effects that could affect them in the future?	-	-	65%
Patient definitely involved in decisions about which treatment	75%	75%	80%

Clinical Nurse Specialist (CNS)

Question	2010	2011	2012
Patient given the name of the CNS in charge of their care	89%	88%	91%
Patient finds it easy to contact their CNS	88%	89%	93%
CNS definitely listened carefully the last time spoken to	96%	95%	95%
Get understandable answers to important questions all/most of the time	95%	94%	97%

Hospital care and treatment

Question	2010	2011	2012
Patient did not think hospital staff deliberately misinformed them	87%	89%	88%
Patient never thought they were given	87%	82%	83%

conflicting information			
All staff asked patient what name they preferred to be called by	-	68%	65%
Always given enough privacy when discussing condition or treatment	84%	88%	84%
Always given enough privacy when being examined or treated	94%	95%	95%
Patient was able to discuss worries or fears with staff during visit	-	72%	69%
Hospital staff did everything to help control pain all of the time	84%	85%	83%
Always treated with respect and dignity by staff	82%	82%	82%

Support for people with cancer

Question	2010	2011	2012
Hospital staff gave information about support groups	82%	80%	84%
Hospital staff gave information about impact cancer could have on work/education	-	-	79%
Hospital staff gave information on getting financial help	55%	64%	59%
Hospital staff told patient they could get free prescriptions	73%	75%	79%

Ward Nurses

Question	2010	2011	2012
Got understandable answers to important questions all/most of the time	70%	75%	67%

Patient had confidence and trust in all ward nurses	69%	70%	64%
Nurses did not talk in front of patient as if they were not there	84%	86%	79% *
Always / nearly always enough nurses on duty	70%	66%	64%

*2012 scores significantly lower than in 2011

Hospital care and treatment

Question	2010	2011	2012
Patient did not think hospital staff deliberately misinformed them	87%	89%	88%
Patient never thought they were given conflicting information	87%	82%	83%
All staff asked patient what name they preferred to be called by	-	68%	65%
Always given enough privacy when discussing condition or treatment	84%	88%	84%
Always given enough privacy when being examined or treated	94%	95%	95%
Patient was able to discuss worries or fears with staff during visit	-	72%	69%
Hospital staff did everything to help control pain all of the time	84%	85%	83%
Always treated with respect and dignity by staff	82%	82%	82%

Information given to you before leaving hospital and home support

Question	2010	2011	2012
Given clear written information about what should / should not do post	87%	92%	87%

discharge			
Staff told patient who to contact if worried post discharge	92%	95%	94%
Family definitely given all information needed to help care at home	61%	64%	68%
Patient definitely given enough care from health or social services	58%	54%	58%

Hospital care as a day patient/outpatient

Question	2010	2011	2012
Staff definitely did everything to control side effects of chemotherapy	90%	90%	93%
Staff definitely did everything they could to help control pain	87%	89%	88%
Hospital staff definitely gave patient enough emotional support	77%	84%	81%
Doctor had the right notes and other documentation with them	97%	96%	97%

Your overall NHS care

Question	2010	2011	2012
Hospital and community staff always worked well together	66%	69%	74%
Given the right amount of information about condition and treatment	90%	94%	92%
Patient offered written assessment and care plan	-	28%	25%
Patient did not feel that they were treated as “a set of cancer symptoms”	81%	82%	82%
Patient’s rating of care *“excellent”/ “very good”*	-	90%	91%

Quality of Data

Good quality information underpins the effective delivery of patient care and helps staff to understand what they do well and where they might improve.

The Board of Directors attend regular development sessions and seminars to ensure that every member of the Board is equipped to interpret data, challenge and oversee improvements where necessary. They consider data provided with other intelligence including listening to what patients are saying. Our executive and non-executive directors can often be seen in clinical areas talking to patients and staff to ensure a fully informed and well rounded approach to decision making.

The members of the Council of Governors are encouraged to test the data reports they receive through participation in PEQS reviews. This enables governors to speak directly to patients and staff and provides assurance that standards are aligned with information reported.

The Trust Board and Council of Governors are presented with a data quality dashboard to the benchmark position against other Trusts within the Strategic Health Authority (SHA).

Non-executive Directors meet with the Director of Nursing and Clinical Governance personnel on a regular basis to review incident related performance data.

They also undertake a quarterly review of complaints related data. This includes monitoring all complaints reported in the previous quarter. A sample is selected for further scrutiny. This provides independent that complaints are dealt with appropriately, in a timely fashion and that lessons are learned and actions taken when we get things wrong.

Training staff in **critical appraisal** is a vital part of ensuring that evidence is considered in an objective and balanced way. We develop clinical staff so that they have the skills and knowledge to use evidence in a way that supports them to make the best clinical decisions.

The Deputy Clinical Effectiveness Manager has been training staff in critical appraisal for over ten years. His courses have been recognised and adopted by the **British Medical Association** (BMA) and the **Department of Health (DH).** They are now used in the **UK, Europe and the United States of America**. He remains the **highest ranked trainer** authorised by the BMA.

Additional assurance in relation to data quality is provided independently by **Audit North**. This provides rigorous and objective testing of data collection and reporting standards. Results of these independent audits are reported to the audit committee and provide the Trust with **independent appraisal of clinical, financial and business governance standards.** This process of internal audit enables the Trust to test quality assumptions and pursue its philosophy of **continual improvement**. In order to test and improve quality of data the Trust will continue to commission independent audits of its key business.

Information governance (IG) (Update Pending) – Pam Gretton

Information governance means keeping information safe. This relies on good systems, processes and monitoring. Every year we audit the quality of specific aspects of information governance through the national information governance toolkit report. In 2013-2014 we had to ensure that **95%** of all of our staff had received information governance training. This target was challenging, however we have continued to make significant progress with a total of **96%** of all staff trained during the year for the third year running.

The Trust Information Governance Assessment Report score overall for 2013-2014 was **81%** and this has been graded as GREEN. A green rating is achieved where Trusts achieve level 2 or above on all requirements (see following table).

We continue to provide assurance to the Trust Board that we are constantly assessing and improving our systems and processes to ensure that information is safe.

Annual ratings of green (pass) or red (fail) are assigned to Trusts each year. The following table shows progress with ratings when compared to the previous year.

Requirement	2011-2012 rating	2012-2013 rating	2013-2014 rating
Information governance management	Green	Green	Green
	93%	93%	93%
Corporate Information Assurance	Green	Green	Green
	66%	66%	66%
Confidentiality and Data Protection assurance	Green	Green	Green
	83%	79%	79%
Clinical information assurance	Green	Green	Green
	73%	93%	93%
Secondary use assurance	Green	Green	Green
	83%	83%	83%
Information security assurance	Red	Green	Green
	75%	75%	75%

The IG toolkit is available on connecting for health website.
www.igt.connectingforhealth.nhs.uk

We receive a number of Freedom of Information (FOI) requests every year. In order to be transparent about information we have been asked to provide, we have developed a virtual reading room on our internet site. Since 1st January 2012, we have been posting responses to Freedom of Information requests on the site and these can be viewed by the public on:
www.nth.nhs.uk/foirr

Clinical coding error rate (Update Pending) – Pam Gretton

Clinical coding translates medical terms written by clinicians about patient diagnosis and treatment into codes that are recognised nationally.

The Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnosis and treatment coding (clinical coding) were:

- Primary diagnoses correct 91.10%
- Secondary diagnoses correct 92.20%
- Primary procedures correct 84.20%
- Secondary procedures correct 84.60%

The services reviewed within the sample were 135 finished consultant episodes (FCEs) in general medicine. The primary procedure has only 19 procedure codes to be audited and 3 were found to have errors. To meet the **90%** target there could have been only 1 error. The results should not be extrapolated further than the actual sample audited.

The errors include both coder and documentation errors of which the coding errors will be fed back to the coders as a group and individually. The documentation errors will be taken to directorate meetings.

Depth of coding and key metrics is monitored by the Trust in conjunction with mortality data. Monthly coding audits are undertaken to provide assurance that coding reflects clinical management.

Our coders organise their work so that they are closer to the clinical teams. This results in sustained improvements to clinical documentation. This supports accurate clinical coding and a reduction in the number of Healthcare Resource Group changes made. This is the methodology which establishes how much we should get paid for the care we deliver. We will continue to work hard to improve quality of information because it will ensure that NHS resources are spent effectively.

KEOGH

North Tees and Hartlepool Foundation Trust will be taking the following actions to improve data quality. Specific issues highlighted within the audit have been feed back to individual coders and appropriate training planned where required.

Coders currently code from discharge summaries within medicine which does not give them a full detail therefore with the commencement of EDM, in approximately 10 weeks time, coders will start to have access to paper light records and scanned notes. Additionally the proposal to have a lead quality coder who will audit individual coders work on an ongoing basis and work with directorates and senior clinicians to improve information within the health record and discharge summary has been approved the Trust going out to advert shortly for this post.

PART 3: REVIEW OF QUALITY PERFORMANCE

Quality Performance over 2013-2014

2013-2014 has been another successful year in relation to safety, quality and patient experience.

Part 3 of this Quality Account provides an opportunity for the Trust to report on progress against the quality priorities that were agreed with external stakeholders last year. We are very pleased to be able to report some significant achievements. Performance relating to C diff was disappointing however and we describe some of the actions we took during the course of the year to manage this.

Where possible, we have provided **additional sources of** (external) **data** to provide members of the public with as much information as possible.

Part 3A will describe Trust performance against additional quality performance indicators.

Part 3B core set of Quality Indicators

Part 3C contains statements from our key stakeholders.

Part 3A:

Trust performance against additional Quality Performance Indicators

In addition to the three local priorities outlined in Part 2, the indicators below further demonstrate that the quality of the services provided by the Trust over 2013/2014 has been positive overall.

In this section are reported in two sections:

1. Quality indicators that Trusts are required to report in their Quality Accounts, including, data made available to the Trust by the Health and Social Care Information Centre (HSCIC). Where applicable a comparison of numbers, percentages, values, scores or rates will be reported. A number of these Indicators are reported in detail within this document and the reader will be signposted to where this information is located.
2. Additional indicators will be presented under the headings of patient safety, effectiveness of care and patient experience. Indicators chosen reflect indicators that have been or remain of interest to key stakeholders as identified through consultation, discussion or enquiries. The indicators that will be reported in this section include:

Patient safety	Effectiveness of care	Patient Experience
• Reducing mortality • SHMI • MRSA bacteraemia • Early Warning System (EWS) • Medication Errors • Safety Thermometer	• Communication • NEQOS effectiveness indicators • Operating framework indicators	• Formal complaints and compliments • Your welcome • People with Learning Disabilities • Pressure Ulcers

Patient Safety

1. Reducing mortality

In 2008 the Trust, in partnership with external and internal stakeholders agreed that its first priority should be to reduce mortality. Through our quality strategy, we set out a five year plan to achieve this. Patient safety remains the first priority of every member of staff from ward to board.

Our **first patient safety priority** identified by external and internal stakeholders as well as well as our staff was to **reduce the number of patients that die** in our hospitals. This year we continued to reduce opportunity for avoidable deterioration at home or in hospital.

Why / How we chose this as a priority:

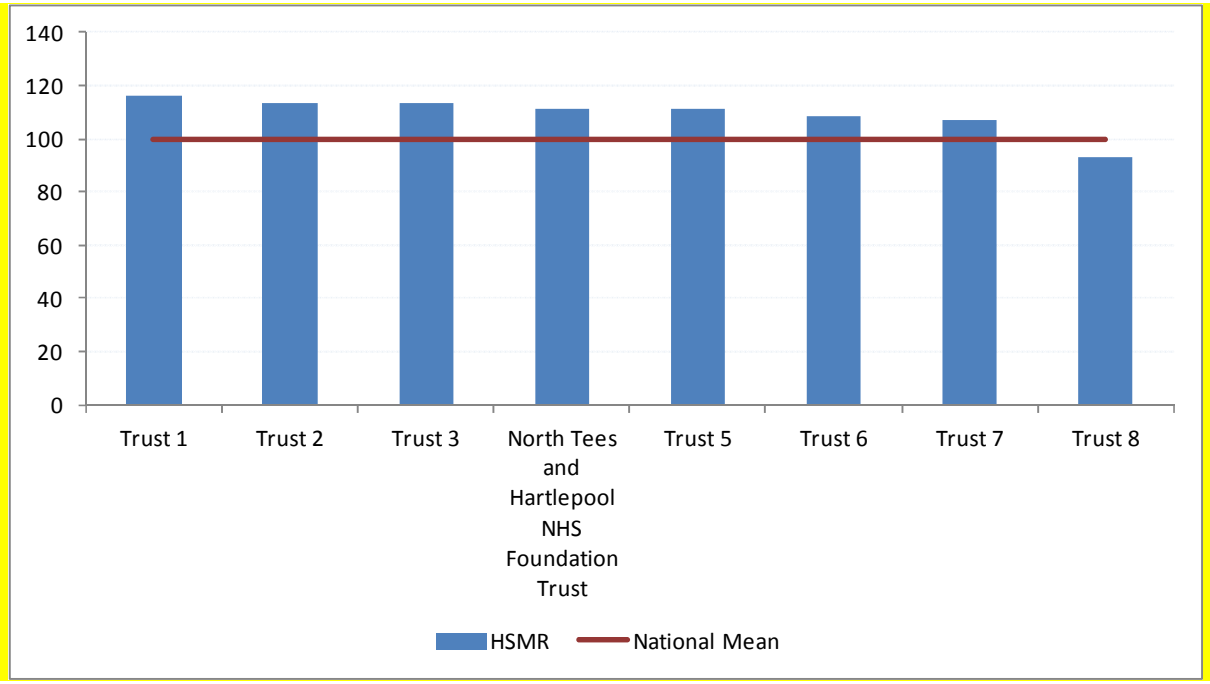
Reducing mortality has been a key priority since 2008. We have been reporting on our progress to external and internal stakeholders, for example to our commissioners, Council of Governors, to health scrutiny committees and to local involvement networks. During the consultation priority everyone agreed that this must remain our number one priority. Stakeholders also asked that we develop a process that can be used in patients own homes to prevent escalation to hospital for patients with chronic conditions where appropriate.

The following evidence provides more detail to demonstrate / support these trends.

The Trust continues to monitor all mortality data including **raw mortality data** (all actual deaths) weekly as well as looking at monthly and quarterly trends. This data is benchmarked regionally and the overall trend remains positive.

Hospital Standardised Mortality Ratio (HSMR)

Healthcare Evaluation Data (HED) reporting period of October 2012 to September 2013 – Hospital Standardised Mortality Ratio (HSMR) measures the Trust as **111.39 against a national mean of 100.**



***Data as of Dec 2013**

The above HSMR graph demonstrates the Trusts 12 month HSMR value throughout the reporting period of October 2012 to September 2013, benchmarked against the other North East Trusts.

The Trusts yearly average for HSMR is currently **111.39**, which is above the national average of 100.

	National Mean	Trust 1	Trust 2	Trust 3	North Tees	Trust 5	Trust 6	Trust 7	Trust 8
Hospital Standardised Mortality Ration (HSMR)	100	116.30	113.20	113.20	**111.40**	111.40	108.30	107.00	92.80

***Data obtained from the Healthcare Evaluation Data (HED)**

Hospital healthcare - evidence in practice

Reduced cardiac arrests - Data as of 12 December 2013

A cardiac arrest is what happens when a patient's heart stops beating.

We believe (and the evidence supports) that this reduction is linked to a reduction in the number of patients that deteriorate whilst in our care.

During 2013-14 the Trust has experienced unprecedented numbers of very sick patients being admitted to hospital. Although this inevitably results in more patients having a cardiac arrest, we are pleased that we are sustaining very low numbers of patients who show signs of deterioration prior to their cardiac arrest.

Cardiac Arrests, April 2013 – March 2014

Deteriorating Physiology

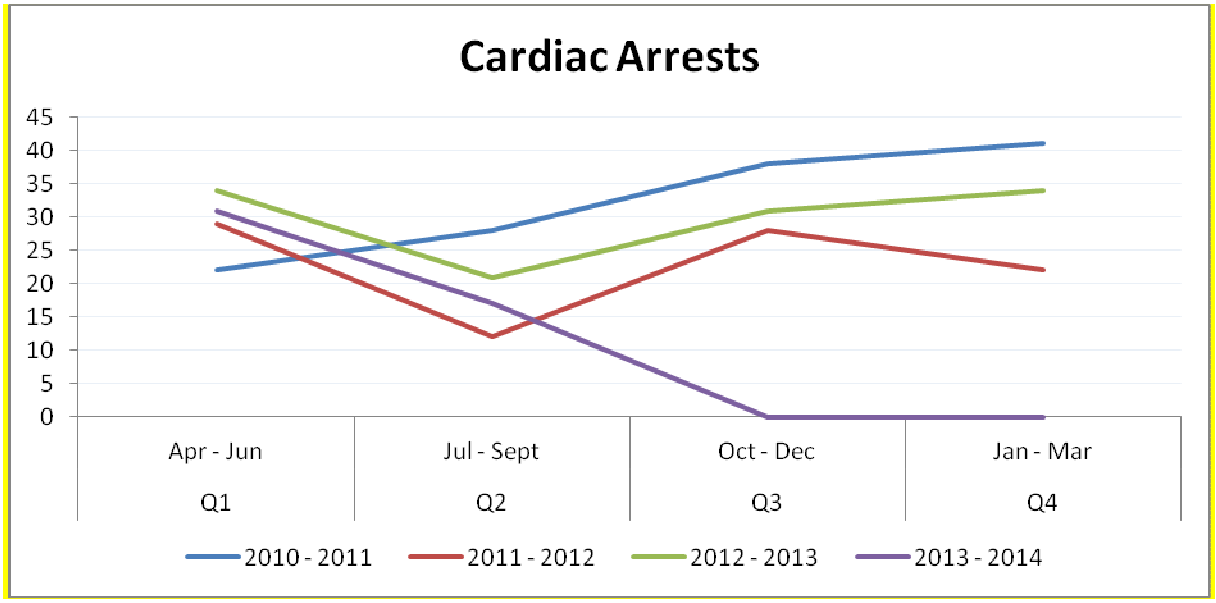
	Q1 Apr - Jun 2013	Q2 Jul - Sept 2013	Q3 Oct - Dec 2013	Q4 Jan - Mar 2014	Total
Number of cardiac arrests	31	17	xx	xx	xx
Deteriorating Physiology prior to cardiac arrest	17	9	xx	xx	xx

There were 48* Cardiac Arrests during this period. 26 had signs of deteriorating physiology prior to cardiac arrest which equates to 54.16%.

