AUDIT AND GOVERNANCE COMMITTEE AGENDA

HARTLEPOOL BOROUGH COUNCIL

Thursday 15 May, 2014

at 9.30 am

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 17 April 2014

   3.2 To confirm the minutes of the meeting held on 2 May 2014 (to follow)

4. **AUDIT ITEMS**

   4.1 Mazars Report - Audit Progress Report 2013/14 – *Chief Finance Officer*

   4.2 Role of the Chief Finance Officer (CFO) In Public Service Organisations – *Chief Finance Officer*

   4.3 Role of the Head of Internal Audit in Local Government – *Chief Finance Officer*

4.4 Internal Audit Outcome Report 2013/14 - *Head of Audit and Governance*

4.5 Review of the Effectiveness of the System of Internal Audit – *Chief Finance Officer*

4.6 Annual Governance Statement 2013/14 – *Chief Finance Officer*

4.7 Letter to Those Charged With Governance - Compliance with Laws and Regulations/Fraud – *Chief Finance Officer*

5. STANDARDS ITEMS

No items.

6. STATUTORY SCRUTINY ITEMS

6.1 North East Ambulance Service Quality Account – 2013/14 – *Scrutiny Manager*

6.2 Tees, Esk and Wear Valleys NHS Foundation Trust Quality Account:-

(a) Covering report – *Scrutiny Manager*
(b) Presentation – *Representatives from Tees, Esk and Wear Valleys NHS Foundation Trust*

6.3 Investigation into Chronic Obstructive Pulmonary Disease – Draft Final Report *(to follow) – Chair of the Audit and Governance Committee*

6.4 Investigation into Re-offending – Draft Final Report *(to follow) – Chair of the Audit and Governance Committee*

6.5 Consultation on how the Care Quality Commission Regulate, Inspect and Rate Services – *Scrutiny Manager*

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

7.1 To receive the minutes of the meeting held on 26 March, 2014 (to follow)

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 25 April 2014

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

No items.

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

10.1 To receive the minutes of the meeting held on 21 March, 2014 (to follow)

11. **REGIONAL HEALTH SCRUTINY UPDATE**

No items.

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

AUDIT AND GOVERNANCE COMMITTEE
MINUTES AND DECISION RECORD
17 APRIL 2014

The meeting commenced at 9.30 am in the Civic Centre, Hartlepool

Present:

Councillor Keith Fisher (In the Chair);

Councillors: Jim Ainslie, Brenda Loynes, and Linda Shields.

Also Present: Co-opted Member; Mr Norman Rollo

In accordance with Council Procedure Rule 5.2 (ii) Councillor Hargreaves was in attendance as substitute for Councillor Brash and Councillor Beck was in attendance as substitute for Councillor Robinson

Andrew Tweed and Deborah Duffy, Job Centre Plus
Peter Smith, Sunderland City Council
Dougie MacDougall and Ray Stevenson - North East Ambulance Service
Steve Thomas, Zoe Sherry,Judith Gray - Healthwatch
Dorothy Wood, NHS Foundation Trust
David Brown, Tees Esk and Wear Valleys NHS Foundation Trust
Lisa Taylor, Service Manager, Offender Health
Paul Cartmell, Tees Esk and Wear Valleys NHS Foundation Trust

Officers: Andy Graham, Public Health Registrar
Mark Smith, Head of Integrated Youth Support Services
Lisa Oldroyd, Community Safety Research and Development Co-ordinator
Richard Starrs, Strategy and Performance Officer
Patrick Wilson, Employment Development Officer
Clare Clark, Neighbourhood Manager
Joan Stevens, Scrutiny Manager
Denise Wimpenny, Democratic Services Team

176. Apologies for Absence

Apologies for absence were submitted on behalf of Councillors Stephen Akers-Belcher, Jonathan Brash, Jean Robinson and Co-opted Member Clare Wilson.

177. Declarations of Interest

None

178. Minutes of the meeting held on 6 March 2014

Confirmed.

179. Matters Arising from the Minutes of the Meeting held on 6 March 2014

In relation to Minute 145, Re-offending Investigation – Family Support Services, a Member requested that the Team Around approach needed to be extended to include other voluntary agencies working with dysfunctional families and that this issue be included within the recommendations of the final report.

180. Minutes of the meeting held on 20 March 2014

Confirmed.

181. Audit Items

No items.

190. Standards Items

No items.

191. North East Ambulance Services (NEAS) Winter Pressures Update – Covering Report/Presentation

(Scrutiny Manager/Representatives from North East Ambulance Service)

A representative from the North East Ambulance Service (NEAS), who was in attendance at the meeting, provided an update on the impact of winter pressures on the ambulance service. The Committee was advised that there had been no major issues during the winter period. Four by four capacity had been increased and winter tyres had been utilised which had contributed to the performance of the service. A number of other measures had been introduced to improve performance which included the introduction of an intelligence reporting system which enabled information sharing with hospitals in relation to patient movements.

In terms of lessons learnt, the service had been working with hospitals to ensure ambulance vehicles were not spending time waiting for long periods of time and arrangements were in place to ensure that any funding

opportunities were explored at the earliest opportunity. In terms of activity, the service had attended 38,951 incidents, 45% of which were life threatening and 41% of which were serious incidents. With regard to response times it was noted that the service was performing well against government targets, details of which were provided. Members were referred to a Demand and Capacity Update Report 2013/14, a copy of which was circulated at the meeting.

In response to a request for clarification in relation to the impact of the implementation of the 111 service, Members were advised that 111 call handlers were trained to the same standards as 999 staff and assurances were provided that irrespective of which number calls were received they were diverted to the appropriate pathway and that the arrangements presented no additional risks to service users.

Recommended

That the information given and comments of Members be noted.

192 . Tees Esk and Wear Valley NHS Foundation Trust – Service Update Covering Report/Presentation

(Scrutiny Manager/Representatives from Tees Esk and Wear Valleys NHS Foundation Trust)

The Chair welcomed the Director of Operations from Tees Esk and Wear Valleys NHS Foundation Trust who had been invited to attend the meeting following the delivery of a presentation on the potential changes to the provision of mental health services in the Trust area which would result in the closure of the rehabilitation unit at Victoria Road and the indication that an update report would be submitted to this Committee on the impact of the changes particularly in relation to crisis beds.

The Director of Operations provided a detailed and comprehensive presentation which included an update on the position following the temporary closure of Victoria Road in October 2013 and focussed on the following:-

- Impact on inpatient beds
- No of admissions to Lincoln Ward
- Changes to the service – Crisis Team, Care Plans, Medical Staffing
- Reduction in overall number of Section 136 assessments since the move from Sandwell Park to Roseberry Park
- Supporting work
- Street Triage Service – funding of £170k for next 12 months had been agreed to continue this service
- 24 people seen by Street Triage Team during the period October to March – roughly 4 or 5 per month
- Increase in CAMHS referrals - investment from CCG to support this
- Rehabilitation services continue to move patients through treatment more quickly

- Memory Clinic working to reduce length of time taken from referral to discharge and increase capacity through this efficiency

Following the conclusion of the presentation, the Director of Operations responded to issues highlighted in the presentation which included clarification on the rehabilitation support arrangements available following discharge from hospital, the various support mechanisms available to deal with crisis situations which may occur over weekends, the role of the Street Triage Team as well as the benefits of the changes to crisis beds and supporting people at home as opposed to in hospital.

Given the recent reports nationally that there was insufficient accommodation to support young people and the perception that police cells were being utilised for undertaking 136 assessments, clarification was sought that there was sufficient accommodation in Hartlepool to support young people given the decision to close rehabilitation and crisis beds at Victoria Road. Assurances were provided that police cells in Hartlepool had not been utilised in such circumstances and details of in-patient support arrangements for young people with mental health problems was provided.

The importance of access to GP services for individuals with mental health problems was emphasised and examples were shared with the Committee of situations where individuals had experienced difficulties in this regard. Whilst the emphasis upon more services being provided in the community was welcomed, a Health Watch representative expressed some concerns that there was no evidence to suggest that the appropriate level of resources were being allocated to meet the increasing demands in this area. In response, the Director of Operations reported on how changes in service provision were being monitored and the reasons such decisions had been taken including the financial considerations. Whilst it was acknowledged that decisions were cost driven as well as service driven, the benefits of delivering services in the community were outlined.

During further discussions, concerns were reiterated regarding the decision to remove further services from the town and the potential impact on individuals as a result. The Chair commented on the importance of continuing to closely monitoring the issue.

Recommended

That the information given and comments of Members be noted.

193. Health Inequalities Covering Report/Presentation

(Scrutiny Manager/Public Health Registrar)

The Public Health Registrar was in attendance at the meeting to provide an update in terms of health inequalities in Hartlepool including female life expectancy.

The report provided background information in relation to the publication of

the Health Profile for Hartlepool in 2009 which highlighted that female life expectancy in the town was the worst in England and the decision of the former Health Scrutiny Forum that the Forum would continue to monitor this issue and, in doing so, would receive an update report on an annual basis focussing on those specific wards causing concerns in relation to life expectancy of women. Details of the Health Profile for Hartlepool in 2009, 2010, 2011 2012 and 2013 in relation to female life expectancy was included in the report.

The Public Health Registrar provided a detailed and comprehensive presentation on health inequalities which focussed on:-

- Female life expectancy in Hartlepool
- Life expectancy by ward
- Major causes of early deaths by ward
- Provision of services across wards
- Causes of health inequalities
- Key areas to reduce health inequalities

In the discussion that followed the conclusion of the presentation the Committee raised a number of comments/views/queries which included the following:-

(i) In response to a request that the Wards be updated to reflect the current boundaries, Members were advised that the updated data was not yet available and would be updated accordingly in due course.

(ii) A Member questioned why Hartlepool's statistics in terms of female life expectancy were being compared with the worst performing areas and was of the view that comparisons should be made against the best performers like Kensington and Chelsea.

(iii) Disappointment was also expressed regarding the level of deaths in Hartlepool.

(iv) With regard to the key areas identified within the presentation to reduce health inequalities which included the need for a clear vision and strategy and to extend leadership and engagement, clarification was sought as to what progress had been made on actions of this type that had been implemented in the past. Emphasis was placed upon the need for answers and Members to be clear on what actions they needed to focus on to reduce health inequalities in the town. The Public Health Registrar referred to the need to focus on the Health and Wellbeing Strategy and ensure continual monitoring of health issues and actions. It was highlighted that there were a number of issues underlying health inequalities. The importance of prevention was highlighted as well as the need to address the rise in obesity

problems, smoking and alcohol related health issues. It was noted that there was a role for Elected Members as well as the Public Health Team in educating local communities on health inequalities.

(v) In concluding the debate, the Committee requested further information/advice from Health Professionals on the role and requirements of Elected Members in terms of addressing health inequalities in Hartlepool and that a future report be presented to this Committee in this regard.

Recommended

(i) That the information given and comments of Members be noted.

(ii) That a report be presented to a future meeting of this Committee to include information/advice from Health Professionals on the role and requirements of Elected Members in terms of addressing the health inequalities agenda together with details of progress made on actions that had been implemented in the past.

194. Sub-Group Structure of Health and Wellbeing Board

(Director of Public Health)

The Scrutiny Manager, on behalf of the Director of Public Health reported that the Health and Wellbeing Board had agreed to establish two engagement forums and a joint commissioning executive to support the Board, the background of which was included in the report. Details of the focus and purpose of the engagement forums and commissioning executive was provided, as outlined in an appendix to the report.

Recommended

That the creation of two engagement forums and a joint commissioning executive to support the work of the Health and Wellbeing Board be noted.

195. Health and Wellbeing Board Strategy Performance Report (Quarter 3) (*Director of Public Health*)

The report provided an update on the performance to date against actions and performance indicators within the Health and Wellbeing Strategy at the end of Quarter 3. Members were referred to detailed performance reports attached as appendices to the report for a number of themes which included Children's, Vulnerable Adults and Health Inequality.

It was noted that the overall position was positive in terms of performance.

Recommended

That Quarter 3 performance of the Health and Wellbeing Strategy be noted.

196. Re-offending Investigation – Additional Evidence - Evidence from North Tees and Hartlepool NHS Foundation Trust and Tees Esk and Wear Valleys NHS Foundation Trust – Mental Health Services – Covering Report *(Scrutiny Manager)*

As part of the Committee's ongoing investigation into re-offending, representatives from Tees Esk and Wear Valleys NHS Foundation Trust were in attendance at the meeting to provide additional evidence in relation to services that impacted, affected and influenced re-offending.

The Head of Offender Health and Service Manager who were responsible for the management of Offender Health on behalf of Tees Esk and Wear Valleys NHS Foundation Trust referred Members to evidence attached as appendices to the report which included an overview of the services provided, hours of operation of the current Criminal Justice Liaison Service, Street Triage Team and the establishment of a Liaison and Diversion Service to commence from April 2014 as a 1 year pilot study. Details of the background to the Government's announcement that £25m would be allocated to a new Liaison and Diversion Service was provided and it was reported that £800,000 had been awarded for the development of a local site at Middlesbrough to provide this service. The funding received for the local site was substantially less than anticipated, the implications of which were outlined.

Members were advised that it was envisaged that there would be a number of benefits for the town as a result of the establishment of a Liaison and Diversion Service despite being located in Middlesbrough.

Some concerns were expressed regarding the level of funding allocated being substantially less than anticipated. In response to a request for clarification, the Service Manager outlined the hours of operation of the various support services. It was noted that discussions were currently ongoing with the Police and Crime Commissioner with a view to securing additional funding to extend the hours of operation of the services provided. The Committee was keen to see provision 24 hours a day 7 days a week.

The representatives went on to respond to queries raised by the Committee in relation to the Section 136 admissions process as well as the potential reasons for the reduction in 136 admissions. A query was raised as to whether it was considered that the services provided were effective and contributed to reducing reoffending. The Head of Offender Health indicated that the Community Team did have some successes. However, additional resources were required to address this issue more effectively.

Recommended

That the information given be noted and discussions be used to assist the Forum in completing the scrutiny investigation.

197. Re-offending Investigation – Additional Evidence from Job Centre Plus – Employment and Benefit Services – Covering Report (*Scrutiny Manager*)

The Scrutiny Manager introduced representatives from Job Centre Plus who were in attendance at the meeting to provide evidence on the support provided to offenders upon release from custody/prison. Support included the provision of a designated advisor to work with local partners ie the Probation Service to identify any barriers for claimants with a view to preventing reoffending. Information on the role of the advisory team was provided. There were a number of conditions that had to be met before claimants qualified for job seekers allowance and it was acknowledged that in the event that claimants did not meet such conditions this could lead to hardship problems. Some of the difficulties encountered with ex-offenders in terms of processing benefit claims were shared with the Committee.

Members were advised of the ongoing work by the service contributing to reducing reoffending. Advisors were located within prisons with a view to establishing claims prior to offenders leaving prison. The service had noted the fundamental cause of reoffending was homelessness and access to benefits. It was highlighted that some of the key elements in terms of reducing reoffending was an attachment to a work programme.

With regard to access to employment opportunities and benefits following release from prison, a query was raised as to whether information was shared with family members to which the representative advised that extensive work was being undertaken in relation to post release support. In response, it was reported that there was some uncertainty as to whether to whether information of this type was shared with family members and clarification would be provided under separate cover following the meeting.

A Member who attended the visit at Holme House Prison shared with the Committee the types of concerns prisoners had raised with Members which included homelessness and the inability to access benefits without a permanent address. The Job Centre Plus representative confirmed that whilst it was acknowledged that this was an issue arrangements were in place to support individuals in these situations. A care of address was acceptable or alternatively claimants could register at the Job Centre daily. Some concerns were expressed by Members regarding the practicalities of registering at the Job Centre on a daily basis as well as the impact on individuals as a result.

The Employment Development Officer commented on the good working relationships between the Council and Job Centre Plus and whilst it was pleasing to report a number of key activities available including national apprenticeship schemes and national careers schemes, one of the key challenges faced by a number of agencies was supporting individuals with access to employment following release from prison. Statistical information

in terms of the number of ex-offenders leaving prison and securing employment was provided. It was noted that nationally only 5 out of 100 people would secure employment.

Reference was made to a new regime where there would be a reduction in the number of job search facilities in the Job Centre and the impact on the Council as a result was discussed by Members. Digitalisation and access to free wifi would be available in Job Centres in the coming months.

Representatives responded to issues raised by the Committee in relation to the potential impact of the changes to the Probation Service, the role of work programme providers and payment by results process.

Recommended

That the information given be noted and discussions be used to assist the Forum in completing the scrutiny investigation.

198. Any Other Items which the Chairman Considers are Urgent

The Chairman ruled that the following item of business should be considered by the Committee as a matter of urgency in accordance with the provisions of Section 100(B) (4)(b) of the Local Government Act 1972 in order that the matter could be dealt with without delay.

199. Any Other Business – Re-offending Investigation - Evidence from Sunderland City Council

Following a brief adjournment, the Committee reconvened whereupon the Scrutiny Manager welcomed the Access to Housing Manager from Sunderland City Council who had been invited to attend the meeting following a request at a previous meeting to provide evidence in relation to the Prison in Reach Initiative.

The Access to Housing Manager informed the Committee of the background and context to the Access to Housing Manager 's role which involved working with offenders and families to understand their behaviour. Details of how the role had evolved was also provided. Members were advised that a number of issues were considered in terms of homelessness prevention which included exploring the reasons for individual offending, ie any underlying factors like substance misuse or mental mental health factors, rough sleeping and the potential reasons for not being able to access maintstream accommodation. It was reported that statistics had fluctuated in relation to offenders being unable to access mainstream accommodation as a result of their behaviour and a scrutiny investigation had been undertaken in this regard. The option for Hartlepool to be represented on a local Homelessness Group was suggested, the benefits of which were

outlined. Part of the work of the Homelessness Group was to support prisoners for up to 6 weeks following release from prison to support with reintegration into the community.

Details of initiatives that had been introduced in Sunderland were shared with the Committee. Reference was made to the impact of the Homelessness Amendments Act which had resulted in prisoners being released on a Friday afternoon and not being treated as a priority for housing accommodation. There were often difficulties encountered by Advisors in prisons determining the nature of the housing issue which contributed to this problem. Whilst it was noted that there was no longer a statutory requirement for an Access to Housing service, the benefits of retaining this role were provided.

In the discussion that followed clarification was provided in terms of the work undertaken with housing providers. Members emphasised the importance of homelessness prevention and the need to support individuals in securing accommodation upon release from prison. The need to explore funding opportunities where possible to address this issue was suggested.

That the information given and comments of Members be noted and utilised to assist the Committee in completing the Scrutiny investigation.

200. Re-offending Investigation - Feedback from the Hartlepool Business Forum Event 'A Chance for Change Exploding the Myths of Employing Ex-Offenders'(*Scrutiny Manager*)

Councillor Ainslie provided feedback from a recent Business Forum Event that he had attended with Councillor Loynes. A copy of the presentation, 'A Chance for Change' that had been delivered at the event was circulated for Members' perusal. The presentation included details of why it was important to see the invisible part of our society, how HM Prison Service made offenders 'work ready', NOMS objectives, resettlement pathways, assessment of need, employability strategy, careers guidance, curriculum vocational skills, the importance of practical skills and creating additional high quality training opportunities, types of training available, breaking the cycle of re-offending as well as details of activities/programmes delivered at various local prisons together with programme outcomes.

The value of the visit to Holme House Prison and the Business Forum Event was highlighted.

Discussion ensued in relation to the misconceptions that prisons offered hotel type facilities. The value of promoting and providing apprenticeships/placements for ex-offenders upon release from prison was emphasised. It was suggested that the option for the Council to provide such opportunities be further explored.

Recommended

That feedback from the event and comments of the Committee be noted and discussions be utilised to assist in completing the Scrutiny investigation.

201. Youth Justice Strategic Plan 2014-15 (*Head of Integrated Youth Support Services*)

The Head of Integrated Youth Support Services sought the Committee's comments on the first draft of the annual Youth Justice Strategic Plan for 2014-15, a copy of which was attached at Appendix 1.

The development of the plan had incorporated recommendations from Children's Services Committee, the views of the Safer Hartlepool Partnership and the current scrutiny investigation into re-offending in Hartlepool. Based upon the findings from the Strategic Assessment, it was proposed that the Youth Offending Service and broader Youth Justice Partnership focused on a number of key strategic objectives as set out in the report which included re-offending, early intervention and prevention, remand and custody, restorative justice, risk and vulnerability, think family and maintain standards and effective governance.

Concerns were expressed regarding the transfer of youth court listings to Teesside, and whilst the full impact of this decision was yet to be fully determined, it was anticipated that there would be an increase in warrants and this would have a detrimental impact on re-offending figures. In response to a query as to how this decision would impact upon Hartlepool, Members were advised that the Team were currently exploring the costs and feasibility of transport provision for young people and their families to avoid an increase in warrants and young people being criminalised for non-attendance. The need to consider the impact on victims of alleged crimes was also highlighted. A view was expressed that there was a need to consider the implications of such provision for this purpose as this may not reflect an accurate picture in terms of how well the revised arrangements were operating.

With regard to the key strategic objective in relation to Restorative Justice, it was reported that Sir Peter Woolf would be speaking at an event in Hartlepool and it was suggested that this invite be extended to as many people as possible.

Recommended

The contents of the report and comments of the Committee be noted.

202. Safer Hartlepool Partnership Performance –

Quarter 3 (*Neighbourhood Manager (Community Safety)*)

The Scrutiny Manager referred Members to the report of the Neighbourhood Manager which provided an overview of the Safer Hartlepool Partnership performance during quarter 3, as set out in an appendix to the report. Information as a comparator with performance in the previous year was also provided.

Members were asked to consider this issue as a future potential topic in the next municipal year.

Recommended

That Quarter 3 performance of the Safer Hartlepool Partnership be noted.

203. Minutes of the recent meeting of the Health And Wellbeing Board held on 13 February 2014

Received.

204. Minutes of the recent meeting of the Finance and Policy Committee Relating to Public Health

No items.

205. Minutes of recent meeting of Tees Valley Health Scrutiny Joint Committee held on 20 January 2014

Received.

206. Minutes of recent meeting of Safer Hartlepool Partnership held on 7 February 2014

Received.

207. Regional Health Scrutiny Update

No items.

208. Duration of Future Meetings

The Chair raised concerns regarding the duration of today's meeting given the number of agenda items for consideration and the wide remit of the Committee and requested that the frequency of future meetings be reviewed with a view to increasing the number of meetings per year.

Recommended

That the frequency of future meetings be reviewed given the wide remit of the Committee with a view to increasing the number of meetings per year.

209. Date and Time of Next Meeting

It was noted that the next meeting would be held on 2 May at 10.00 am.

The meeting concluded at 1.00 pm.

CHAIR

AUDIT AND GOVERNANCE COMMITTEE
MINUTES AND DECISION RECORD
2 MAY 2014

The meeting commenced at 10.00 am in the Civic Centre, Hartlepool

Present:

Councillor Keith Fisher (In the Chair)

Councillors: Jim Ainslie, Stephen Akers-Belcher, Jean Robinson and Linda Shields.

Also Present: Sally Thompson, Assistant Director for Anaesthetics and Emergency Care, North Tees and Hartlepool NHS Foundation Trust (NTHFT)
Sandra Stych, Lung Health Matron, (NTHFT)
Dorothy Wood, Senior Clinical Matron, NTHFT
Dr Catherine Monaghan, Consultant Respiratory Physician, NTHFT
Dr Kate Elmer, Consultant Respiratory Physician, NTHFT
Dr Posmyk, Chair, Hartlepool and Stockton Clinical Care Group (CCG)
Deborah Ward, Hartlepool and Stockton CCG
Paul Thompson, Hartlepool Families First

Officers: Laura Stones, Scrutiny Support Officer
Andy Graham, Public Health Registrar
Lorraine Harrison, GP Referral Coordinator
David Cosgrove, Democratic Services Team

210. Apologies for Absence

Councillors Brash and Loynes and Co-opted Members Norman Rollo and Clare Wilson.

211. Declarations of Interest

None.

212. Minutes of the meeting held on 17 April 2014

Deferred.

213 Any Other Items which the Chairman Considers are Urgent

The Chairman ruled that the following items of business should be considered by the Committee as a matter of urgency in accordance with the provisions of Section 100(B) (4)(b) of the Local Government Act 1972 in order that the matter could be dealt with without delay.

University Hospital Hartlepool - Near Miss Never Event

The Chair indicated that the Vice-Chair, Councillor Stephen Akers-Belcher, had raised concern with him relating to the press reports of a near miss where an operation was nearly done on a patient's wrong limb; a 'never event'.

The Vice-Chair commented that the event was extremely alarming and proposed that the Committee request that the Trust attend the meeting on 15 May to explain the incident. The Vice-Chair indicated that no confidentiality in relation to the event need be breached but that an explanation of how a 'never event' nearly occurred should be given to Members.

The Chair highlighted that due to purdah restrictions he had requested that the press speak to the Vice-Chair on this matter. The proposal was unanimously supported by the Committee.

Recommended

That North Tees and Hartlepool NHS Foundation Trust be requested to attend the meeting of the Committee on 15 may to provide to the Committee an explanation in relation to the recently reported near miss event at University Hospital Hartlepool.

214. Audit Items

No items.

215. Standards Items

No items.

216. Investigation into Chronic Obstructive Pulmonary Disease (COPD) – Service Provision – Third Evidence Gathering Session – Presentation from Hartlepool and Stockton-on-Tees Clinical Commissioning Group

The Chair of Hartlepool and Stockton Clinical Care Group (CCG) gave a

presentation to the Committee outlining the care pathways for COPD sufferers, the community service provision and pathways, the Primary Care service provision and pathways, service access, unplanned hospital admissions, effective partnerships for early diagnosis and the challenges faced by service commissioners.