- 17 cases in April to June 2013, 2 were avoidable and 15 unavoidable.
- 9 cases in July – September 2013, 3 were avoidable and 6 unavoidable.

A full Root Cause Analysis (RCA) has been undertaken in relation these cases to ensure that there was a clear understanding of events that led up to cardiac arrest.

Multi-professional teams review RCAs from all patients who have sustained cardiac arrests.



*Data as of end of Q2

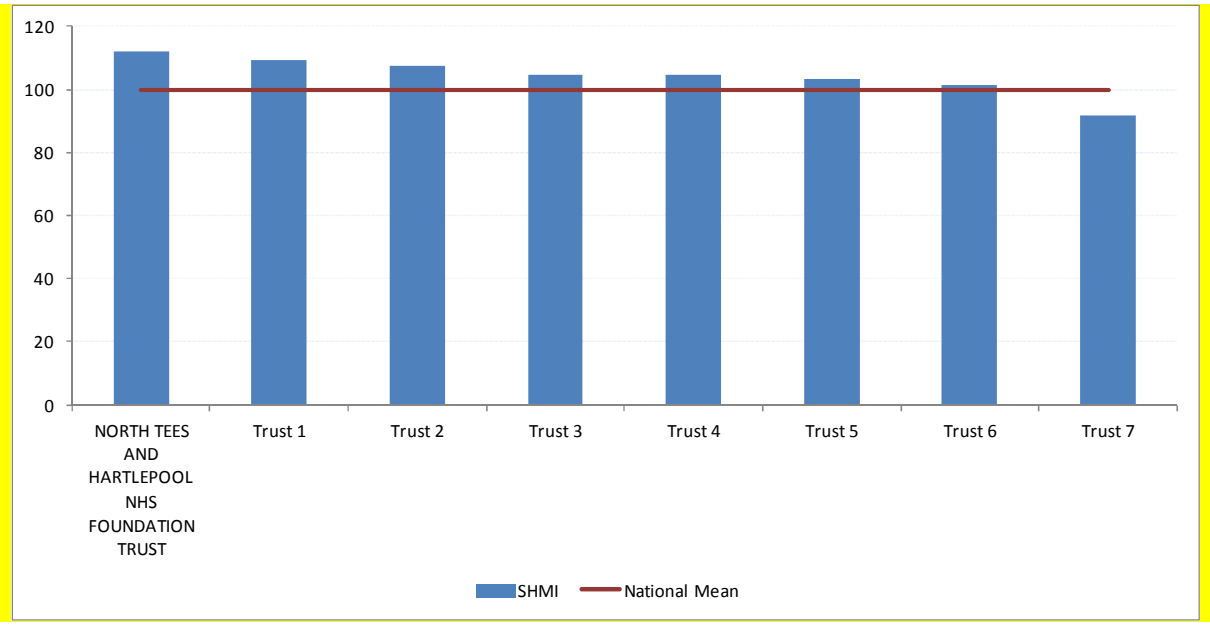
Quarter/Year	Q1 Apr - Jun	Q2 Jul - Sept	Q3 Oct - Dec	Q4 Jan - Mar	Totals
2010 - 2011	22	28	38	41	**129**
2011 - 2012	29	12	28	22	**91**
2012 - 2013	34	21	31	34	**120**
2013 - 2014	31	17	xx	xx	xx

2. Summary Hospital-level Mortality Indicator (SHMI) – April 2012 to March 2013

The SHMI indicator provides an indication on whether the mortality ratio of a provider is as expected, higher than expected or lower than expected when compared to the national baseline in England.

SHMI includes deaths up to 30 days after discharge and does not take into consideration palliative care. Although the Trust SHMI has remained within the as expected range at **112.06** actions are being taken to understand the value. What actions? (case note reviews etc)

The following chart and table demonstrate the Trust current SHMI position utilising the latest time period of April 2012 to March 2013, the other North East Trusts have been anonymised.



***Data as of Dec 2013**

	National Mean	North Tees	Trust 1	Trust 2	Trust 3	Trust 4	Trust 5	Trust 6	Trust 7
Summary Hospital-level Mortality Indicator (SHMI)	100	**112.06**	109.33	107.48	104.51	104.44	103.05	101.50	91.52

***Data obtained from the Healthcare Evaluation Data (HED)**

Pneumonia reviews from external source – Morecambe Bay

NEQOS – Pneumonia process review

KEOGH T&F

3. Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia

The importance of personal hygiene is fully understood by all staff and is visible through the ***bare below the elbow*** policy and the presence of alcohol gel dispensers and hand-washing facilities. Further improvements to our environment and practices are constantly being implemented and evaluated. What improvements?

Many patients **carry MRSA** on their skin, this is called colonisation. It is important that we screen patients when they come in to hospital so that we know if they are carrying MRSA. Screening involves a simple skin swab. If positive, we can provide special skin wash that helps to get rid of MRSA.

Our rate of screening for MRSA is very high and we believe that this has helped us to achieve the results reported during the course of the last two years.

Screening patients on admission showed that around 200 patients every month bring MRSA into hospital on their skin. This carriage will not harm them unless they become very poorly.

How did we do?

In 2012-2013, our organisation performed well against regional and national standards in relation to almost all aspects of infection prevention and control and this reflects the hard work of all staff, both clinical and non-clinical, in ensuring that high standards are maintained all of the time. We reported two hospital MRSA bacteraemia during 2012-2013, having had over 560 days without a case. In both cases the patients had MRSA on their skin when they arrived in hospital. Despite our best attempts to decolonise them (treatment to remove skin contamination) we were unable to prevent a bacteraemia.

Please see the following data has been taken from **North East Quality Observatory System's Acute Trust Quality Dashboard autumn v9.00**.

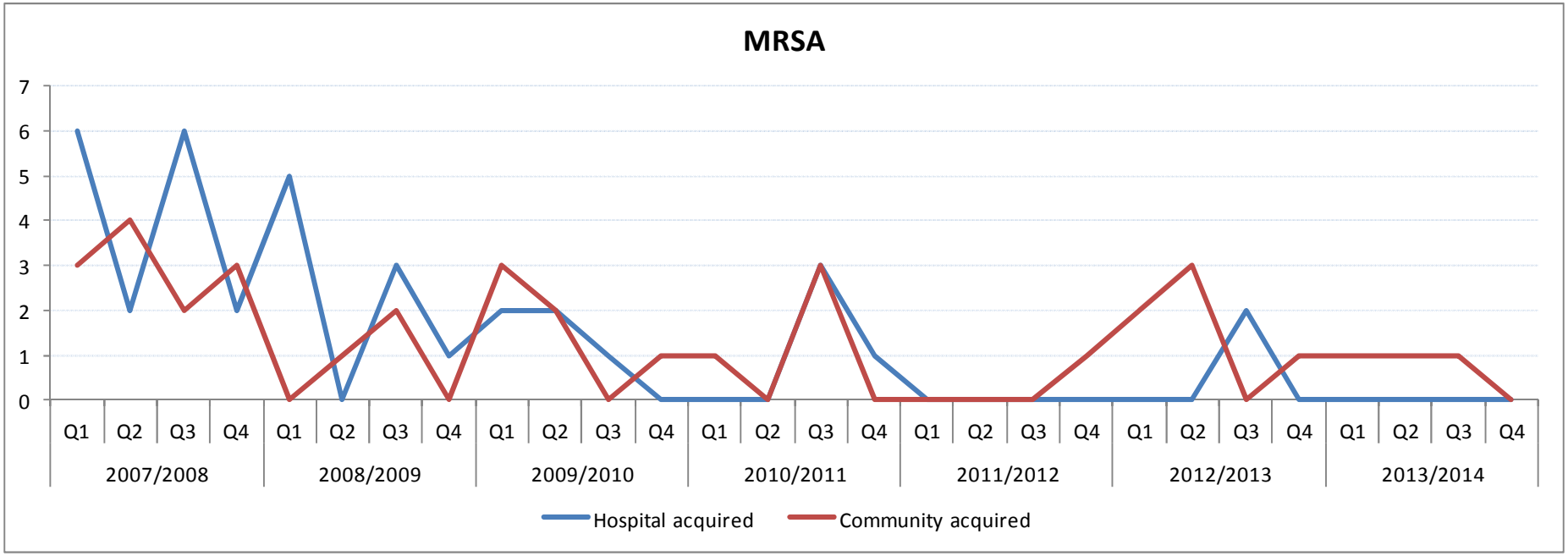
NB: The other North East Trusts have been anonymised.

The **North East Quality Observatory System** benchmark data reports the Trust at **0.00* cases** of MRSA bacteraemia **per 1,000,000** bed days compared to a **national mean of 12.20*.**

		National Mean	North Tees	Trust 1	Trust 2	Trust 3	Trust 4	Trust 5	Trust 6	Trust 7
HCAI - MRSA bacteraemia rate per 1,000,000 occupied beds (HQU01)	RY Q1 1314	12.20	**0.00**	12.10	31.40	25.20	0.00	0.00	0.00	19.20

*Data correct as of autumn v9.0 Acute Trust Quality Dashboard – period Q1 2013/14

North Tees and Hartlepool NHS Foundation Trust MRSA data trend



	2007/2008				2008/2009				2009/2010				2010/2011				2011/2012				2012/2013				2013/2014			
Hospital acquired total	16				9				5				4				0				2				0*			
Community acquired total	12				3				6				4				1				6				3*			
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Hospital acquired	6	2	6	2	5	0	3	1	2	2	1	0	0	0	3	1	0	0	0	0	0	0	2	0	0	0	0	0*
Community acquired	3	4	2	3	0	1	2	0	3	2	0	1	1	0	3	0	0	0	0	1	2	3	0	1	1	1	1	0*

***Data as of 16 January 2013**

4. Early Warning System (EWS)

Rationale: *stakeholders were pleased that we managed to develop an early warning status tool in the community. They wanted to understand the impact of this over a period of time (check what yellow section means)*

Healthcare	Overview of how we said we would do it	Overview of how we said we would measure it	Overview of how we said we would report it	How did we do?
Community	• We will roll out use of the new community early warning status allied to Telehealth status tool to more areas	• Monitor admissions to hospital.	• Quarterly reports to the IPNMB	• Quarterly Reports to IPNMB ✓ • Number of alerts monitored ✓ • Number of red alerts from patients on Telehealth use monitored ✓ • Number of red alerts from patients managed at home ✓ • Number of patients with red alerts admitted to hospital ✓

Community healthcare - evidence in practice

Development and use of bespoke Telehealth early warning status (EWS) tool for use in community services. We could find no nationally developed early warning status for use in community settings. Our community staff therefore tested the hospital EWS tool for use in the community. The hospital EWS did not work in the community, therefore some staff developed and tested their own system linked to Telehealth.

The community EWS track and trigger tool measures patient blood pressure, temperature, pulse and oxygen levels and a trigger (of worsening condition) results in a speedy review of medication and care. The system supports real-time flow of information from patient to clinical staff, supporting **continuous evaluation of care needs, risks and appropriately timed interventions**. We believe that the system designed by staff will help avoid crisis or deterioration resulting in a need for unscheduled care (unplanned intervention or admission to hospital).

The key measurable benefits to patients using this tool include:

- Supported early discharge
- Improved confidence because patients know that their condition is being closely monitored
- Rapid response to any change in worsening condition
- Improved clinical risk management for a group of patients known to a service
- Fewer unplanned admissions or readmissions to hospital
- Convenience and comfort of being monitored at home

The Telehealth EWS track and trigger tool was implemented in December 2011 with baseline outcomes being measured and reported in the 2012-2013 Quality Account. Introduction and early success of this ground-breaking work had resulted in our staff aim of developing a virtual ward in the community.

6.2 (a)

Summary of community EWS alerts: - Data as of 16 December 2013 (response in 2hrs column, query data)

		Red alerts		Number managed at home	Amber alerts		Number managed at home	Green alerts	Was the response within 2 hours?
Q1	April	5		1	8		2	62	5
	May	9	↑	5	13	↑	5	197	60
	June	13	↑	2	7	↓	3	143	90
Q2	July	7	↓	1	2	↓	1	172	98
	August	9	↑	2	0	↓	0	167	96
	September	7	↓	1	0	→	0	139	95
Q3	October	0	↓	0	0	→	0	67	0
	November	3	↑	1	0	→	0	27	3
	December								
Q4	January								
	February								
	March								

↓ Positive Change

↑ Negative Change

→ No Change

	Q1	Q2	Q3	Q4
Total number of patients accessing Telehealth	20	10	6	xx

6.2 (a)

Possible add paragraph relating to the low numbers

5. Medication errors

Between April and November 2013, staff reported 356 medication related incidents across hospital and community services of which 324 originated within the Trust. Some of these will have been actual incidents and some will have been near misses. A near miss is the name for a situation when the error did not actually happen but the circumstances were such that there was potential for an error.

Medication errors can happen at a number of steps in the process for example, when the medication is prescribed, when it is dispensed by pharmacy, or when it is administered to the patient.

There are many thousands of contacts made by our hospital and community teams every day. We estimate there could be around 12 million staff interactions with medications during a year which results in a very **low risk of error** when the reported incidents are considered against the proportion of:

- the number bed days (around 400,000)
- the number of drugs a patient might be given, possibly five different drugs three or four times a day
- the steps in the process (prescribing, dispensing and administration).

We have a culture of encouraging all staff to report actual medication errors as well as opportunities for error. The annual figures above show that reporting is increasing, our staff are doing an excellent job and that **patient safety is paramount**.

The reason for encouraging reporting is not to look for blame; it is very much about understanding why these rare things happen, learning from them and putting in systems which will improve things in the future. For example, an increase in reporting of omitted doses is allowing this problem to be assessed.

Actions taken by the Trust:

We have undertaken a number of actions this year to further raise awareness of opportunity for medication errors.

The pharmacy department has implemented the use of discharge teams in Surgery to enable more efficient medicines supply at the time a patient goes home. This is being extended to include medical patients too. It also increased the number of wards operating the system of Patient Orientated Pharmacy (POP). Both of these allow the early identification of drug interactions and dosing errors by pharmacy staff working closely with patients, nursing and medical staff. Additionally the POP service increases patient safety as medication is administered from individual patient lockers reducing the risk of incorrect selection of medication.

Omnicell electronic medicine cabinets have been introduced in areas of high medicine supply such as Accident and Emergency and this reduces errors by indicating where a product is which has shown a reduction in medicine ordering and staff time used in medicine supply. Pharmacy re-supply has also been more efficient.

The pharmacy department is now open for longer hours on a weekend to support increased activity and aid medicine management on the wards.

Medicine safety bulletins/alerts are regularly produced by a multi-disciplinary team to highlight those medicines needing extra care when administering, prescribing or dispensing. These reflect the reporting within the Trust to ensure they are relevant. They are posted on all the wards and publicised through directorate teams.

The training department and pharmacy continue to work together to ensure that all staff involved with the prescribing or administration of medicines receive on going, evidence based training to allow them to practice safely. In the last year we have revised the training needs analysis to ensure all staff groups who are involved in medicines management receive appropriate training. The development and regular

updating of E-learning packages and workbooks ensure multiple access points are available for training. In depth audit and training programmes have been introduced to areas such as paediatrics and antibiotic prescribing.

The Community Directorate has developed a competency based proficiency tool to **support staff** involved in medication errors including lessons learnt.

Our **positive reporting culture** enables staff to understand what contributes to actual or potential error and helps them to come up with solutions to continually review and reduce risk. This is the reason why we have checks and balances in place across the Trust to improve patient safety and help our staff in any situation, whether they are caring for patients in our hospitals or in the community.

The latest benchmarking data published by the **North East Quality Observatory System** demonstrates that the Trust rate of medication errors is **38% lower than the national mean** rate with **4.75*** per 1,000 bed days against a national rate **7.70***.

*Data correct as of autumn v9.0 Acute Trust Quality Dashboard – period Oct12- Mar12

6. Safety Thermometer – (Waiting Update) – James Andrew/Sue Hoare-Leather

The Trust contributes to the Safety Thermometer which reports on four areas of harm:

- Pressure ulcers,
- Patient falls
- Catheter acquired urine infection
- VTE

The Trust has been in discussion with the national leads due to problems relating to data upload and accuracy. We continue to submit data for our wards and community services; however we continue to have concerns about the validity of data.

The Trust currently triangulates different sources of Pressure ulcer data in order to provide an accurate reflection of performance.

Safety Thermometer data shows regional benchmarking data for the Trust in relation to new pressure ulcers as follows: as far as we are aware, we are only one of a small number of Trusts national who **includes community data** with hospital data.