The presentation highlighted that the majority of COPD patients were managed in the community by their GP and GP based services. There was the Hartlepool Community Respiratory Assessment and Management Service (CRAMS) which assisted in the management of the more severe cases of COPD though if patients suffered 'exacerbations' of their symptoms, particularly difficulty in breathing, they would be admitted to hospital.

The Chair of the CCG commented that the Pulmonary Rehabilitation programme had some very good outcomes despite some reticence among sufferers to attend an 'exercise class'. The programme was designed to improve sufferers respiratory fitness to assist and ease their symptoms. A pilot project was also underway with Hartlepool Hospice to help with COPD sufferers anxiety when they had breathing difficulties or exacerbations. Care pathways were being improved so that sufferers that were having a flare up of symptoms could get early care in the community rather than them ending up at hospital.

Hartlepool had a larger proportion of COPD diagnosis than the national average. GPs therefore had a larger than average number of COPD patients giving them a better than average position for dealing with such patients. With the potential changes under Better Care Funding, there was an expectation that 15% of primary care funding would move to the community setting so there needed to be the services available in the community to handle that. Effective partnership working was essential in all areas including COPD and most GPs had now signed up to the early screening programme for COPD to make early diagnosis of patients. An aging population was a sign of medical success in some ways but did mean that more people would be living with COPD in the future.

The Chair thanked Dr Posmyk for his informative presentation. The Chair commented that a large step in tackling the numbers of smokers should be done at a national political level.

A Member of the public commented that as a sufferer she had access in the past to a 'rescue pack' which contained the necessary antibiotics that could be taken early in the onset of the symptoms of an exacerbation in order to minimise the effects and ensure a quicker recovery. The issuing of these 'rescue packs had stopped and patients had to make a GP appointment instead. This could put a delay of several days in getting access to antibiotics and was leading to more exacerbations for COPD sufferers. The rescue packs should be reinstated for patients. The Chair of the CCG commented that the rescue packs did catch people early in the stages of an exacerbation. If the system wasn't working then he would look into the

reasons for that as the packs had not been withdrawn to the best of his knowledge.

Members considered that if the rescue packs had proved beneficial for patients then they should be reinstated. HealthWatch representatives balanced the views on the rescue packs by indicating that some sufferers were concerned with the levels of antibiotics they were using, essentially uncontrolled by their GP. It was also commented that since the removal of the receptionist for the CRAMS Team at the One Life Centre, it had become much more difficult to contact the team, make appointments and gains access to the rescue packs.

It was indicated at the meeting that some additional funding had been obtained through the CCG to fund a 6-week 'breathlessness' support group that COPD sufferers could attend. A Member of the public present at the meeting commented that their partner had been through one of the groups and had found it very helpful. Another member of the public suggested that one way of stopping children taking up smoking would be to have COPD sufferers go into school as part of the stop smoking campaigns to introduce them to the real cost of smoking. The Chair considered this to be a good suggestion as there appeared to have been a 'plateau' reached with the numbers of smokers where it was difficult to break through that number and get a further reduction in smokers.

Recommended

That the presentation and discussions be noted.

217. Investigation into Chronic Obstructive Pulmonary Disease (COPD) – Service Provision – Presentation from North Tees and Hartlepool NHS Foundation Trust

Representatives from North Tees and Hartlepool NHS Foundation Trust (NTHFT) gave a presentation to the Committee outlining their services to patients with COPD. The Pulmonary Rehabilitation programme already mentioned in the meeting was seen as a 'gold standard' service that many other areas did not have. The service being run in conjunction with the Hospice on breathlessness was another high quality service aimed at reducing sufferers anxiety through cognitive behaviour therapy.

The removal of the receptionist at the CRAMS clinic had also been raised earlier in the meeting. The Trust was looking at ways of improving the numbers of patients that could be seen by the clinic and would review the situation. There had been some concerns with the location of the service staff being on their own. The potential of a 'drop in' clinic once a week was also being considered as well as a late opening clinic.

The Trust were aware that not all patients were happy with some of the changes that had been made and staff were keen to regain that faith in the

services provided. Patients would be contacted to inform them of the proposed improvements to the service and there would be patient involvement in a task and finish group which would provide feedback to the Trust.

The CCG had a new programme to measure the quality of diagnosis and management of COPD through GP Practices. This would look to consistency of management of COPD and the rolling out of the gold standard services. Training was also a major issue and training for practice nurses had been undertaken which was very well attended and further training was anticipated.

Every COPD exacerbation reduced the sufferer's lung function, so created something of a vicious circle. Around six COPD sufferers were admitted to hospital each week, though most only spent a day or so in hospital. The number of emergency admissions would be reduced through the improvement in care in the community. Specialist nurses would undertake visits to patients feeling their symptoms deteriorating in advance of an exacerbation. The nurses would be able to issue rescue packs, antibiotics and nebulisers and would make follow up visits. This service would be backed up by rapid access to a GP if needed.

There were still challenges and SPA (Single Point of Access) had been one. The Trust was now aware of all the patients diagnosed with COPD and while there was a high level of patients, having them identified did make management of services easier.

The Pulmonary Rehabilitation programme had proven benefits for patients that attended with those benefit lasting for up to 18 months afterwards. However, uptake from COPD sufferers was still low. A resident commented that her husband had been through the programme and was now no longer on a transplant list, such was the level of improvement it gave him.

There was still concern that when being diagnosed, patients were still not seeing a chest specialist. The Trust did believe that the improvements in community care would be of great benefit to COPD sufferers and would reduce the numbers needing admission to hospital.

Members asked if there was any action that the authority could take possibly through the Health and Wellbeing Board to improve the uptake of the Pulmonary Rehabilitation Programme as it did appear to have great benefits for those that attended. It was suggested that an appropriate recommendation could be included to. look at ways to promote COPD support programmes, such as the pulmonary rehabilitation programme.

Recommended

That the presentation and discussions be noted.

218. Investigation into Chronic Obstructive Pulmonary Disease (COPD) – Service Provision – Families First Health Bus and COPD Screening - Presentation

The Manager of Hartlepool Families First gave a presentation to the Committee highlighting the services the group ran through its Health Bus. The Health Bus had recently undergone a refurbishment and provided facilities for general information and private and confidential health checks. There were professionally qualified staff able to undertake private consultations, healthy heart checks and sexual health and general advice. Some 3314 residents had used the bus in the past year with over two thirds being men; an often hard to reach group. 1762 lifestyle audits and healthy heart checks had been undertaken with 35% categorised as higher risk.

In the past the bus did have spirometry equipment and undertook those tests. The equipment had, however, been removed for use elsewhere and had not come back to the Health Bus. Trust representatives commented that if spirometry tests were undertaken and did bring back a cause for concern they did prefer a trained nurse to offer the appropriate advice. The service did offer a questionnaire used by the smoking cessation service that would lead people to seek further advice from a GP. It was considered that this would be more appropriate for the Health Bus setting.

Members understood the point being made by the Trust representatives in relation to the spirometry tests but also considered that the Health Bus did reach people that were often hard to reach or simply didn't attend their GP.

The Manager of Hartlepool Families First did feel that as a service provider there was some work that may need to be done with GP Practices. Some GPs did use the services provided and was hoped to widen the service provided.

Recommended

That the presentation and discussions be noted.

219. Investigation into Chronic Obstructive Pulmonary Disease (COPD) – Service Provision – Feedback from the Community COPD Exercise Support Group

(*GP Referral Co-ordinator*)

The GP Referral Coordinator provided the Committee with feedback received from COPD patients who had been involved in the Exercise for Life Programme. The significant point to highlight was that six of the ten respondents felt that the programme had reduced their need for hospital visits and had also lifted their spirits which was an excellent outcome for those suffering what could be a very depressing illness.

Recommended

That the feedback report be noted.

220. Inquorate Meeting

The Chair noted that following Councillors S Akers-Belcher and Robinson leaving, the meeting was now inquorate.

221. HealthWatch Hartlepool – Call To Action – Listen to the Seldom Heard (*Scrutiny Support Officer*)

The Scrutiny Support Officer outlined the report from Hartlepool HealthWatch on its engagement activity in relation to the Call to Action questionnaire. Full details of the results were set out in the appendix to the report.

Recommended

That Hartlepool HealthWatch be thanked for their report and that the report be noted.

222. Minutes of the recent meeting of the Health And Wellbeing Board

No items.

223. Minutes of the recent meeting of the Finance and Policy Committee Relating to Public Health

An extract from the minutes of the meeting of the Finance and Policy Committee held on 28 March relating to Workplace Health was submitted for the Committee's information.

Recommended

The extract was noted.

224. Minutes of recent meeting of Tees Valley Health Scrutiny Joint Committee

No items.

225. Minutes of recent meeting of Safer Hartlepool Partnership

No items.

226. Regional Health Scrutiny Update

No items.

The meeting concluded at 11.55 am.

CHAIR

AUDIT AND GOVERNANCE COMMITTEE

15.05.14

Report of: Chief Finance Officer

Subject: MAZARS REPORT- AUDIT PROGRESS REPORT 13/14

1. PURPOSE OF REPORT

1.1 To inform Members of the Audit Committee that arrangements have been made for representatives from Mazars to be in attendance at this meeting, to present the content of the Audit Progress Report.

2. BACKGROUND

2.1 This report updates the Audit Committee on Mazars progress in meeting their responsibilities as the Councils external auditor. It also highlights key emerging issues and national reports which may be of interest to the Audit Committee.

3. FINDINGS OF THE AUDIT COMMISSION

3.1 Details of key messages are included in the main body of the report attached as Appendix 1.

4. RECOMMENDATIONS

4.1 That the Audit and Governance Committee:

i. Note the report of Mazars.

5. REASON FOR RECOMMENDATIONS

5.1 To ensure the Audit Committee is kept up to date with the work of our External Auditor.

6. BACKGROUND PAPERS

6.1 Code of Audit Practice 2010.

7. CONTACT OFFICER

7.1 Chris Little
Chief Finance Officer
Civic Centre
Victoria Road
Hartlepool
TS24 8AY

Tel: 01429 523003
Email: Chris.Little@Hartlepool.gov.uk

Hartlepool Borough Council
Audit Progress Report
April 2014

Contents

01 Introduction

The purpose of this report is to update the Audit and Governance Committee on progress in delivering our responsibilities as your external auditors.

We have highlighted key emerging national issues and developments which may be of interest to Committee Members.

In addition, we have included our annual letter to 'those charged with governance' in respect of how you gain assurance over management processes and arrangements, including details of any fraud and non-compliance with laws and regulations in this report. A similar letter has been sent to the Chief Executive.

If you require any additional information, please contact us using the contact details at the end of this update.

Finally, please note our website address (www.mazars.co.uk) which sets out the range of work Mazars carries out, both within the UK and abroad. It also details the existing work Mazars does in the public sector.

02 2013/14 audit progress

Since our last Audit Progress Report we have:

- carried out interim testing of transactions;
- completed our IT risk assessment; and
- started work on our Value for Money (VfM) conclusion.

Internal control weaknesses
We noted one weakness in relation to journal controls from our interim testing as set out in the table below along with the Council's response. We have not classed this as a significant internal control weakness as the control was operating, but not fully as designed plus compensating controls were in place and a retrospective review has been undertaken.

Internal control weakness	Risk	Council response
Periodic journal review – evidenced review only partially operating as designed Several years ago the Council put in place a periodic review of journals control in order to strengthen its control environment. This involved the periodic evidenced review by the Head of Finance – Corporate and Schools of journals over a certain value. Our testing of the periodic review of journals control highlighted that whilst a download of journals for periods 1, 2 and 3 had been produced and reviewed by a member of staff, it had not been 'signed-off' by the Head of Finance – Corporate and Schools.	Journals could be posted incorrectly or an invalid journal processed. This could lead to a material misstatement within the financial statements. There is also a risk that journals could be posted with fraudulent intent.	We would highlight that the periodic review of journals control still took place in periods 1-3 as stated by the auditors. In addition, the Head of Finance – Corporate and Schools carried out other compensating checks on journals. We have since carried out a retrospective 'sign-off' of the review of periods 1-3.

4.1 Appendix 1

Our work in the next period includes the following:

- completing work to support our VfM conclusion; and
- carrying out the detailed work on the financial statements.

We will continue to have regular meetings with senior officers and will read and consider committee papers.

Overall, our work has not highlighted any significant weaknesses we need to report and there is no change to our planned testing strategy at this stage.

03 Letter to Chair of the Audit and Governance Committee

Dear Chair,

I have a good understanding of how the Audit and Governance Committee, as those charged with governance, gains assurance over management processes and arrangements. This enables me to deliver an efficient audit, reducing the time which finance staff need to spend responding to auditor queries.

Auditing standards require me to formally update my understanding annually. Therefore, I am writing to ask that you please provide a response to the following questions. Where your response to questions 2 to is 'yes', please provide details.

1) How do you exercise oversight of management's processes in relation to:

- undertaking an assessment of the risk that the financial statements may be materially misstated due to fraud or error (including the nature, extent and frequency of these assessments?);
- identifying and responding to risks of fraud in the Council, including any specific risks of fraud which management have identified or that have been brought to its attention, or classes of transactions, account balances, or disclosure for which a risk of fraud is likely to exist?;
- communicating to employees its view on business practice and ethical behavior (eg by updating, communicating and monitoring against the Council's code of conduct?); and
- communicating to you the processes for identifying and responding to fraud or error

2) How do you oversee management processes for identifying and responding to the risk of fraud and possible breaches of internal control? Are you aware of any breaches of internal control during 2013-14?

3) How do you gain assurance that all relevant laws and regulations have been complied with? Are you aware of any instances of non-compliance during 2013-14?

4) Are you aware of any actual or potential litigation or claims that would affect the financial statements?

5) Have you carried out a preliminary assessment of the going concern assumption and if so have you identified any events which may cast significant doubt on the Council's ability to continue as a going concern?

In addition to the above questions about how you gain assurance from management, I have included below, eight questions about your views on fraud. Your responses will inform my assessment of the risk of fraud and error within the financial statements, which in turn determines the extent of audit work I will undertake.

Please contact me if you wish to discuss anything in relation to this request.

Yours sincerely

Mark Kirkham
Director and Engagement Lead

No	Question	Those charged with governance response
1	Are you aware of any instances of actual, suspected or alleged fraud during the period 1 April 2013 – 31 March 2014?	
2	Do you suspect fraud may be occurring within the Council? • Have you identified any specific fraud risks within the Council? • Do you have any concerns that there are areas within your Council that are at risk of fraud? • Are there particular locations within the Council where fraud is more likely to occur?	
3	Are you satisfied that internal controls, including segregation of duties, exist and work effectively? If not where are the risk areas? • What other controls are in place to help prevent, deter or detect fraud?	
4	How do you encourage staff to report their concerns about fraud? • What concerns about fraud are staff expected to report?	
5	From a fraud and corruption perspective, what are considered to be high risk posts within your Council? • How are the risks relating to these posts identified, assessed and managed?	

No	Question	Those charged with governance response
6	Are you aware of any related party relationships or transactions that could give rise to instances of fraud? • How do you mitigate the risks associated with fraud related to related party relationships and transactions?	
7	Are you aware of any entries made in the accounting records of the Council that you believe or suspect are false or intentionally misleading? • Are there particular balances where fraud is more likely to occur? • Are you aware of any assets, liabilities or transactions that you believe could be improperly included or omitted from the accounts of the Council? • Could a false accounting entry escape detection? If so, how? Are there any external fraud risk factors, such as income collection, which are high risk of fraud?	
8	Are you aware of any organisational, or management pressure to meet financial or operating targets? Are you aware of any inappropriate organisational or management pressure being applied, or incentives offered, to you or colleagues to meet financial or operating targets?	

04 National publications and other updates

Annual fraud and corruption survey, Audit Commission, April 2014

The Audit Commission's annual fraud and corruption survey opened for audited bodies to complete from 7 April, with a requirement for external audit to review responses for reasonableness.

The survey requests information on detected fraud and corruption for the 2013/14 financial year, including any housing benefit fraud greater than £10,000. Completion and submission of the survey by audited bodies is a mandatory requirement under section 48 of the Audit Commission Act 1998 and feeds into its overall annual report on fraud.

The Head of Audit and Governance is leading on completion of the survey as in previous years.

2014/15 scale fees, Audit Commission, March 2014

Following consultation, the Audit Commission has issued the work programme and scales of fees for local government bodies.
There is no change for Hartlepool Borough Council, with the 2014/15 audit fee remaining the same as in 2013/14.

http://www.audit-commission.gov.uk/audit-regime/audit-fees/201415-work-programme-and-scales-of-fees/

Local authority waste management, Audit Commission, March 2014

The Audit Commission has published *Local authority waste management*, the latest in a series of value for money (VfM) data briefings analysing data in the VfM profiles tool. The briefing examines spending and performance on household waste management.

In 2012/13 the average spending on household waste management varied between local authorities with similar responsibilities. For example most authorities that both collect and dispose of waste (58 per cent) spent between £125 and £175 per household in 2012/13 but thirteen per cent spent more than £200 per household.

In 2012/13, the amount of waste recycled varied from 12 per cent up to 67 per cent, with 40 authorities recycling less than 30 per cent of their household waste. And while landfill has reduced everywhere some regions are still more reliant than others.

The variation in performance and spending suggests there may be opportunities to reduce expenditure. If councils were able to reduce their spending to the average for their authority type and waste responsibilities up to a possible £464 million could be saved overall. This saving could be used to support more sustainable forms of waste management or be reinvested in other services.

We have highlighted the briefing paper to officers for consideration. http://www.audit-commission.gov.uk/2014/03/local-authority-waste-management/

Oversight of audit quality, quarterly reports, Audit Commission, quarterly

Our regulator, the Audit Commission, also publishes quarterly and annual reports on the quality of the work it has outsourced to the firms. There are no significant issues highlighted in respect of Mazars LLP. See section 5 for a summary of Mazars' internal quality control processes.

http://www.audit-commission.gov.uk/audit-regime/audit-quality-review-programme/

05 Contact details

Please let us know if you would like further information on any items in this report.

www.mazars.co.uk

Mark Kirkham
Director
0191 383 6300

mark.kirkham@mazars.co.uk

Diane Harold
Senior Manager
0191 383 6322

diane.harold@mazars.co.uk

AUDIT AND GOVERNANCE COMMITTEE

15 May 2014

Report of: Chief Finance Officer

Subject: ROLE OF THE CHIEF FINANCE OFFICER (CFO) IN PUBLIC SERVICE ORGANISATIONS

1. PURPOSE OF REPORT

1.1 To inform Members of the CIPFA statement – 'The Role of the CFO in Public Service Organisations', and how the Council complies with this guidance.

2. BACKGROUND

2.1 The role of the CFO is a fundamental building block of good corporate governance and the Local Government Act 1972 (section 151) requires 'every local authority shall make arrangements for the proper administration of their financial affairs and shall secure that one of their officers has responsibility for the administration of those affairs'. This statutory requirement is reinforced by the Local Government and Housing Act 1989 (section 6) which requires that the Section 151 officer is a qualified accountant and a member of an accountancy body approved by the Secretary of State.

2.2 The two critical aspects of the CFO's role are stewardship and probity in the use of resources; and performance, extracting the most value from the use of those resources. The CFO, as the organisation's most senior executive role charged with leading and directing financial strategy and operations, occupies a pivotal role, both for external stakeholders and within the Leadership Team. CFOs everywhere have a responsibility to ensure that their organisations control and manage money well, and that strategic planning and decision making are supported by sound analysis.

2.3 In the public service context, CFOs must also meet the demands of openness and accountability in decision making, balance competition for limited resources across a range of worthwhile objectives, deliver value for money and safeguard taxpayers' money. Delivering these requires a range of personal qualities, as well as support from both the finance function and the organisation as a whole. It is these expectations, combined with the personal qualities and leadership skills

needed for them to be met, that have shaped the CIPFA Statement on the Role of the CFO in Public Service Organisations (the statement).

2.4 The Statement sets out the five principles that define the core activities and behaviours that belong to the role of the CFO in public service organisations and the organisational arrangements needed to support them. Successful implementation of each of the principles requires the right ingredients in terms of:

- The Organisation;
- The Role: and
- The Individual.

2.5 For each principle the Statement sets out the governance arrangements required within an organisation to ensure that CFOs are able to operate effectively and perform their core duties. The Statement also sets out the core responsibilities of the CFO role within the organisation. Many of the day-to-day responsibilities may in practice be delegated or in some authorities may even outsource, but the CFO should maintain oversight and control. Summaries of personal skills and professional standards then detail the leadership skills and technical expertise organisations can expect from their CFO. These include the key requirements of CIPFA and the other professional accountancy bodies' codes of ethics and professional standards to which the CFO as a qualified professional is bound. The personal skills described have been aligned with the most appropriate principle, but in many cases can support other principles as well.

3. CIPFA STATEMENT ON THE ROLE OF THE CFO IN PUBLIC SERVICE ORGANISATIONS

3.1 **The CFO in a public service organisation:**

1 is a key member of the Leadership Team, helping it to develop and implement strategy and to resource and deliver the organisation's strategic objectives sustainably and in the public interest;

2 must be actively involved in, and able to bring influence to bear on, all material business decisions to ensure immediate and longer term implications, opportunities and risks are fully considered, and alignment with the organisation's financial strategy; and

3 must lead the promotion and delivery by the whole organisation of good financial management so that public money is safeguarded at all times and used appropriately, economically, efficiently and effectively.

To deliver these responsibilities the CFO:

4 must lead and direct a finance function that is resourced to be fit for purpose; and
5 must be professionally qualified and suitably experienced.

3.2 Appendix A of the report details how the Council ensures that the requirements of the statement are met.

4. RECOMMENDATION

4.1 It is recommended that Members

i) note that I have reviewed the CIPFA statement – 'The Role of the CFO in Public Service Organisations' and can advise Members that the Council complies with these requirements as detailed in Appendix A.

5. REASON FOR RECOMMENDATIONS

5.1 To ensure that the Audit and Governance Committee meets its remit, it is important that it is kept up to date with best practice in relation to the information it receives from officers.

6. BACKGROUND PAPERS

6.1 CIPFA Statement on the Role of the CFO in Public Sector Organisations.

7. CONTACT OFFICER

7.1 Chris Little
Chief Finance Officer
Civic Centre
Victoria Road
Hartlepool
TS24 8AY

Tel: 01429 523003
Email: Chris.little@hartlepool.gov.uk

Appendix A

How the Five Principles Are Met

Principle 1 – The CFO is a key member of the Leadership Team, helping it to develop and implement strategy and to resource and deliver the organisation's strategic objectives sustainably and in the public interest.

Governance requirements	HBC Arrangements	Core CFO responsibilities	HBC Arrangements	Personal skills and professional standards	HBC Arrangements
Set out a clear statement of the respective roles and responsibilities of the Leadership Team and its members individually.	Constitution, Delegated Powers, Job Descriptions in place and clearly define roles and responsibilities.	Contributing to the effective leadership of the organisation, maintaining focus on its purpose and vision through rigorous analysis and challenge.	Corporate Management Team role, delegated powers. CFO leads on all financial matters and ensures Policy and Finance Committee and Corporate Management Team (CMT) buy-in in to Medium Term Financial Strategy and supporting strategies.	Role model, energetic, determined, positive, robust and resilient leadership, able to inspire confidence and respect, and exemplify high standards of conduct.	Actively engaged in the Leadership and Management Development Programme (LMDP). Provides training regarding financial issues to members and staff. Mentors senior finance staff and has regular Finance Management Team meetings and 1 to 1 meeting with senior finance staff.
Ensure that the CFO reports directly to the Chief Executive and is a member of the Leadership Team with a status at least equivalent to other members.	CFO reports directly to Chief Executive. Has regular 1 to 1 meetings with Chief Executive. Is a member of Corporate Management Team.	Contributing to the effective corporate management of the organisation, including strategy implementation, cross organisational issues, integrated business and resource planning, risk management and	See Above	Adopt a flexible leadership style, able to move through visioning to implementation and collaboration/consultation to challenge as appropriate.	See Above.

		performance management.			
If different organisational arrangements are adopted, explain the reasons publicly, together with how these deliver the same impact.	Not applicable - see Above	Supporting the effective governance of the organisation through development of – corporate governance arrangements, risk management and reporting framework; and – corporate decision making arrangements.	Responsible for the provision an adequate and effective Internal Audit service. Key role in formulating the Annual Governance Statement and Code of Corporate Governance.	Build robust relationships both internally and externally.	See Above. Regular meetings with Directors and other senior managers facilitate establishment of robust relationships. Active member of Tees Valley Strategic Finance Officers Group, ANEC Finance Group and CIPFA Municipal Treasurers Group. Regular meetings with external auditors.
Determine a scheme of delegation and reserve powers, including a formal schedule of those matters specifically reserved for collective decisions by the Board, and ensure that it is monitored and updated.	Constitution and Scheme of Delegation in place.	Leading or promoting change programmes within the organisation.	Key role in Business Transformation Programme and Service Delivery Options.	Work effectively with other Leadership Team members with political awareness and sensitivity.	Member of CMT. Regular contact with all members including Leader, Policy Committee Chairs and Audit and Governance Committee.
Ensure that organisation's governance arrangements allow the CFO: – to bring influence to bear on all	Constitution and Scheme of Delegation in place as well as defined reporting arrangements.	Leading development of a medium term financial strategy and the annual budgeting process to ensure financial balance and a monitoring process to ensure its	Responsibility for Medium Term Financial Strategy (MTFS) and budgetary control processes matters and ensuring Members and Corporate Management Team	Support collective ownership of strategy, risks and delivery.	Member of CMT. Represented on Performance and Risk Management Group. Member of Annual Governance Statement Group.

material business decisions; and – direct access to the Chief Executive, other Leadership Team members, the Audit Committee and external audit.		delivery.	(CMT) buy-in in to Medium Term Financial Strategy and supporting strategies, such as Business Transformation Programme.		
Review the scope of the CFO's other management responsibilities to ensure financial matters are not compromised.	Review of corporate financial management through Business Transformation Programme has focused CFO role on core financial management to ensure and effective strategy is developed and implemented to address the financial challenges facing the Council over the next few years.	Ensuring the medium term financial strategy reflects joint planning with partners and other stakeholders.	Wide consultation undertaken with all relevant stakeholders.	Address and deal effectively with difficult situations.	Peer review carried out by Chief Executive. Ongoing review of skills via LMDP.
Assess the financial skills required by members of the Leadership Team and commit to develop those skills to enable their roles to be carried out effectively.	Overarching Leadership and Management Development Programme (LMDP)/Management Academy in place.			Implement best practice in change management and leadership.	Ongoing development through LMDP/Management Academy and peer review/mentoring. Involvement in SDO reviews.
				Balance conflicting pressures and needs, including short and longer term trade-offs.	Responsibility for Medium Term Financial Strategy (MTFS) and budgetary control processes.

Demonstrate strong commitment to innovation and performance improvement.	Key role in Business Transformation Programme and Service Delivery Options.
Manage a broad portfolio of services to meet the needs of diverse communities.	Responsible for full range of financial services aligned with corporate priorities and needs through MTFS.
Maintain an appropriate balance between the deeper financial aspects of the CFO role and the need to develop and retain a broader focus on the environment and stakeholder expectations and needs.	See Above.
Comply with the IFAC Code of Ethics for Professional Accountants, as implemented by local regulations and accountancy bodies, as well as other ethical standards that are applicable to them by reason of their professional status. The fundamental principles set out in the Code are integrity, objectivity, professional competence and due care, confidentiality, and	Professional standards integral to role. Commitment to Professional CPD and LMDP/Management Academy.

				professional behaviour. Impartiality is a further fundamental requirement of those operating in the public services.	

Principle 2 – The CFO must be actively involved in, and able to bring influence to bear on, all material business decisions to ensure immediate and longer term implications, opportunities and risks are fully considered, and alignment with the organisation's overall financial strategy.

Governance requirements	**HBC Arrangements**	**Core CFO responsibilities**	**HBC Arrangements**	**Personal skills and professional standards**	**HBC Arrangements**
Establish a medium term business and financial planning process to deliver the organisation's strategic objectives, including: – a medium term financial strategy to ensure sustainable finances; – a robust annual budget process that ensures financial balance; and – a monitoring process that enables this to be delivered.	MTFS in place, monitoring arrangements and role of Council, Policy and Finance Committee and Audit and Governance Committee enshrined in the Constitution.	**Responsibility for financial strategy:** Agreeing the financial framework with sponsoring organisations and planning delivery against the defined strategic and operational criteria.	Responsibility for the production, implementation and monitoring of the MTFS.	Implement appropriate management, business and strategic planning techniques.	Responsibility for MTFS and budgetary control processes.
Ensure that professional advice on matters that have financial implications is available and recorded well in	The reporting of key decisions is enshrined within the Constitution.	Maintaining a long term financial strategy to underpin the organisation's financial viability within the agreed performance	See Above.	Link financial strategy and overall strategy.	Responsibility for MTFS and budgetary control processes.

advance of decision making and used appropriately.		framework.			
Ensure that those making decisions are provided with information that is fit for the purpose – relevant, timely and giving clear explanations of financial issues and their implications.	See Above	Implementing financial management policies to underpin sustainable long-term financial health and reviewing performance against them.	Responsibility for the production, implementation and monitoring of Financial Procedure Rules (FPRs) and Standing Orders.	Demonstrate a willingness to take and stick to difficult decisions – even under pressure.	Key role in Business Transformation Programme and Service Delivery Options.
		Appraising and advising on commercial opportunities and financial targets.	Budget monitoring process and Budget Strategy, key decision advice.	Take ownership of relevant financial and business risks.	Represented on Performance and Risk Management Group. Member of Annual Governance Statement Group
		Developing and maintaining an effective resource allocation model to deliver business priorities.	See Above	Network effectively within the organisation to ensure awareness of all material business decisions to which CFO input may be necessary.	Member of CMT. Regular contact with Chief Executive, Directors, other senior officers, members, Trade unions,
		Co-ordinating the planning and budgeting processes.	See Above. Annual budget timetable well established and enshrined in constitution.	Role model persuasive and concise communication with a wide range of audiences internally and externally.	See Above. Externally represent Council in meeting with Business sector and various resident groups/ad –hoc budget consultation events.
		Influencing decision making: Ensuring that	Budget Strategy and monitoring process, key decision advice in relation	Provide clear, authoritative and impartial professional advice and	Addressed in MTFS and associated presentation to Finance and Policy

opportunities and risks are fully considered and decisions are aligned with the overall financial strategy.	to financial and governance matters.	objective financial analysis and interpretation of complex situations.	Committee and other groups. Ongoing development through LMDP and management review/mentoring.
Providing professional advice and objective financial analysis enabling decision makers to take timely and informed business decisions.	Key decision advice in relation to financial and governance matters.	Apply relevant statutory, regulatory and professional standards both personal and organisational.	See Above.
Ensuring that the organisation's capital projects are chosen after appropriate value for money analysis and evaluation using relevant professional guidance.	Member of Strategic Asset Management Programme Team (SCRAPT).	Demonstrate a strong desire to innovate and add value.	
Checking, at an early stage, that innovative financial approaches comply with regulatory requirements.	Close working relationship with CMT ensure early involvement with innovative approaches to services and financial arrangements to ensure compliance with regulatory requirement and proposals are based on robust business cases.	Challenge effectively, and give and receive constructive feedback.	Ongoing development through LMDP and management review/mentoring. 1 to 1 meetings with Chief Executive and key financial staff.
Financial information for decision makers: Monitoring and reporting on financial performance that is linked to related	Budget Strategy and monitoring process, key decision advice in relation to financial and governance matters.	Operate with sensitivity in a political environment.	Ongoing development through LMDP and peer review/mentoring. Regular contact with members, TU's local

performance information and strategic objectives that identifies any necessary corrective decisions.	Corporate Plan aligned with financial PI's.		business and the community.
Preparing timely management accounts.	Final Accounts timetable.		
Ensuring the reporting envelope reflects partnerships and other arrangements to give an overall picture.	Effective and wide ranging consultation process in place.		

Principle 3 – The CFO must lead the promotion and delivery by the whole organisation of good financial management so that public money is safeguarded at all times and used appropriately, economically, efficiently, and effectively.

Governance requirements	**HBC Arrangements**	**Core CFO responsibilities**	**HBC Arrangements**	**Personal skills and professional standards**	**HBC Arrangements**
Make the CFO responsible for ensuring that appropriate advice is given on all financial matters, for keeping financial records and accounts, and for maintaining an effective system of financial control.	Delegated Powers, FPRs and Standing Orders enshrined within Constitution.	**Promotion of financial management:** Assessing the organisation's financial management style and the improvements needed to ensure it aligns with the organisation's strategic direction.	Strategic direction reflected in MTFS.	Generate 'buy-in' to, and support delivery of, good financial management across the organisation.	**Achieved through** detailed involvement of Finance and Policy Committee and CMT in development of financial management strategy and procedures for ensuring good financial management arrangements are in place.
Ensure that systems and processes for financial administration, financial control and protection of the organisation's	Delegated Powers, FPRs and Standing Orders enshrined within Constitution. Audit and Governance Committee in line with legislative arrangements.	Actively promoting financial literacy throughout the organisation.	Allocation of named financial leads to support named budget holders promotes close working relationship and ensure financial management arrangements are	Develop and sustain partnerships, and engage effectively in collaboration.	

resources and assets are designed in conformity with appropriate ethical standards and monitor their continuing effectiveness in practice.			effective. Influencing force behind LMDP.		
Address the organisation's arrangements for financial and internal control and for managing risk in Annual Governance Reports.	Delegated Powers, FPRs and Standing Orders enshrined within Constitution. Audit and Governance Committee in line with legislative arrangements. Internal Audit Section adequately resourced.	**Value for money:** Challenging and supporting decision makers, especially on affordability and value for money, by ensuring policy and operational proposals with financial implications are signed off by the finance function.	Advisory role in terms of CMT and all key committee decisions in respect of financial matters.	Deploy effective facilitation and meeting skills.	
Publish annual accounts on a timely basis to communicate the organisation's activities and achievements, its financial position and performance.	Delegated Powers and Final Accounts process.	Developing and maintaining appropriate asset management and procurement strategies.	Key member of SCRAPT (Strategic Capital Resource and Asset Programme Team) and Corporate Procurement Group.	Build and demonstrate commitment to continuous improvement and innovative, but risk-aware, solutions.	
Maintain and resource an effective internal audit function.	Audit and Governance Committee remit and effective internal audit assessment carried out annually.	Managing long term commercial contract value.		Place stewardship and probity as the bedrock for management of the organisation's finances.	Budget Strategy and monitoring process, key decision advice in relation to financial and governance matters. Corporate Plan aligned

					with financial PI's. Review of System of Internal Audit.
Develop and maintain an effective Audit Committee.	Audit and Governance Committee role and responsibility enshrined in Constitution. Regular training of Audit and Governance Committee members.	**Safeguarding public money:** Applying strong internal controls in all areas of financial management, risk management and asset control.	Direct line management responsibility for all audit matters.		
Ensure that the organisation makes best use of resources and that taxpayers and/or service users receive value for money.	Delegated Powers relating to Budget Strategy and Budget Monitoring Process.	Establishing budgets, financial targets and performance indicators to help assess delivery.	Budget Strategy and Budget Management Process aligned to corporate plan.		
Embed financial competencies in person specifications and appraisals.	Corporate competencies framework, job descriptions and person specifications.	Implementing effective systems of internal control that include standing financial instructions, operating manuals, and compliance with codes of practice to secure probity.	Direct line management responsibility for all audit matters, FPR's and Standing Orders.		
Assess the financial skills required by managers and commit to develop those skills to enable their roles to be carried out effectively.	See Above	Ensuring that delegated financial authorities are respected.	Performance review mechanisms PI's, Direct line management responsibility for all audit matters.		

Promoting arrangements to identify and manage key business risks, including safeguarding assets, risk mitigation and insurance.	Performance and Risk Management Group, Line management responsibility for Insurance matters.
Overseeing of capital projects and post completion reviews.	Direct line management responsibility for capital accounting and member of SCRAPT.
Applying discipline in financial management, including managing cash and banking, treasury management, debt and cash flow, with appropriate segregation of duties.	Direct line management responsibility for all audit matters, FPR's and Standing Orders. CFO personally involved in development and implementation of Treasury Management strategy.
Implementing appropriate measures to prevent and detect fraud and corruption.	Direct line management responsibility for all audit matters, FPR's and Standing Orders. Money Laundering Reporting Officer (MLRO) responsibilities.
Establishing proportionate business continuity arrangements for financial processes and information.	Corporate lead on Business Continuity.
Ensuring that any partnership arrangements are	Direct line management responsibility for all audit matters, FPR's and

underpinned by clear and well documented internal controls.	Standing Orders.
Assurance and scrutiny: Reporting performance of both the organisation and its partnerships to the board and other parties as required.	Performance review mechanisms PI's, Direct line management responsibility for all audit matters.
Supporting and advising the Audit Committee and relevant scrutiny groups.	Regular attendance enshrined in job specification.
Preparing published budgets, annual accounts and consolidation data for government-level consolidated accounts.	Responsibility for the production, implementation and monitoring of the MTFS, publishing budget information on Council Tax leaflet and Hartbeat. Responsible for preparing accounts and consolidated government returns.
Liaising with the external auditor.	Direct line management responsibility for all audit matters. Regular meeting with external auditor.

Principle 4 – The CFO must lead and direct a finance function that is resourced to be fit for purpose.					
Governance requirements	**HBC Arrangements**	**Core CFO responsibilities**	**HBC Arrangements**	**Personal skills and professional standards**	**HBC Arrangements**
Provide the finance function with the resources, expertise and systems necessary to perform its role effectively.	Delegated Powers, FPRs and Standing Orders enshrined within Constitution.	Leading and directing the finance function so that it makes a full contribution to and meets the needs of the business.	Direct line management responsibility for all corporate financial matters.	Create, communicate and implement a vision for the finance function.	Responsibility for the production, implementation and monitoring of the MTFS. Regular 1 to 1 with senior finance officers
Ensure there is a line of professional accountability to the CFO for finance staff throughout the organisation.	Structural makeup enshrined in Delegated Powers. FPRs and Standing Orders enshrined within Constitution.	Determining the resources, expertise and systems for the finance function that are sufficient to meet business needs and negotiating these within the overall financial framework.	Delegated powers regarding all financial and governance matters.	Role model a customer focussed culture within the finance function.	Leads by example in approach with Directors and other senior managers that finance function role is to help achieve organisations objectives, whilst ensuring compliance with best practice and legislative requirements.
		Implementing robust processes for recruitment of finance staff and/or outsourcing of functions.	See Above. Recruitment follows corporate proceeds and based on job descriptions and person specification.	Establish an open culture, built on effective coaching and a “no blame” approach.	Regular 1 to 1 meetings with senior finance staff. Open door policy for all staff. CFO accepts responsibility for actions of all team members and encourages staff to use learn from experiences in a ‘no blame’ environment.
		Reviewing the performance of the finance function and ensuring that the	Corporate Plan reviewed and monitored. 1 to 1 meetings with senior finance manager and	Promote effective communication within the finance department, across the broader	Finance Management Team meetings for internal communication. All finance staff briefing

services provided are in line with the expectations and needs of its stakeholders.	regular performance appraisals.	organisation and with external stakeholders.	as and when appropriate. Presentations to external groups as appropriate. Article in Hartbeat.
Seeking continuous improvement in the finance function.	Departmental plans constantly monitored. Key role in BTP.	Apply strong project planning and process management skills.	
Identifying and equipping finance staff, managers and the Leadership Team with the financial competencies and expertise needed to manage the business both currently and in the future.	1 to 1 meetings with finance managers. Full engagement of CMT in development of financial strategies. Lead officer in financial aspects of LMDP.	Set and monitor meaningful performance objectives for the finance team.	Corporate appraisal system in place. Regular 1-2-1's
Ensuring that the Head of Profession role for all finance staff in the organisation is properly discharged.	Delegated Section 151 responsibilities enshrined in Constitution. All finance staff report directly to CFO.	Role model effective staff performance management.	Mentor key finance staff across the Division/regular 1-2-1's. Encourage CPD involvement.
Acting as the final arbiter on application of professional standards.	See Above	Coach and support staff in both technical and personal development.	As above.
		Promote high standards of ethical behaviour, probity, integrity and honesty.	Mentor key finance staff across the Division/regular 1-2-1's. Encourage CPD involvement.
		Ensure, when necessary, that outside expertise is called upon for specialist	Actively seek professional expertise where needed i.e.

				advice not available within the finance function.	Treasury management, complex taxation issues etc.
				Promote discussion on current financial and professional issues and their implications.	Mentor key finance staff across the Division/regular 1-2-1's. Encourage CPD involvement.
Principle 5 – The CFO in a public service organisation must be professionally qualified and suitably experienced.					
Governance requirements	**HBC Arrangements**	**Core CFO responsibilities**	**HBC Arrangements**	**Personal skills and professional standards**	**HBC Arrangements**
Appoint a professionally qualified CFO whose core responsibilities include those set out under the other principles in this Statement and ensure that these are properly understood throughout the organisation.	Constitution and delegated powers in operation. Job description and person specification for CFO.			Be a member of an accountancy body recognised by the International Federation of Accountants (IFAC), qualified through examination, and subject to oversight by a professional body that upholds professional standards and exercises disciplinary powers.	CFO is member of CIPFA and meets CPD requirements.
Ensure that the CFO has the skills, knowledge, experience and resources to perform effectively in both the financial and non-financial areas of their role.	See Above.			Adhere to international standards set by IFAC on: – ethics – Continuing Professional Development.	As above.
				Demonstrate IT literacy.	CFO has required IT

	skills for role and is able to manage and challenge the departmental IT experts to ensure they are able to effectively discharge their responsibilities.
Have relevant prior experience of financial management in the public services or private sector.	CFO qualified with CIPFA in 1993 and has held a variety of position with Hartlepool, before appointment as CFO in 2010, including Chief Accountant and ACFO (Corporate Finance). Since 1996 the current CFO has acted as lead finance officer for financial services provided to Cleveland Fire Authority (CFA) and in April 2010 was appointed Deputy Treasurer to the CFA.
Understand public service finance and its regulatory environment.	CFO has 21 years post qualification experience and sound understanding of public service finance and its regulatory environment.
Apply the principles of corporate finance, economics, risk management and accounting.	See above

Understand personal and professional strengths.	CFO has a clear understanding of these issues and is committed to continuous improvements. These issues addressed through performance appraisal.
Undertake appropriate development or obtain relevant experience in order to meet the requirements of the non-financial areas of the role.	CFO role has been refocused on core financial responsibilities to ensure financial challenges faces the Council can be managed. CFO has clear understanding of no-financial areas affecting his role.

AUDIT AND GOVERNANCE COMMITTEE

15 May 2014

Report of: Chief Finance Officer

Subject: ROLE OF THE HEAD OF INTERNAL AUDIT IN LOCAL GOVERNMENT

1. PURPOSE OF REPORT

1.1 To inform Members of the CIPFA statement – "The Role of the Head of Internal Audit in Local Government", and to demonstrate how the Council complies with this guidance.

2. BACKGROUND

2.1 The Statement describes the role of the Head of Internal Audit (HIA) in local government. CIPFA believes the HIA occupies a critical position in a local authority, helping it to achieve its objectives by giving assurance on its internal control arrangements and playing a key role in promoting good corporate governance. Local authorities need to know that they have strong arrangements for controlling their resources and for delivering their objectives. CIPFA believes that HIA's have a unique role to play here. They are senior managers whose business is objectively assessing these arrangements and the risks that authorities face and giving appropriate assurances. HIA's must also provide leadership, promoting good governance and helping authorities to address future challenges.

2.2 HIA's need to review the whole system of control, both financial and non-financial, and focus on the areas where assurance is most needed. The HIA also has to give an annual opinion on the adequacy and effectiveness of the control environment; this is used by Chief Executives as a primary source of evidence for their annual governance statement.

2.3 HIA's must also be able to show that they can meet the needs of stakeholders such as Chief Executives and Audit Committees, adding value by helping to improve services whilst retaining their objectivity. They also need to work well with partners and other auditors. Authorities should see the Statement as best practice and use it to assess their HIA arrangements to drive up audit quality and governance arrangements.

3 THE KEY ROLE PLAYED BY THE HIA

3.1 Internal audit is one of the cornerstones of effective governance. The HIA is responsible for reviewing and reporting on the adequacy of the authority's control environment, including the arrangements for achieving value for money. Through the annual internal audit opinion and other reports the HIA gives assurance to the Leadership Team and others, and makes recommendations for improvement.

3.2 The HIA's role is a unique one, providing objective challenge and support and acting as a catalyst for positive change and continual improvement in governance in all its aspects. The role is particularly important when authorities are facing uncertain or challenging times. Fulfilling the role requires a range of personal qualities. The HIA has to win the support and trust of others, so that he/she is listened to, and the HIA's role as a critical friend means that sometimes difficult messages must be given and acted on. It is these expectations, combined with the professional, personal and leadership skills required, that have shaped the CIPFA Statement on the role of the HIA in Local Government.

3.3 **Primary audience**
The primary audience for this Statement is those who rely on the HIA's assurances – the Leadership Team and the Audit Committee. CIPFA recommends that they should examine their own authority against this Statement to satisfy themselves that they have effective HIA arrangements in place.

3.4 **Local government context**
CIPFA has drawn up a separate Statement for local government because of the statutory responsibility of specific post holders regarding internal audit and governance. In local government the 'Section 151' officer (the Chief Financial Officer or CFO) is a statutory post as is the Monitoring Officer (often the Head of Legal Services) and the Head of Paid Service (often the Chief Executive). The HIA needs to work well with these post holders and lines of responsibility need to be clear.

3.5 The Statement sets out the five principles that define the core activities and behaviours that belong to the role of the HIA in local government and the organisational arrangements needed to support them. Successful implementation of each of the principles requires the right ingredients in terms of:

- the organisation;
- the role; and
- the individual.

For each principle the Statement sets out the governance arrangements required within an authority to ensure that HIAs are able

to operate effectively and perform their core duties. The Statement also sets out the core responsibilities of the HIA. Summaries of personal skills and professional standards then detail the leadership skills and technical expertise authorities can expect from their HIA. These include the requirements of CIPFA and the other professional bodies' codes of ethics and professional standards to which the HIA as a qualified professional is bound. The personal skills described have been aligned with the most appropriate principle, but in many cases support other principles as well.

3.6 **Demonstrating compliance**
The Statement supports CIPFA's work to strengthen governance, risk management and internal audit across public services. It is intended to allow the Leadership Team of a local authority to benchmark its existing arrangements against a defined framework.

3.7 CIPFA recommends that authorities use the Statement as the framework to assess their existing arrangements and that they should report publically on compliance to demonstrate their commitment to good practice. CIPFA also proposes that authorities should report publicly where their arrangements do not conform to the compliance framework in this Statement, explaining the reasons for this, and how they achieve the same impact. CIPFA will consider how to take this forward in the context of the CIPFA/Society of Local Authority Chief Executives (SOLACE) guidance on good governance.

4. CIPFA STATEMENT ON THE ROLE OF THE HIA IN LOCAL GOVERNMENT

The Head of Internal Audit in a local authority plays a critical role in delivering the authority's strategic objectives by:

1 – championing best practice in governance, objectively assessing the adequacy of governance and management of existing risks, commenting on responses to emerging risks and proposed developments; and

2 – giving an objective and evidence based opinion on all aspects of governance, risk management and internal control.

To perform this role the Head of Internal Audit:

3 – must be a senior manager with regular and open engagement across the authority, particularly with the Leadership Team and with the Audit Committee;

4 – must lead and direct an internal audit service that is resourced to be fit for purpose; and

5 – must be professionally qualified and suitably experienced.

5. PROCESS FOLLOWED

5.1 The review is undertaken annually in line with best practice requirements. Appendix A of the report details how the Council ensures that the requirements of the statement are met. Details of the requirements of the statement are outlined along with how the arrangements in place at the council satisfy those requirements.

6. RECOMMENDATION

6.1 It is recommended that Members

i) Note that I have reviewed the CIPFA statement – "The Role of the Head of Internal Audit in Local Government" and can advise Members that the Council complies with these requirements as detailed in Appendix A.

7. REASON FOR RECOMMENDATIONS

7.1 To ensure that the Audit Committee meets its remit, it is important that it is kept up to date with current best practice in relation to the information it receives from officers.

8. BACKGROUND PAPERS

8.1 CIPFA statement – "The Role of the Head of Internal Audit in Local Government".

9. CONTACT OFFICER

9.1 Chris Little
Chief Finance Officer
Civic Centre
Victoria Road
Hartlepool
TS24 8AY

Tel: 01429 523003
Email: chris.little@hartlepool.gov.uk

Appendix A

How the Five Principles Are Met

Principle 1 – The HIA in a local authority plays a critical role in delivering the authority's strategic objectives by championing best practice in governance, objectively assessing the adequacy of governance and management of existing risks, commenting on responses to emerging risks and proposed developments.

Governance requirements	HBC Arrangements	Core HIA responsibilities	HBC Arrangements	Personal skills and professional standards	HBC Arrangements
Set out the HIA's role in good governance and how this fits with the role of others, in particular the CFO, the Monitoring Officer and the Head of Paid Service.	*Role of HIA enshrined in the Constitution, Audit Charter and Audit Strategy as agreed by members and reflected in the Audit Manual.*	Working with others (including the CFO, the Monitoring Officer and the Head of Paid Service) to promote the benefits of good governance throughout the organisation.	*Relationships with key officers detailed in agreed protocols i.e. Relationship between CFO and IA.*	Provide leadership by giving practical examples of good governance that will inspire others.	*HIA undertakes proactive role on relevant working parties and officer groups i.e. Performance and Risk Management Group.*
Ensure that the importance of good governance is stressed to all in the authority, through policies, procedures and training.	*Code of Corporate Governance agreed by the Audit and Governance Committee And adopted by Council. Job descriptions and Management Academy training programme cover governance requirements.*	Giving advice to the Leadership Team and others on the control arrangements and risks relating to proposed policies, programmes and projects.	*Regularly report to Audit and Governance Committee and Senior Management through CFO and CMT on all aspects of governance arrangements.*	Deploy effective facilitating and negotiating skills.	*HIA undergoes Continuous Professional Development (CPD) tailored to requirements of the role i.e. CIPFA Certificate in Investigatory Practices..*
Ensure that the HIA is consulted on all proposed major projects, programmes and policy initiatives.	*Protocols in place to ensure regular liaison with key officers and CMT.*	Promoting the highest standards of ethics and standards across the authority based on the principles of integrity, objectivity, competence	*HIA role as per CIPFA Code of Practice for Internal Audit in Local Government as enshrined in the Audit Manual.*	Build and demonstrate commitment to continuous improvement.	*As above*

Governance requirements	HBC Arrangements	Core HIA responsibilities	HBC Arrangements	Personal skills and professional standards	HBC Arrangements
		and confidentiality.			
Require staff to report suspected or detected fraud, corruption or impropriety to the HIA.	*Corporate Anti-Fraud and Corruption Strategy agreed by Audit and Governance Committee*	Demonstrating the benefits of good governance for effective public service delivery and how the HIA can help.	*HIA undertakes proactive role on relevant working parties and officer groups i.e. Performance and Risk Management Group.*	Demonstrate consultancy skills as appropriate – analytical, problem solving, influencing and communicating.	*As above*
		Offering consultancy advice where the HIA considers that it is appropriate, drawing up clear terms of reference for such assignments.	*Resource built into Audit Plan for advice and guidance to be provided, within strictly agreed scope, terms of reference and outcomes.*		

Principle 2 – The HIA in a local authority plays a critical role in delivering the authority's strategic objectives by giving an objective and evidence based opinion on all aspects of governance, risk management and internal control.