	Pressure Ulcers - All	Pressure Ulcers - New	Falls with harm	UTI + Catheter	All VTEs
***North Tees & Hartlepool (inc. community data)**	5.88%	1.71%	1.93%	1.93%	7.34%
Trust 1	5.34%	1.07%	0.72%	1.19%	2.34%
Trust 2	8.30%	1.54%	1.22%	0.86%	0.30%
Trust 3	6.35%	0.96%	1.44%	2.99%	7.57%
Trust 4	5.97%	2.42%	0.94%	1.07%	1.53%
Trust 5	3.02%	1.28%	0.21%	0.74%	2.15%
National Averages	**5.34%**	**1.20%**	**1.03%**	**1.12%**	**2.87%**

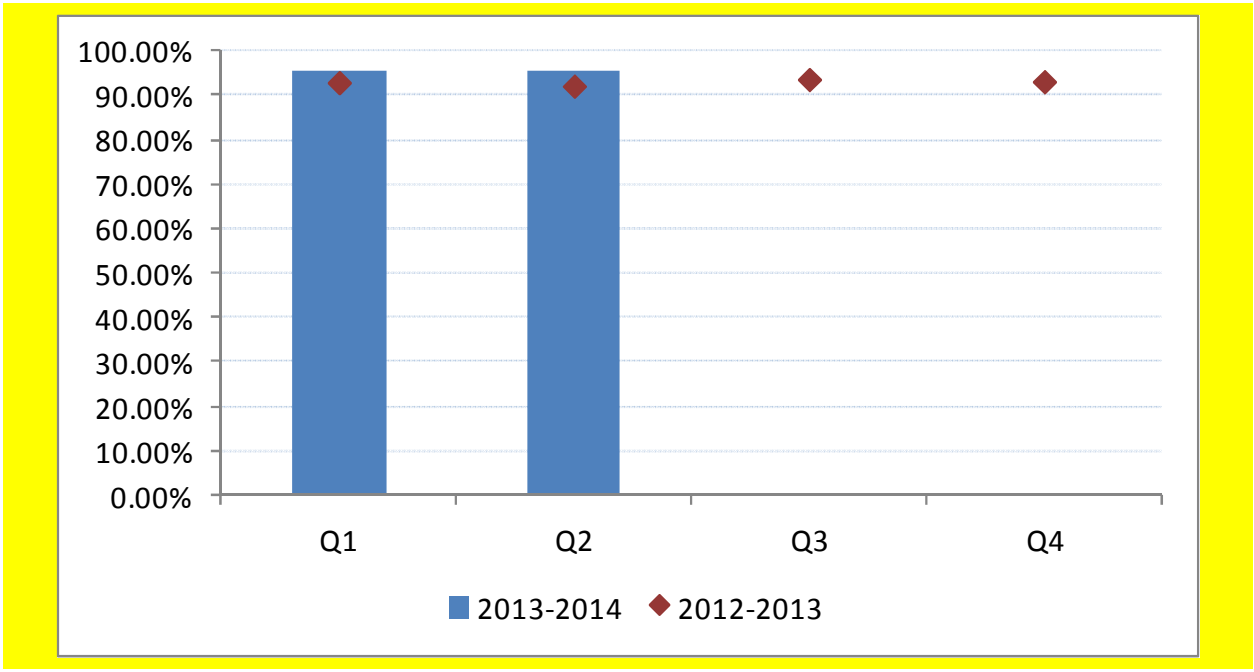
Pressure Ulcers from the Acute Trust Quality Dashboard autumn v9.00

		National Mean	North Tees	Trust 1	Trust 2	Trust 3	Trust 4	Trust 5	Trust 6	Trust 7
Incidence of patients with pressure ulcers per 1,000 admissions	Aug-13	3.01	3.50	1.99	4.27	1.10	9.68	6.53	2.62	0.87

7. Venous Thromboembolism

The Healthcare Evaluation Data (HED) dataset identifies the Trust has a month on month improvement along with a year on year improvement, in relation to the number of patients who are readmitted to hospital due to a VTE.

The trust has a consultant led committee that provide leadership and monitoring of VTE.



***Data as of Dec 2013**

Quarter	2012-13	2013-14	Increase or decrease on previous year
Q1	93.00%	95.42%	Increase Yr on Yr
Q2	92.20%	95.55%	Increase Yr on Yr
Q3	93.70%		
Q4	93.20%		

Average	93.03%		

***Data obtained from the Healthcare Evaluation Data (HED)**

Effectiveness of Care

1. Communication

Hospital healthcare – evidence in practice

Our continued success with the PEQS reviews provides additional opportunity for senior nurses to undertake adhoc intentional rounding. Also, the Board of Directors have commenced regular unannounced reviews of care which is a good example of corporate intentional rounding.

Over the reporting year, during our scheduled PEQS reviews, our senior nurses, governors and directors have had **seven** day-time PEQS reviews and **one** night-time review, visiting a total of *223 wards and departments in our hospitals and speaking to *714 patients and/or relatives as well as reviewing standards in community clinics and in patients own homes.

The following table provides data relating to 2011-2012 to 2013-2014 visits:

	2011/2012	2012/2013	2013/2014	2013/2014 - 2012/2013 Comparison
Wards Visited	209	224	*223	xx
Patients Seen	777	961	*714	xx

***Data correct as of January 2013**

In 2012 the Trust has developed a comprehensive PEQS database to record all reviews allowing detailed analysis. Trends are available for each area and ward. This enables them to monitor and share good practice and provide support where needed.

Reports from PEQS reviews are provided to Board of Directors and to the Council of Governors.

The Board of Directors have visited the hospitals at night to review standards of care and to derive assurance that standards remain high no matter what time or day patients are treated in our hospitals. Commissioners have also undertaken an unannounced night time review with positive feedback.

Please see the comparison for 2013/14 against previous reporting PEQS data for the three key areas:

	2011/2012 (max 100)	2012/2013 (max 100)	2013/2014 (max 100)		2013/2014 - 2012/2013 Comparison
First Impressions	91	85	92*	⇧	7*

Nursing Evidence	90	87	90*	⇧	3*
Patient Experience	98	96	96*	→	0*

***Data correct as of January 2013**

Community PEQS

Please see the comparison between 2012/13 and 2013/14 for the Community PEQS Scores.

In 2013/14 there were **48** patient homes visited.

	2011/2012	**2012/2013**	**2013/2014**	**2013/14 - 2012/2013 Comparison**
First Impressions	98	100	xx	xx
Nursing Evidence	77	90	xx	xx
Patient Experience	95	100	xx	xx

Include arrow showing increase or decrease in the above chart

Detail of the impact of the improvements linked to Priority 2 are demonstrated further below:

Hospital healthcare – evidence in practice

The way we captured information within the complaints department meant that we were unable to disaggregate nursing complaints. Therefore a nursing dashboard has been developed to support capture and reporting of this information more effectively.

Overall patients tell us that they are satisfied with communication

In 2013-14 our governors and non-executive board members spoke to **714*** patients to ask amongst other things, whether our healthcare professionals communicate well with them. They were asked if they understood what the plan of care is and whether they have been involved in decisions about them with staff communicating in a way they understand, using language they understand. Patients and relatives were asked if they knew what their medications are for and if they knew what tests they are having and why. They were also asked if our staff treat them with dignity and respect, with kindness and compassion and whether or not they would recommend our Trust. 94.46% of the **714*** patients spoken to report that they were satisfied with quality of communication, 97.89% reported that they were always treated with dignity and respect. 97.19% of patients interviewed reported that they would recommend the ward or department they were being treated on.

These questions continue to be asked on a regular basis and whilst recognising that we don't get it right every time, we have learned from these reviews as well as from the **national survey** that patients are satisfied with the following aspects of communication:

- We are involving people in decisions about their care
- People can find someone to talk to about their worries and fears
- Patients believe they are given enough privacy when discussing their condition or treatment
- Although we score well when compared to Trusts nationally in relation to telling people about the medication side-effects to watch out for when they go home, there are still improvements we can make.
- Our patients gave us a good score when they were asked if they knew who to contact if they were worried about their condition.

The National Cancer Patient Survey reported that 69% of patients felt they could discuss worries or fears with staff during visits, placing us in the middle 60% nationally. We were also in the top 20% nationally in giving the patient enough emotional support (81% down from 84% in 2011).

2. Selected quality performance indicators and national benchmarks from the North East Quality Observatory System (NEQOS)

NEQOS collects benchmark data on Trusts for a number of clinical indicators. The following indicators provide an indication of Trust performance when compared to other NHS Trusts nationally.

Effectiveness indicator	Date	Trust value	National Mean
95th percentile wait for elective inpatient treatment (weeks)	Aug 13	23.10	21.70
Median wait for elective inpatient treatment (weeks)	Aug 13	11.20	8.98
Delayed transfer of care per 1,000 occupied beds – NHS responsibility	Q1 13/14	375.30	652.00
% of all admissions who have had venous thromboembolism risk assessment	July 13	95.50%	95.90%
Medication errors per 1,000 bed days	Oct 12-Mar 13	4.75	7.70
Admitted patient care - % valid data (average for all fields)	Aug 13	99.00%	97.82%
Outpatient - % valid data (average for all fields)	Aug 13	92.20%	95.75%
Accident and emergency - % valid data (average for all fields)	Aug 13	99.90%	97.23%
Admitted patient care - % records submitted with valid HRG on first submission	Jul 13	99.80%	98.70%
Staff recommendation of the Trust as a place to work (last CQC survey)	2012	55.10%	55.20%
Staff recommendation of the Trust as a place to receive treatment (last CQC survey)	2012	60.60%	62.10%
Overall medical trainees global satisfaction score (last GMC survey)	2012	83.10%	78.60%
Consultant clinical supervision trainers given to their trainees	2012	91.60%	86.80%

***Information taken from Release 9.00 autumn 2013/2014**

3. **Performance from key national priorities from the Department of Health Operating Framework, Appendix B of the Compliance Framework – data as of 16 December 2013**

The Trust continued to deliver on key cancer standards throughout the year; two week outpatient appointments, 31 days diagnosis to treatment and 62 day urgent referral to treatment access targets. The Trust demonstrated a positive position with evidence of continuous improvement against the cancer standards introduced in the Going Further with Cancer Waits guidance (2008).

www.connectingforhealth.nhs.uk/nhais/cancerwaiting/cwtguide7.pdf

The compliance framework forms the basis on which the Trusts' Annual Plan and in year reports are presented. Regulation and proportionate management remain paramount in the Trust to ensure patient safety is considered in all aspects of operational performance and efficiency delivery. The current performance against national priority, existing targets and cancer standards are demonstrated in the table with comparisons to the previous year.

Existing commitments	National Standard	Performance 2013/14	Performance 2012/13	Achieved
4 hour emergency care target	**95%**	Apr-Nov 13 96.23%	2012/2013 97.00%	√
In patient waiting time	**26 weeks**	Apr-Nov 13 0	2012-2013 0	√
Out patient waiting time	**13 weeks**	Apr-Nov 13 0	2012/2013 0	√
Access to rapid access chest pain clinics within 2 weeks of referral from GP	**100%**	Apr-Nov 13 100%	2012/2013 100%	√
Cancelled operations for non medical reasons	**Year on year improvement**	Apr-Nov 13 0.49%	2012/2013 0.40%	√
Readmission within 28 days of non medical cancellation	**100%**	Apr-Nov 13 100%	2012/2013 100%	√
Delayed Transfers of Care	**3.50%**	Apr-Nov 13 1.69%	2012/2013 2.09%	√
18 weeks maximum wait referral to treatment (RTT)- admitted pathways	**90%**	Apr-Nov 13 92.87%	2012/2013 92.53%	√
RTT 95th percentile wait – admitted pathways	**23 weeks**	Apr-Nov 13 22.3	2012/2013 20.6	√

18 weeks maximum wait referral to treatment (RTT) - non admitted pathways	**95%**	Apr-Nov 13 99.07%	2012/2013 99.25%	√
RTT 95th percentile wait – non admitted pathways	**18.3 weeks**	Apr-Nov 13 13.3	2012/2013 11.9	√
18 weeks maximum wait referral to treatment (RTT) – incomplete pathways	**92%** **(Operating Framework 2012/13)**	Apr-Nov 13 97.43%	2012/2013 96.75%	√
RTT 95th percentile wait – incomplete pathways	**28 weeks**	Apr-Nov 13 16.0	2012/2013 16.9	√
MRSA (post 48 hours)		Apr-Nov 13 0	2012/2013 2	
C Diff (post 48 hours)		Apr-Nov 13 27	2012/2013 61	
Eliminating Mixed Sex Accommodation	**0**	Apr-Oct 13 0	2012/2013 0	√
Compliant with access to healthcare for patients with learning disabilities	**Full Compliance**		Full Compliance	√

Cancer standards	National Standard	Performance 2013/14	Performance 2012/13	Achieved
14 day maximum wait for a first outpatient appointment following urgent GP referral	**93%**	2012/2013 94.5%	95.4%	√
14 day maximum wait for a first outpatient appointment for breast symptomatic referral	**93%**	2012/2013 94.0%	92.6%	√
31 day maximum wait to decision to treat	**96%**	2012/2013 99.7%	99.4%	√
31 day maximum wait decision to treat to subsequent treatment (drug therapy)	**98%**	2012/2013 100%	98.8%	√
31 day maximum wait decision to treat to subsequent treatment (surgery)	**94%**	2012/2013 99.1%	98.3%	√
62 day maximum wait referral to treatment - all cancers	**85%**	2012/2013 87.5%	88.1%	√

62 day maximum wait from screening recall to treatment	**90%**	2012/2013 97.6%	94.1%	√

NB: Cancer Standards position was not finalised at time of print

Patient Experience

1. Formal complaints and compliments

The Trust continues to work hard to improve customer satisfaction through patient experience.

We do recognise that we don't always get things right and this is why we have a dedicated **patient experience team** to listen to and investigate any concerns or complaints.

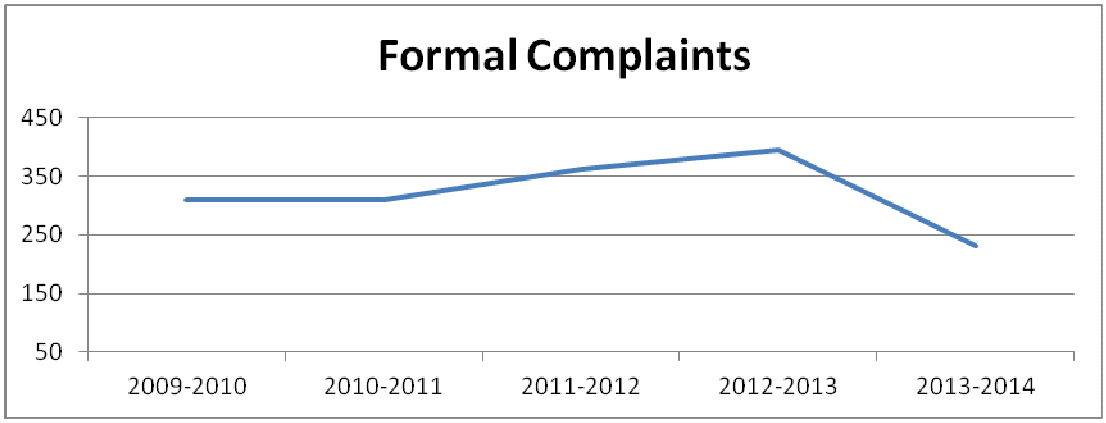
We continue to work hard to provide high standards of clinical care delivered with dignity and compassion for everyone. Feedback from patients is important because it helps us to understand what we do well and what we can improve further.

Complaints:

The number of formal complaints received over the last 5-years is shown in the following table:

Year	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014
Formal Complaints	*358*	*341*	*371*	*396*	*231**

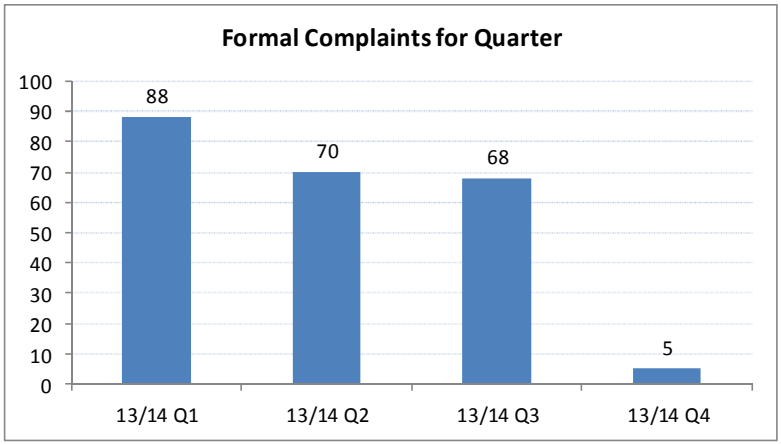
***data till 17 January 2013**



***data till 17 January 2013**

The following table trends the 2013/2014 formal complaints by quarter.

	13/14 Q1	13/14 Q2	13/14 Q3	13/14 Q4	Total
Totals:	88	70	68	5	231



2013-2014 Formal Complaints by subject type:

From the **231** formal complaints received in 2013/2014 there are **530** complaint types. Please see the following breakdown of those types per quarter.

	13/14 Q1	13/14 Q2	13/14 Q3	13/14 Q4	Total
Clinical - Medical Staff	90	57	49	8	204
Clinical - Nursing	63	63	74	4	204
Admissions, transfer and discharge issues	11	14	9	1	35
Medication	8	8	11	0	27
Appointments	14	3	2	0	19
Clinical Staff - Scientific	3	2	8	0	13
Clinical - Therapy Staff	6	4	0	0	10
Complaints of non clinical issues including staff	3	4	3	0	10
Aids, appliances equipment	0	2	1	0	3
Consent	2	0	0	0	2
Hotel Services incl food	0	0	2	0	2
PCT/Commissioning issues incl strategic decisions	1	0	0	0	1
Totals:	**201**	**157**	**159**	**13**	**530**

***data till 17 January 2013**

Changes to the way complaints are handled within the Trust:

In August 2013 the Trust undertook a Rapid Process Improvement Workshop (RPIW) to review the current complaints process. The main aim of the review was to reduce the number of formal complaints that the Trust receives.

The main outcome of the process was to establish a more front end approach to the complaints procedure, ensuring that the Trust gives the complainant every opportunity to put across their view and receiving a comprehensive response from the relevant area involved in the complaint, rather than automatically setting the complaint as a formal one.

The Trust now has three new complaints streams:

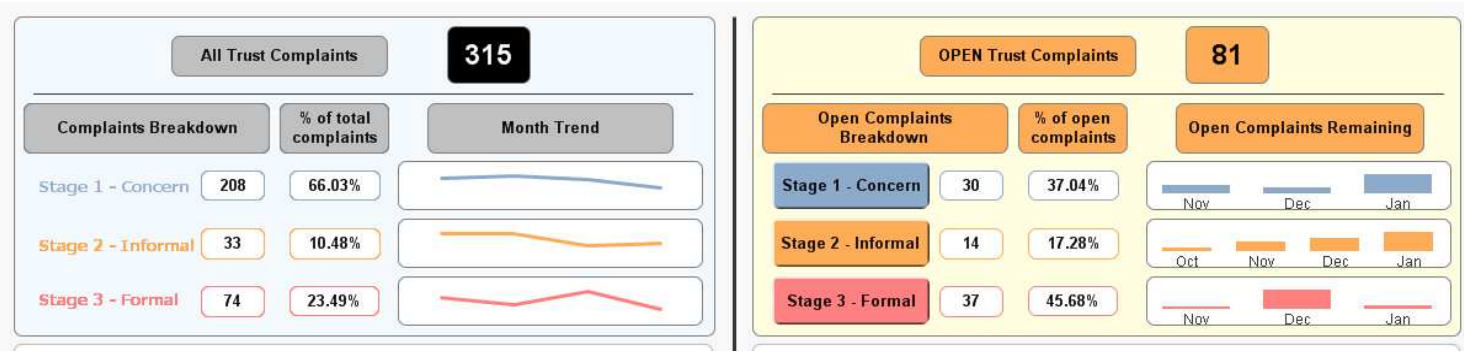
- Stage 1 – concern; to be dealt with by the Patient Experience Team (PET) or at the time of complaint at ward level,
- Stage 2 – Informal; for a meeting to be arranged with the complainant to come into the Trust to discuss the complaint with the Senior Clinical Matron and relevant personnel involved in the complaint with hopefully a resolution at this stage.
- Stage 3 – Formal; if Stage 1 or stage 2 did not resolve the issue or the complaint did not want to go through those routes, then a formal stage 3 is raised.