Governance requirements	HBC Arrangements	Core HIA responsibilities	HBC Arrangements	Personal skills and professional standards	HBC Arrangements
Set out the responsibilities of the HIA, which should not include the management of operational areas	*Job Description in place. Audit Strategy and Charter sets out terms of reference as agreed by Audit and Governance Committee.*	Giving assurance on the control environment. This includes risk and information management and internal controls across all systems.	*Annual opinion provided to Audit and Governance Committee in line with Public Sector Internal Audit Standards, covering all aspects of governance arrangements.*	Give clear, professional and objective advice.	*Reporting arrangements agreed with management based on a shared understanding of requirements.*
Ensure that internal audit is independent of external audit.	*Internal and External Audit protocol in place.*	Reviewing the adequacy of key corporate arrangements including e.g. risk strategy, risk register, anti fraud and corruption strategy, corporate plan.	*All aspects of governance arrangements covered in the annual Internal Audit Plan as agreed by management and the Audit and Governance Committee.*	Report on what is found, without fear or favour.	*Reporting arrangements enshrined within the Audit Strategy and Charter as reflected in the Audit Manual in line with best practice.*
Where the HIA does	*Not Applicable.*	Producing evidence	*Annual opinion report*	Demonstrate integrity to	*HIA undergoes CPD*

Governance requirements	HBC Arrangements	Core HIA responsibilities	HBC Arrangements	Personal skills and professional standards	HBC Arrangements
have operational responsibilities the HIA's line manager and the Audit Committee should specifically approve the IA strategy for these and associated plans and reports and ensure the work is independently managed.		based annual internal audit opinion on the authority's control environment.	*HIA is produced and presented to the Audit and Governance Committee by the HIA.*	staff and others in the authority.	*tailored to requirements of the role i.e. CIPFA Certificate in Investigatory Practices.*
Establish clear lines of responsibility for those with an interest in governance (e.g. Head of Paid Service, Monitoring Officer, Head of Paid Service, Audit Committee, Members). This covers responsibilities for drawing up and reviewing key corporate strategies, statements and policies.	*Role of HIA enshrined in the Constitution, Audit Charter and Audit Strategy as agreed by members and reflected in the Audit Manual. Code of Corporate Governance outlines responsibilities with regard to governance arrangements.*	Working closely with others to ensure that sufficient and relevant evidence is used. Where relying on others, clarifying the degree and basis for the reliance.	*Reporting arrangements compliant with Public Sector Internal Audit Standards.*	Exercise sound judgement in identifying weaknesses in the authority's control environment and a balanced view on how significant these are.	*Experience gained over 21 year Internal Audit career. Professional guidance followed in relation to risk measurement.*
Establish clear lines of reporting to the Leadership Team and to the Audit Committee where the HIA has	*Role of HIA enshrined in the Constitution, Audit Charter and Audit Strategy as agreed by members and reflected in the Audit Manual. Rights*	Reviewing significant partnership arrangements and major services provided by third parties and the controls in place to	*Internal Audit plan encompasses partnership arrangements and highlighted as key area of concern of Audit and Governance Committee.*	Work well with others with specific responsibilities for internal control, risk management and governance including the Head of Paid Service, the	*Relationships with key officers detailed in agreed protocols i.e. Relationship between CFO and IA. Relationships built up*

Governance requirements	HBC Arrangements	Core HIA responsibilities	HBC Arrangements	Personal skills and professional standards	HBC Arrangements
significant concerns.	*of access to key members and officers detailed.*	promote and protect the authority's interests. Assessing whether lines of responsibility and assurance are clear.		Monitoring Officer, the CFO, Audit Committee and Members.	*over a number of years.*
Agree the terms of reference for internal audit with the HIA, the Audit Committee and the CFO, as well as with the Leadership Team.	*Role of HIA enshrined in the Constitution, Audit Charter and Audit Strategy as agreed by members and reflected in the Audit Manual.*	Liaising closely with the external auditor to share knowledge and to use audit resources most effectively.	*Protocol in place for joint working with External Audit.*	Be concerned for action - influencing the Leadership Team, Audit Committee and others to ensure that the HIA's recommendations are implemented.	*As above*
Set out the basis on which the HIA can give assurances to other organisations and the basis on which the HIA can place reliance on assurances from others.	*Audit Manual sets out roles and levels of assurances.*	Producing an internal audit strategy that fits with and supports the authority's objectives.	*Strategy produced and agreed by management and Audit and Governance Committee.*	Be a role model, dynamic, determined, positive, robust and with resilient leadership, able to inspire confidence and respect and exemplify high standards of conduct.	*Experience gained over 21 year Internal Audit career. HIA CPD tailored to requirements of the role.*
Ensure that comprehensive governance arrangements are in place, with supporting documents covering e.g. risk management, corporate planning, anti fraud and corruption and whistle blowing.	*Production of Annual Governance Statement in line with best practice covering all aspects of the governance framework and supporting documentation in place.*	Reviewing the authority's risk maturity (including the authority's own assessment) and reflecting this in the strategy.	*Key member of Performance and Risk Management Group reviewing risk strategy, maturity and tolerance.*		
Ensure that the annual internal audit	*Reported independently by the HIA to the Audit*	Consulting stakeholders, including senior	*Internal Audit Strategy agreed by senior*		

Governance requirements	HBC Arrangements	Core HIA responsibilities	HBC Arrangements	Personal skills and professional standards	HBC Arrangements
opinion and report are issued in the name of the HIA.	*and Governance Committee.*	managers and Members on the internal audit strategy.	*management before approval sought from the Audit and Governance Committee.*		
Include awareness of governance in the competencies required by members of the Leadership Team.	*Job descriptions and CIPFA's "Excellent Auditor Framework" covering governance requirements*	Setting out how the HIA plans to rely on others for assurance on the authority's controls and risks and taking account of any limitations in assurance given by others.	*Internal Audit Strategy and Charter in place with Public Sector Internal Audit Standards detailing day to day arrangements.*		
Set out the framework of assurance that supports the annual governance statement and identify internal audit's role within it. The HIA should not be responsible for preparing the report.	*Included in the Annual Governance Statement which is produced by senior management.*	Liaising with external inspectors and review agencies where appropriate when drawing up the internal audit strategy.	*The process followed is recorded in the Audit Manual.*		
Ensure that the internal audit strategy is approved by the Audit Committee and endorsed by the Leadership Team.	*Internal Audit Strategy agreed by senior management before approval by the Audit and Governance Committee.*	Liaising with the external audit on the internal audit strategy, but not being driven by external audit's own priorities.	*Protocol in place for joint working with External Audit.*		

Principle 3 – The HIA in a local authority must be a senior manager with regular and open engagement across the authority, particularly with the Leadership Team and with the Audit Committee.

Governance requirements	HBC Arrangements	Core HIA responsibilities	HBC Arrangements	Personal skills and professional standards	HBC Arrangements
Designate a named individual as HIA in line with the principles in this Statement. The individual could be someone from another organisation where internal audit is contracted out or shared. Where this is the case then the roles of the HIA and the client manager must be clearly set out in the contract or agreement.	*HIA designated individual employed within the Authority.*	Escalating any concerns through the line manager, CFO, Monitoring Officer, Head of Paid Service, Audit Committee, Leadership Team and external auditor as appropriate.	*Protocols in place and enshrined in Internal Audit Charter and Strategy for escalation of concerns.*	Network effectively to raise the profile and status of internal audit.	*Relationships built up over a number of years backed up by regular meetings, 1-2-1s with key officers.*
Ensure that where the HIA is an employee that they are sufficiently senior and independent within the authority's structure to allow them to carry out their role effectively and be able to provide credibly constructive challenge to the Management Team.	*HIA senior manager within the Finance function reporting directly to the CFO with access to key officers as detailed in the Internal Audit Strategy Charter and Councils Constitution.*	Supporting the Audit Committee in reviewing its own effectiveness and advising the Chair and line manager of any suggested improvements.	*Audit and Governance Committee provided with advice and guidance to enable it to fulfil its function.*	Adopt a flexible style, being able to collaborate and advise but also able to challenge as appropriate.	*Experience gained over 21 year Internal Audit career. HIA undergoes CPD tailored to requirements of the role. Regular 1-2-1s with CFO in order to support development in all areas.*
Ensure that where the HIA is an employee the HIA is line managed by a member of the	*HIA senior manager within the Finance function reporting directly to the CFO.*	Consulting stakeholders, including senior managers and Members on the internal audit strategy.	*Internal Audit Strategy agreed by senior management before approval by the Audit and Governance Committee.*	Deploy effective facilitation and meeting skills.	*As above*

Governance requirements	HBC Arrangements	Core HIA responsibilities	HBC Arrangements	Personal skills and professional standards	HBC Arrangements
Management Team. Where the HIA is not an employee then the reporting line must be clearly set out in the contract or agreement with the internal audit supplier.					
Establish an Audit Committee in line with guidance and good practice.	*Audit and Governance Committee established in line with CIPFA guidelines.*			Build and demonstrate commitment to continuous improvement and innovative, but risk-aware, solutions.	*As above*
Set out the HIA's relationship with the Audit Committee and its Chair.	*Role of HIA enshrined in the Constitution, Audit Charter and Audit Strategy as agreed by members and reflected in the Audit Manual.*			Place stewardship and probity as the bedrock for management of the organisation's finances.	*Leads by example in approach with Directors and other senior managers that Internal Audit function role is to help achieve organisations objectives, whilst ensuring compliance with best practice and legislative requirements.*
Ensure that the authority's governance arrangements allow the HIA: □ to bring influence to bear on material decisions reflecting governance □ direct access to the Chief Executive,	*Role of HIA enshrined in the Constitution, Audit Charter and Audit Strategy as agreed by members and reflected in the Audit Manual. Rights of access to key members and officers detailed.*			Build productive relationships both internally and externally.	*Relationships built up over a number of years backed up by regular meetings, 1-2-1s with key officers.*

Governance requirements	HBC Arrangements	Core HIA responsibilities	HBC Arrangements	Personal skills and professional standards	HBC Arrangements
other Leadership Team members, the Audit Committee and external audit to attend meetings of the Leadership Team and Management Team where the HIA considers this to be appropriate.					
Set out unfettered rights of access for internal audit to all papers and all people in the organisation, as well as appropriate access in (significant) partner organisations.	*Councils Constitution details access arrangements for Internal Audit, reflected in the Audit Manual.*			Work effectively with the Leadership Team and Audit Committee with political awareness and sensitivity.	*Experience gained over 21 year Internal Audit career. HIA undergoes CPD tailored to requirements of the role. Regular 1-2-1s with CFO in order to support development in all areas.*
Set out the HIA's responsibilities relating to partners including joint ventures and outsourced and shared services.	*Major ventures undertaken detail rights of access to Internal Audit for governance opinion purposes.*			Be seen to be objective and independent but also pragmatic where appropriate.	*As above*

Principle 4 – The HIA in a local authority must lead and direct an internal audit service that is resourced to be fit for purpose.

Governance requirements	HBC Arrangements	Core HIA Responsibilities	HBC Arrangements	Personal skills and professional standards	HBC Arrangements
Provide the HIA with	*Internal Audit Strategy*	Leading and directing	*Approval and consultation*	Demonstrate leadership	*HIA undergoes CPD*

Governance requirements	HBC Arrangements	Core HIA Responsibilities	HBC Arrangements	Personal skills and professional standards	HBC Arrangements
the resources, expertise and systems necessary to perform their role effectively.	*and Charter details the resource implications and responsibilities for ensuring they are met.*	the internal audit service so that it makes a full contribution to and meets the needs of the authority and external stakeholders.	*process for the Internal Audit plan ensures that it adds value to the organisation. HIA responsible for facilitating this process.*	and be an ambassador for internal audit.	*tailored to requirements of the role i.e. CIPFA Certificate in Investigatory Practices.*
Ensure that the Audit Committee sets out a performance framework for the HIA and their team and assesses performance and takes action as appropriate.	*Internal Audit report annually to the Audit Committee on a wide range of performance measures.*	Determining the resources, expertise, qualifications and systems for the internal audit service that are required to meet internal audit's objectives; using a full range of resourcing options including consultancy, working with others and buying in where appropriate.	*Internal Audit Strategy and Charter details the resource implications and responsibilities for ensuring they are met.*	Create, communicate and implement a vision for the internal audit service.	*HIA has a clear understanding of these issues and is committed to continuous improvements. These issues addressed through performance appraisal.*
Ensure that there is a regular external review of internal audit quality.	*Constant review by CFO via performance monitoring and appraisal system. Currently considering how to comply with Public Sector Internal Audit Standards regarding four yearly reviews.*	Informing the CFO, the Leadership Team and Audit Committee if there are insufficient resources to carry out a satisfactory level of internal audit, and the consequence for the level of assurance that may be given.	*Internal Audit Strategy and Charter details the resource implications and responsibilities for ensuring they are met and reporting arrangements if shortfalls are anticipated.*	Create a customer focused internal audit service	*HIA has a clear understanding of these issues and is committed to continuous improvements.*
Ensure that where the HIA is from another organisation that they do not also provide the external audit service.	*Not Applicable.*	Implementing robust processes for recruitment of internal audit staff and/or the procurement of internal audit services from external suppliers.	*Corporate recruitment process followed for any appointments made.*	Establish an open culture, built on effective coaching and a constructive approach.	*HIA undergoes CPD tailored to requirements of the role.*

Governance requirements	HBC Arrangements	Core HIA Responsibilities	HBC Arrangements	Personal skills and professional standards	HBC Arrangements
		Ensuring that the professional and personal training needs for staff are assessed and seeing that these needs are met.	*Professional guidance implemented in respect of training needs and development issues are addressed.*	Promote effective communication within internal audit, across the broader organisation and with external stakeholders.	*HIA has a clear understanding of these issues and is committed to continuous improvements.*
		Developing succession plans and helping staff with their career progression.	*As above*	Set and monitor meaningful performance objectives for staff.	*CIPFA "Excellent Auditor Framework" implemented within section for all training and development needs.*
		Establishing a quality assurance and improvement programme that includes: ensuring that professional internal audit standards are complied with; reviewing the performance of internal audit and ensuring that the service provided is in line with the expectations and needs of its stakeholders; providing an efficient and effective internal audit service – demonstrating this by agreeing key performance indicators and targets with the line manager and Audit Committee; annually reporting achievements against targets; putting	*CIPFA guidance in relation to continuous improvement followed.*	Manage and coach staff effectively	*As above.*

Governance requirements	HBC Arrangements	Core HIA Responsibilities	HBC Arrangements	Personal skills and professional standards	HBC Arrangements
		in place adequate ongoing monitoring and periodic review of internal audit work and supervision and review of files, to ensure that audit plans, work and reports are evidence based and of good quality; ensuring that any internal auditors declare any interests that they have; seeking continuous improvement in the internal audit service.			
		Keeping up to date with developments in governance, risk management, control and internal auditing, including networking with other HIA's and learning from them, implementing improvements where appropriate.	*Member of Better Governance Forum, Technical Information Service, CIPFA NE IA Group, North East Fraud Forum in order to ensure up to date with current best practice and ideas.*	Comply with professional standards and ethics	*Professional standards and ethics outlined within Audit Manual and also bound Public Sector Internal Audit Standards.*
		Demonstrating how internal audit adds value to the authority.	*Annual report to the Audit and Governance Committee.*	Require the highest standards of ethics and standards within internal audit based on the principles of integrity, objectivity, competence and confidentiality. In particular, ensuring that internal auditors identify and report any conflicts of	*As above as well as procedures for the identification and recording of conflicts of interest are detailed in the Audit Manual.*

Governance requirements	HBC Arrangements	Core HIA Responsibilities	HBC Arrangements	Personal skills and professional standards	HBC Arrangements
				interest and act appropriately	
				Ensure, when necessary, that outside expertise is called upon for specialist advice not available within the internal audit service.	*Arrangements in place to ensure specialist services can be procured as and when necessary.*
				Promote discussion on current governance and professional issues and their implications.	*HIA mentors audit staff undertaking regular team meetings to facilitate discussion. Role on various working groups ensures topics are discussed and disseminated.*

Principle 5 – The HIA in a local authority must be professionally qualified and suitably experienced

Governance requirements	HBC Arrangements	Core HIA responsibilities	HBC Arrangements	Personal skills and professional standards	HBC Arrangements
Appoint a professionally qualified HIA whose core responsibilities include those set out under the other principles in this Statement and ensure that these are properly understood throughout the organisation.	*Job description and recruitment process ensure only appropriately qualified and experienced individuals considered.*			Be a full member of an appropriate professional body and have an active programme for personal professional development.	*HIA qualified with CIPFA in 1997 and actively participates in mandatory CPD scheme*
Ensure that the HIA has the skills, knowledge,	*As above, monitoring and mentoring role undertaken by CFO in his role as*			Adhere to professional internal auditing (and where appropriate	*HIA member of CIPFA for 17 years and is bound by all relevant*

Governance requirements	HBC Arrangements	Core HIA responsibilities	HBC Arrangements	Personal skills and professional standards	HBC Arrangements
experience and resources to perform effectively in his or her role.	*Section 151 officer ensures compliance.*			accounting and auditing) standards.	*professional and personal requirements.*
				Demonstrate a range of skills including communicating, managing and influencing, as well as an understanding of IT and consultancy.	*HIA undergoes CPD tailored to requirements of the role as well as mentoring by CFO.*
				Have prior experience of working in internal audit.	*HIA has held a variety of position within Local Government, before appointment as HIA in 2008, including Group Auditor at HBC and Head of Audit at a district council.*
				Understand and have experience of strategic objective setting and management.	*HIA undergoes CPD tailored to requirements of the role as well as mentoring by CFO.*
				Understand the internal audit and regulatory environment applicable to public service organisations.	*HIA has 17 years post qualification experience and sound understanding of public service governance arrangements and its regulatory environment.*
				Demonstrate a comprehensive understanding of governance, risk management and internal control.	*Regularly advises management on these issues and is a key member of the Performance and risk Management Group.*
				Undertake appropriate	*HIA undergoes CPD*

Governance requirements	HBC Arrangements	Core HIA responsibilities	HBC Arrangements	Personal skills and professional standards	HBC Arrangements
				development or obtain relevant experience as appropriate in order to demonstrate an understanding of the full range of the authority's activities and processes.	*tailored to requirements of the role as well as mentoring by CFO.*

AUDIT AND GOVERNANCE COMMITTEE

15.05.14

Report of: Head of Audit and Governance

Subject: INTERNAL AUDIT OUTCOME REPORT 2013/14

1. PURPOSE OF REPORT

1.1 To inform members of the outcomes of audit work covering the period April 2013 to March 2014.

2. BACKGROUND

2.1 This report provides accountability for Internal Audit delivery and performance and allows Members to monitor the application of the delegated authority for ensuring an effective and satisfactory internal audit function. All audit work carried out during the year has been in accordance with the CIPFA Code of Practice for Internal Audit in Local Government in the UK 2006 as reflected in the Internal Audit Manual, and has taken into account new UK Public Sector Internal Audit Standards (PSIAS). Auditors are instructed to declare if they have any links to the subject matter of any audits undertaken or relationships with auditees that could compromise the impartiality or objectivity of the work undertaken.

2.2 Information for Members on the standards of financial administration and management arrangements operating within the Authority is detailed in this report, together with a progress report on the extent of implementation of audit action plans. The consideration and effective implementation of audit action plans is fundamental in ensuring effective financial stewardship and robust financial systems, controls and procedures.

2.3 This report also details the performance of Internal Audit in 2013/14 on a range of key performance indicators.

2.4 Hartlepool Borough Council also provides the audit services to the Cleveland Fire Authority. In addition to the audits detailed in Appendix

A, Internal Audit completed 12 major systems and probity reviews for the CFA during 2013/14.

3. AUDIT INPUTS 2013/14

3.1 There were 1005 audit days allocated at 1.04.13 to planned and responsive activities during 2013/14.

3.2 Staffing resources were as anticipated, ensuring that all high-risk functions were reviewed and a balanced program of work covering all Council departments was achieved for 2013/14.

4 OUTCOMES

4.1 Appendix A schedules all the planned audits undertaken in 2013/14. At the time this report was completed work was being finalised on the Payroll System, however sufficient reliance could be placed on testing completed for the purposes of the 2013/14 audit opinion. Only a minority of systems and arrangements reviewed required improvement in Hartlepool.

4.2. From the work undertaken during the year 2013/14, I have reached the opinion that reliance can be placed on the adequacy and effectiveness of the organisations control environment. Key systems are operating soundly and that there is no fundamental breakdown in controls resulting in material discrepancy. Satisfactory arrangements were implemented to ensure the effective, efficient and economic operation of Hartlepool Borough Council's financial affairs.

4.3 No system of control can provide absolute assurance against material misstatement or loss, nor can Internal Audit give that assurance; this statement is intended to provide reasonable assurance. These risks are reflected in the audit plan and are the subject of separate reports issued during the course of 2013/14.

5. FOLLOW UP

5.1 Audit reports are issued to auditees following a discussion of any audit findings and risks. Each report includes an Action Plan developed by management and agreed with audit, recording:

- Action taken to revise systems, procedures and operating arrangements;
- The response of the auditees;
- A timescale for introducing the action plan improvements.

5.2 In accordance with the CIPFA Code of Practice for Internal Audit in Local Government in the UK, a system of follow up of agreed action plans is in operation to monitor what action has been taken by management in response to audit work. During 2013/14, all audits

completed, that had reached the date when a follow up was due, have been the subject of follow up activity.

This position is positive and indicates a commitment by management to further improve controls and financial systems throughout the Authority. Further follow up work is planned in 2014/15 for those actions not yet implemented.

6 MONITORING INTERNAL AUDIT PERFORMANCE

6.1 Internal Audit is committed to the delivery of a quality service, which accords with the CIPFA Code of Practice for Internal Audit in Local Government in the UK, and to being responsive to the needs of service departments. In common with other central service providers, a number of core performance indicators for Internal Audit Services have been determined for 2013/14. Performance against these targets is detailed below:

Internal Audit Performance Indicators

Indicator	Target Set for 2013/14	Actual Performance 2013/14
Completion of fundamental systems audits provides assurance that financial procedures are operating effectively.	90%	92%
In addition to the managing auditor reviews, quality reviews of Teammate working paper files and evidence by the Head of Audit and Governance to ensure compliance with the standards laid down in Codes of Practice and adopted in the Internal Audit Manual.	10%	10%
Percentage of Audit Reports issued within 10 working days of audit completion.	87.5%	100%
Percentage of Action Plans followed up within 6 months of completion of the audit.	100%	100%
Annual Report to Members by 30th June following year-end.	30.06.14	15.05.14

7. RECOMMENDATION

7.1 That Members note the contents of the report.

8. REASONS FOR RECOMMENDATIONS

8.1 The information in the report allows members of the committee to review the opinion of the Head of Audit and Governance and fulfils the statutory requirement of the Head of Audit and Governance.

9. BACKGROUND PAPERS

9.1 Internal Audit Reports;
Internal Audit Quarterly Updates;
CIPFA Code of Practice for Internal Audit in Local Government in the UK 2006;
UK Public Sector Internal Audit Standards (PSIAS 2013).

10. CONTACT OFFICER

10.1 Noel Adamson
Head of Audit and Governance
Civic Centre
Victoria Road
Hartlepool
TS24 8AY

Tel: 01429 523173
Email: Noel.Adamson@Hartlepool.gov.uk

Appendix A

Summary of Internal Audit Planned Work Undertaken for 2013/14

Chief Executives	Attendance Management
Chief Executives	Benefits - Housing
Chief Executives	Budgetary Control
Chief Executives	Cash/Bank
Chief Executives	Communication - Mobile Phones
Chief Executives	Computer Audit
Chief Executives	Continuous Audit
Chief Executives	Council Tax
Chief Executives	Council Tax Benefit
Chief Executives	Creditors
Chief Executives	Debtors
Chief Executives	Duplicate Payments
Chief Executives	Employees Registers of Interest/Gifts and Hospitalities
Chief Executives	Fraud Awareness
Chief Executives	Information/Data Management Security
Chief Executives	Journal Review
Chief Executives	Loans & Investments
Chief Executives	Main Accounting
Chief Executives	Members Allowances/Travel/Subsistence
Chief Executives	NFI
Chief Executives	NNDR
Chief Executives	Officers Expenses
Chief Executives	Partnerships
Chief Executives	Performance Management Systems
Chief Executives	Public Services (Social Value Act)
Chief Executives	Recruitment, Selection and Retention
Chief Executives	Risk Management
Chief Executives	Salaries and Wages
Chief Executives	VAT
Child and Adult Services	Adoption
Child and Adult Services	Avondale Centre
Child and Adult Services	Barnard Grove Primary School
Child and Adult Services	Catcote Special School
Child and Adult Services	Children Services Capital Programme
Child and Adult Services	Clavering Primary School
Child and Adult Services	Early Intervention Strategy
Child and Adult Services	Fostering
Child and Adult Services	Grange Primary School
Child and Adult Services	Greatham C Of E Primary School
Child and Adult Services	Libraries
Child and Adult Services	Public Health Responsibilities
Child and Adult Services	Sacred Heart Primary School
Child and Adult Services	Social Fund/Section 17
Child and Adult Services	Social Care - Direct Payments
Child and Adult Services	Springwell Special School
Child and Adult Services	St. Aidans Primary School
Child and Adult Services	St. Begas Primary School
Child and Adult Services	Throston Primary School
Child and Adult Services	Tourism - Town Hall Theatre/Borough Hall
Child and Adult Services	Ward Jackson Primary School
Child and Adult Services	West Park Primary School

Child and Adult Services	West View Primary School
Regeneration and Neighbourhoods	Community Grants
Regeneration and Neighbourhoods	Grant Certification
Regeneration and Neighbourhoods	Highways - Repairs and Maintenance
Regeneration and Neighbourhoods	Industrial Estate Lettings/Rental
Regeneration and Neighbourhoods	Integrated Transport Unit - Highways Capital Grant
Regeneration and Neighbourhoods	Integrated Transport Unit - Child and Adult Provision
Regeneration and Neighbourhoods	Integrated Transport Unit - Private Hire
Regeneration and Neighbourhoods	New Homes Bonus
Regeneration and Neighbourhoods	NSD Income Generation
Regeneration and Neighbourhoods	Project Management (Capital Programme)
Regeneration and Neighbourhoods	Stores
Regeneration and Neighbourhoods	Procurement

AUDIT AND GOVERNANCE COMMITTEE

15 May 2014

HARTLEPOOL BOROUGH COUNCIL

Report of: Chief Finance Officer

Subject: REVIEW OF THE EFFECTIVENESS OF THE SYSTEM OF INTERNAL AUDIT

1. PURPOSE OF REPORT

1.1 To inform Members of the outcome of the review of the effectiveness of the system of Internal Audit in compliance with the Accounts and Audit Regulations (England) 2011.

2. BACKGROUND

2.1 Regulation 4 of the Accounts and Audit Regulations (2003) was amended in 2006 with new reporting requirements, applicable to local authorities in England, on the effectiveness of the system of internal audit. The Regulations came into force on 1 April 2006 and applied for the 2006/07 reporting year. These Regulations have been amended again with new requirements coming into place in April 2011.

2.2 The Department for Communities and Local Government issued guidance on the amended Regulations in March 2011. This Guidance covers the significant changes made to the 2006 Regulations. In the consultation draft 6(3) the regulations included a change to the need to conduct an annual review of the effectiveness of the system of internal audit by changing it to an annual 'review of the effectiveness of its internal audit'. In its response to the consultation on the regulations CIPFA referred to its guidance relating to the previous regulations which advised that the system of internal audit should be interpreted as:

"the framework of assurance available to satisfy a local authority that the risks to its objectives, and the risks inherent in undertaking its work, have been properly identified and are being managed by controls that are adequately designed and effective in operation".

2.3 The current wording could lead to a narrow focus on internal audit alone rather than the adequacy of the wider assurance framework and consequently CIPFA had recommended in its consultation response that it be removed. In light of the adopted regulations, CIPFA's Audit

Panel is currently considering drafting further guidance to support practitioners.

2.4 The view of the Better Governance Forum is that a review of the effectiveness of the assurance framework would be a necessary stage to support the Annul Governance Statement and should form a normal agenda item for the Audit Committee. This would include the contribution made by internal audit but would also cover the wider assurance framework and the audit committee itself. By reviewing the effectiveness of internal audit as part of this wider review then the specific requirements of the Regulations will be met.

2.5 At its meeting of 19.03.09, the Audit Committee agreed that the Chief Finance Officer would undertake the review and the committee would receive and consider a report on the findings of the review. Given that it is considered best practice this approach will be continued.

3. CARRYING OUT THE REVIEW

3.1 In order to assess whether the system of internal audit has been effective, the definition of effective for the purpose of the review was the satisfactory operation of the framework of assurance that is available to the council in identifying and mitigating the risks it faces in pursuit of its objectives. The review will be an ongoing process that will address new and emerging risks to the authority as they arise and take into consideration different aspects of the system of internal audit on an annual basis.

3.2 As a major part of the system of assurance is the role played by the Internal Audit section and the independent opinion given by the Head of Audit and Governance, I carried out the following tasks;

- Reviewed the planning and development work undertaken by Internal Audit in producing an annual audit plan,
- Reviewed the ongoing use and effectiveness of new audit software,
- Undertook monthly performance reviews with Head of Audit and Governance.

3.3 The role played by the Audit and Governance Committee is pivotal to the assurance framework in place at the Council. As such the reports and information provided to the committee were reviewed to ensure they supported the committee in meeting its remit.

3.4 The production of the Annual Governance Statement was reviewed to ensure that it reflects the practices in place at the council.

3.5 The structure of Internal Audit reporting was reviewed in light of a review of Internal Audit practices.

4 RESULT OF REVIEW

4.1 From the tasks undertaken as described above I am satisfied that the system of internal audit, as defined by the CIPFA Audit Panel in respect of the requirements of the Accounts and Audit Regulations, 2011, is operating effectively in accordance with that described in the Annual Governance Statement.

4.2 The Internal Audit annual plan is closely aligned to the risks faced by the Council in achieving its objectives and Internal Audit's own performance management and quality assurance programme ensures CIPFA code of practice requirements are met. The section has reviewed its own procedures to ensure it meets the challenges that the Council faces and the ongoing use of audit software has also enabled Internal Audit to provide a wider opinion on the control environment within existing resources.

4.3 The role of the Audit and Governance Committee continues to develop and is supported through the reports and information provided by both internal and external sources.

4.4 The process of compiling the Annual Governance Statement ensures that officers across the authority are involved in its production and that Corporate Management Team formally approves the contents of the statement.

5 RECOMMENDATIONS

5.1 That members consider and approve the findings of the review of the effectiveness of the system of internal audit.

6 REASON FOR RECOMMENDATIONS

6.1 In order for members to fulfil the remit of the committee it is important they receive all relevant information that allows a through review of the governance arrangements in place at the Council to be undertaken.

7. BACKGROUND PAPERS

7.1 Internal Audit Reports;
Internal Audit Charter and Strategy;
Accounts and Audit Regulations 2011.

8. CONTACT OFFICER

8.1 Chris Little
Chief Finance Officer
Civic Centre
Victoria Road
Hartlepool
TS24 8AY

Tel: 01429 523003
Email: Chris.little@hartlepool.gov.uk

AUDIT AND GOVERNANCE COMMITTEE

15.05.14

Report of: Chief Finance Officer

Subject: ANNUAL GOVERNANCE STATEMENT 2013/14

1. PURPOSE OF REPORT

1.1 To inform Members of the implications to the Council of the Accounts and Audit Regulations (England) 2011 requirement; that the Council publish an Annual Governance Statement (AGS) with the Financial Statements, and the action undertaken by the Council to meet its obligations within the scope of the Regulations.

1.2 The report considers the following areas:

- Why the Council needs an AGS,
- Who is responsible,
- How the AGS was produced.

2. WHY

2.1 To clearly demonstrate to stakeholders, that the Council has adequate arrangements in place to ensure that it effectively manages and controls its financial and operational responsibilities in accordance with acknowledged best practice. Paragraphs 2.2 to 2.3 detail positive benefits to the Council of achieving this end.

2.2 Statutory Requirement

The Accounts and Audit Regulations require that: "the Council ensures that its financial management is adequate and effective and that there is a sound system of internal control which effectively facilitates its functions and which includes arrangements for the management of risk.
The Council shall conduct a review at least once a year of the effectiveness of its internal controls and shall include a statement on internal control with any statement of accounts it is obliged to publish".

2.3 Good Governance

Production and publication of an AGS are the final stages of an ongoing review of internal control and are not activities which can be planned and viewed in isolation. Compilation of an AGS involved the Council in:

- Reviewing the adequacy of its governance arrangements,
- Knowing where it needs to improve those arrangements, and
- Communicating to users and stakeholders how better governance leads to better quality public services.

3. WHO

3.1 Corporate Responsibility

The Council's system of internal control must reflect its overall control environment, not just financial, which encompasses its organisational structure. Internal control is a corporate responsibility and the scope of internal control accordingly spans the whole range of the Council's activities and includes controls designed to ensure:

- The Council's policies are put into practice and its values are met,
- Laws and regulations are complied with,
- Required processes are adhered to,
- Financial statements and other information are accurate and reliable,
- Human, financial and other resources are managed efficiently and effectively, and
- High quality services are delivered efficiently and effectively.

3.2 Contributors to the AGS

- Audit and Governance Committee
- CMT
- Assistant Chief Executive
- CFO
- Monitoring Officer
- External Auditors and other Review Bodies
- Internal Audit and
- Management.

4. HOW

4.1 Having established a system of internal control, it is then necessary to consider which of these controls are key in mitigating against significant risk. By obtaining assurance on the effective operation of these key controls the Council is able to conclude on the effectiveness of the systems and identify where improvement is needed.

The review of internal control and AGS assurance gathering included:

- Establishing obligations and objectives,
- Identifying principal risks,
- Identifying and evaluating key controls to manage risks,
- Obtaining assurances on the effectiveness of controls,
- Evaluating assurances,
- Action planning to correct issues and continuously improve.

4.2 In practice the Council already had most of the necessary internal controls in place, what was required was to incorporate them into a framework for producing an AGS that met the requirements of the Regulations. In order to do this the Council has:

- Identified roles and responsibilities,
- Provided training,
- Gone through a process of establishing objectives, identifying risks and recording controls,
- Gathered and retained evidence for inspection,
- Drafted the AGS.

4.3 The AGS will form part of the Councils Statement of Accounts and will be publicised and available on the Councils Website or by request to the Councils Contact Centre.

4.4 In order to support members in the process of approving the Annual Governance Statement the Better Governance Forum has provided briefing papers for Audit and Governance Committee members in public sector bodies. The briefing paper is attached after the statement for members consideration in relation to issues they may want assurance on regarding the content and process followed in producing the statement. This committee report has been drafted in such a way as to answer the questions posed within the Better Governance Forum Briefing.

5. RECOMMENDATIONS

5.1 That Members review and approve the attached 2013/14 Annual Governance Statement.

6. REASONS FOR RECOMMENDATIONS

6.1 In order for members to fulfil the remit of the committee it is important they review and approve the Annual Governance Statement in the context of all reports and information received over the course of the municipal year.

7. BACKGROUND PAPERS

7.1 Accounts and Audit Regulations 2011;
CIPFA/Solace Good Governance Framework;
Internal Audit Opinion/Reports;
External Audit Reports.

8. CONTACT OFFICER

8.1 Chris Little
Chief Finance Officer
Civic Centre
Victoria Road
Hartlepool
TS24 8AY

Tel: 01429 523003
Email: Chris.little@hartlepool.gov.uk

Appendix A

HARTLEPOOL BOROUGH COUNCIL ANNUAL GOVERNANCE STATEMENT

1 Scope of Responsibility

1.1 Hartlepool Borough Council is responsible for ensuring that:

- Its business is conducted in accordance with the law and proper standards,
- Public money is safeguarded and properly accounted for, and used economically, efficiently and effectively.

1.2 The Council also has a duty under the Local Government Act 1999 to make arrangements to secure continuous improvement in the way in which its functions are exercised, having regard to a combination of economy, efficiency and effectiveness.

1.3 In discharging these overall responsibilities, Hartlepool Borough Council is also responsible for putting in place proper arrangements for the governance of its affairs, facilitating the effective exercise of its functions, which includes arrangements for the management of risk.

1.4 The Council has approved and adopted a code of corporate governance, which is consistent with the principles of the CIPFA/SOLACE Framework *Delivering Good Governance in Local Government*. A copy of the code is on our website at www.Hartlepool.gov.uk or can be obtained from the Councils Contact Centre. This statement explains how the Council has complied with the code and also meets the requirements of the Accounts and Audit (England) Regulations 2011, Regulation 4(3), which requires all relevant bodies to prepare an annual governance statement.

2 The Purpose of the Governance Framework

2.1 The governance framework comprises the systems and processes, and culture and values, by which the authority is directed and controlled and its activities through which it accounts to, engages with and leads the community. It enables the authority to monitor the achievement of its strategic objectives and to consider whether those objectives have led to the delivery of appropriate services and value for money.

2.2 The system of internal control is a significant part of that framework and is designed to manage risk to a reasonable level. It cannot eliminate all risk of failure to achieve policies, aims and objectives and can therefore

only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the Council's policies, aims and objectives, to evaluate the likelihood of those risks being realised and to manage them efficiently, effectively and economically. The governance framework has been in place at the Council for the year ended 31st March 2014 and up to the date of approval of the statement of accounts.

2.3 In order to facilitate the completion of the Statement, an officer working group has been formed and a programme of work developed. To ensure that the Statement has been given sufficient corporate priority and profile, the working group included both the Chief Finance Officer and the Assistant Chief Executive. As part of the process regular updates have been given to the Performance and Risk Management Group and Corporate Management Team.

3 Significant Governance Issues Update from 2012/13 Statement

3.1 Progress has been made over the course of 2013/14 to address weakness in the system of governance identified as part of the 2012/13 process. The table below identifies action that has been taken to mitigate the areas of concern raised.

Issue Raised	Action Undertaken
Delivery of Peer Review Action Plan.	The action plan following on from the review was completed during the last year. This included the independent enquiry undertaken by a party external to the council that was reported to both a public meeting and Council. All aspects of the Peer review have been completed.
Delivery of Medium Term Financial Strategy	Revised Savings Programme encompassing key required programme elements at a corporate and department level. Strategic multi year approach to financial management has been implemented. Member's seminars and staff communication strategy In conjunction with budget monitoring and defunding budgets at decision point process have been implemented. Project planning and management reporting to Finance and Policy Committee and CMT have all been implemented.
Delivery of Council Plan	The Council plan has been largely delivered and is reported to members via Finance and Policy Committee on a quarterly basis. The revised plan for 2014 – 15 has been developed based on the priorities established and in the light of the revised MTFS and will

	be the subject of the same approval processes and monitoring. It has been agreed by Finance and Policy Committee that separate performance agreements are not required for the Chief Executive and Directors but that these should be based on the delivery of the Council Plan, the medium term financial strategy and the issues raised in this AGS.
Welfare Reform Act.	Review of financial consequences of proposals undertaken, including approval of updated Local Council Tax Support Scheme. Update reports provided to Finance and Policy Committee and CMT.
Health and Social Care Act, re transfer of some Public Health responsibilities to the LA.	Review of statutory requirements in place. Regular update reports to Finance and Policy Committee, CMT and on known issues insuring clarity of Local Authority responsibilities. Liaison undertaken with all relevant parties to shape future delivery proposals and procurement strategy agreed.
New governance arrangements.	Training was implemented for all members and appropriate officers in advance of the implementation of the new governance arrangements with ongoing support provided as part of the establishment of the new system. A review of the new governance arrangements has been undertaken by the Monitoring Officer and has been the subject of a public Council Working Group meeting. A report will be considered by Council in April in terms of any further changes which are required in the light of the experiences of the last year.

4 The Governance Framework

4.1 The key elements of the Council's Governance Framework are as follows:

Hartlepool Borough Council has adopted a constitution, which sets out how the Council operates, how decisions are made, the procedures that are followed to ensure that these decisions are efficient and transparent, and sets out the terms of reference for the Portfolio and Committee structure. The constitution was developed in accordance with the Local Government Act 2000 and it sets out the delegated responsibilities to Key Officers such as the Monitoring Officer and Section 151 Officer. An officer working group supported the governance working group in developing proposals for the new constitution in line with the outcome of the Mayoral referendum. The new constitution was agreed on 6th March 2013 with training delivered

for officers and members in respect of the requirements and expectations.

4.2 Effective procedures to identify, evaluate, communicate, implement, comply with and monitor legislative change exist and are used. Workforce Services policies identify suitable recruitment methods and ensure appropriate job descriptions exist for legal staff. Induction training is arranged by Customer and Workforce Services for all staff, departments have responsibility to provide induction training specific to their departmental needs. Legal Division procedures exist for monitoring new legislation, advising relevant departments, and members where appropriate. Legal personnel participate in training events.

4.3 Portfolio and Committee terms of reference are included in the constitution. A procedure is in place to ensure that all Portfolio and Committee agendas, minutes and supporting material are available to all staff on the Council's intranet, and to the public on the Council's Internet site.

4.4 The constitution contains financial and contract procedure rules, and code of conduct for Members, which have been formally approved. Financial procedure rules have been updated and agreed by Council and contract procedure rules have also been updated to take into account new procurement procedures. The constitution is available to all employees on the intranet and to the public on the Internet. A register of gifts and hospitality is maintained for Members and Officers. The Authority has a Treasury Management Strategy that was approved by Audit and Governance Committee on 12th December 2013 and referred to Council for approval on 6th February 2014. The approved Treasury Management Strategy includes the Investment and Borrowing strategies in compliance with revised CIPFA Prudential Code, CIPFA Treasury Management Code of Practice and DCLG guidance. The Audit and Governance Committee is responsible for ensuring effective scrutiny of the Treasury Management Strategy and policies before making any necessary recommendations to Council. The Chief Finance Officer reports to the Audit and Governance Committee how the Authorities financial arrangements conform to the governance requirements of the CIPFA Statement on the Role of the Chief Financial Officer in Local Government (2010).

4.5 The full range of Member committees regularly meet to review specific policy areas, to consider plans, reports and progress of the Authority.

4.6 Workforce Services has drawn up policies to ensure suitably qualified employees are employed in key areas, and supporting terms and conditions of employment for all employees cover all aspects of good employment. Induction courses for key new officers and all new members incorporate suitable training on corporate governance issues

according to responsibilities and there is a general staff awareness programme in place.

4.7 A Health and Safety Policy has been approved and published and a Communication Strategy implemented to ensure general awareness.

4.8 The Authority and the Hartlepool Partnership adopted their Community Strategy in 2008 following an extensive consultation process. Public priorities were established and these are a key element of the budget setting process. The council's corporate plan, departmental plans and performance management arrangements are based around an Outcome Framework which has been developed with partners over a number of years. This integration has enhanced management and political accountability. The Council produces an annual Council Plan that incorporates the 4 departmental plans. This will avoid the duplication of reporting that has sometimes happened in previous years and demonstrates how strategic in nature departmental plans have become over the last few years.

4.9 CMT has defined what it considers to be its significant partnerships and an assurance framework has been developed to ensure that adequate governance arrangements are in place that are proportional to the responsibilities and risks of each partnership. The Authority has an ongoing programme of monitoring and reviewing arrangements in place in respect of the operation of its key partnerships. A framework of reporting by exception to Corporate Management Team operates and Internal Audit provides annual audit coverage of partnership arrangements. The Audit and Governance Committee has highlighted partnerships as a key area of interest and the Authority's control framework will be developed further and the committee regularly updated on progress.

4.10 All departments produce departmental and service plans using a corporate framework to ensure that they reflect the agreed corporate outcomes. The Council's Outcome Framework is reviewed annually and agreed by Finance and Policy Committee, most recently on 18th October 2013. Departments also complete extensive consultation with service users, forums, partners and the Viewpoint panel. The feedback from these exercises is used to link service and departmental objectives to both the planning process for service delivery and to the corporate outcomes. In order to further embed the process of risk management, control identification and the production of the AGS into the culture and management processes at the council, risks to meeting departmental outcomes and the controls to mitigate those risks are recorded as part of the corporate service planning process at a departmental level. This has brought together service planning, risk management and control identification which has enabled a much more focussed and joined up approach to the use of management information and the production of the AGS. Progress against the

Corporate Plan and departmental plans is reported to CMT and relevant Policy Committees on a quarterly basis.

4.11 A corporate performance management framework approved by CMT and Cabinet is operating across the Council. The framework sets out the process and timetable for reporting on performance. A Data Quality framework is in place with Internal Audit conducting a targeted annual review of PIs. The Council's Performance Management system (Covalent) includes information relating to departmental and officer responsibility for the collation of data, target setting and addressing performance issues. Covalent also includes action plans, risks and performance indicators enabling clearer links between corporate, departmental and service planning outcomes, actions, risks and PIs.

4.12 Key performance indicators are identified in the corporate and departmental plans. These indicators are monitored throughout the year and quarterly reports are presented to members on the delivery of performance targets.

4.13 Key policies such as the Corporate Complaints Procedure, Proceeds of Crime (Money Laundering), Whistle Blowing Policy and Counter Fraud and Corruption Policy have been developed and approved for use across the whole Authority. The policies are available to employees via the intranet. Reports are made to portfolio holders every six months summarising, for example, the complaints dealt with and the outcome. The Authority is a member of the IPF Better Governance Forum, the National Anti Fraud Network and also takes part in regular National Fraud Initiative reviews and the North East Fraud Forum. Fraud Awareness assessments took place during 2012-13 using the CIPFA Red Book 2 - Managing the Risk of Fraud - Actions to Counter Fraud and Corruption; as a basis for good practice and the FRED1 (Fraud Risk Evaluation Diagnostic) assessment tool as a means to assess HBC's awareness of fraud. The Red Book 2 was produced by CIPFA Better Governance Forum Counter Fraud Advisory Panel after consultation with fraud practitioners. As it is aligned to the approach by the National Fraud Authority its use as good practice is recommended by organisations such as ALARM. The Audit Commission publication Protecting the Public Purse 2013 is being used to review practices undertaken at the Council.

4.14 The Council agreed the Risk Management Framework and Guidance Document on 23rd August 2013. At this point the structure of the risk registers was changed and a specific risk tolerance level to help prioritise risk activity was introduced. Risks on the accepted risk register are reported to elected members on an annual basis and they are monitored more regularly within departments. A small number of risks are on the actively managed risks register and these are the risks that the department/responsible officer plan to take further action/increase control measures to help reduce the likelihood or

impact. These risks are reported to elected members quarterly through the service planning process.

4.15 The Framework and Guidance Document is available to all staff via the intranet. Key staff have undergone appropriate training and departmental risk champions lead on communicating the revised process to all relevant staff in their departments.

4.16 There is corporate support at senior management level for development of Risk Management with risk assessment procedures published and training given to officers. Regular risk introduction/refresher sessions are offered as and when individual departments/teams require them.

4.17 The Finance and Policy Chair is Hartlepool Borough Councils risk 'champion'. Each department also has a risk co-ordinator. Risks and control measures relating to corporate and departmental plans are analysed within the quarterly departmental reports to help ensure that risk and performance reporting are linked. Both corporate and departmental plans are considered as part of the preparation of the AGS.

4.18 The Council's Performance and Risk Management system (Covalent) holds the actively managed and accepted risk registers. Risk registers are also maintained for significant projects, such as the ICT re-procurement. Officers that manage risks are notified that risks need to be reviewed and progress is monitored on a quarterly basis through the service planning process. Departments may use a central funding pot for risk management to assist in the financing of risk mitigation.

4.19 The Council has long-standing, nationally and regionally recognised emergency planning arrangements through the Cleveland Emergency Planning Unit (EPU). The Council's Emergency Management Response Team (EMRT) meets monthly and exercises at least every 6 months.

4.20 Departmental business continuity plans have been developed and specific property and flu pandemic plans are in place. ICT resilience is assisted through remote access to Email and calendars and UPS system. Arrangements were further strengthened in Autumn 2009 when a Disaster Recovery Solution was implemented with Northgate and Housing Hartlepool to facilitate the speedy recovery of key systems in particular those relating to adult and children's care such as Carefirst and ICS.

4.21 Flu pandemic planning has identified critical services particularly in respect of vulnerable people, with alternative service provision arrangements identified as part of that process. Considerable work was undertaken in preparing for potential flu pandemic and an Influenza Pandemic Plan has been approved. A future workstream is to integrate

the Influenza Pandemic Plan into the new corporate Business Continuity Plan and associated database framework.

4.22 The Corporate Business Continuity Group meets monthly and includes lead officers from all departments and the Hartlepool Emergency Planning officer. A revised Business Continuity Plan (BCP) is being developed and a corporate business continuity ICT database has been implemented to record supporting BCP data. New levels of priority / definitions for service restoration have been defined. Population of the new database is complete and a work programme is underway to identify and document new formal decant arrangements for the delivery of priority services in the event of a disruption. Building on previous test exercises of the existing business continuity plan, training exercises on the new plan will be scheduled for 2012/13 to ensure the robustness of the plan, aid familiarity by officers and test communication protocols.

4.23 The Equality Act 2010 came into force on 1st October 2010 and brings together over 116 separate pieces of legislation into one single Act. Combined, they make up a new Act that will provide a legal framework to protect the rights of individuals and advance equality of opportunity for all. The Act covers the 9 protected characteristics – age, disability, gender reassignment, marriage/civil partnership, pregnancy/maternity, race, religion/belief, gender and sexual orientation.

4.24 The Public Sector Equality Duty (PSED) is supported by "specific duties" to assist public bodies to achieve the aims of the general duty. Under the specific duties, the Council must:

- Publish equalities information to demonstrate its compliance with the Equality Duty by the 31st January 2012 and then annually after that; and
- Develop and publish equality objectives by 6th April 2012 and then every four years.