By changing the process the Trust is ensuring that all possible complainants have an opportunity to air their grievances/concerns with an immediate Trust response, rather than waiting the statutory 25/40 days if the complaint goes the formal route.

The Trust has also built a complaints dashboard which breakdown all of the complaints that the Trust receives into the three categories from the new metrics (1 October 2013):

- Stage 1 – Concern
- Stage 2 – Informal
- Stage 3 – Formal

The complaints dashboard displays how many complaints the Trust has received along with how many are still open and in which category.



***data till 16 January 2013**

There are additional pages on the dashboard which show monthly trends on the complaints for Directorate split, method of complaint, method of receipt, average time take to close complaint types and the complaints subject.

Since the 1st October 2013, the Trust has received **315** complaints of which **74** have gone onto the formal complaint process, this only equates to **24.49%** of the complaints. This is a vast improvement over the old process when over 50% were going to the formal process.

Complaint Category

The top 10 complaint types since 1st October 2013 are as follows:

Complaint type	Number of complaints
Communication - Insufficient	**61**

Competence of staff member	**27**
Discharge arrangements	**24**
Treatment and procedure delays	**23**
Attitude - unhelpful	**18**
Communication - Inappropriate	**17**
Failure to monitor	**17**
Attitude - unprofessional	**17**
Admission delays and communication	**16**
Outpatient cancellation	**16**

External feedback

The **North East Quality Observatory System** benchmark data reports the Trust at **5.84* written complaints** per **1,000** episodes of care which is significantly lower than the **national mean of** 6.26*.

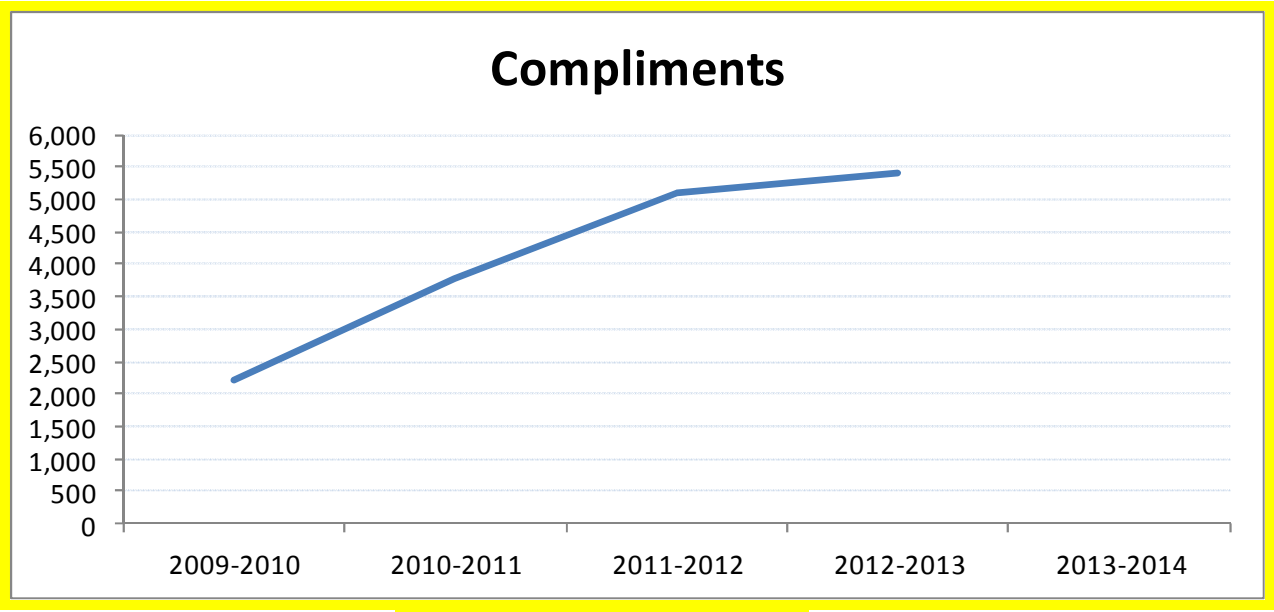
*Data correct as of autumn v9.0 Acute Trust Quality Dashboard – period 2012/2013

Compliments:

In 2009-2010 we started to record the number of **compliments** received. The number of thank you and complimentary comments has increased year on year. Trends in compliments can be seen in the following table and chart.

Year	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014
Compliments	*2,212*	*3,786*	*5,097*	*5,414*	*xx*

Data needs updating on table and chart



***data till 10 December 2013**

North East Quality Observatory System reports (2011-2012), for **inpatient experience measure** for the Trust as **7.60* against a national mean score of 7.50*.**

*Data correct as of autumn v9.0 Acute Trust Quality Dashboard – period 2011/2012

2. You're welcome

Your Welcome is a Department of Health quality criteria for young, people friendly, health services which the Paediatric service are participating in. The service will be assessed by a panel including young people, of their provision within nine topical areas:

1. Accessibility
2. Publicity
3. Confidentiality and consent
4. Environment
5. Staff training, skills, attitudes and values
6. Joined-up working
7. Young people's involvement in monitoring and evaluation of patient experience
8. Health issues for young people
9. Sexual and reproductive health services

3. People with Learning Disabilities – Molly Taylor

The Trust held successful events in September 2012 and December 2012. These events were focused on the broad issues of protecting those most vulnerable in our communities. Post Winterbourne View Interim Report prompted us to commission the performance Out of Sight which is an **interactive drama** which was produced and performed by Operating Theatre. The December 2012 event also promoted the recently adopted "Deciding Right" approach to advance decisions about end of life choices.

Hospital Tours for people with learning disabilities have been introduced in 2012 across both the sites and are proving to be a success.

Every ward has been provided with a copy of the Winterbourne View Interim Report as part of the learning resource files.

Learning resource files have been developed during 2012 and are in place as a support tool to dealing with people with learning disabilities. MCA, MHA and DoLS codes of practice and posters have been distributed for quick reference.

We have updated the Learning Disability Pathways of Care and will continue to refine this in 2013.

We have strengthened the Trusts People With Learning Disabilities Strategy Group and this includes people with LD.

The Board of Directors have been updated in relation to the Francis report, **Winterbourne View** report, Airedale report, Six Lives report, Care Ombudsman report and recently have been briefed on the Savile enquiry.
Winterbourne review – Easy Read version

www.wp.dh.gov.uk/publications/files/2012/12/easy-read-of-final-report.pdf

The Trust hosted **multi agency conferences** in Hartlepool to highlight its passionate about safeguarding work. Over 300 people attended and provided excellent feedback.

4. Pressure ulcers (also known as decubitus ulcer or pressure sores) – Linda Watson

Reducing opportunity for pressure ulcers has been a high priority for all healthcare staff in the community and in hospital.

Actions taken by the Trust:

Over the year, training in the prevention and management of pressure ulcers has been further enhanced. Every pressure ulcer graded as category two, three or four that is acquired whilst in our care is subject to a full investigation to help us to understand whether it was avoidable or not and importantly, whether there is anything that we can learn. At the end of 2011-2012 a new **body-mapping process** was introduced. This should be completed on admission to hospital or admission onto a district nursing caseload. It is also completed on discharge from hospital for all patients who have a wound and the information passed onto the next care provider. The IPNMB oversee actions to pursue continuous improvement in performance.

Bi-annual pressure ulcer prevalence audits are carried out across both the hospital and community services. Our specialist nurses support bespoke training and support clinical teams to maximise treatment options. In 2013-2014, we will continue to focus on the reduction of avoidable pressure ulcers in hospital and in the community setting. At the end of 2012-2013 **a new care bundle** is to be introduced. The SSKIN (Surface, Skin inspection, Keep moving, Incontinence, and Nutrition) bundle focuses on interventions proven to reduce the risk of pressure ulcers occurring.

The Trust participated in a research study ending in 2011 to assist the development and validation of a patient reported outcome measure of health related quality of life for patients with pressure ulcers (PUQOL). This was part of a programme of research and the team have submitted an expression of interest to be a recruiting site for a further two research studies to commence in 2012.

The Pressure Ulcer Quality of Life Adjusted Years (PUQALY) is a small sample study of patients with pressure ulcers and involves the completion of an nurse administered questionnaire.

The Pressure 2 trial proposes to compare high specification foam mattresses and alternating pressure mattresses for patients at high risk of pressure ulcers in hospital settings.

It is anticipated portfolio studies will commence in early 2013 with funding support for research nurse input from the CLRN.

Part 3C: Core set of Quality Indicators

In 2012/2013 Quality Accounts the core set of Quality Indicators first appeared, all Trusts are required to report against these indicators every year.

For ease of reference the Trust has grouped the eight indicators together under this section.

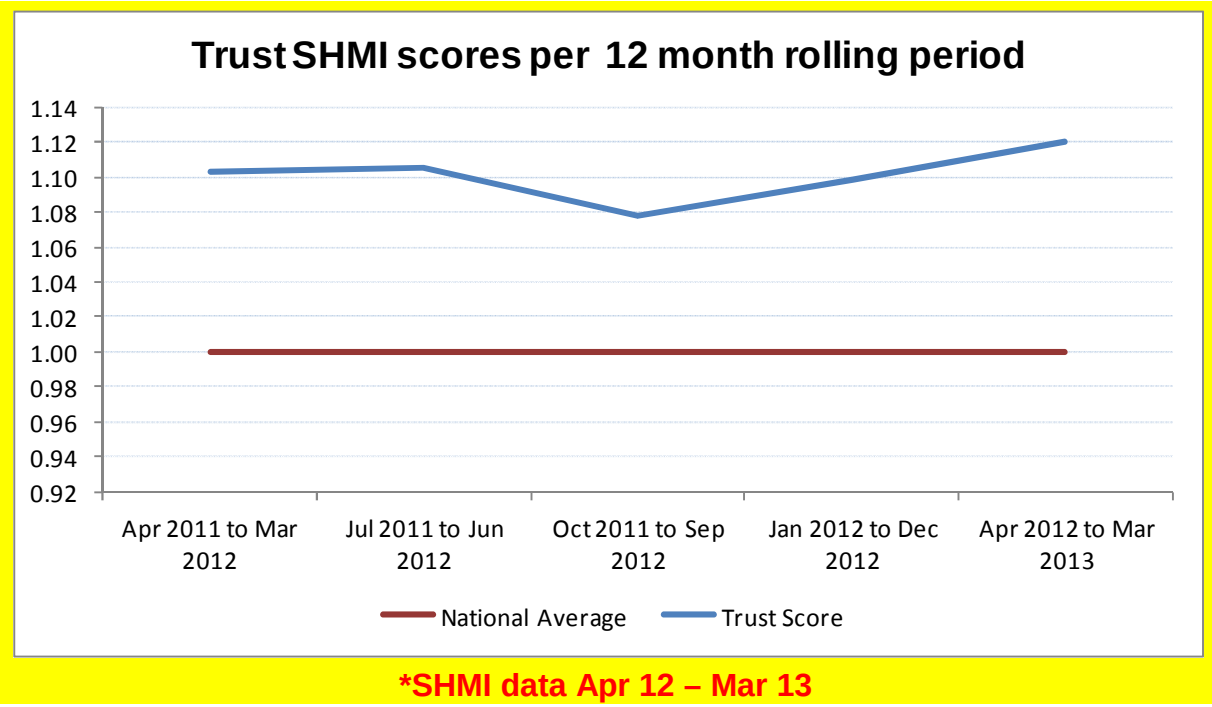
Measure	Measure Description	Data Source
1a	The value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust	NHS Information Centre Portal (NHSIC)

Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation, England, April 2012 - March 2013

Time period	OD banding	Trust Score	National Average	Highest - SHMI Trust Value in the country	Lowest - SHMI Trust Value in the country
Apr 2011 - Mar 2012	Band 2	1.1028	1.00	1.2475	0.7102
Jul 2011 - Jun 2012	Band 2	1.1050	1.00	1.2550	0.7108
Oct 2011 - Sep 2012	Band 2	1.0778	1.00	1.2107	0.6849
Jan 2012 - Dec 2012	Band 2	1.0990	1.00	1.1919	0.7031
Apr 2012 - Mar 2013	Band 2	1.1206	1.00	1.1235	0.8901

OD banding descriptions:

OD banding 1 - higher than expected
OD banding 2 - as expected
OD banding 3 - lower than expected



***SHMI data Apr 12 – Mar 13**

Measure	Measure Description	Data Source
1b	The percentage of patient deaths with palliative care coded at either diagnosis or specialty lever for the Trust	NHS Information Centre Portal (NHSIC)

Percentage of deaths with palliative care coding, April 2012 - March 2013

19.30% of patients that die within the Trust are coded as patients receiving palliative care. This has been evidenced through the SHMI mortality review and reported to the board.

Time period	Diagnosis Rate	Diagnosis Rate National Average	Highest - Diagnosis Rate	Lowest - Diagnosis Rate	Combined Rate	Combined Rate National Average	Highest - Combined Rate	Lowest - Combined Rate
Apr 2011 - Mar 2012	23.00	17.85	44.20	0.00	23.00	18.10	44.20	0.00
Jul 2011 - Jun 2012	24.10	18.38	46.30	0.30	24.10	18.60	46.30	0.30
Oct 2011 - Sep 2012	21.60	19.00	43.30	0.20	21.60	19.20	43.30	0.20
Jan 2012 - Dec 2012	19.30	19.30	42.70	0.10	19.30	19.47	42.70	0.10
Apr 2012 - Mar 2013	17.80	20.25	43.90	0.10	17.80	20.38	44.00	0.10
Jul 2012 – Jun 2013								

Latest Time Period benchmarking position - April 2012 - March 2013

Provider	Diagnosis Rate	Combined Rate
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	17.80	17.80
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	12.90	12.90
SOUTH TYNESIDE NHS FOUNDATION TRUST	26.70	27.00
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	18.20	18.20
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	25.10	25.20
GATESHEAD HEALTH NHS FOUNDATION TRUST	14.10	14.70
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	12.80	12.80
CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST	11.00	11.00

National Average	20.25	20.38

The benchmark data identifies the Trust as having a higher proportion of patients receiving palliative care admitted to hospital than many other organisations in the North East and significantly more than the average across the hospitals in England.

The **North Tees and Hartlepool NHS Foundation Trust** considers that this data is as described for the following reason. SHMI mortality data when reviewed against other sources of mortality data including Hospital Standardised Mortality Ratio (HSMR) and when benchmarked against other NHS organisations will provide a robust overview of overall mortality performance.

The **North Tees and Hartlepool NHS Foundation Trust** has taken the following actions to improve this score, the quality of its services, by undertaking a comprehensive review of cases to help understand where and why deaths outside of hospital occur.

This review demonstrates that there are a high number of patients who have been discharged home to die in accordance with their wishes and this has affected the hospital SHMI score.

The Trust is working with commissioners to review pathways of care and support patient choice of residence at end of life wherever possible.

Measure	Measure Description	Data Source	Value
2	The Trust's patient reported outcome measure scores (PROMS) for- 1. Groin hernia surgery 2. Varicose vein surgery 3. Hip replacement surgery 4. Knee replacement surgery	NHS Information Centre Portal (NHSIC)	Adjusted average health gain

Time period	Value	April 12 - May 13	April 12 - March 12	April 11 - March 12	April 09 - January 11
Groin hernia	Trust Score	xx	0.0690	0.0740	0.0540
	National Average	xx	0.0910	0.0870	0.0840
	Highest National	xx	0.1580	0.1430	0.1370
	Lowest National	xx	0.0170	-0.0020	0.0160
Varicose vein	Trust Score	xx	**No data**	**No data**	0.0920
	National Average	Xx	0.0930	0.0940	0.0950
	Highest National	Xx	0.1380	0.1670	0.1410
	Lowest National	Xx	0.0240	0.0470	-0.0060
Hip replacement	Trust Score	Xx	**No data**	0.3940	0.3550
	National Average	Xx	0.4370	0.4160	0.4110
	Highest National	Xx	0.5020	0.5320	0.5040
	Lowest National	Xx	0.3330	0.3060	0.2920
Knee replacement	Trust Score	Xx	**No data**	0.3190	0.3110
	National Average	Xx	0.3120	0.3020	0.2980
	Highest National	Xx	0.3870	0.3850	0.4070
	Lowest National	xx	0.2440	0.1800	0.2060

Positive numbers are an improvement and negative reduction

The **North Tees and Hartlepool NHS Foundation Trust** considers that this data is as described for the following reasons. The Trust has been identified as an outlier in relation to hips.

The **North Tees and Hartlepool Foundation Trust** has taken the following actions to improve this score, and so the quality of its services, by undertaking a comprehensive review of hips PROMS cases and has established that, patients score positively in relation to the outcome in related to their operation; however patients are scoring less positively in their general health. A review of case notes has identified that the low score relates to overall health and not to the surgery itself in the majority.

6.2 (a)

The Trust participated in the original pilot for PROMS, as such this is well embedded into practice with high numbers of returns for our patients admitted via elective pathways for hip, knee replacement hernia repair and varicose vein surgery.

Please see the following table for the four PROMS measures compared with the other North East Trusts.