4.25 In order to demonstrate our compliance with the above requirements, we have compiled two equality reports 'Equality Information 2012' and 'Workforce Equalities Information 2012' to demonstrate the progress that the Council has made to date. We are aware that there are gaps in our data and are working to provide more information in an accessible format. On that basis both reports will be regularly updated.

4.26 Equality issues must influence the decisions reached by public bodies - in how they act as employers; how they develop, evaluate and review policy; how they design, deliver and evaluate services, and how they commission and procure from others. We do this by undertaking Impact Assessments which are an integral part of our decision-making process.

4.27 Internal Audit reports on a regular basis to the Audit and Governance Committee on the effectiveness of the organisation's system of internal control. Recommendations for improvement are also made and

reported on. Internal Audits performance is measured against standards agreed by management and Members. Internal Audit reporting arrangements have been formalised and strengthened as part of the review of financial procedure rules.

4.28 Other review bodies external to the Authority also make regular reports on efficiency, effectiveness and compliance with regulations. Ofsted has rated the Council's children's services as performing well. Most childcare and schools are rated good or outstanding and none are inadequate. The Care Quality Commission has rated the Council's adult social care as excellent. The Council achieved full corporate Investors in People status in August 2008 and Hartlepool Connect has achieved the Customer Service Excellence standard.

5 Review of Effectiveness

5.1 The Council has responsibility for conducting, at least annually, a review of the effectiveness of its governance framework including the system of internal control. The review of effectiveness is informed by the work of the executive managers within the authority who have responsibility for the development and maintenance of the governance environment, the Head of Audit and Governance's annual report, and also by comments made by the external auditors and other review agencies and inspectorates.

5.2 The process that has been applied in maintaining and reviewing the effectiveness of the system of internal control includes:

- Corporate Management Team agreed process for the review of the internal control environment. The risk inherent in meeting departmental objectives and the controls to mitigate those risks are recorded as part of the corporate service planning process at a departmental level. This has brought together risk management, control identification and the process for compiling the evidence needed to produce the AGS. This enables managers to provide documented evidence regarding the controls within their service units as part of the service planning process. The controls in place are designed to negate the identified and recorded risks of not achieving service, departmental or corporate objectives. In order to ensure adequate controls are in place the procedures, processes and management arrangements in place to mitigate identified risks and the officers responsible for them are also documented. Gaps in controls can be addressed as part of the regular reviews of departmental risks and control measures.

- Chief Finance Officer – The CFO carries out a review of the effectiveness of the system of internal audit and reports the findings to the Audit and Governance Committee. The CFO reports to the Audit and Governance Committee how the

Authorities financial arrangements conform with the governance requirements of the CIPFA Statement on the Role of the Chief Financial Officer in Local Government (2010).

- Internal Audit – the Council has the responsibility for maintaining and reviewing the system of internal control and reviewing annually Internal Audit. In practice, the Council, and its External Auditors, takes assurance from the work of Internal Audit. In fulfilling this responsibility:

- Internal Audit operates in accordance with CIPFA's Code of Practice for Internal Audit in Local Government in the United Kingdom 2006 and is reviewing its procedures in line with Public Sector Internal Audit Standards (PSIAS).
- Internal Audit reports to the Section 151 Officer and Audit and Governance Committee.
- The Head of Audit and Governance provides an independent opinion on the adequacy and effectiveness of the system of internal control, quarterly update reports and an annual internal audit performance report to the audit committee.
- Internal audit plans are formulated from an approved risk assessment package.

- External Audit – in their annual audit letter, comment on their overall assessment of the Council. It draws on the findings and conclusions from the audit of the Council.

- Other review and assurance mechanisms: for example, Department of Education, Care Quality Commission, Ofsted, Audit Commission, HMI Probation, Investors in People and Service Excellence.

5.3 HBC business continuity group meets quarterly and co-ordinates the Councils business continuity strategy. The group has undertaken testing of the plan within departments.

5.4 We have been advised on the implications of the result of the review of the effectiveness of the governance framework by the Audit and Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

6 Significant Governance Issues

6.1 The following significant governance issues have been identified:

No	Issue	Action	Timescale	Responsible Officer
1	Delivery of Medium Term Financial Strategy, the sustainability of services and level of performance.	Revised Savings Programme encompassing key required programme elements at a corporate and department level. Strategic multi year approach to financial management implemented. Member's seminars and staff communication strategy. Budget monitoring and defunding budgets at decision point process. Project planning and management reporting to Finance and Policy Committee and CMT. Enhanced financial management and reporting as identified in peer review.	2014/2016	CMT
2	Delivery of Council Plan	The development and agreement of a revised Council Plan taking into account the integration of health responsibilities and the impact of the financial challenges facing the Council, with regular performance reporting to CMT and Members.	2014/15	CMT

3	Welfare Reform Act.	Continued review of financial consequences of proposals, including further update of Local Council Tax Support Scheme. Removal of welfare support scheme. Update reports to Finance and Policy Committee and CMT.	2014/15	CMT

6.2 We propose over the coming year to take steps to address the above matters to further enhance our governance arrangements. We are satisfied that these steps will address the need for improvements that were identified in our review of effectiveness and will monitor their implementation and operation as part of our next annual review.

Signed on behalf of Hartlepool Borough Council:

……

Chief Executive

……

Chair of Audit and Governance Committee

Reviewing the Annual Governance Statement or Statement on Internal Control

What is an Annual Governance Statement (AGS), Statement on Internal Control (SIC) or Statement on Internal Financial Control (SIFC)?

The AGS, SIC or SIFC is a public statement, normally included with your statement of accounts, which explains how your organisation manages its governance and control arrangements. They are produced by both public and private sector organisations.

What does my organisation need to have?

Confusingly not all public bodies have the same requirement! While CIPFA recommends that all local government bodies in the UK have an Annual Governance Statement, this is only a statutory requirement in England and Northern Ireland. Welsh authorities have a Statement on Internal Control although an AGS is likely to be required from 2010/11 as the Welsh Assembly Government have consulted on this. In Scotland authorities are required to have a Statement on Internal Financial Control. Central government bodies and health authorities are all required to have a Statement on Internal Control.

What's included in these statements?

Although the names are different, there are many similarities between these statements as they all evolved out of the Statement on Internal Financial Control. And there are common features in all good statements. A good statement is open and honest, stating what works well and where improvements are needed. It includes a plan, showing who is responsible for taking action and when they will take action by. It also outlines progress against previous action plans. Whilst the focus of an SIFC is on financial controls, the other statements cover the full range of internal controls and the AGS covers wider governance matters such as ethics and leadership too. The statement summarises the key processes for delivering good systems of control and governance and indicates who is responsible for what. Processes are likely to include internal audit activity, risk management, performance management and other types of review and challenge. Responsibility lies with management, especially senior management, and the audit committee has an important role to play in providing challenge and oversight.

What does the Audit Committee do?

The audit committee has an on-going role in delivering good governance. Every time it reviews an audit report (internal or external) or holds an officer to account for his or her action (or inaction), it is helping to deliver good governance. In relation to the statement itself, the audit committee should take a robust and challenging approach, ensuring that:

- The statement reflects the organisation and is an honest self-assessment. Members should review evidence and challenge it where they believe it to be inaccurate or incomplete.
- They have sufficient assurance from enough separate parts of the organisation (this is known as 'triangulation' in audit circles) to be confident that, where controls and governance are deemed to be good, they are good and, where weaknesses are identified, the statement contains an accurate assessment of those weaknesses.
- The statement itself is well written and would be understood by someone with no knowledge of your organisation. In other words, it should be in plain English, with no jargon and it should include sufficient explanations.
- The action plan addresses all identified problem areas, including those identified in previous years where actions remain incomplete. Actions should be SMART (specific, meaningful, allocated, realistic and timely).

What makes for good governance?

Good practice approaches include:

- Creating and regularly reviewing a vision and direction for your organisation so that everyone understands what they are there to deliver.
- Indicating the level of service to be delivered – you can't be excellent at everything so what will you concentrate on and what can be good enough?
- Board / Member and officer roles are clearly defined, with schemes of delegation and codes of practice/conduct, so that everyone understands what they should and should not be doing.
- Having standing orders, financial regulations and guidance notes so that everyone knows what procedures are to be followed.
- A robust, challenging and supporting audit committee to provide oversight and review.
- Arrangements to ensure that you comply with laws and regulations and identify and act on changes promptly.
- Appropriate and flexible whistle-blowing arrangements.
- Methods to identify and act on officer and member development needs.
- Excellent and open communication with your community.
- Ways to ensure good governance in all your partnerships.
- Promotion of the values of good governance and ethical standards.

How do you draw up a good statement?

- Review and map your assurance framework to make sure that it covers all areas, including the hard to reach ones such as partnerships, and that you do not have any duplication in assurance.
- Obtain wide engagement – not just the head of audit or governance doing everything, but getting mini-governance or assurance statements from directors and heads of service that contribute to the overarching statement and/or setting up a working group to develop the statement.
- Be open and honest – it's about improvement and adding value, not about looking good.
- Be prepared to challenge yourself and look for areas for improvement, perhaps by benchmarking or comparing yourself with other organisations.
- Compare the assurances received to the strategic risk register. Are there any high risk areas that have not been adequately covered?
- Look for any inconsistencies or discrepancies. For example, has assurance been provided that there are no significant problems in an area but you have conflicting evidence from elsewhere (audit, risk, performance, complaints, fraud, etc)?
- Check progress against action plans during the year so problems can be dealt with quickly and governance becomes part of the way we do things round here, not just a once-a-year activity.
- Ensure that the action plan is widely known and understood in the organisation and beyond so that those charged with action are held to account and delivery is more likely.

Key questions to ask:

1. What process has the organisation gone through to gather evidence to support the AGS/SIC/SIFC? Has it involved staff from across the organisation?

2. Have assurance statements already gone through a process of challenge and review prior to presentation to the audit committee? What did this show?

3. Does the action plan flow out of the statement and identify the major issues we need to address as an organisation?

4. Does the action plan include actions outstanding from previous years, prioritised as necessary?

5. How will the action plan be communicated to staff, stakeholders and the public?

AUDIT AND GOVERNANCE COMMITTEE

15 May 2014

Report of: Chief Finance Officer

Subject: LETTER TO THOSE CHARGED WITH GOVERNANCE - COMPLIANCE WITH LAWS AND REGULATIONS/ FRAUD

1. PURPOSE OF REPORT

1.1 To inform Members of the proposal to reply to the letter received from the Director and Engagement Lead of our External Auditor, Mazars, to those charged with governance regarding compliance with laws and regulations and fraud.

2. BACKGROUND

2.1 In carrying out the annual accounts audit, Mazars have to demonstrate compliance with International Standards for Auditing (UK and Ireland). The Standard requires Mazars to gain each year, an understanding of how the Committee exercises oversight of management's processes for identifying and responding to the risks of fraud and the internal controls established to mitigate them.

2.2 Mazars must also gain a general understanding of the legal and regulatory framework applicable to the audited body and how the audited body is complying with that framework. After gaining a general understanding auditors need to undertake audit procedures to help identify instances of non-compliance with those laws and regulations where this impacts on preparing the financial statements. This includes:

- Enquiring of management whether they have complied with all relevant laws and regulations;
- Written representation from management that they have disclosed to the auditor all known actual or possible areas of non-compliance; and
- Enquiring with "those charged with governance" whether they are aware of any possible instances of non-compliance.

3. AUDIT AND GOVERNANCE COMMITTEE RESPONSE

3.1 Attached as Appendix A is a letter to Mazars from the Chair of the Committee detailing how the committee has complied with the requirements of International Standards for Auditing.

4 RECOMMENDATION

4.1 It is recommended that Members agree the contents of the letter to Mazars outlining how the activities of the Committee comply with the requirements of International Standards for Auditing.

5 REASON FOR RECOMMENDATIONS

5.1 To ensure that in order for Mazars to comply with legislative requirements, those charged with governance supply the requested information.

6. BACKGROUND PAPERS

6.1 Letter to Those Charged With Governance - Compliance with Laws and Regulations/ Fraud

7. CONTACT OFFICER

7.1 Chris Little
Chief Finance Officer
Civic Centre
Victoria Road
Hartlepool
TS24 8AY

Tel: 01429 523003
Email: Chris.little@hartlepool.gov.uk

Appendix A

Cllr Keith Fisher
Audit and Governance Committee Chair
Civic Centre
Hartlepool
TS24 8AY

Tel: 01429 266522
www.hartlepool.gov.uk
Our Ref:
Your Ref:

15.05.14

Mark Kirkham,
Director and Engagement Lead,
Mazars.

Dear Mark,

Further to your letter to those charged with governance - compliance with laws and regulations / fraud; in relation to understanding how Mazars gains assurance from management, I have outlined below in the answers to the questions posed, how the Audit and Governance Committee gains assurance that all relevant laws and regulations are complied with and how we exercise oversight of the processes in place for identifying and reporting the risk of fraud and possible breaches of internal control.

1) How do you exercise oversight of management's processes in relation to?

- *undertaking an assessment of the risk that the financial statements may be materially misstated due to fraud or error (including the nature, extent and frequency of these assessments?);*
- *identifying and responding to risks of fraud in the Authority, including any specific risks of fraud which management have identified or that have been brought to its attention, or classes of transactions, account balances, or disclosure for which a risk of fraud is likely to exist?;*
- *communicating to employees its view on business practice and ethical behavior (e.g. by updating, communicating and monitoring against the Authority's code of conduct?); and*
- *communicating to you the processes for identifying and responding to fraud or error*

As the Audit and Governance Committee we review the Councils Financial Statements and take advice from both officers' internally and externally regarding the accounting statements and processes in place to ensure they are a true and fair view of the Council's financial position. We are regularly updated in relation to issues regarding potential fraud and review and approve the Councils Anti Fraud and Corruption Strategy. The Audit and Governance Committee review and approve the Councils Code of Corporate Governance and also the Councils Risk Management Strategy. As an independent committee of the Council, the Audit and Governance Committee can at any time seek explanation from any officer of the Council regarding issues it considers.

2) How do you oversee management processes for identifying and responding to the risk of fraud and possible breaches of internal control? Are you aware of any breaches of internal control during 2013-14?

We considered Internal Audit Plan 2013/14 Updates. Four of these reports were reviewed by the committee during the year which allowed members to be kept up to date with the ongoing progress of the Internal Audit section in completing its annual audit plan. These reports allowed the committee to review the outcomes of all completed internal audit reports and comment upon any areas of concern. As a Committee we are not aware of any breaches of internal control during 2013-14, and will consider those significant governance issues highlighted in the Annual Governance Statement in the context of our knowledge and understanding of the Council over the financial year.

3) How do you gain assurance that all relevant laws and regulations have been complied with? Are you aware of any instances of non-compliance during 2013-14?

As detailed above we considered Internal Audit Plan 2013/14 updates. Four of these reports were reviewed by the committee during the year which allowed members to be kept up to date with the ongoing progress of the Internal Audit section in completing its annual audit plan. These reports allowed the committee to review the outcomes of all completed internal audit reports and comment upon any areas of concern. Members of the Audit and Governance Committee are active in other areas of Council activity and bring that knowledge and experience to the Audit and Governance Committee in relation to the Councils operation. The Audit and Governance Committee reviews performance and risk management arrangements in place through the work of Internal Audit and other reports received and is not aware of any non compliance with relevant laws or regulations during 2013-14.

4) Are you aware of any actual or potential litigation or claims that would affect the financial statements?

The Committee is not aware of any new significant litigation or claims or changes to any existing litigation / claim that would affect the financial statements.

5) Have you carried out a preliminary assessment of the going concern assumption and if so have you identified any events which may cast significant doubt on the Authority's ability to continue as a going concern?

Having reviewed the reports and information provided to the Committee over the course of the year, including reviewing the Councils Financial Statements and Annual Governance Statement, the Committee has no significant doubt as to the Councils ability to continue as a going concern.

In addition to those processes and procedures detailed above, the Committee has also considered the information outlined below:

- *Considered the 2013/14 Internal Audit Plan* – This informed the committee of the direction of Internal Audit activity and sought approval of the annual operational Internal Audit Plan for 2013/14. It also provided accountability for internal audit services allowing the committee to monitor the application of the delegated authority for ensuring an effective and satisfactory internal audit function in accordance with the Accounts and Audit Regulations 2011 and CIPFA Code of Practice for Internal Audit in Local Government in the UK (2006).
- *Reviewed the Internal Audit Outcome Report 2013/14* – This provides accountability for internal audit delivery and performance and allowed the committee to monitor the application of the delegated authority for ensuring an effective and satisfactory Internal Audit function in accordance with the Accounts and Audit Regulations 2011 and CIPFA Code of Practice for Internal Audit in Local Government in the UK (2006).
- *Reviewed and approved the findings of the review of the effectiveness of internal audit* – This allowed the committee to place reliance on the totality of systems and procedures in operation at the council in pursuit of its objectives.
- *Reviewed the Treasury Management Outturn 2012/13* – This report provided a review of the Treasury Management activity for 2012/2013 and the outturn Prudential Indicators for this period.
- *Treasury Management Strategy 2014/15* – To enable the Audit Committee to consider the proposed Treasury Management Strategy for 2014/2015 prior to the strategy being referred to Council in February 2014.
- *Review of External Auditor Reports.*

In relation to the questions posed regarding fraud, the Committee would make the following comments;

1) Are you aware of any instances of actual, suspected or alleged fraud during the period 1 April 2013 – 31 March 2014?

The Committee is aware of fraud perpetrated against the Council in respect of benefit claims and I as Chair of the Committee was aware of an instance of abuse of Council time and property during the period 1 April 2013 – 31 March 2014.

2) Do you suspect fraud may be occurring within the Authority?
- *Have you identified any specific fraud risks within the Authority?*
- *Do you have any concerns that there are areas within your Authority that are at risk of fraud?*
- *Are there particular locations within the Authority where fraud is more likely to occur?*

The Committee does not suspect fraud may be occurring within the Authority and is satisfied that adequate arrangements are in place to tackle suspected fraud.

3) Are you satisfied that internal controls, including segregation of duties, exist and work effectively? If not where are the risk areas? What other controls are in place to help prevent, deter or detect fraud?

The Committee is satisfied that the Council has adequate governance arrangements in place to in relation to its internal control environment and gains assurance from the work of its internal and external auditors.

4) How do you encourage staff to report their concerns about fraud?
What concerns about fraud are staff expected to report?

The Council has a well established and publicised Whistleblowing Policy in place as well as an up to date Anti Fraud and Corruption plan. Staff are expected to report all instance of suspected fraud and corruption and are encouraged to do so.

5) From a fraud and corruption perspective, what are considered to be high risk posts within your Authority? How are the risks relating to these posts identified, assessed and managed?

The Committee considers those posts dealing with all aspects of procurement and cash handling to high risk. The Committee takes assurance from the fact that risk assessment of posts is undertaken and training is provided to enable awareness of fraud to be highlighted to staff.

6) Are you aware of any related party relationships or transactions that could give rise to instances of fraud? How do you mitigate the risks associated with fraud related to related party relationships and transactions?

The Committee is not aware of any related party relationships or transactions that could give rise to instances of fraud. The Committee is assured that adequate arrangements are in place for the recording and declaration of any relationships or interests that may raise cause for concern.

7) Are you aware of any entries made in the accounting records of the authority that you believe or suspect are false or intentionally misleading?
- *Are there particular balances where fraud is more likely to occur?*
- *Are you aware of any assets, liabilities or transactions that you believe were improperly included or omitted from the accounts of the Authority?*
- *Could a false accounting entry escape detection? If so, how?*

Are there any external fraud risk factors, such as income collection, which are high risk of fraud?

The Committee is not aware of any entries made in the accounting records of the authority that we believe or suspect are false or intentionally misleading. We do not believe any assets, liabilities or transactions have been improperly included or omitted from the accounts of the Authority. The Committee takes assurance from both its internal and eternal audit coverage of the Councils accounting records and is satisfied that sufficient checks and balances are in place.

8) Are you aware of any organisational, or management pressure to meet financial or operating targets? Are you aware of any inappropriate organisational or management pressure being applied, or incentives offered, to you or colleagues to meet financial or operating targets?

The Committee is not aware of any organisational, or management pressure to meet financial or operating targets or any inappropriate organisational or management pressure being applied, or incentives offered, to meet financial or operating targets. The Committee takes assurance from the governance arrangements the Council has in place and the independent assurance it receives over the course of the year that these arrangements are working in practice.

Yours Faithfully

Cllr Keith Fisher
Audit and Governance Committee Chair

AUDIT AND GOVERNANCE COMMITTEE

15 May 2014

HARTLEPOOL BOROUGH COUNCIL

Report of: Scrutiny Manager

Subject: NORTH EAST AMBULANCE SERVICE QUALITY ACCOUNT – 2013/14

1. PURPOSE OF REPORT

1.1 To provide the Audit and Governance Committee with the North East Ambulance Service's (NEAS) Quality Account for consideration and comments.

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. Quality Accounts inform stakeholders and the public about the quality of services provided by NHS Trusts. They set out:-

- what an organisation is doing well;
- where improvements in service quality are required;
- what the priorities for improvement are for the coming year;
- how the organisation has involved service users, staff and others with an interest in your organisation in determining those priorities for improvement.

2.2 The Quality Accounts are circulated to key organisations including commissioners, patient groups and relevant overview and scrutiny committees. These groups have the opportunity to submit a statement for inclusion in the published version setting out their views on a Trust's performance and priorities.

2.3 A copy of NEAS's Quality Account is attached as **Appendix 1.**

3. RECOMMENDATIONS

3.1 That the Audit and Governance Committee consider and comment on NEAS's Quality Account and agree for the Committee's views to be submitted to NEAS.

Contact Officer:- Joan Stevens – Scrutiny Manager

Chief Executive's Department – Legal Services
Hartlepool Borough Council
Tel: 01429 284142
Email: joan.stevens@hartlepool.gov.uk

BACKGROUND PAPERS

No background papers were used in the preparation of this report

North East Ambulance Service NHS Foundation Trust

Quality report for the year ending 31 March 2014

Colour guide to sections within the quality report

Part 1	
Part 2	
Part 3	

Highlighted = updates required

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Note: Where the source of data is not stated, the source is internal Trust data systems. Where it is not stated that a national definition has been applied, then the definition has been agreed locally.

Part 1

Introduction to us and the services we provide

The North East Ambulance Service NHS Foundation Trust (NEAS) covers the counties of Northumberland, Tyne and Wear, Durham and Teesside – an area of around 3,230 square miles. We employ over 2,700 people and serve a population of 2.66 million.

We provide emergency ambulance services and non-emergency transport and respond to 999 calls for people in the North East of England. From April 2013 the trust has been successfully delivering NHS 111 for the region and has been able to demonstrate how this service can run alongside the provision of the 999 service to provide a seamless access point for patients.

Our headquarters is based at Newburn Riverside business park, to the west of Newcastle upon Tyne city centre. These headquarters house the Patient Transport Service (PTS) contact centre and a large number of our support services staff. We split our 999 and NHS 111 contact centre between our headquarters site and our site at Russell House in South Tyneside. We can also take calls at Scotswood House in Newcastle, where our training department is based.

We currently have 64 locations, including 56 emergency-care ambulance stations. A number of these stations also house non-emergency Patient Transport Service (PTS) employees and vehicles and, to save public money, we share some of our sites with fire and rescue services.

We have a fleet of various vehicles to cover the different areas we serve in terms of population and geography. We can adapt to road conditions in urban and rural areas and can respond in all weather situations. Our fleet of emergency-care vehicles is made up of over 195 vehicles and we have 232 non-emergency vehicles within PTS.

Our performance during 2013/2014 has remained strong. We have met all the targets in the service-performance areas, including achieving both category-A8 and -A19 performance targets. We generated a financial surplus in 2013/14 and achieved our cost improvement target.

Since becoming a Foundation Trust in November 2011 we have received feedback from Monitor, the healthcare regulator, on how we are performing. Monitor rated us as 'Green' for compliance (meeting the relevant standards) and we received a financial risk rating of 4 (where 1 represents the highest risk and 5 the lowest) for 2013/2014.

Our vision is:
"To make a difference by integrating care and transport in pursuit of equity and excellence for our patients".

Patients remain at the heart of everything that we do and we uphold our mission to ensure patients receive the right care in the right place at the right time. We have a strong track record of delivering high-quality patient care, focusing limited resources to produce the most effective outcomes possible and we have been at the leading edge of innovative service design for some time. This has consistently led to us being one of the highest performing ambulance trusts in the country. Times are changing and we recognise we need to work differently and have the persistence to continue to drive through improvements in service delivery whilst working to ensure all of our patients have a positive experience.

Ambulance services are being recognised as being able to play an enhanced role as a care provider, utilising the skills of Paramedics to treat more patients at scene. There is also the potential for ambulance services to drive integration and co-ordinate other elements of emergency and urgent care being at the heart of 'first

contact' made by many patients and being a key decision maker in determining the best place for definitive care. These nationally documented proposals are key drivers of our operational plan and long term strategic ambitions.

The transformation of our service is now of paramount importance we are committed to working with our Commissioners across the region to improve patient care through:

- Transforming the Emergency Care service delivery model whilst protecting service provision in the interim, delivering more care and treatment on scene and at home to our patients
- Improving response time performance while realising efficiencies wherever possible
- Integrating the way in which we provide care and patient transport across the full spectrum of our core services i.e. high end Emergency Care through to planned patient transport
- Develop partnership working with primary and community care that helps support admission avoidance programmes, working as a team to meet the needs of our patients

Introduction to quality within NEAS

We have a strong track record for delivering high-quality, good-value patient care and we plan to build on that in 2014/2015 by taking forward every opportunity to continue to improve patient care.

Like all NHS organisations we have closely reviewed the recommendations of the second Francis Inquiry into Mid-Staffordshire hospitals. We will continue to put the patients at the heart of everything we do, delivering effective clinical care as well as excellent patient experience. In line with the Francis Inquiry recommendations, our quality report provides full and accurate information about how we are keeping to the fundamental standards of quality and safety and our aim to deliver quality to patients in everything that we do.

The national direction of travel specifically for mobile treatment services and Emergency Care centres (Emergency Care centres to serve the more remote and rural communities) and the establishment of major emergency centres, is not yet emerging in local commissioning plans. It is likely the next iteration of the Urgent and Emergency Care review due in spring may help to firm up local plans. The national review is now being considered in more detail at urgent care working groups, now that winter planning and review has subsided.

For this report, we developed a list of potential 'quality priorities', covering patient safety, patient experience and clinical effectiveness. We based our priorities on the needs of the public and the potential priorities of the Clinical Commissioning Groups (CCGs), and by taking into account guidance from the 'Everyone Counts Planning Guidance 2013/14', which sets out the plans for the NHS in the year ahead.

To help us develop the priorities, we hold a Quality Report Task and Finish Group made up of governors and staff who shared their views and those of the people they represent. We consulted the local Healthwatch teams, the regional Overview and Scrutiny Committee (OSC) and our commissioners when deciding on the final list.

We felt it was important to make sure that the priorities were in line with our business plans so that we could support real improvements. It was also important, to ensure that priorities are measurable and meaningful for patients.

This year has seen us further develop our arrangements for governing the way we work through the Quality Committee. They will monitor the progress of our plans to deliver our clinical governance, quality and patient safety strategy. The purpose of the Quality Committee is to give the Board an independent review of, and reassurance about, the following.

- All aspects of the quality of services, particularly clinical effectiveness and how we will maintain this over the long term, patient experience and patient safety, and monitoring whether we meet essential standards of quality and safety set by the Care Quality Commission (CQC).

- Improvements in quality and patient safety – making sure these are central to all our activities.
- How we encourage and monitor high-quality, clinically safe patient care.
- Whether we are meeting our own and other quality and clinical improvement targets, and the action management should take if we are not meeting these targets.
- Whether we are meeting the committee's legal, mandatory and regulatory requirements.
- Making sure that the clinical governance, quality and patient safety strategy covers:
  - the experience of patients and the public, including how a patient's care is planned and the situation in which care is given;
  - how information is used in terms of patient experience, resources, process and outcomes;
  - improvements in quality, including the clinical audit programme, decisions made based on research studies (evidence-based practices), the way we manage risk, and learning from incidents and complaints;
  - staffing and staff management, education, training and continuing professional development; and
  - the leadership strategy and planning, including involving the community and patients and clinical leadership;
  - evaluating our own quality data and that provided by other sources such as the CQC.

The Quality Committee is attended by the Director of Clinical Care and Patient Safety and is chaired by a Non-Executive Director. The Quality Review Group we formed with our commissioners helps provide assurance of joined-up working and quality across the region. This group allows us direct access to clinicians and we are developing relationships to help influence the commissioning of our services. The group are progressing a cycle of business which will ensure that the quality agenda is progressed locally.

Statement of quality from our Chief Executive: our senior employee

This is our fifth quality report and our third as a foundation trust. We have prepared it under the National Health Service (Quality Accounts) Regulations 2010. We have reviewed all the information available on the quality of care in all core services and, as far as we know, the information in this report is accurate. This quality report for 2013/2014 includes a quality review which tells you how we did in 2013/20143. It sets out how we will continue to deliver high-quality healthcare services in 2014/2015.

The report gives details of some of the progress we are making in achieving our vision. Last year we identified a number of areas where we would make improvements and this report describes the progress we have made. Also, we identify new priorities for the coming year, which we have chosen after careful discussion with those with an interest in our work. We will report on our progress in next year's quality report.

The report describes a number of successes. However, we are not going to just sit back. We recognise that we can always make further improvements. Part of this is about maintaining and improving our response times and improving our performance with the national ambulance quality indicators (AQIs). These are measures of performance which will help us to show the quality of care that we provide and to focus on improving the quality of our services. This will help us to improve the care we provide for our patients by making sure that our staff have the right skills and training to properly care for and treat patients.
Does Simon want to update this section with reference to it being his last report?

Simon Featherstone
Chief Executive

Part 2

An introduction to our quality report

In 2009, the Department of Health (DH) ruled that all NHS provider trusts must publish a quality report every year. The purpose of the report is to show our commitment to quality and for others to hold us to account. Quality is broken down into three areas.

- Patient safety
- Clinical effectiveness
- Patient experience

This report reviews our performance for 2013/2014 and sets out our main priorities for 2014/2015.

We are yet to agree targets and associated payments with commissioners for the 2014/2015 Commissioning for Quality and Innovation (CQUIN) scheme but the intention is for the funding to be targeted at the progression of the integrated transport model and implementation of the Friends and Family Test.

Review of the 2012/2013 priorities

Our performance in 2013/2014

Patient experience			
Priority 1	**2011/2012**	**2012/2013**	**2013/2014**
Demonstrate ways to gather and measure the patient experience across our region and learn about patient experiences by recording patient stories in emergency care, PTS and from our contact centre.	We used a number of methods to get patients' views of our services, doing so shortly after their care: • Telephone survey for NHS 111 • Postal surveys for PTS • Focus Groups for PTS • Questionnaires for those who use emergency services	We developed a new way of measuring patient experience. We set up a pilot in 2012-2013 with North of Tyne Patient Advice and Liaison Service (PALS) at Newcastle's Royal Victoria Infirmary to test this new method. PALS volunteers and staff were trained to survey ambulance patients arriving by emergency and PTS ambulances.	We have developed SMS text and website based questionnaires, both are live and publicised on ambulance vehicles and on the NEAS website. Posters are also displayed on PTS vehicles and smartphone users can access the survey using a QR code. We have also input into the structure and questions of the national ambulance survey.
Priority 2	**2011/2012**	**2012/2013**	**2013/2014**
To work with healthcare professionals to improve the management of their patient transport requirements.	Does not apply	Baselines as shown below: 52% within 60 mins 63% within 120 mins 76% within 240 mins	The target for 2013/14 was to increase these percentages Need data for full year
Priority 3	**2011/2012**	**2012/2013**	**2013/2014**
To introduce an appointment based Patient Transport Service through 2013/14, across the entire NEAS area.	Does not apply	Does not apply	The target for 2013/14 was set at 75% Need data for full year

Patient safety			
Priority 4	**2011/2012**	**2012/2013**	**2013/2014**
Work with the acute trusts to reduce the impact of hospital turnaround delays in order to ensure a positive, safe patient experience.	Does not apply	Baselines as shown below: 6365 delays over 60 mins 465 delays over 120 mins	The target for 2013/14 was to reduce the numbers Need data for full year
Priority 5	**2011/2012**	**2012/2013**	
Lead the work with those with an interest in our services to deliver support, both medical and social, to high-intensity users to make sure that they get the most appropriate response in the most appropriate place to meet their needs.	Does not apply	Does not apply	The target for 2013/14 was to set a baseline for the number of patients flagged on the system as high intensity users Need data for full year

Clinical Effectiveness			
Priority 6	**2011/2012**	**2012/2013**	**2013/2014**
Explore with Commissioners a system and structure which supports implementation of individual treatment plans (ITPs) and new pathway developments.	Does not apply	Does not apply The target for 2013/14 was to review 10 ITPs per month.	Volumes this year?
Priority 7	**2011/2012**	**2012/2013**	**2013/2014**
More use of other options (other than going to an emergency department) during 2013/14 if other options are available	32.7% see and treat 3.3% hear and treat.	30.7% see and treat 4.0% hear and treat	Volumes this year?

Priorities for the year ending 31 March 2015

To make our quality report useful to, and include, all readers, we asked a wide range of organisations and others with an interest, including our Board of directors, our staff, the local Healthwatch teams, the regional Overview and Scrutiny Committee and our commissioners, how we could make the three areas of quality, patient safety, clinical effectiveness and patient experience, meaningful to them.

Our aim was to develop a report which was shaped by patients, the public and our staff so that they had an opportunity to understand, contribute to and promote quality within NEAS. We considered their feedback and agreed on five local priority areas for 2014/2015.

Clinical Effectiveness		
Priority 1		
Where appropriate, drive up the use of treatment other than conveyance to an Emergency Department.		
	Baseline 2013/2014	**Target 2014/2015**
	% conveyance	To reduce
Reason for doing this	A key issue facing the NHS is the increasing demand for emergency care. The rise in demand is unsustainable and the use of more appropriate alternative dispositions is critical at a time when costs and workforce pressures are rising.	

	We have a pivotal role to play in the entire urgent and emergency care system as an ambulance service. Traditionally, the ambulance service has been seen primarily as a call-handling and transportation service, encompassing some aspects of patient care. However increasingly, it is recognised as having a wider role, as a conduit to other NHS services and ensuring patients can access the right care, at the right place in the right time. Providing clinical advice and signposting to callers - known as 'hear and treat'- treating patients at the scene -'see and treat'- and conveying patients to a wider range of appropriate care destinations other than Emergency Departments where alternative destinations are commissioned and are known to NEAS can help ease emergency care pressures by reducing conveyance rates to Hospitals. We have a number of initiatives and activities planned in order to increase the use of alternative dispositions, which collectively should result in an improvement in the use of alternative pathways: • Continuing to use the Logistics Desk in the Control Room to search for alternative pathways on the Directory of Services (DoS) and ensuring the DoS is regularly updated as new facilities come on stream • Maximising use of the Clinical Hub in the contact centre to support staff with increasingly complex issues around prioritisation of competing clinical resource demands, safeguarding, mental capacity and consent as well as supporting decision making around alternative pathway utilisation • Using the skills of the Enhanced CARe paramedic at the scene for treatment rather than conveyance ensuring that the patient can stay at home or close to home where possible • Developing the role of the Specialist Paramedic (primary care) and using those skills in appropriate circumstances to reduce conveyance levels • Working across NEAS to determine what might be an appropriate regional target changes in case mix • Using our research and development function to draw in possible funding sources that may help us to deliver changes in behaviour that would lead to a reduced conveyance rate • Analysing the information we hold on electronic patient report forms to establish the level of clinical intervention with a patient and use that information to look at call matching possibilities • Training additional paramedics if appropriate based on the analysis above • Undertaking a gap analysis of services across the region to identify where an Emergency Department may be the only option in an area • Engaging with stakeholders to educate system users about the role of NEAS and the care that can be provided at locations away from hospital

Patient Experience		
Priority 2		
Improve the average hospital turnaround time at target hospitals.		
	Baseline 2013/2014	**Target 2014/2015**
	tbc	Reduce handover time at hospitals with the longest delays
Reason for doing this	Delays in transferring the care of a patient from an ambulance crew to hospital staff are unwelcome because there is the potential for harm to patients waiting for an ambulance response in the community and because they waste valuable NHS resources. Historically delays would occur only in times of extreme pressure during the winter months as pressure builds in acute settings from increased levels of activity, however in more recent times there have been delays throughout the year which are yet further exacerbated during the winter. This indicator is very important to us because at times of increased system	

	pressure, our performance against the 8 minute standard for red calls can be impacted. We have reports that measure the handover time based on staff utilising information technology in every Emergency Department across the North East. We work with the acute hospitals to ensure that the figures are accurate and that we take action to address concerns across the whole health economy. We have seen improvements in handover at a number of hospitals across the region and there are now opportunities to learn from those success stories and develop best practice for those hospitals that are not achieving the target times for handover. We recognise that there may be improvements to the total turnaround time for at a hospital i.e. the time it takes to handover the patient together with the time it takes for the ambulance crew to clear to be ready for the next job. We have a number of initiatives and activities planned in order improve the total turnaround times across the region: • Reviewing handover performance across the entire region to fully understand turnaround performance at all hospitals • Agreeing and developing revised handover report incorporating all requirements of the trust • Identifying improvement targets for specific hospitals where performance is poor • Working with those hospitals performing well to identify specific practices that are contributing to their success • Sharing ideas for improvement with the hospitals finding it difficult to achieve the 15 minute target turnaround time • Reviewing the amount of time post-handover it takes crews to clear across the region and establish any learning that can be used to reduce this proportion of the total turnover time • Undertaking stakeholder engagement activity with the Chair and the Chief Executive to build an understanding of the issues with other trusts and how we can work together with them to improve the performance for the benefit of the wider system
Priority 3	
Reduce the frequency of extended shifts across all of NEAS to optimise patient care and staff welfare.	
	Baseline 2013/2014 **Insert staff satisfaction score in here** **Target 2014/2015** To improve
Reason for doing this	We recognise that our staff are our most important asset and they continually rise to the challenges they are set. Whilst the Trust is a top performing service these standards are very much attributable to our workforce, however, for a long time front-line staff have been doing more for less and are feeling the pressure of the rising activity. There are just as many demands placed on staff not directly related to patient care such as vehicle checks and drug audits, but are just as important in maintaining adequate levels of safety for patients, as well as themselves. The current morale and motivation of staff is reportedly low, but is not at the point where it is adversely affecting patient care. We are committed to achieve a work life balance for all staff, effectively reducing late meal breaks and late finishes, and ensuring the creation of opportunities for their engagement in implementing the changes necessary to meet the challenges ahead. We want to ensure that our staff feel valued to ensure that patient care is optimised. We have a number of initiatives and activities planned in order to help improve staff satisfaction which will hopefully lead to an increase in the staff satisfaction

	score as measured through the annual staff survey: • Base lining the volumes of late finishes for 2013/14 • Considering the use of staggered shift patterns • Investigating any complaints or serious incidents that could be linked to late finishes • Tracking the volumes of patients that are conveyed to an Emergency Department rather than being treated at the scene when a shift has overran. • Starting the implementation of the Team Leader review to help address gaps in the existing infrastructure and enhance the front line leadership role so that it more fully supports the staff delivering care to the patients • Reviewing staff satisfaction in the staff survey and aim to see improvement in scores. Target specific areas for feedback based on issues identified by staff. • Engaging with staff using the results of the staff survey to seek input from them about the issues they feel are most important • Identifying any quick wins from the survey that can be implemented easily with a positive impact • Identifying questions in the Friends and Family Test that also provide insight do interim surveys/pulse surveys to monitor progress • Tracking reductions in late finishes for 2014/15

Patient Safety

Priority 4

Set up systems in NEAS that demonstrate all mandatory requirements are being met that could impact on the safety of patients and staff.

	Baseline 2013/2014	Target 2014/2015
	Does not apply	Introduce e-ledger by March 2015

Reason for doing this	Safeguarding our staff and patients is something we take very seriously indeed and we want to ensure that all relevant checks are being carried out within the Trust. The checks are those that apply to staff, vehicles, buildings and equipment. We will be introducing an e-ledger that logs and tracks all checks required across the Trust and aim to have it in place by the end of the financial year. We have a number of initiatives and activities planned in order to help us deliver this requirement and these are shown below: • Reconfirming across the Trust all of the checks that are required checks e.g. DBS (previously known as CRB), driving licences etc. • Ensuring all policies are up to date in line with national requirements or internal guidance • Generating a list of all checking requirements and using this to create a ledger that covers checks for all staff, vehicles, buildings and equipment checks • Conducting monthly reviews of the ledger and generating monthly reports • Using dashboard functionality to report progress • Introducing 'holding to account' meetings across the Trust to help ensure all checks are being made in a timely manner.

Priority 5

Lead the work with those with long term conditions to make sure they get the most appropriate response in the most appropriate place to meet their needs.

	Baseline 2013/2014	Target 2014/2015
	Add in this year's info from above	**tbc**

Reason for doing this	We have on going work with high intensity users which are mainly managed by the Customer Care Department within NEAS and this was agreed as a priority area for us in the last report, we would like to build on that work in the coming year. We want to ensure that resources are targeted appropriately at those with long term conditions, but also want to ensure that frequent users who do not really need our services are pointed towards other more appropriate options. Frequent users rely heavily on resources that could otherwise be delivering an emergency response to those in greater need but also they represent an ineffective use of health resources, particularly where ambulance attendance is linked to hospital attendance. Further, the high attendance may indicate a crucial unmet health need for the individual which needs addressing by the wider health and social care community. Current cases are managed on an individual basis following on from an MDT meeting and a care pathway is developed depending on the circumstances of the individuals. In the last year we have worked with Yorkshire Ambulance Service and York University to look at a way of identifying a potential frequent caller and looking at trends and patterns of calls. We have a number of initiatives and activities planned in order to help us further progress this area of work: • Reviewing and embedding the work that has been undertaken so far and learn from positive impacts • Categorising different types of users based on whether they have a long term condition that may need clinical intervention or whether they would benefit from using other services, perhaps in the social care arena • Reviewing whether the existing flags on our systems are still appropriate • Updating the actions on the system associated with different types of flag • Targeting resources appropriately for regular service users that need the help of our service • Working with GPs to signpost and refer users to the most appropriate service for them, within or outside of the health community.

How we will measure, monitor and report on all of our priorities	We will report to the Quality Committee on our progress on the quality priorities for the year ahead. The Governance and Risk Committee will receive an update at each of their meetings and our Board of directors will monitor the progress of the priorities at meetings twice a year. We will draw up an action plan for the quality report, to take action and report on any areas which need to improve. The Performance Team will keep a track of this. Also, we will update our full council of governors, Overview and Scrutiny committees and healthwatch and members of NEAS. We will continue to build our dashboard that monitors the quality of our service and our quality reporting mechanisms to monitor progress.

Involving those with an interest in our work	
The views of patients, public and staff	We recognise the value of listening to patients, public and staff when setting our quality priorities. When producing this report we have involved everyone who has an interest in our organisation. This has been a continuing process throughout the financial year. Throughout 2013/2014 we attended a regional Healthwatch and Overview and Scrutiny Committee meetings to help us collect views on the priority areas for 2014/2015. We also have a Task and Finish Group which includes both staff and public governors to involve people further. When making a shortlist of the priority areas, we sent the draft list to all those with an interest and asked for their feedback. All the feedback we received agreed that the areas we had identified were areas where improving quality would further improve our services. Once an initial shortlist had been agreed, we engaged further with all of ours staff to ensure the emphasis on quality was in the right areas and is clearly linked to the welfare of patients and staff. **What we have done as a result of the feedback we have received** We refined the shortlist in light of comments received and used input to agree measures and activities that would help us to deliver the priorities. Based on staff feedback we have also listed our priorities in this report in order of importance to provision of a quality service.

Statements of assurance from the Board

The Department of Health identifies a number of mandatory statements (statements which we have to include by law) that we must report on. The information also gives assurance that the Board has reviewed and taken part in initiatives which link strongly to improving services.

During 2013/2014 the North East Ambulance Service NHS Foundation Trust (NEAS) provided three relevant health services. The North East Ambulance Service NHS Foundation Trust has reviewed all the data available to them on the quality of care in all three of these relevant health services.

The income generated by the NHS services reviewed in 2013/2014 represents 96.0 per cent of the total income generated from the provision of relevant health services by NEAS for 2013/2014.

The data reviewed within the quality report covers the area of patient experience, patient safety and clinical effectiveness, where data has not been available this has been indicated.

Please note where the source of data is not stated, the source is internal Trust data systems. Where it is not stated that a national definition has been applied, then the definition has been agreed locally.

Clinical audit

Clinical audit aims to improve patient care and outcomes by reviewing the care that we deliver. It tries to find out if things are being done correctly and asks 'Are we following best practice?'

During 2012/2013 **44** national clinical audits and **0** national confidential enquiries covered relevant health

services that NEAS provides.

During 2012/2013 NEAS participated in **100%** of national clinical audits and **0%** of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that NEAS was eligible to participate in during 2012/2013 are shown within table 1.

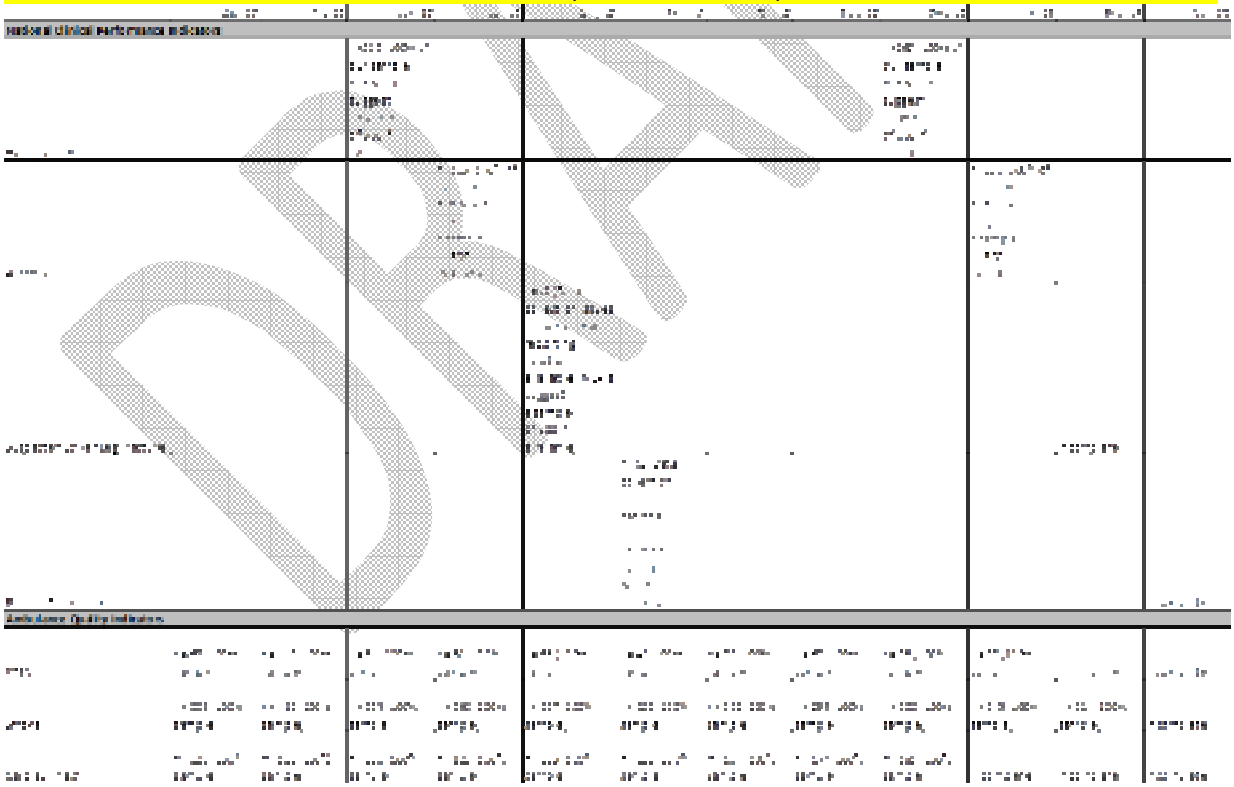
Table 1. National Clinical Audits and Confidential Enquiries NEAS Participated in.

	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
National Clinical Performance Indicators												
Hypoglycaemia			✓						✓			
Asthma				✓						✓		
Suspected Lower Leg Fracture					✓						✓	
Febrile Convulsions						✓						✓
Ambulance Quality Indicators												
STEMI	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Stroke	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Cardiac Arrest	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Note: Data has been produced in line with standard national definitions

The national clinical audits and national confidential enquiries that NEAS participated in, and for which data collection was completed during 2012/2013, 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, are shown in table 2.

Table 2. National Clinical Audits and Confidential Enquiries NEAS Participated in with number of cases submitted



The reports of 44 national clinical audits were reviewed by the provider in 2012/2013 and NEAS intends to take the following actions to improve the quality of healthcare provided:

- Two quality improvement (QI) officers will carry out clinical audits and provide feedback to front-line staff where improvement is needed. They will visit stations, discuss issues arising from the clinical audit,

organise forums to improve quality and workshops to discuss, identify, apply, test and monitor appropriate ways to improve clinical outcomes and provide higher-quality patient care.
- We will continue to communicate with staff through 'The Pulse' magazine on the topic 'Delivering Quality Care for Patients through Care Bundles', through patient care updates, and by putting promotional literature, such as leaflets and posters, in ambulance stations.
- We will continue to produce information on how we are doing at divisional level so that we can monitor our progress and make improvements where necessary.

The reports of 10 local clinical audits were reviewed by the provider in 2012/2013 and NEAS intends to take the following actions to improve the quality of healthcare provided;

- We will continue to audit how we process our paper patient report forms so that we are confident the methods we are using are accurate.
- We will continue to publish best-practice guidance in 'The Pulse' and patient care updates for front-line staff.
- Our quality improvement officers will visit stations to discuss clinical quality improvement face-to-face with operational staff.
- We will make changes to clinical practice where necessary to improve the care we give to patients and to keep to best practice.
- We will continue to give feedback to, and receive it from, front-line staff where clinical guidelines have not been followed, so that we know any improvements we suggest will be carried out.
- We will coach and mentor any front-line staff that needs support.
- We will continue to audit call-handling in our contact centres so that we know patients are being prioritised correctly and the appropriate triage (assessment) is being given.
- We will carry out further audits of patient report forms and electronic patient report forms to make sure there are no clinical risks when crews decide, based on a patient's symptoms, not to take them to hospital or to treat a child under two years old. This audit will also show that front-line staff are correctly recording what they do.
- We will continue to audit life-threatening incidents which had a response time of more than 20 minutes to find out why there was a delay and where we can make improvements.
- We will continue to audit patients who:
  a) contact us again within 24 hours after they were given advice during their initial call; and
  b) contact us again within 24 hours after they have been treated at the scene of the incident, when the rate of recontact is above the national average, to make sure there was no risk to them.