Acute Trust Quality Dashboard (Aug v8.0)					Trusts							
			National Mean	North Tees	Trust 1	Trust 2	Trust 3	Trust 4	Trust 5	Trust 6	Trust 7
IH23	Patient Reported Outcome Measure - % Patients reporting an improvement following **hip replacement (Apr 11-Mar 12)**	1213	87.20%	81.50%							
IH24	Patient Reported Outcome Measure - % Patients reporting an improvement following **knee replacement (Apr 11-Mar 12)**	1213	79.10%	80.60%							
IH25	Patient Reported Outcome Measure - % Patients reporting an improvement following **varicose vein procedure (Apr-Jun 12)**	1213	52.60%	66.70%							
IH26	Patient Reported Outcome Measure - % Patients reporting an improvement following **hernia procedure (Apr-Jun 12)**	1213	51.00%	40.70%							

*Data taken from the Acute Trust Quality Dashboard summer v 9.0

Measure	Measure Description	Data Source
3	The percentage of patients readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period; aged: (i) 0 to 14; and (ii) 15 or over.	NHS Information Centre Portal (NHSIC)

The **North Tees and Hartlepool Foundation Trust** considers that this data is as described for the following reasons. The Trust is reported as higher than average rates of readmission to hospital within 28 days of being discharged.

Age Group	Value	Data for 2011/12 standardised to persons 2006/07	Data for 2010/11 standardised to persons 2006/07	Data for 2009/10 standardised to persons 2006/07	Data for 2008/09 standardised to persons 2006/07
0 to 14	Trust Score	9.44	11.45	12.23	11.87
	National Average	xx	10.15	10.18	10.09
	Band	xx	A1	A1	A1
	Highest National	xx	25.80	22.53	22.73
	Lowest National	xx	0.00	0.00	0.00
15 or over	Trust Score	11.80	11.48	11.23	11.32
	National Average	xx	11.42	11.16	10.90
	Band	xx	W	W	A5
	Highest National	xx	23.99	16.82	24.43
	Lowest National	xx	0.00	0.00	0.00

5 Band Comparison against national average

Note 1: National Comparison, based on 95% and 99.8% confidence intervals of the rate

B1 = Significantly better than the national average at the 99.8% level;
B5 = Significantly better than the national average at the 95% level but not at the 99.8% level;
W = National average lies within expected variation (95% confidence interval);
A5 = Significantly poorer than the national average at the 95% level but not at the 99.8% level;
A1 = Significantly poorer than the national average at the 99.8% level.

The **North Tees and Hartlepool Foundation Trust** has taken the following actions to improve this percentage, and so the quality of its services, by preventing avoidable readmissions within 30 days of discharge has presented a considerable challenge for the Trust and is being addressed by the investment of a significant amount of work and effort. With the required focused clinical leadership and strategic approach there has been a marked improvement to the elective and emergency readmission position.

A readmission strategy has been produced, patient pathways have been redesigned and new initiatives implemented including: community integrated assessment teams and teams around practices to ensure that patients receive timely care, at home, by the most appropriate health care professional; the introduction of a dedicated cholecystectomy list to provide timely access to surgery for patients who may have had recurrent admissions to hospital with acute cholecystitis whilst awaiting a date for surgery; the implementation of a single telephone access point to direct patients, carers and health care professional to the most appropriate service to meet the needs of the patient; and the utilisation of ambulatory care so that patients can be assessed, seen and treated by senior clinicians and return home without the need for admission to hospital.

Regular audits are undertaken to identify pathways to redesign and other initiatives are being developed, tested and implemented, resulting is a better patient experience whilst maintaining a safe, quality and efficient service.

Measure	Measure Description	Data Source
4	The Trusts responsiveness to the personal needs of its patients	NHS Information Centre Portal (NHSIC)

Responsiveness to the personal needs of patients

Period of Coverage	National Average	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	***Highest*** National Trust Average Weighted Score	***Lowest*** National Trust Average Weighted Score
		(out of 100)	(out of 100)	(out of 100)
2013/14	xx	xx	xx	xx
2012/13	68.10	68.70	84.40	57.40
2011/12	67.40	71.00	85.00	56.50
2010/11	67.30	70.10	82.60	56.70
2009/10	66.70	65.70	81.90	58.30
2008/09	67.10	68.50	83.40	56.90
2007/08	66.00	66.30	83.10	54.60
2006/07	67.00	72.40	84.00	55.10
2005/06	68.20	72.80	82.60	55.80
2003/04	67.40	73.00	83.30	56.00

In **2012/13** the National Average score for England in response to this question was **68.10%**.

NB: Average weighted score of 5 questions relating to responsiveness to inpatients' personal needs (Score out of 100)

The Trust has worked hard in order to further enhance its culture of responsiveness to the personal needs of patients.

The **North Tees and Hartlepool NHS Foundation Trust** considers that this data is as described for the following reasons. The Trust has developed its Patients First strategy and understanding patient views in relation to responsiveness, personal needs helps us to understand how well we are performing.

The **North Tees and Hartlepool NHS Foundation Trust** has taken the following actions to improve this score, and so the quality of its services, by delivering accredited programmes that focus on responsiveness of patient and carers for both **registered and unregistered nurses** on. We use **human factors training** to raise awareness of the impact of individual accountability on patient outcomes and experience. When compared against the national average score the Trust continues to be rated well by patients.

Measure	Measure Description	Data Source
5	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE)	NHS Information Centre Portal (NHSIC)

Measure	Value	2013/2014				2012/2013			
Venous Thromboembolism	Quarter	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Value	95.42%	95.40%			93.01%	92.21%	93.69%	93.22%
	National Average					93.40%	93.80%	94.10%	
	Highest National					100.00%	100.00%	100.00%	
	Lowest National					80.80%	80.90%	84.60%	

The Trust has promoted the importance of doctors undertaking assessment of risk of VTE for all appropriate patients in line with **best practice**.

The **North Tees and Hartlepool Foundation Trust** considers that this data is as described for the following reasons. Understanding percentage of patients who were admitted to hospital who were risk assessed for VTE helps the Trust to understand and reduce cases of avoidable harm.

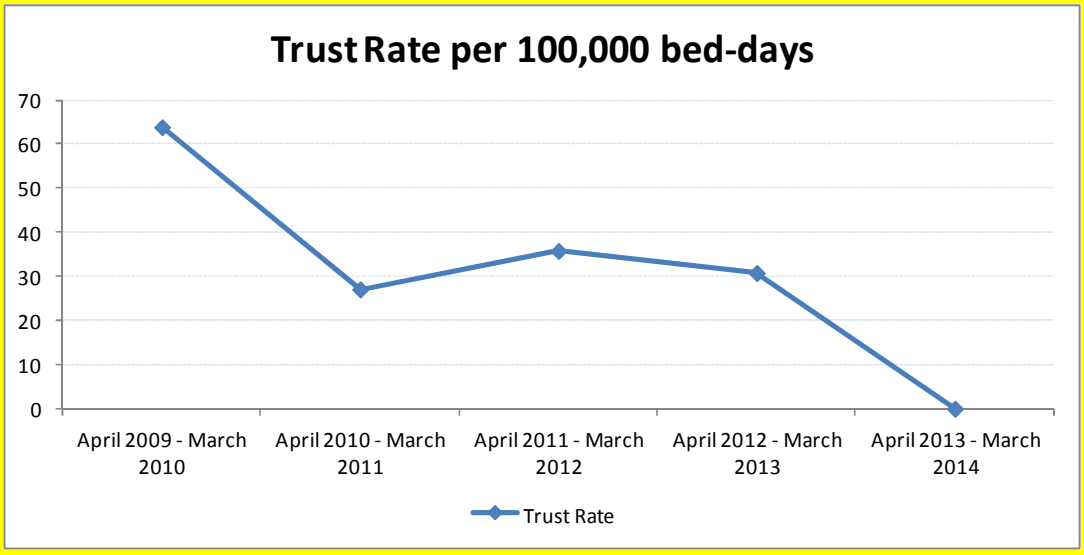
The **North Tees and Hartlepool Foundation Trust** has taken the following actions to continue to improve this percentage, and so the quality of its services, by including training on the importance of VTE risks assessment at induction of clinical staff. Consultants monitor performance in relation to VTE risk assessment on a daily basis.

Sue Piggott/Nick Roper

Measure	Measure Description	Data Source
6	The rate per 100,000 bed days of cases of C.difficile infection that have occurred within the trust amongst patients aged 2 or over during the reporting period.	NHS Information Centre Portal (NHSIC)

When compared to Trusts nationally the organisation is reported as an outlier:

	Rate per 100,000 bed-days for specimens taken from patients aged 2 years and over				
Reporting Period	Trust C difficile cases	Trust Rate	National Average	Highest National rate	Lowest National rate
April 2013 - March 2014	*28	xx	xx	xx	xx
April 2012 - March 2013	61	30.8	17.3	30.80	0.00
April 2011 - March 2012	68	35.8	22.2	58.20	0.00
April 2010 - March 2011	53	27.1	29.7	71.20	0.00
April 2009 - March 2010	136	63.9	35.3	128.90	0.00



***Data as of 10 December 2013**

The **North Tees and Hartlepool Foundation Trust** considers that this data is as described for the following reasons. Understanding the Trusts benchmark position in relation to C difficile is important and informs actions that can be taken to understand and reduce the burden of this infection.

The **North Tees and Hartlepool Foundation Trust** has taken the following actions to improve this rate, and so the quality of its services, by undertaking a comprehensive review of all data in relation to C difficile, including not only the number of cases reported, but also the number of samples sent for analysis. This provides evidence that the Trust is proactive in its testing regime when compared to many organisations.

For more detailed information in regards to C difficile for the Trust, please refer to page 18.

Measure	Measure Description	Data Source
7	The number and, where available, rate of patient safety incidents that occurred within the trust during the reporting period, and the percentage of such patient safety incidents that resulted in severe harm or death.	NHS Information Centre Portal (NHSIC)

Reporting and understanding patient safety incidents is an important indicator of a safety culture within an organisation.

The **North Tees and Hartlepool Foundation Trust** considers that this data is as described for the following reasons. Understanding numbers and rate of incidents reported alongside the percentage of deaths reported enables the organisation to understand whether actions taken are effective.

Medium Acute organisations - Organisational incident data by organisation in 6-month period, **1st October 2012 – 31 March 2013**

	Based on occurring dataset		National			Our Trust		National			Our Trust	
			Degree of harm - Severe			Degree of harm Severe		Degree of harm - Death			Degree of harm Death	
Report period	Number of incidents occurring	Rate per 100 admissions	Average %	Highest %	Lowest %	Number of incidents	%	Average %	Highest %	Lowest %	Number of incidents	%
xx	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx
Oct 12 – Mar 13	2,576	6.18	0.50	1.70	0.00	**25**	**0.97**	0.20	3.00	0.00	**3**	**0.12**
Apr 12 – Sept 12	2,615	6.27	0.60	3.10	0.00	**17**	**0.70**	0.20	1.30	0.00	**1**	**0.00**
Oct 11 - Mar 12	2,309	5.23	0.60	3.00	0.00	**30**	**1.30**	0.20	0.60	0.00	**3**	**0.10**
Apr 11 - Sept 11	2,272	5.15	5.50	24.80	0.50	**16**	**0.70**	0.50	0.90	0.00	**2**	**0.10**
Oct 10 - Mar 11	2,011	4.66	0.60	2.80	0.00	**8**	**0.40**	0.20	1.00	0.00	**2**	**0.10**

The **North Tees and Hartlepool Foundation Trust** has taken the following actions to improve this reporting rate and so the quality of its services, by weekly monitoring if incidents and actions taken to reduce risk of recurrence. The trust also undertakes regular mortality reviews and these are described within the Quality Account. The Trust remains proactive in its review of incident reporting and its monitoring of impact of actions taken.

This proactive approach to patient safety has supported a reduction in deterioration ad serious harm, as is evidence on the following pages.

Some of our ambitions for 2012-2013 were more complex than anticipated and took us longer than expected to achieve. For example, developing an early warning score for use by

community nurses took longer than expected because we had to develop and test a new product before we could introduce it for use by community staff

Our community team developed a process for identifying patients at risk of deterioration at home through the use of Telehealth. During the last year we have collected data which identifies the contribution that this assistive technology makes, in conjunction with skilled clinical support, to safely care for patients in their own home.

Janet Alderton – Spirit of Candour

Measure	Measure Description	Data Source
8	The percentage of staff employed by, or under contract to, the trust who would recommend the trust as a provider of care to their family	NHS Information Centre Portal (NHSIC)

National NHS Staff Survey

Question: If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust

Measure	Value	Staff survey 2013	Staff survey 2012
National Staff Survey	**Trust Score**	xx	60.62
	National Average	xx	64.51
	Quartile	xx	2nd
	Highest National	xx	94.20
	Lowest National	xx	35.34

The Trust believes that the attitude of its staff is the most important factor in the experience of patients. We will continue to work with staff to develop the leadership and role modeling required to further enhance the experience of patients, carers and staff.

The **North Tees and Hartlepool NHS Foundation Trust** considers that this data is as described for the following reasons. The Family or Friends (F&F) test identifies the percentages of patients who would recommend the Trust as a provider of care to their family or friends.

The **North Tees and Hartlepool Foundation Trust** has taken the following actions to further improve this percentage, and so the quality of its services, by involving patients relatives and staff in developing a strategy for care. All wards and departments are monitored in relation to the F&F test.

In 2012/2013, 98% of patients said they would recommend the Trust to care for their family or friends.

Understanding the views of staff is an important indicator of the culture of care within the organisation. The percentage of staff who would recommend the Trust as a provider of care to family or friends was a little better than the national average.

Also, please refer to our Family and Friends data at page 42 for additional information

Measure	Measure Description	Data Source
9	Friends and Family Test – Patient. The data made available by National Health Service Trust or NHS Foundation Trust by the Health and Social Care Information Centre for all acute providers of adult NHS funded care, covering services for inpatients and patients discharged from Accident and Emergency (types 1 and 2)	NHS ENGLAND

Part 3B: Third party declarations

We have invited comments from our key stakeholders. Third party declarations from key groups are outlined below:

Council of Governors

Feedback from NHS County Durham and Darlington Commissioners

Hartlepool LINk response to Annual Quality Account of North Tees and Hartlepool NHS Foundation Trust

Health Scrutiny Forum, Hartlepool

Third Party Statement from Healthcare User Group (HUG)

NHS Hartlepool and Stockton-on Tees Clinical Commissioning Group

Joint Statement for inclusion from Stockton Council's Adult Service and Health Select Committee, and Stockton LINk

Annex A

Statement of Directors' Responsibilities in Respect of the Quality Account

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Reports) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendments Regulations 2011).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the trust's performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- The Quality Account has been prepared in accordance with Department of Health guidance

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

By order of the Board

Paul Garvin	**Alan Foster**
Chairman	**Chief Executive**
[Date]	**[Date]**

(Signature and Date can be in any colour other than Black)

Annex B

Independent Auditors Limited Assurance Report to the Council of Governors of North Tees and Hartlepool NHS Foundation Trust on the Annual Quality Account.

Glossary

A&E	Accident and Emergency
ACE Committee	Audit and Clinical Effectiveness Committee - the committee that oversees both clinical audit (i.e. monitoring compliance with agreed standards of care) and clinical effectiveness (i.e. ensuring clinical services implement the most up-to-date clinical guidelines)
ACL	Anterior Cruciate Ligament - one of the four major ligaments of the knee
AMT	Abbreviated Mental Test
CABG	Coronary Artery Bypass Graft (or "heart bypass")
CCG	Clinical Commissioning Group
CHKS	Comparative Health Knowledge System
Clostridium Difficile (infection)	An infection sometimes caused as a result of taking certain antibiotics for other health conditions. It is easily spread and can be acquired in the community and in hospital
CLRN	Comprehensive Local Research Network
COPD	Chronic Obstructive Pulmonary Disease
CSP	Co-ordinated System for gaining NHS Permission
CQC	The Care Quality Commission - the independent safety and quality regulator of all health and social care services in England.
CQRG	Clinical Quality Review Group
CQUIN	Commissioning for Quality and Innovation - a payment framework introduced in 2009 to make a proportion of providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care
DAHNO	Data for Head and Neck Oncology (Head and Neck Cancer)
DARs	Data Analysis Reports
DoLS	Deprivation of Liberty Safeguards
Dr Foster	A major provider of healthcare information and benchmarking
DVLA	Driver and Vehicle Licensing Agency
EAU	Emergency Assessment Unit
E coli (infection)	Escherichia coli - An infection sometimes caused as a result of poor hygiene or hand-washing.
EWS	Early Warning Score - a tool used to assess a patient's health and warn of any deterioration
FCE	Finished Consultant Episode - the complete period of time a patient has spent under the continuous care of one consultant
FOI (act)	The Freedom of Information Act - gives you the right to ask any public body for information they have on a particular subject

FFT	Friends and Family Test
Global trigger tool (GTT)	Used to assess rate and level of potential harm. Use of the GTT is led by a medical consultant and involves members of the multiprofessional team. The tool enables clinical teams to identify events through triggers which may have caused, or have potential to cause varying levels of harm and take action to reduce the risk
GCP	Good Clinical Practice
GM	General Manager
HCAI	Health Care Acquired Infection
HED	Healthcare Evaluation Data
HES	Hospital Episode Statistics
HMB	Heavy Menstrual Bleeding
HQIP	Healthcare Quality Improvement Partnership
HRG	Healthcare Resource Group - a group of clinically similar treatments and care that require similar levels of healthcare resource.
HSMR	Hospital Standardised Mortality Ratio - an indicator of healthcare quality that measures whether the death rate in a hospital is higher or lower than you would expect
HUG	Healthcare User Group
IBD	Inflammatory Bowel Disease
ICNARC	Intensive Care National Audit and Research Centre
IMR	Intelligent Monitoring Report
LD	Learning Difficulties
IG	Information Governance
Intentional rounding	A formal review of patient satisfaction used in wards at regular points throughout the day
IPNMB	Integrated Professional Nursing Midwifery Board
IPC	Infection Prevention and Control
Kardex (prescribing kardex)	A standard document used by healthcare professionals for recording details of what has been prescribed for a patient during their stay
LD	Learning disabilities
Liverpool End of Life Care Pathway	Used at the bedside to drive up sustained quality of care of the dying patient in the last hours and days of life.
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK
MCA	Mental Capacity Act
MHA	Mental Health Act
MHRA	Medicines and Healthcare products Regulatory Agency
MINAP	The Myocardial Ischaemia National Audit Project

Monitor	The independent regulator of NHS foundation trusts
MRSA	Methicillin-Resistant Staphylococcus Aureus - a type of bacterial infection that is resistant to a number of widely used antibiotics
MUST	Malnutrition Universal Screening Tool
NCEPOD	The National Confidential Enquiry into Patient Outcome and Death
NCRN	National Cancer Research Network
NEPHO	North East Public Health Observatory
NEQOS	North East Quality Observatory System
NICE	The National Institute of Health and Clinical Excellence
NICOR	The National Institute for Cardiovascular Outcomes Research
NIHR	National Institute for Health Research
NNAP	National Neonatal Audit Programme
OFSTED	The Office for Standards in Education
PALS	Patient Advice and Liaison Service
PAS	Patient Administration System
Patient Safety and Quality Standards (Ps&Qs) Committee	The committee responsible for ensuring provision of high quality care and identifying areas of risk requiring corrective action.
PEQS	Patient Experience and Quality Standards
PICANet	Paediatric Intensive Care Audit Network
PROMs	Patient Reported Outcome Measures
Pseudonymisation	A process where patient identifiable information is removed from data held by the Trust
Quality Risk Profile (QRP)	A CQC tool for monitoring compliance with essential standards of quality and safety that helps to identify where risks lie within an organisation.
R&D	Research and Development
RCA	Root Cause Analysis
RCOG	The Royal College of Obstetricians and Gynaecologists
RCPCH	The Royal College of Paediatric and Child Health
RESPECT	"Responsive, Equipped, Safe and secure, Person centred, Evidence based, Care and compassion and Timely" - a nursing and midwifery strategy developed with patients and governors aimed at promoting the importance of involving patients and carers in all aspects of healthcare.
RMSO	Regional Maternity Survey Office
SBAR	Situation, Background, Assessment and Recommendation - a tool for promoting consistent and effective communication in relation to patient care

SCM	Senior Clinical Matron
SHA	Strategic Health Authority
SHMI	Summary Hospital Mortality-level Indicator - a hospital-level indicator which reports inpatient deaths and deaths within 30-days of discharge at trust level across the NHS
SINAP	Stroke Improvement National Audit Programme
SSU	Short Stay Unit
STAMP	Screening Tool for the Assessment of Malnutrition in Paediatrics
STERLING	Environmental Audit Assessment Tool
Tough-books	Piloted in 2010, these mobile computers aim to ensure that community staff has access to up-to-date clinical information, enabling them to make speedy and appropriate clinical decisions.
UHH	University Hospital of Hartlepool
UHNT	University Hospital of North Tees
VSGBI	The Vascular Society of Great Britain and Ireland
VTE	Venous Thromboembolism

Audit and Governance Committee

20 February 2014

Report of: HealthWatch Hartlepool

Subject: LOCAL HEALTHWATCH WORK PLAN 2013/14

1. PURPOSE OF REPORT

1.1 To inform the Audit and Governance Committee of HealthWatch Hartlepool's agreed work plan together with their Communication and Engagement proposal. The Committee is also asked to note the work plan and comment on the intended priorities.

2. BACKGROUND

2.1 HealthWatch Hartlepool is the independent consumer champion for patients and users of health and social care services in Hartlepool. To support our work we have appointed an Executive committee, which enables us to feed information collated through our communication and engagement plan to form the strategic vision. This ultimately should lead to influence of all services within the borough. Further information relating to the work of Healthwatch can be viewed via www.healthwatchhartlepool.co.uk

2.2 The purpose of this work programme is to set out the activities, priorities and outcomes expected from Healthwatch Hartlepool in 2013/14 (attached as **Appendix 1**). This will be delivered in conjunction with the Governance Framework, meetings of associated task and finish groups, public meetings and service specification.

3. PROPOSALS

3.1 Established under the Health and Social Care Act 2012, the requirements set out in the legislation mean HealthWatch Hartlepool will be expected to:

- Obtain the views of the wider community about their needs for and experience of local health and social care services and make those views known to those involved in the commissioning, provision and scrutiny of health and social care services.
- Promote and support the involvement of a diverse range of people in the monitoring, commissioning and provision of local health and social care services through membership of local residents and service users.

- Make reports and recommendations about how those services could or should be improved.
- Provide information to the public about accessing health and social care services together with choice in relation to aspects of those services.
- Represent the views of the whole community, patients and service users on the Health & Wellbeing Board and the Hartlepool Clinical Commissioning Group (locality) Board.
- Make the views and experiences of the broad range of people and communities known to Healthwatch England helping it to carry out its role as national champion.
- Make recommendations to Healthwatch England to advise the Care Quality Commission (CQC) to carry out special reviews or investigations into areas of concern (or, if the circumstances justify it, go direct to the CQC with recommendations, if for example urgent action were required by the CQC).

4. EQUALITY & DIVERSITY CONSIDERATIONS

4.1 HealthWatch Hartlepool is for adults, children and young people who live in or access health and/or social care services in the Borough of Hartlepool. HealthWatch Hartlepool aims to be accessible to all sections of the community. The Executive committee will review performance against the work programme on a quarterly basis and report progress to our membership through the 'Update' newsletter and an Annual Report. The full Healthwatch Hartlepool work programme will be available from www.healthwatchhartlepool.co.uk

5. RECOMMENDATIONS

5.1 That the Audit and Governance Committee note the HealthWatch Hartlepool work plan 2013/14 and provide feedback where necessary.

6. REASONS FOR RECOMMENDATIONS

6.1 Coordinated communication and engagement between any local healthwatch organisation and their partner Health & Wellbeing board are integral to the success of both service areas. The proposals laid out here within the HealthWatch Hartlepool work plan intend to ensure that the vision and expectations of joint working can be achieved.

7. BACKGROUND PAPERS

7.1 Governance Framework and Communication & Engagement proposal

8. CONTACT OFFICER

Christopher Akers-Belcher - HealthWatch Manager
Hartlepool Voluntary Development Agency
'Rockhaven'
36 Victoria Road
HARTLEPOOL. TS24 8DD

Work Programme 2013/14

HealthWatch Hartlepool is the independent consumer champion for patients and users of health & social care services in Hartlepool. To support our work we have appointed an Executive committee, which enables us to feed information collated through our communication & engagement plan to form the strategic vision. This ultimately should lead to influence of all services within the borough. Further information relating to the work of Healthwatch can be viewed via www.healthwatchhartlepool.co.uk

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- Provide information to the public about accessing health and social care services together with choice in relation to aspects of those services.
- Represent the views of the whole community, patients and service users on the Health & Wellbeing Board and the Hartlepool Clinical Commissioning Group (locality) Board.
- Make the views and experiences of the broad range of people and communities known to Healthwatch England helping it to carry out its role as national champion.
- Make recommendations to Healthwatch England to advise the Care Quality Commission (CQC) to carry out special reviews or investigations into areas of concern (or, if the circumstances justify it, go direct to the CQC with recommendations, if for example urgent action were required by the CQC).

HealthWatch Hartlepool is for adults, children and young people whom live in or access health and/or social care services in the Borough of Hartlepool. HealthWatch Hartlepool aims to be accessible to all sections of the community. The Executive committee will review performance against the work programme on a quarterly basis and report progress to our membership through the 'Update' newsletter and an Annual Report. The full Healthwatch Hartlepool work programme will be available from www.healthwatchhartlepool.co.uk

Please note Appendix (A) details the key principles we shall follow when delivering the HealthWatch Hartlepool work programme

Theme	Objective	Time frame
Acute Care	Sensory Loss – Examine the provision of services for those patients/residents with any form of sensory loss in the access of acute services	May to December 2013
Acute Care	Transport – Examine equality of access in relation to arrangements for patients travelling from Hartlepool to North Tees hospital	Completed

Acute Care	To ensure discharge procedures are followed and patients feel supported with a timely discharge from hospital. Review equality of access and design of service.	November 2013 to March 2014
Acute	Review implementation of Hartlepool LINk recommendations in relation to Dementia Awareness with North Tees & Hartlepool NHS Hospital Trust	January to March 2014
Primary Health	Review prescribing and distribution arrangements of Methadone within Hartlepool Pharmacies	October 2013 to February 2014
Primary Health	Consult with GP's regarding the purpose and adherence of Palliative Care registers and the wider community in respect of Cancer Care. Objective to influence and design the future of cancer care services.	Ongoing – Referred to NHS England due to failure to respond from practices. May require FOI re Palliative Care questionnaires
Primary Health	Participate in NHS Call to Action – Discrete piece of work to compliment the work of the CCG by consulting groups, which are seldom heard.	November 2013 to January 2014
Social Care	Review the quality of domiciliary care services within Hartlepool. Engage on the development of the new specification based on review.	June 2013 to date

Life Long conditions	Organise and host 3 seminars focusing on member led priorities. Arthritis, Respiratory & Heart conditions	September complete January 2014 March 2014
Strategic	Review policies and procedures in line with service specification e.g. Governance Framework	Complete
Strategic	Agree monitoring framework in line with service specification – Focus on quality	Complete Review January 2014
Strategic	Represent and contribute to strategic decision making across the borough. Examples of such: • Health & Wellbeing Board • Audit & Governance • Clinical Commissioning Group • Vulnerable Adults Board • Quality Standards Steering Group • North East Ambulance Service	Complete
Strategic	Managing expectations, relationships and responsibilities through HealthWatch development review	Completed and to be reviewed six monthly in line with Governance Framework

Enter & View	Review training & development in respect of legal responsibilities, Dignity in care, role of the volunteer, interviewing skills, report writing	1st phase completed November 2014
Training & development	Undertake member training needs analysis Complete member development programme to include all aspects of training required including: Dementia training & Safeguarding	Ongoing
Communication & Engagement	Adhere to communication and engagement proposal: • Engaging with local communities • Understanding stakeholders in the community • Mapping outreach • Collating patient stories • Effective outreach • Analysis and reporting • Annual General Meeting	Ongoing
Communication & Engagement	Promote the work of Healthwatch with the wider community: • Website • Monthly newsletters • Press releases • Annual report •	Ongoing

Communication & Engagement	Develop and publish a guide to Health & Social Care services in Hartlepool to fulfil our signposting and choice duty	July 2013 to January 2014

Workplan:-

Appendix A:

Clear-We will be clear about what activities we are carrying out. For example, we will be honest about whether we are informing, consulting, involving or co-producing.

Identify the need-We will be clear about the need to engage the community by:

a. Being clear about the identified need or knowledge gap
b. Involving the community at the earliest stage in the process
c. Identify and justify the target audience
d. Produce a clear project plan with deadlines including details of when results and actions will be available.

Consider other options/information

a. Where possible, look to coordinate consultation
b. Identify if there has been recent research –sharing results
c. Sharing common intelligence
d. Forward planning-where possible linking consultation to the business planning cycle

Consistent-We are committed to involving citizens in all aspects of our work. These principles apply to the way we involve and consult across the board, including the way that we involve our own staff in decisions that affect their working lives.

Accountable-We will make sure that we feed citizen's views into decisions, policies and service developments and we will demonstrate and communicate what has changed as a result of public involvement.

Purposeful-We will only carry out engagement when there is a clear purpose. For example:

a. Stakeholders themselves want to be involved
b. The policy or strategy will have a direct impact on stakeholders' lives
c. We have identified a gap in our knowledge
d. There is a statutory requirement

Honest-when involving and consulting we will be honest about:

a. What we are doing
b. Why we are doing it
c. What level of commitment we are asking from participants
d. Be clear about individual responsibilities (that is both those asking and those responding)
e. Only consult on what is achievable
f. How we will use our findings
g. How this feeds into our decision-making process
h. How we will feed back

Open-We will make sure that our full meetings are held in public and that stakeholders can easily access the records of our meetings. We will also increase the opportunities for stakeholders to be involved.

Accessible- We will make sure that engagement is accessible by:

a. Using plain English in any documents we publish
b. Using the right methods of engagement for the right audiences
c. Actively promoting materials in a range of formats, for example on tape, in Braille or in large print
d. Using venues that are easy to get to and held at times and place that are appropriate to the participants.

Inclusive-We will be inclusive by:

a. Making extra efforts to involve people whose views have been underrepresented in the past
b. Making sure that people are not excluded from engagement processes through circumstances. This might mean providing crèches or carer support, hearing loop systems, language signers and holding meetings at appropriate times and in appropriate venues
c. Making sure that no participants are out-of-pocket for taking part in involvement activities
d. Ensuring consultees have the necessary information to participate effectively
e. Enabling people to participate through building their capacity or by providing advocacy arrangements
f. Communicating using plain English, avoiding jargon and abbreviations
g. Making sure the consultation is widely communicated to the target audience
h. Making sure information is available on request in large print or other formats (e.g. audio tape) and in both paper and electronic formats

Flexible- We will endeavour to provide a flexible approach by:

a. Making sure that we allow enough time and space so that participants can contribute
b. Where we have time constraints, making this clear and explaining the reasons why
c. Making sure, where possible, to involve stakeholders at the earliest stages in the planning of services and projects rather than simply consulting then about pre-determined options
d. Giving people the chance to get involved in ways that suit them best by offering a range of ways they can respond
e. Making sure, with reason everyone who wants to take part can do so
f. Giving people enough time to take part
g. Working within the VCS Compact when involving voluntary and community groups
h. Undertake robust research that can stand up to scrutiny

Safe- We will make sure that participants are safe and their views respected by:

a. Making sure that we consider the needs of vulnerable participants
b. Respecting what participants tell us in confidence
c. Complying with the Data Protection Act 1998
d. Recognising our duties under the Freedom of Information Act 2000.

Efficient-We will co-ordinate and link our community engagement activities where appropriate to help avoid duplication of effort, time and resources. We will take an active

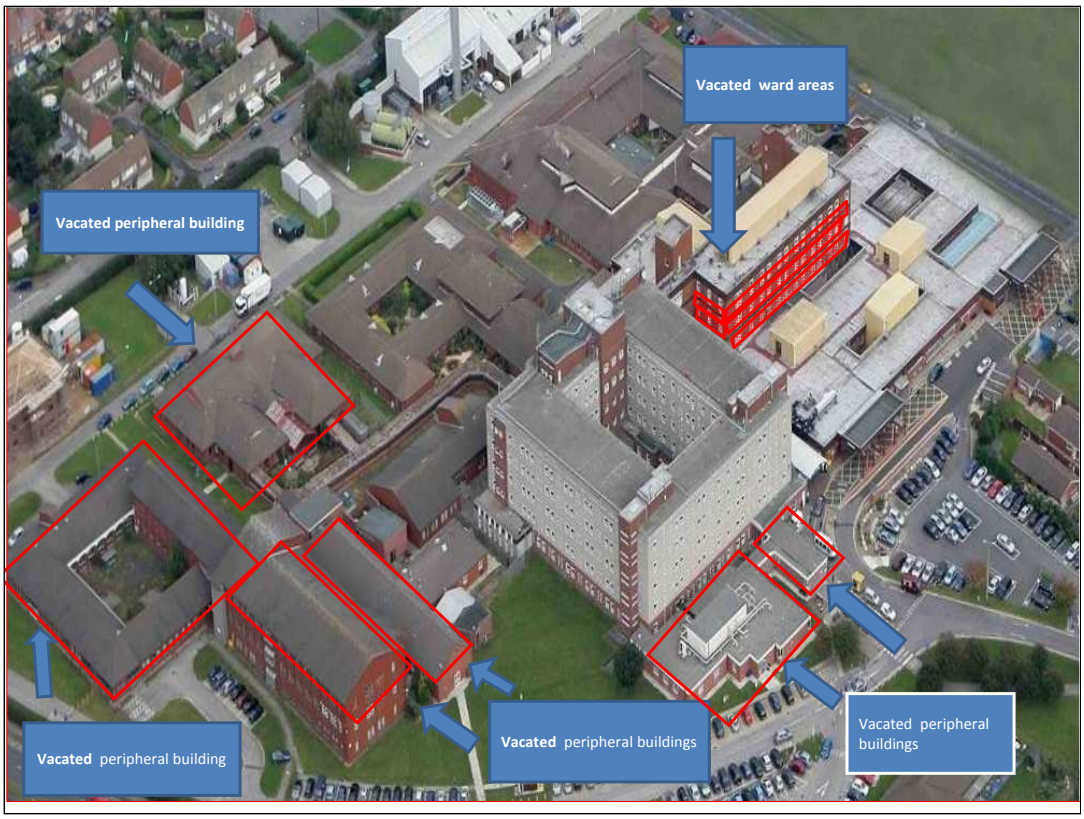
part in regional and countrywide activities and networks intended to achieve cost effectiveness.

Supported-We will make sure that elected members and staff undertaking public involvement activities are properly supported resourced and trained.

Evaluated- We will make sure that we build evaluation and monitoring into our consultation planning so that there is a way of measuring whether the outcomes have impacted on policy and strategy development.

Shared- We will make the results of engagement available to participants, partners and wherever possible, the general public and other key stakeholders.

Improved- We will learn lessons from our own activities and those conducted elsewhere so that we share, promote ad publicise good practice and innovation in engagement



- This shows the areas at UHH which will be closed and vacant.
- Wards 5,6,7,8,910,11, and Critical Care will have no patients.
- Wards 1,2,3,4 will be in partial use.
- There will be the opportunity for space rationalisation and reconfiguration.

Car parking charges and the length of stay and cost whilst visiting North Tees and Hartlepool NHS Foundation Trust

The current car parking charges are :

First 15 minutes - free
0- 2 hours - £3
2 – 4 hours - £ 3.30
Over 4 hours - £4.00

Car parking charges for all patients visiting the Trust are supported by a range of discretionary arrangements available to limit expenditure; a weekly pass is £15 and a monthly pass £25. No patient or relative is expected to pay more than £25 to attend regular appointments for a period of treatment that might extend beyond a month up to one year. For this reason we offer a "season ticket" at no additional cost that runs subsequent to a monthly ticket being purchased. These arrangements are advertised at the main payment stations and the Trust's internet site.

For those patients who are unfortunate enough to need to attend the Trust for cancer related treatment they are able to park free by requesting such an arrangement through the ward or department providing their care.

Patients who are in receipt of certain benefits are entitled and encouraged to reclaim the costs of their hospital travel including car park charges. The document "Health Care Travel Costs" (HTCS) may be accessed via www.dh.gov.uk/publications. HTCS is a national initiative and is part of the NHS low-income scheme and was set up to provide financial assistance to those patients who do not need an ambulance for transport, but who require assistance with their travel costs. Whilst not an exhaustive list, those patients on the following benefits are eligible for claiming travel expenses:-

- Income Based Jobseekers Allowance
- Working Tax Credit with an attached disability element
- Guarantee Pension Credit

Please refer to the full document for a list of all currently qualifying benefits as these may be subject to change as determined by government policy.

Health Care Travel Costs booklets are also available from the Cashiers Office at both hospital sites.

Income generated from the charges to park within the Trust car parks for 2011 – 12 were:

Staff: £650,952
Visitors: £835,791

Expenditure on the provision of car parking and security staff, the upkeep of the car parking systems and on-going investment into the car parks and inter-site shuttle service for staff and visitors during the same period was £670,828

While we are reluctant to pass any financial burden on to our patients, visitors or staff, we do have £40m to save from efficiencies and other schemes, and naturally we want to preserve front line services and jobs as far as possible. With savings of this magnitude to achieve, we are faced with stark choices. Given the situation and the options and support outlined above, we believe that these arrangements represent an acceptable compromise between the need to meet our efficiency targets (and so protect the continuing delivery of our front line services), and to ensure that the financial inconvenience to the public and our staff is not excessive.

AUDIT AND GOVERNANCE COMMITTEE

20th February 2014

Report of: Assistant Director (Neighbourhoods)

Subject: Access to One Life Centre

1. PURPOSE OF REPORT

1.1 To update the Committee on access to the One Life Centre, for both vehicles and pedestrians.

2. BACKGROUND

2.1 At the Committee meeting of 28 November 2013, concerns were expressed regarding the way in which people access the One Life Centre.

2.2 Pedestrians

Car parking on site is limited, however, there is ample space in the public car parks at Waldon Street and Roker Street, on the other side of Park Road.

Issues have been raised previously relating to the green man phase at the traffic signals, and the length of crossing time given, however investigations determined that sufficient time is provided for pedestrians.

There is a 6 second green man phase, but following this there is also a 13 second “inter-green” period. This is the time that will elapse before the red light on display to traffic will change, and therefore gives a total of 19 seconds for people to cross the road, which should be ample for all.

The green man is actually an “invitation to cross” and once this phase has passed pedestrians should not then start to cross, but those who have already started have a further 13 seconds before vehicles receive a green light.

To extend the green man phase further would lengthen the overall signals cycle, increasing congestion at the junction.

2.3 Vehicles

The other issue raised, of vehicular traffic approaching from the west (York Road direction) has also been investigated in detail.

The vast majority of traffic on this approach either turns left into the Shopping Centre car parks, or continues down towards the A689, hence them being split into two lanes to reduce delays.

To put this volume of traffic all into one lane (thus allowing a right turn lane for the One Life Centre) would result in major congestion, with queues regularly going back to the York Road junction and beyond, causing significant delays in the town centre.

Consequently, a right turn into the One Life Centre can not be introduced, as these vehicles would hold up eastbound traffic wishing to travel straight ahead towards the A689.

2.4 The only way to introduce a right turn lane at this location would be to widen the road to a 3 lane approach, using part of the Roker Street car park.

This has been investigated previously, and was estimated to cost in the region of £150,000 - £200,000, for which there is no budget at present.

It would also necessitate the loss of around 20 parking spaces, and the resulting revenue from these spaces to the Council each year.

3. PROPOSALS

3.1 It is planned to introduce changes to the way traffic uses the adjacent York Road/ Park Road junction in the near future. At present, traffic heading west along Park Road towards this junction is allocated as left turning and straight ahead traffic using the left hand lane, and the right hand lane being left for buses and taxis only, however no buses use this route.

3.2 The alterations will see the left hand lane used by left turning traffic only, with the right hand lane used by vehicles travelling straight ahead. This will considerably shorten the queues currently experienced by all traffic having to use one lane, and lead to much improved traffic flows through the junction. These improvements were approved at Regeneration and Neighbourhoods in March 2013.

3.3 These improvements may, in the future, enable the provision of a right turn filter for vehicles turning right from York Road, towards the One Life Centre junction. This manoeuvre can lead to delays at peak times, however, the junction improvements will need to be monitored to ensure delays are not increased on the other approaches.

4. FINANCIAL CONSIDERATIONS

4.1 The changes to the York Road/ Park Road junction outlined in 3.2 are expected to cost around £500, and will be met from the Council's Local Transport Plan.

5. EQUALITY AND DIVERSITY CONSIDERATIONS

5.1 There are no equality and diversity implications.

6. SECTION 17 OF THE CRIME AND DISORDER ACT 1998 CONSIDERATIONS

6.1 There are no Section 17 implications.

7. RECOMMENDATIONS

7.1 That the operation of the One Life Centre junction, and the forthcoming improvements to the York Road/ Park Road junction be noted.

8. REASONS FOR RECOMMENDATIONS

8.1 To ensure the best use of the highway network, for both motorists and pedestrians.

9. BACKGROUND PAPERS

9.1 There are no background papers.

10. CONTACT OFFICER

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AUDIT AND GOVERNANCE COMMITTEE

20 February 2014

HARTLEPOOL BOROUGH COUNCIL

Report of: Scrutiny Manager

Subject: SIX MONTHLY MONITORING OF AGREED SCRUTINY RECOMMENDATIONS

1. PURPOSE OF REPORT

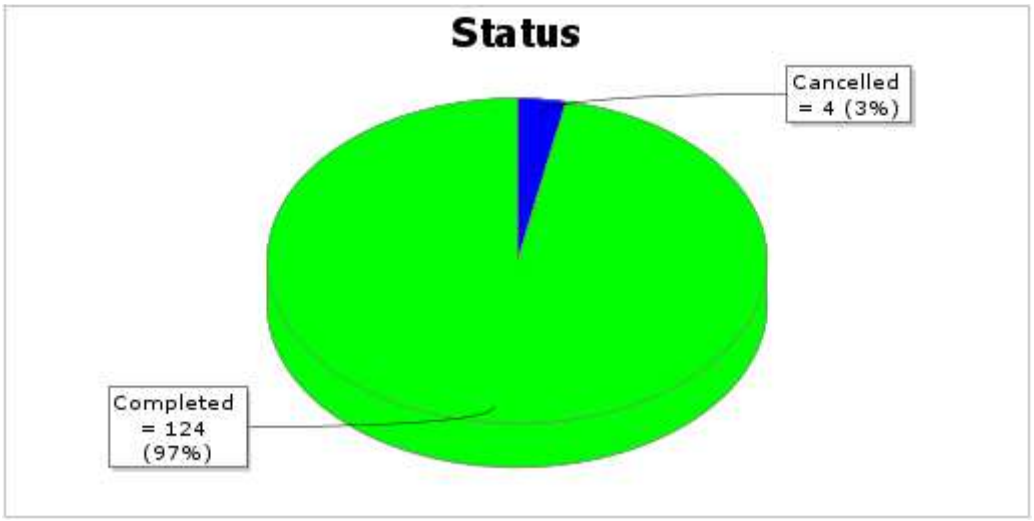
1.1 To provide Members with the six monthly progress made on the delivery of scrutiny recommendations that fall within the remit of this Committee.

2. BACKGROUND INFORMATION

2.1 This report provides details of progress made against the investigations undertaken by the previous Health Scrutiny Committee. These recommendations now fall within the remit of the Audit and Governance Committee. **Chart 1** (overleaf) provides a detailed explanation of progress made against each scrutiny recommendation since the last six monthly monitoring report was presented to this Committee in September 2013.

Health Scrutiny Forum - All

Generated on: 06 February 2014



Year 2009/10
Investigation Alcohol Abuse - Prevention and Treatment

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
SCR-HSF/3c/iii Undertakes specific work in conjunction with on-licensed premises and major off-licence retailers to look at the issue of the pricing and promotion	SCR-HSF/3c/iii	Police and Licensing Officers have positive relationships with the retailers and have had some success with limiting irresponsible promotions on licensed premises.	Ian Harrison	29-Oct-2010	29-Oct-2010		100% Completed	

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
of the very cheapest alcohol		Enforcement action will be a priority to address illegal supply of alcohol There is national work in hand to try to influence the larger retailers such as supermarkets who can sell alcohol at low cost which is causing licensees major economic pressure and fuelling anti social behaviour. In addition Hartlepool have strong working relationships with Balance and are supporting their regional campaigns and responses to government consultation on minimum pricing						
SCR-HSF/3d/i Reducing opening hours of on-licensed premises as and when they come forward	SCR-HSF/3d/i	The current review of the Licensing Policy provides an early opportunity to place crime and disorder in the night time economy higher in the licensing agenda and set a more rigorous tone in a range of conditions that could be applied in appropriate cases in Hartlepool. Work is in hand with licensees to reach a voluntary agreement to reduce opening hours.	Ian Harrison	31-Jan-2011	31-Jan-2012	07-Mar-2011 There appears to be no realistic prospect of ALL licensed premises agreeing to an earlier closing time but premises are, one by one, either having their hours reduced by the Council's Licensing Sub-Committees or by voluntary agreement. The Shades has applied for a new licence with a closing time of 2:00 a.m., The Office has done the same. Rockies licence is being reviewed and its neighbouring premises, Busbys, has now voluuntarily applied to reduce its hours to 2:00. Sorrentos had its licence revoked by sub-committee on 7th March. The Council has adopted a new licensing policy that states new licences will not be granted after 2:00 a.m. and new legislation is still progressing through parliament that is likely to give local authorities the	100% Completed	

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
						opportunity to close all premises at a specified terminal hour. 18-Jan-2011 Licence review has taken place for The Office and its hours were reduced. Also Sorrentos has had its hours reduced through variation and Shades has had its licence revoked by licensing committee. Negotiations are ongoing with other nightclubs to acheive a voluntary early closing time. More licence reviews are expected from Cleveland Police and legislation is currently passing through Parliament that would allow licensing authorities to close all premises earlier. Once law, this matter would be taken to Licensing Committee for consideration.		
SCR-HSF/3g That licensees are encouraged to participate in a trial period of early closing and that the impact on alcohol related incidents is recorded	SCR-HSF/3g	Joint work between the Police, the Principal Licensing Officer and Hartlepool Licensees Association continues. Negotiations are reaching a satisfactory conclusion with the potential for a reduction in opening hours and an agreement on an appropriate closing time across establishments in the key area of Church Street.	Ian Harrison	31-Jan-2011	31-Jan-2012	07-Mar-2011 Efforts have been made through the Council, Police and Hartlepool Licensees Assn but it has not been possible to achieve a 100% agreement to an earlier closing time and no one has been prepared to do it unilateraly for fear of losing business to those who stayed open. However, through a robust approach adopted by the Police a number of licences have been called in for review and the Council has used this opportunity to revoke 2 licences (Shades and Sorrentos). Other licence reviews are pending. This approach has resulted in some premises now applying to have their licensed hours reduced to 2:00 a.m. To summarise, all licensees have been encouraged on a number of occasions but it may be necessary to await new legislation that is	100% Completed	

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
						currently progressing through parliament before 100% early closing can be achieved.		
						18-Jan-2011 Work between all agencies is continuing with licensed hours being reduced through a use of formal licence review powers and voluntary arrangement. Early closing may become easier in late 2011 as legislation is likley to be passed that will allow licensing authorities to close all premises early.		
SCR-HSF/3h In promoting safe, sensible drinking, that the Council be encouraged to evaluate any opportunities to work towards recognising the Town Centre as a Purple Flag zone.	SCR-HSF/3h	Securing Purple Flag status would be challenging and is an aspiration at this time considering the current level and baseline. Improvements would include not only the participation of licensees but also consideration of the wider night time economy environment which does need significant investment. There is however a tiered development plan in place to work towards this award. This includes more positive engagement with the trade to develop higher standards of customer care; more consideration of safe routes home and closer working with town centre management. One of the first stages is the voluntary adoption of voluntary codes by operators and moving to the introduction of the Best Bar None scheme. There will also be a review of the impact of the Transport Interchange.	Ian Harrison	30-Sep-2011	30-Sep-2013	03-Feb-2014 Significant time has been invested working with the Hartlepool Licensees Assn but we are now at a point where any further progress towards a Purple Flag must come from the Association itself. There has been 2 separate attempts to begin a 'Best Bar None' scheme but licensees, for one reason or another, are reluctant to take part. There can be no more progress towards securing Purple Flag status until licensees agree to work together. The adoption of 'Purple Flag' status has been 'explored' as required. The Licensing Team shall continue to work closely with the trade and will push for progress on all occasions.	100% Completed	
						13-Jan-2014 The Council is continuing to make incremental improvements to the Night time Economy and the introduction of an EMRO in August 2013 will play a significant positive role. Achieving Purple Flag status is however dependent upon the agreement and cooperation of licensees and other		

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
						businesses and therefore, whilst partnership working remains strong, it is not possible to state that Purple Flag will be achieved by any particular date.		

Year 2011/12
Investigation Cancer Awareness and Early Diagnosis

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
SCR-HSF/6g/i That in line with the smoke free workplace, HBC develops a strategy with partner organisations that Educates licensed taxi drivers about the effects of passive smoking, reminding them of the legislation of not smoking in the workplace	SCR-HSF/6g/i	HBC's Public Protection Team carry out programmed inspections of all premises, including licensed vehicles such as taxis. These inspections include confirmation of compliance with the requirement to display 'No Smoking' signs in the vehicles. Failure to display the appropriate signage or to smoke, or allow smoking, in a licensed vehicle is a criminal offence. Drivers and vehicle owners who breach this requirement face prosecution. Drivers are tested on their knowledge and understanding of tobacco control law as part of their 'knowledge test' prior to obtaining their first licence. To date, no one has been prosecuted in Hartlepool for a continued breach of these requirements but a number of warnings have been issued.	Michelle Chester; Ian Harrison	30-Apr-2013	30-Apr-2013	22-Apr-2013 With the assistance of the Trading Standards Tobacco Control Officer the 'knowledge test' for new taxi drivers has been amended to incorporate questions about smoking in vehicles. This is backed up by the inclusion of 'No Smoking' material, including advice on the law, in the licence application pack that is sent to all new and existing drivers on an annual basis. Private Hire Operators and other companies that manage taxis and their drivers have also been visited by officers to ensure they understand their obligations with regard to smoking being permitted in their offices and their vehicles. 18-Jan-2013 The Trading Standards Service has, on a temporary basis, a tobacco control officer who monitors legal compliance on all tobacco issues, including smoking in smoke free areas, the underage sale of tobacco products and the sale and supply of illicit tobacco. This officer has contributed towards the current information that is passed to taxi drivers prior to their knowledge tests and will be working with	100% Completed	

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
						partner agencies to shortly develop a plan to deal with existing drivers.		
SCR-HSF/6g/ii That in line with the smoke free workplace, HBC develops a strategy with partner organisations that determines appropriate enforcement options for licensed taxi drivers who are in breach of the smoke free workplace	SCR-HSF/6g/ii	HBC's Public Protection Team carry out programmed inspections of all premises, including licensed vehicles such as taxis. These inspections include confirmation of compliance with the requirement to display 'No Smoking' signs in the vehicles. Failure to display the appropriate signage or to smoke, or allow smoking, in a licensed vehicle is a criminal offence. Drivers and vehicle owners who breach this requirement face prosecution. Drivers are tested on their knowledge and understanding of tobacco control law as part of their 'knowledge test' prior to obtaining their first licence. To date, no one has been prosecuted in Hartlepool for a continued breach of these requirements but a number of warnings have been issued.	Michelle Chester; Ian Harrison	30-Apr-2013	30-Apr-2013	06-Aug-2013 Additional advisory literature has been produced and distributed to taxi drivers, vehicle owners and taxi offices advising of the legal requirements relating to smoking in vehicles. The Trading standards (Tobacco Control) officer is carrying out unannounced inspections of licensed premises and taxi ranks to ensure that smoking is not taking place. The officer is also liaising with taxi operators to assist in the education of drivers. Work has been done with neighbouring authorities with regard to the possibility of issuing FPN's to those drivers found smoking but no decision has been taken yet to proceed with this step. 18-Jan-2013 Enforcement options available to the Council are detailed in legislation and generally involves either prosecution, fixed penalty notice or an informal warning. To date, no prosecutions have taken place and enforcement officers do not have the delegated power to issue fixed penalty notices. A number of warning have been issued - including to taxi drivers and taxi operators. The ability for Public Protection Officers to issue fixed penalty notices is being investigated by a number of North East Councils and the matter will be considered further if it is established that delegations are possible.	100% Completed	

Year 2012/13
Investigation JSNA Topic - Sexual Health

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
SCR-HSF/7a/i HBC increases awareness and understanding of the types of STIs, prevention and the services available through:- (i) social media; (ii) schools/colleges/literature; (iii) counselling/advisory services available.	SCR-HSF/7a/i	A comprehensive sexual health communications plan will be developed across all partners to ensure sound evidenced based advice and support is available to the whole population. This plan will look at all forms of communication including social media. It will be targeted at different age groups with consistent messages about safe sex.	Deborah Gibbin; Louise Wallace	31-Dec-2013	31-Dec-2013	10-Jan-2014 This action is now complete, working with the provider to implement. 04-Oct-2013 Research complete and report currently being written up and will inform the development of materials	100% Completed	
SCR-HSF/7a/ii The need to raise awareness of good sexual health is highlighted within the JSNA 'Sexual Health' entry and HBC:- (ii)Works with partner organisations to produce marketing material to raise awareness	SCR-HSF/7a/ii	A comprehensive sexual health communications plan will be developed across all partners to ensure sound evidenced based advice and support is available to the whole population. This plan will look at all forms of communication including social media. It will be targeted at different age groups with consistent messages about safe sex.	Deborah Gibbin; Louise Wallace	31-Dec-2013	31-Dec-2013	10-Jan-2014 This action is now complete, working with the sexual health service provider to distribute marketing and service materials to young people and practitioners 04-Oct-2013 Research complete and report currently being written up and will inform the development of materials	100% Completed	
SCR-HSF/7b/i ccessibility to services is identified as a key issue within the JSNA 'Sexual Health' entry and Hartlepool Borough Council improves accessibility to	SCR-HSF/7b/i	The local authority became the commissioner of sexual health services on 1 April 2013. Commissioning sexual health services is a mandatory function and the local authority will seek to maximise all service	Deborah Gibbin; Louise Wallace	31-Dec-2013	31-Dec-2013	10-Jan-2014 This action is now complete and monitored through contract meetings between the commissioner and the provider 04-Oct-2013 Data for inclusion in the needs assessment for Hartlepool has been completed and awaiting the outcome	100% Completed	

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
services		provision in existing contracts. The commissioning of services will ensure that services provide open access comprehensive sexual health services for the whole population.						
SCR-HSF/7b/ii Accessibility to services is identified as a key issue within the JSNA 'Sexual Health' entry and HBC improves accessibility to services by:(ii) Integrating easy access to sexual health services into the 'Youth Offer'	SCR-HSF/7b/ii	The local authority became the commissioner of sexual health services on 1 April 2013. Commissioning sexual health services is a mandatory function and the local authority will seek to maximise all service provision in existing contracts. The commissioning of services will ensure that services provide open access comprehensive sexual health services for the whole population.	Deborah Gibbin; Louise Wallace	31-Oct-2013	31-Oct-2013	10-Jan-2014 This action is now complete and easy access to sexual health services is embedded within the "Youth Offer" 04-Oct-2013 Ongoing work to ensure that easy access to sexual health services is embedded into the "Youth Offer"	100% Completed	
SCR-HSF/7b/iii Accessibility to services is identified as a key issue within the JSNA 'Sexual Health' entry and Hartlepool Borough Council improves accessibility to services by: (iii) Making condoms freely available at the Sexual Health Clinic	SCR-HSF/7b/iii	The local authority became the commissioner of sexual health services on 1 April 2013. Commissioning sexual health services is a mandatory function and the local authority will seek to maximise all service provision in existing contracts. The commissioning of services will ensure that services provide open access comprehensive sexual health services for the whole population.	Deborah Gibbin; Louise Wallace	31-Oct-2013	31-Oct-2013	04-Oct-2013 Condoms are available from the One Life Sexual Health Service free of charge 03-Jul-2013 Meeting arranged with the Sexual Health provider to discuss the availability of condoms within the sexual health clinic at the One Life Centre	100% Completed	

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
SCR-HSF/7c/i hat partnership working is integrated into the JSNA 'Sexual Health' entry and that Hartlepool Borough Council: (i) Improves communication links between all services that delivery sexual health services, advice and support	SCR-HSF/7c/i	The Public Health Team will ensure effective partnerships and relationships between all sexual health service providers. This will be done through contract management and pathway development.	Deborah Gibbin; Louise Wallace	31-Mar-2014	31-Mar-2014	10-Jan-2014 Contract management meetings continue t take place with the sexual health provider and Tees Public Health Shared Service Contract Managers 04-Oct-2013 Regular contract management meetings take place with the sexual health provider and the Tees Public Health Shared Service Contract Managers.	100% Completed	
SCR-HSF/7d That Hartlepool Borough Council commissions the APAUSE programme through the allocated budget for sexual health	SCR-HSF/7d	The Public Health Team will develop a proposal regarding the commissioning of the APAUSE programme through the ring fenced public health grant.	Deborah Gibbin; Louise Wallace	31-Aug-2013	31-Aug-2013	04-Oct-2013 Only one school wishes to deliver the APAUSE programme ~ all other schools deliver their own programme of Sex and Relationship Education 03-Jul-2013 Preparatory work has been undertaken to develop a proposal in respect of the commissioning of the APAUSE programme	100% Completed	

3. RECOMMENDATIONS

3.1 That Members note progress against the agreed recommendations and explore further where appropriate.

4. REASONS FOR RECOMMENDATIONS

4.1 In order for Members to continue to monitor the progress of Scrutiny recommendations.

5. BACKGROUND PAPERS

(a) Report of the Scrutiny Support Officer entitled 'Six Monthly Monitoring of Agreed Scrutiny Recommendations' presented to the Audit and Governance Committee on 20 September 2013.

6. CONTACT OFFICER

Joan Stevens – Scrutiny Manager
Chief Executive's Department – Legal Services
Hartlepool Borough Council
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Extract from the minutes of the Finance and Policy Committee on 19 December 2013 relating to Public Health

174. Sexual Health Update (*Director of Public Health)*

Type of decision

For information.

Purpose of report

To update Members in respect of the incidence and prevalence of sexually transmitted infections in Hartlepool. The report also provided the Committee with assurance that the statutory duty as laid down in the Health and Social Care Act 2012 to commission integrated sexual health services was being undertaken in Hartlepool.

Issue(s) for consideration

The Director of Public Health updated the Committee on the position in relation to sexual health services and specifically in relation to the incidents of sexually transmitted infections in Hartlepool and the commissioning of Tees-wide sexual health services.

Decision

That the report be noted.

TEES VALLEY HEALTH SCRUTINY JOINT COMMITTEE
9TH DECEMBER 2013

PRESENT:-
Representing Hartlepool Borough Council:
Councillors Shields, Fisher
Representing Redcar & Cleveland Borough Council:
Councillors Carling, Cllr Ray Goddard, Cllr John P Hannon
Representing Middlesbrough Borough Council
Councillor Cole
Representing Stockton-On-Tees Borough Council:
Councillors Javed (Chair) Mrs Wilburn, Mrs Womphrey.

APOLOGIES – Councillors Newall, H Scott, J Taylor (Darlington Borough Council), Councillor Mrs Wall (Redcar & Cleveland Borough Council)

IN ATTENDANCE - Cllr Mrs Skilbeck (Hambleton District Council).

OFFICERS – L Stones(Hartlepool Borough Council), E Pout(Middlesbrough Borough Council), Mehmoona Ahmeen (Redcar & Cleveland Borough Council), P Mennear and Kirsty Wannop(Stockton Borough Council)

EXTERNAL REPRESENTATIVES – Sandra Ansah (Public Health England), Melanie Brown, Hillary Hall (NHS England), Gill Carton (North of England Commission Unit), Ruth Hill (Tees, Esk and Wear Valleys NHS Foundation Trust) and Sue Watson (South Tees NHS Foundation Trust).

Due to there not being a representative present from each of the Tees Valley Local Authorities, the meeting was inquorate and an informal meeting was held.

DECLARATIONS OF INTEREST –
Cllr Mohammed Javed declared a disclosable pecuniary interest as he was employed by Tees, Esk and Wear Valley NHS Foundation Trust. Cllr Javed had been granted a dispensation in this regard.

MINUTES – Submitted –The informal notes of the inquorate meeting of the Tees Valley Health Scrutiny Joint Committee held on 28th October 2013 were submitted for consideration.

AGREED – That the Minutes be approved in principle and be referred to the next meeting for confirmation as a correct record.

Winter Planning and Management in the Tees Valley

Members were provided with information on the winter planning and management in the Tees Valley.

The information included:-

- National and local context and the plans and procedure that were in place.
- Role and responsibility of the CCG ensuring plans were in place.
- The winter communication strategy advising the public on how to look after themselves. Details of the sitrep (situation report) system and how it worked was provided, along with the how the daily operational management process worked.

- Update on the winter position 2013/14 for James Cook University Hospital that included comparative figures from previous years.

As of the date of the meeting, the NHS in the Tees Valley area was at a low NEEP (escalation plan) level, but pressures were greater in the north of the region. It was noted that surges could take place quickly over a 24 hour period.

The Committee also queried the 7 day week system that is looking to be brought in and highlighted that this was needed. It was noted that various schemes were being put into place across the area to increase access to GP services. In addition, for two weeks in January temporary resources had been allocated to enable 7-day working, including links with social care. Full 7 day services would require investment in hospital diagnostic services, for example, increased numbers of trainees, and a review of terms and conditions, together with increased local authority services.

Ambulance handover delays at James Cook had peaked in March/April 2013; these had since been reduced but not yet eradicated. Arrivals could vary to between 60 to 100 per day, and a peak of 16-17 per hour may be expected. During the busiest periods of 2012-13, ambulance arrivals peaked at around 25-26 arrivals per hour for a sustained period.

Sundays were notably busy for A and E, and this combined with elective admissions.

It was noted that additional funding had been provided by NHS England to Trusts to cope with winter pressures. As with previous years this was not provided until December each year making it difficult for hospitals to plan. South Tees itself had already planned to invest £4m in increased beds, staff hours and community therapy services, and the NHS England funding would help to offset this.

In 2013-14 overall attendances were down on the same period as the previous year; it was too early whether this was as a result of system improvements or weather conditions.

South Tees Trust had cancelled large numbers of elective procedures during the previous winter and this was the reason behind the delays in referral to treatment times that the Trust was experiencing. The Trust had commissioned 750 procedures from two private providers, and 16 nursing home beds.

Delayed discharges had been rising and this was due to various reasons including patient choice when deciding on next steps in care. If the delay was due to discussion around where the patient will go to next, the average delay was 12 days. Work had taken place between the Trust and the three main local authorities it works with to build relationships and re-design processes.

Members were also provided with information on the seasonal flu vaccine update from across the Tees Valley for both the key at risk groups in the community and for NHS Trust Staff. South Tees and County Durham and Darlington Trusts had staff coverage rates close to 70% and North Tees and Hartlepool rates were nearer to 50% but had been improving in recent weeks. North East Ambulance Service also had a low rate. The community figures were similar to the same period in the previous year.

It was highlighted that there was a lack of a national publicity campaign this year. It was outlined that the Department of Health had concluded that a national campaign was ineffective unless there was a flu epidemic/pandemic. Work would be done to evaluate what more could be done to increase uptake in the sub-region.

Rehabilitation Services at Tees, Esk and Wear Valley NHS Foundation Trust, including proposed changes to Victoria Road, Hartlepool.

Members noted that the Victoria Road building was only 17 years old. However it was reported that this did not meet the current needs of a mental health rehab unit (it did not have ensuite facilities, ADL kitchens, and had inappropriate waiting areas).

Members requested that due consideration be given to adapting the property. It was reported that estates teams had assessed the building however major work would be required. Members felt that such investment should be provided if necessary. The importance of keeping people close to home and family in their recovery was discussed.
The length of stay for the unit had in some cases been over two years previously, but this was no longer appropriate and some patients were staying longer than necessary in in-patient care.

It was highlighted by the TEWV representative that rehabilitation was best provided in patient's own homes wherever possible, and investment in community care would allow many more people to benefit from this wherever possible. The more specialist end of rehab care could then be provided in fewer, better equipped in-patient units, due to fewer patients requiring it.

It was reported that the impact of removing the crisis beds would need close monitoring.

It was noted that TEWV would return to Hartlepool's health scrutiny committee in the new year to outline the result of the engagement and the monitoring of local patients, since the closure of the unit in September.

Any urgent items which in the opinion of the Chair can be considered.

There were no further items to be considered.

SAFER HARTLEPOOL PARTNERSHIP
MINUTES AND DECISION RECORD
13 December 2013

The meeting commenced at 9.30 am in the Civic Centre, Hartlepool

Present:

Councillor: Christopher Akers-Belcher (In the Chair)
Councillor Allan Barclay, Elected Member, HBC
Denise Ogden, Director of Regeneration and Neighbourhoods
Clare Clark, Neighbourhood Manager
Chief Superintendent Gordon Lang, Cleveland Police
Chief Inspector Lynn Beeston, Chair of Youth Offending Board
Luicia Saiger-Burns, Durham Tees Valley Probation Trust
Councillor Carl Richardson, Cleveland Fire and Rescue Authority Nominated Member
Ian McHugh, Cleveland Fire and Rescue Authority
Andy Powell, Housing Hartlepool

In accordance with Council procedure rule 5.2 (ii) Sharon Robson was in attendance as substitute for Louise Wallace, Director of Public Health, and Paula Swindale as substitute for Karen Hawkins, Stockton on Tees Clinical Commissioning Group

Also present:
Councillor Keith Fisher, Chair of Audit and Governance Committee, HBC
Tony Lowes, NoMs North East

Officers: Lisa Oldroyd, Community Safety Officer
Richard Starrs, Strategy and Performance Officer
Rachel Parker, Community Safety Research Officer
Laura Stones, Scrutiny Support Officer
Denise Wimpenny, Principal Democratic Services Officer

51. Apologies for Absence

Apologies for absence were submitted on behalf of John Bentley, Safe in Tees Valley, Louise Wallace, Director of Public Health

52. Declarations of Interest

None

53. Minutes of the meeting held on 1 November 2013

Confirmed

54. Matters Arising from the Minutes

Minute 42 – Working with Communities Presentation - The Neighbourhood Manager indicated that a meeting had been held with the Fire Service with a view to extending activities available to young people in Hartlepool and a report would be submitted to the next meeting of the Partnership.

55. Environmental Crime Campaign (*Director of Regeneration and Neighbourhoods*)

Purpose of report

To consider a proposal to take forward an Environmental Enforcement Campaign in Hartlepool.

To seek agreement from SHP Partners to sign up to the Environmental Enforcement Campaign.

Issue(s) for consideration

The Director of Regeneration and Neighbourhoods presented the report which provided information relating to the outcome of a recent scrutiny investigation and the background to the establishment of a proposed Environmental Enforcement Campaign to be delivered across Hartlepool which had been approved by the Council's Neighbourhood Services Committee in November.

The proposed Environmental Crime Campaign and the proposed branding of 'Respect Your Neighbourhood' aimed to improve collaborative working and consisted of the following three elements:-

- Neighbourhood Action Days – one per month
- Creating a bank of Neighbourhood Improvement Volunteers
- Making use of new technologies to improve reporting and feedback to communities

Members welcomed the campaign highlighting that environmental crime and clean streets continued to be a priority for local residents and were

pleased to note that litter problems had reduced over the years. The benefits of the campaign were also noted and welcomed.

Decision

(i) That the proposed 'Respect Your Neighbourhood Campaign' and action plan be supported.

(ii) The Partnership agreed to their own agencies participating in the scheme underpinned by a Partnership Compact.

56. Safer Hartlepool Partnership Strategic Assessment (Executive Summary) (*Director of Regeneration and Neighbourhoods*)

. **Purpose of report**

To consider the Safer Hartlepool Partnership's Annual Strategic Assessment 2012/13.

To consider and agree the Partnership's strategic objectives 2014-2017

To consider and agree the Partnership's annual priorities

Issue(s) for consideration

It was reported that the Partnership had a statutory responsibility to undertake an annual strategic assessment to identify and address the community safety issues that really mattered to the community.

The strategic assessment contained information to aid understanding of the priority community safety issues identified for the communities of Hartlepool including what had changed over the last year, what work the Partnership were doing as well as how the Partnership measured effectiveness and future challenges. An executive summary was attached to the report which provided a description of the current local and national delivery landscape and a reminder of the objectives and priorities that had been set the previous year. The assessment would assist the Partnership in setting strategic objectives for 2014-17.

The Community Safety and Research Officer and the Community Safety Officer, who were in attendance at the meeting, provided a detailed and comprehensive presentation which focussed on the following:-

- Strategic Objectives 2011-14
- Annual Priorities 2013-14

- The Delivery Landscape
- Performance figures as a comparator with neighbouring authorities
- Crime figures
- Anti-social behaviour incidents
- Deliberate fires
- Acquisitive Crime
- Violent Crime
- Hate Crime and Incidents
- Victims
- Community Perceptions and Neighbourhoods
- Substance Misuse
- Re-offending

Proposed Strategic Objectives and Priorities

- Reduce crime and repeat victimisation
- Reduce the harm caused by drug and alcohol misuse
- Create confident, cohesive and safe communities
- Reduce offending and re-offending

Annual Priorities 2014-15

- Create Confident Cohesive and Safe Communities
  - Re-offending
  - Acquisitive crime
  - Domestic violence and abuse
  - Anti-social behaviour
  - Substance misuse
  - Reduce hate crime

- Proposed SHP Delivery Groups

Following conclusion of the presentation, discussion ensued which included the following issues:-

(i) A Member referred to a recent English Defence League march in Hartlepool and sought clarification as to the costs associated with policing this event as well as the reasons why the event had been allowed to proceed. In response, Members were advised that the Council were unable to prevent permitted organisations from taking part in events of this type. The Chief Inspector added that the cost of the event was managed as a result of cancelling planned leave or rest days, utilising resources from other forces and highlighted that the new policing structure was much better equipped to deal with managing such events. It was noted that there were no arrests as a consequence of the march. Some concerns were raised regarding the potential costs of policing this event and officers went on to respond to further queries raised by Members in relation to the event.

(ii) In response to a query raised in relation to whether there had been

any analysis of retail crime in the town and whether the offenders were new or re-offenders, the Partnership was advised that in terms of shop lifting, the majority of offenders tended to be re-offenders. There had been no analysis undertaken in relation to new offenders as evidence suggested the need to focus on repeat offending.

(iii) The potential impact of welfare reform on crime figures, particularly shop lifting was discussed including the need to monitor this issue.

(iv) It was noted that crime figures in Hartlepool continued to remain above the national average. An explanation of victim based crime and non-victim based crime was provided, details of which were set out in the executive summary to the report.

(v) Clarification was provided in response to a number of issues/queries raised which included the role of the police and magistrates relating to law enforcement issues.

The Partnership took the opportunity to thank the Community Safety and Research Officer, the Community Safety Officer as well as all members of the team involved in production of the strategic assessment.

The Director of Regeneration and Neighbourhoods sought the Partnership's agreement in relation to the proposed strategic objectives and partnership delivery options:-

- Hate crime be included within the anti-social behaviour priority and the Neighbourhood Manager to lead on this issue.

- That the Re-offending Group continue to deal with the re-offending and acquisitive crime priorities on behalf of the Partnership and be led by the representative from Durham Tees Valley Probation Trust.

- That the Director of Regeneration and Neighbourhoods lead on domestic violence and abuse with support from the representative from the CCG.

- The Director of Public Health to Chair and continue to lead on the Substance Misuse Group.

Decision

(i) That the strategic assessment be agreed.

(ii) That the strategic objectives of the Partnership for the next three years, as detailed above, be agreed.

(iii) That the annual priorities 2014/15 of the Partnership, as detailed

above, be agreed.

(iv) That the proposed delivery options, as set out above, be agreed.

The meeting concluded at 10.45 am.

CHAIR