Research and innovation

Research helps the NHS to improve the current and future health of the people it serves. It is essential in successfully promoting health and plays a major part in continuing to improve the services and supporting safe and effective care. It identifies new ways of preventing, diagnosing and treating disease (see http://www.nihr.ac.uk/Pages/QualityAccounts.aspx). Our involvement with clinical research shows our commitment to testing and offering the latest medical treatments and techniques.

The number of patients receiving relevant health services provided by NEAS in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 221.

CQUIN

"CQUIN is a national framework for locally agreed quality improvement schemes. It enables commissioners to reward excellence by linking a proportion of English healthcare provider's income to the achievement of local quality improvement goals. The framework aims to embed quality within commissioner-provider discussions and to create a culture of continuous quality improvement, with stretching goals agreed in contracts on an

annual basis" (Department of Health, 2011).
We agree our CQUIN framework locally with our commissioners based on areas where we feel we can improve quality and increase the number of new working practices.

A proportion of NEAS income in 2013/2014 was conditional upon achieving quality improvement and innovation goals agreed between NEAS and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. *Further details of the agreed goals for 2013/14 and for the following 12 month period are available online at: http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275* **link to be updated**

CQUIN scheme values			
	2011/2012	2012/2013	2013/2014
CQUIN value (£)	£1.43 million	£2.3 million	£2.42 million
CQUIN achieved (£)	£1.38 million	£2.3 million	£2.37 million

CQUIN Scheme 2012/2013	
Indicator	
1	Show the measures we have taken to ask patients about their experience and develop improvement plans based on that feedback.
2	Increase the number of patients referred or transported to alternative care providers rather than A&E.
3	Improve our performance in rural areas.

CQUIN Scheme 2013/2014	
Indicator	
1	Involvement in whole system and pathway reviews with CCGs.
2	Increase the use of alternative dispositions other than A&E during 2013/14 where alternative pathways are available.
3	Demonstrate measures to capture & measure the patient experience, and publish patient stories.
4	Improvement in emergency response times for patients outside of national target.
5	To improve its responses times to GP urgent transport requests.
6	Reduce the number of PTS journeys that are cancelled on the day of travel.

CQUIN Scheme 2014/15	
Indicator	
1	**Table to be updated when scheme agreed**
2	
3	

Care Quality Commission

NEAS is required to register with the Care Quality Commission and its current registration status is registered without conditions.

The Care Quality Commission has not taken enforcement action against NEAS during 2013/2014.

NEAS has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

In February 2014, the CQC carried out a routine, unannounced inspection to check that we met all essential standards of quality and safety. The review looked at the following.

- The patient's ability to agree to care and treatment.
- The care and welfare of people who use services.
- The level of cleanliness and infection control.
- Requirements relating to workers.
- Complaints.

In all five areas the CQC found we kept to the relevant standards.

UPDATE USING SPECIFIC WORDING FROM GUIDANCE WHERE APPROPRIATE

Quality of information

NEAS did not submit records during 2013/2014 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

NEAS Information Governance Assessment Report overall score for 2013/2014 was 86% and was graded green.

We have a Data Quality Assurance Group which aims to provide an open forum to discuss quality across our main systems. They share knowledge and expertise in the quality of information and deal with any issues to do with the quality of the information.

The group reports directly to the Information Governance Working Group and also makes sure we keep to all our legal and regulatory responsibilities in terms of what we do.

NEAS was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

NEAS will be taking the following actions to improve data quality:

- Continue to undertake data quality audits
- Make sure that all staff are aware of the associated quality strategies, policies and procedures;
- Develop, put into practice and regularly monitor standards for healthcare and data quality;
- Report instances when we do not keep to standards on information quality;
- Match up information on trust data sets, billing data sets and Payment by Results (PbR) data sets;
- Review and update relevant evidence to support the NHS Information Governance Toolkit (IGT) and report the group's progress on IGT initiatives;
- Make sure we finish a review of documents describing databases, systems and their structure;
- Review, develop and improve the way we report on the quality of information for 999, PTS and 111 calls to find and correct inaccuracies as they arise;
- Review all procedures for reviewing and correcting the quality of information for all systems critical to

continued service provision.

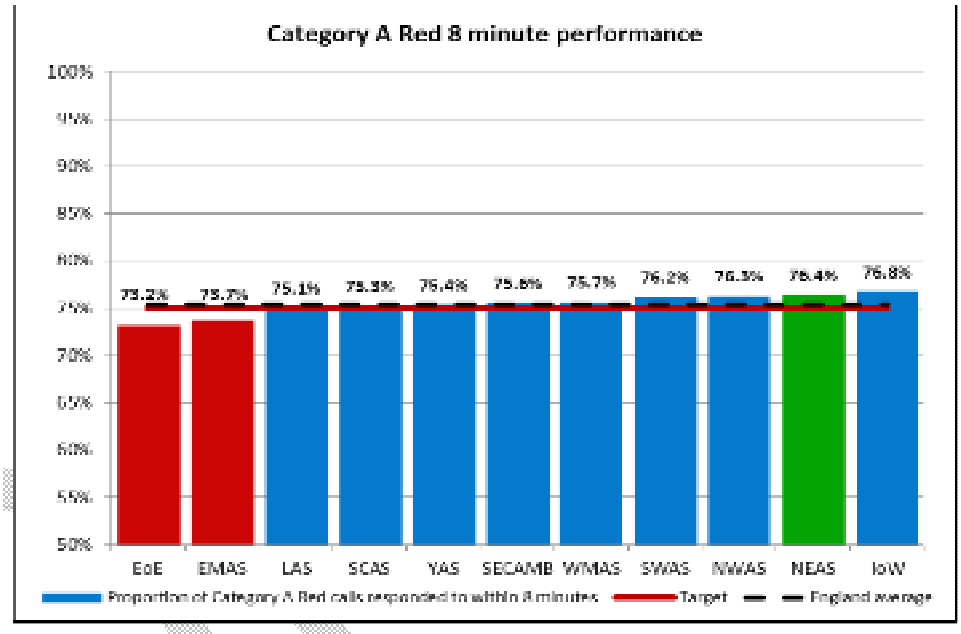
- Review all privileges users have for access to all business critical systems, making sure we restrict access to personal identifiable information (PII) wherever possible;
- Audit our functions against local procedures by sampling record sets; and
- Make sure all clinical systems keep to the NHS Number Strategy and connect to the NHS Demographic Batch Service (DBS) and Summary Care Records (SCR) to check a patient's personal information, such as name and date of birth.

Quality review of mandatory measures

The following section sets out how we have improved, measured against the six mandatory indicators given to us by Monitor. This allows us to compare ourselves with other providers and to help you assess whether our performance was good or bad.

National priorities

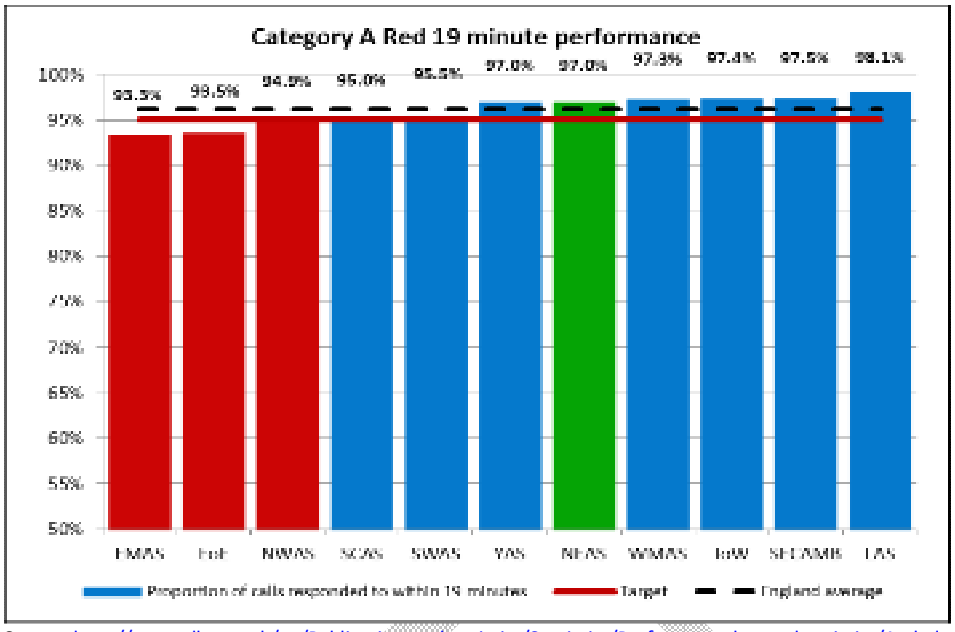
Category A 8-minute performance Note: the final figures at the end of the year can alter by up to 0.5% as trusts finalise end-of-year reporting and checks on the quality of information.



Source:
http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/AmbulanceQualityIndicators/index.htm **update link**

Note: Data has been produced in line with standard national definitions

Category A 19-minute performance Note: the final figures at the end of the year can alter by up to 0.5% as trusts finalise end-of-year reporting and checks on the quality of information.



Source::http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/AmbulanceQualityIndicators/index.htm **update link**

Note: Data has been produced in line with standard national definitions

The North East Ambulance Service considers that this data is as described for the following reasons:

- We follow national guidance and definitions for KA34 submissions to the NHS Information Centre when producing category-A performance information. This information is published every month on the DH statistics web pages as part of the AQIs. Ambulance trusts review each other's AQI definitions and calculations as part of the yearly workload of the NAIG (National Ambulance Information Group) to make sure that all are measured consistently.

The North East Ambulance Service has taken the following actions to improve this score and so the quality of its services, by:

- Twice weekly trust-wide meetings to monitor performance led by the Chief Operating Officer.
- Introducing performance dashboards through our online reporting centre that allow all parts of the business to access performance information that is updated every 15 minutes. This information is also displayed in the contact centre for call takers and dispatch staff to view at all times.
- Increasing the use of PTS and voluntary drivers to support less critical patients and this is now developing into the plans for an integrated transport service.
- Targeted use of other providers such as St John Ambulance, British Red Cross and contracted taxi firms when NEAS staff and vehicles are fully utilised
- Expanding the extra desk in the contact centre dedicated to managing urgent patients. This has freed up time for dispatchers to concentrate on 999 calls.
- Identifying and training extra community first responders in areas of greatest need.
- Agreeing the process for when there is a surge in demand.
- Anything else specific to this year?

	2012/2013	2013/2014	National average 2013/2014	Trust with lowest 2013/2014	Trust with highest 2013/2014
Care bundle delivered to patients presenting with signs or symptoms of a suspected heart attack (average)	84.7%*	tbc	77.6%*	67.3%* London Ambulance Service	94.1%* Great Western Ambulance Service
Care bundle delivered to patients presenting with signs or symptoms of a stroke (average)	97.2%*	tbc	95.6%*	90.7%* South East Coast Ambulance Service	100%* Great Western Ambulance Service

*** Data for April-12 to December-12 inclusive.**

Note: Information has been produced in line with standard national definitions.

The North East Ambulance Service considers that this data is as described for the following reasons:

- We follow national guidance and definitions for clinical AQIs when producing performance information for care bundles delivered to patients. This information is published every month on the DH statistics web pages.

The North East Ambulance Service has taken the following actions to improve this score and so the quality of its services, by:

- carrying out monthly audits for patients who have a pre-hospital diagnosis of suspected ST elevation myocardial infarction (STEMI) confirmed on electrocardiogram, or new suspected stroke or transient ischaemic attack;
- having two quality improvement officers carrying out audits for 100% of the cases associated with these clinical indicators and reviewing the clinical element of each record to assess whether the 'care bundle' (a set of interventions that, when used together, significantly improve patient outcome) had been delivered;
- asking the quality improvement officers to work hard to improve performance by feeding back to those individuals who have missed a care element of the care bundle to encourage reflection and learning;
- asking our quality improvement officers to carry out station visits and promote care bundles to those operational staff on shift with the aim of creating a quality improvement culture throughout the service; and
- promoting the care bundles using other methods of communication, for example, patient care updates, posters and inserts in the staff handbook.

Table to be updated with 2013/14 info

	2011/2012	2012/2013	2013/2014	National average 2013/2014	Trust with lowest 2013/2014	Trust with highest 2013/2014
2013 staff survey results (higher the score the better)	3.34 out of 5	3.12 out of 5	tbc	tbc	Xxx out of 5 Xxx Ambulance Service	Xxx out of 5 Xxx Ambulance Service

Source: http://nhsstaffsurveys.com/cms/

The NHS staff survey includes the following statement: "If a friend or relative needed treatment, I would

be happy with the standard of care provided by this Trust", and asks staff whether they strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree with the statement.

The North East Ambulance Service considers that this data is as described for the following reasons:

- The information has been produced in line with standard national definitions.
- We measure the feedback reports produced by the Co-ordination Centre against other trusts of a similar type. This allows people to make a fair comparison between trusts.

The North East Ambulance Service has taken the following actions to improve this score and so the quality of its services, by:

- creating a small Task and Finish group to develop trust-wide as well as local action plans to tackle the areas where staff experience has deteriorated and to build on those areas where it has improved; and
- developing a communication plan to make sure staff are aware of what action is being taken and to allow us to promote the areas where there have been some improvement

Tables and narrative needs to be updated with info for 2013/14 please

	Reported Patient Safety Incidents 2011 - 2012				Reported Patient Safety Incidents 2012 - 2013			
Actual Impact	**Total**	**% against total reported incidents**	**Total Calls**	**% of incidents against call rate per 1000 calls**	**Total**	**% against total reported incidents**	**Total Calls**	**% of incidents against call rate per 1000 calls**
No Harm	165	37.24	980530	0.16	144	25.71	1110700	0.12
Minor	150	33.86	980530	0.15	220	39.28	1110700	0.19
Moderate	62	13.99	980530	0.06	129	23.03	1110700	0.11
Major	0	0	980530	0	8	1.42	1110700	0.007
Catastrophic, Death	5	1.12	980530	0.005	10	1.78	1110700	0.009
Near Miss	50	11.28	980530	0.05	44	7.85	1110700	0.03
Death (not related to provision of healthcare)	11	2.48	980530	0.01	5	0.89	1110700	0.004
Totals	**443**		**980530**		**560**		**1110700**	

Our staff report patient safety incidents through our local risk-management systems. These reports are then forwarded to the National Reporting and Learning System (NRLS). The information collected in that national database allows trends to be identified. This information guides the development of patient safety strategies and resources.

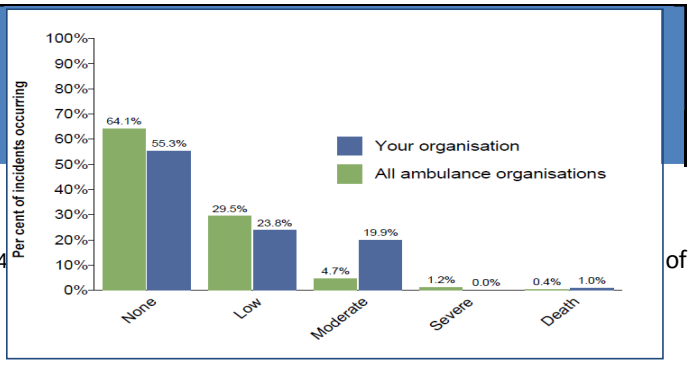
Between 1 April 2012 and 30 September 2012, we reported a total of 206 patient safety incidents. The table and graph below show a breakdown of the actual effect of the incidents and provides a comparison against all ambulance organisations for the same reporting period.

There is emerging evidence that organisations with a higher rate of reporting have a stronger safety culture, with high reporters aiming to learn from incident reporting to improve patient care and safety.

Incidents reported by degree of harm for ambulance organisations

1 April 2012 until 30 September 2012 (information taken from the Organisation Patient Safety Incident Reports, ninth data release: 20 March 2013)

Actual Effect	Totals
None	114
Low	49



Moderate	41
Severe	0
Death	2
Total	**206**

The North East Ambulance Service considers that this data is as described for the following reasons:

- We use the Ulysses Safeguard system for reporting and managing all negative incidents. We use the system to create reports and add data to the National Risk Learning System (NRLS).

The North East Ambulance Service has taken the following actions to increase reporting of patient safety incidents whilst reducing the severity of the actual impact to the patients involved, and so improve the quality of its services, by the following measures:

- Streamlining the way we report on safety incidents by introducing online reporting (which is accessible using ambulance laptop) for operational staff, and using PCs for office-based staff.
- A weekly audit on the quality of data to make sure all patient safety incidents are correctly reported. This then makes it easier to add the data to NRLS.
- Providing feedback to those who report patient safety incidents to encourage a responsive and open culture.
- We have a dedicated clinical investigating officer in post.
- We hold a weekly panel to review cases and find the root cause of problems.
- Each month we report back information to the trust board using the Integrated Performance Report (IPR). This includes exception reports when needed.
- Data is reported and reviewed by our Experience, Complaints, Litigation, Incident and PALs group (ECLIPs).
- We will have a 'Being Open' policy and a team of family liaison officers (FLOs) in place.
- We have carried out a Manchester Patient Safety Framework (MaPSaF) review.
- We are creating a quality dashboard to display key data, including information on patient safety.
- We will develop a clinical governance, quality and patient safety strategy.
- We will continue with the Trust Quality Committee which provides direct assurance to the Board on matters of patient safety, clinical quality and our overall clinical governance.

Part 3

Quality review – Local Indicators

Note: Where the source of data is not stated, the source is internal Trust data systems. Where it is not stated that a national definition has been applied, then the definition has been agreed locally.

Local indicators			
Patient experience			
Priority 1	**2012/2013**	**Internal target for 2013/2014**	**2013/2014**
Develop better methods of collecting patient experience, and make use of 'net promoter score'	Developed new methodology to measure patient experience. Test at RVI to test the methodology before rolling it out across the North East Region in 2013/2014. Built a relationship with PALS to put the survey into practice. Worked with other ambulance trusts to develop a national agreement to use the 'friends and family test' as a benchmark.	Rollout survey tool across the North East region. Development and implementation of SMS texting and website based questionnaire. Establishment of a baseline measure for 2014/15 for PTS and Emergency Care. Development and pilot of telephone and/or postal surveys to measure callers' experience of NEAS contact centre. Postal survey of emergency care and PTS patients. Report Patient stories to commissioners for each of the three service lines.	Partially achieved covering hospitals in Newcastle, Gateshead, Durham and Middlesbrough and we are aiming for full implementation by March 2015. Fully implemented. To be reported by Ipsos Mori in their annual report of patient experience. This target was not pursued to avoid conflicting with the national survey. To be reported by Ipsos Mori in their annual report of patient experience. Target not pursued as CQUIN funding was withdrawn by Commissioners.

Our aims in this priority were to build a clear picture of the patient experience based on gathered evidence rather than assumptions. This priority built on the work carried out previously under a pilot developed through working with the Royal Victoria Infirmary (RVI) and further work with a specialist research organisation, Ipsos MORI and feedback from PALS and patient groups. We also wanted to use patient stories to help build understanding based on actual experience as they can stimulate reflection and help develop new ideas.

We have used our existing contracts with CRT Viewpoint through CQUIN funds to develop an SMS-text survey. Patients can now text the word "NEAS" to 88882 using a scale of 0-10 to mark their level of experience of the service

We have used our existing contracts with CRT Viewpoint through CQUIN funds to develop a web-based survey. The live survey can be seen from this link: https://secure.crtviewpoint.com/OnlineSurvey/Default.aspx?Session=b419fd27-b79f-4fba-9370-27deb1e31499, which sits on the CRT Viewpoint server alongside other NEAS surveys developed through CQUIN. The link to this survey is publicised on the homepage of the NEAS website and other pages on the web.

Both surveys are now live and are being publicised on-board ambulance vehicles and on the NEAS website www.neas.nhs.uk. In addition, A4 size posters have been displayed inside PTS and ECS

vehicles, giving patients the opportunity to let us know their experiences.

The web address www.neas.nhs.uk/contact-us/tell-us-your-views is given on the poster. This will take the user directly to the CRT Viewpoint secure server for the website questionnaire.

In addition, a QR code is displayed for those patients who have a smart phone and QR code reader app (which is free to download). The app is used to scan this code and the user can then answer the survey from their smartphone.

The CQC has commissioned the Picker Institute to conduct a national ambulance survey on hear and treat. We decided not to pilot a survey of callers' experience at the same time as this national survey to avoid influencing the results, but have influenced the structure and questions in the national survey to represent all ambulance surveys as the original survey was based around ambulance services that use AMPDS rather than Pathways.

Priority 2	2012/2013	Internal target for 2013/2014	2013/2014
To work with healthcare professionals to improve the management of their patient transport requirements.	Baselines as shown below: 52% within 60 mins 63% within 120 mins 76% within 240 mins	to increase	Update required

Our aims in this priority were to ensure that we improved the performance in regard to transferring patients between healthcare providers.

Urgent transport requests are for those patients that are referred by a Doctor or other health care professional (HCP), usually from the patient's home to a place of treatment such as an acute hospital or a non-emergency transfer between hospitals. The time period within which transport is required is agreed with the referrer and is usually between 1 hour and 4 hours.

We had been experiencing delays in responding to 'GP Urgents' within the requested timeframe due to increased demand by emergency cases. As part of the A&E review implementation we have created a dedicated urgent service and made a number of other changes to our dispatch services to help reduce delays including amending call takers scripts to establish at the beginning of the call whether the patient can be transported by PTS, NEAS car or Taxi.

We have also introduced a better monitoring and recording system and a clinical escalation system of ring backs to check the patient's condition and where appropriate a clinical triage and an emergency response where there is a delay in the urgent response.

We have provided more vehicles with appropriately trained staff, particularly at the weekend to transport patients. PTS Operational managers and the Customer Care team have also been aligned with hospitals across the region to work in a relationship management role and strengthen lines of communication between us and the hospital and to manage issues relating to the PTS service. It is anticipated that this engagement will align the PTS service more closely with the needs of hospitals and commissioners in the region.

Priority 3	2012/2013	Internal target for 2013/2014	2013/2014
To introduce an appointment based Patient Transport Service through 2013/14, across the entire NEAS area.	Does not apply	75% of ??	Update required

Our aims in this priority were to act on the feedback we had relating to transport times not being linked to appointment times.

In the Tees part of the region, the use appointment time service has been in place for some time and operating successfully. Across the rest of the region, PTS ambulances were commissioned and scheduled to deliver patients to hospitals twice in the morning and once in the afternoon, and collect patients from hospitals once in the morning and twice in the afternoon. This service model is at odds with hospital outpatient service models where patients have individual appointment times spread through the day. The banding time model of transport can lead to patients waiting unnecessary amounts of time in hospital.

It was agreed that the appointment based PTS model in the Tees area is more consistent with our vision and strategic intentions by having a patient centred service delivering patients to their destination at the 'right time'.

We began a phased rollout of an appointment based service on the 1st October in parts of our region. To date, there has been an increase in performance for those patients that arrive for their appointments within the allocated 1 hour window, which has improved the patient experience of PTS. The current phase of the rollout provides an appointment based service for patients living within a 20 mile radius of the hospital with the intention of a full roll out the service to all patients during 2014/15.

Patient safety			
Priority 4	**2012/2013**	**Internal target for 2013/2014**	**2013/2014**
Work with the acute trusts to reduce the impact of hospital turnaround delays in order to ensure a positive, safe patient experience.	Baselines as shown below: 6365 delays over 60 mins 465 delays over 120 mins	To reduce the numbers	Update required

Our aims in this priority were reduce the number of delays when handing over a patient at hospital.

Delays in transferring the care of a patient from an ambulance crew to hospital staff are unwelcome because there is the potential for harm to patients waiting for an ambulance response in the community and an impact on NHS resources. Historically delays were only experienced in times of pressure builds in acute settings from increased levels of activity, but they have been on the increase more generally.

We worked with other members of the health community to try to address the issue which is recognised as a North East whole system issue by all North East NHS organisations. There is a potential for this issue to also impact on achievement of the national target for ambulances to response to 75% of emergency incidents within 8 minutes.

We have developed reporting tools that measure the handover time based on staff utilising information technology in every Emergency Department across the North East.

During 2013/14 we have worked with all hospitals in the region to improve handover and turnaround times, looking at specific handover processes and improving our management of the post-handover period. We have introduced a message that is delivered to the crews handheld device 10 minutes after handover was recorded, this message informs crews of the time elapsed since handover and that should they continue to delay in clearing their vehicle they should contact control immediately.

There has been a substantial improvement in post-handover time in August. This is the result of a change in the ambulance turnaround process that has been introduced as a consequence of not having an accurate recorded patient hand-over time. The average handover time has reduced since April to 8.1 minutes in November. However, handover's over one and two hours have increased during the winter period and pressures increase at A&E departments. A majority of the delays

experienced are at University Hospital of North Durham A&E.

We expect improvements in patient flow from 2014/15, when new contractual penalties come into force and investment, through CQUIN, is used to make the necessary changes to minimise delays. We have recognised there is still more work to be done and have prioritised this activity again for 2014/15.

Priority 5	2012/2013	Internal target for 2013/2014	2013/2014
Lead the work with those with an interest in our services to deliver support, both medical and social, to high-intensity users to make sure that they get the most appropriate response in the most appropriate place to meet their needs.	Does not apply	To set a baseline for the number of patients flagged on the system as high intensity users	Update required

Our aims in this priority were to ensure that high intensity users are being managed appropriately.

We have on going work with high intensity users which are mainly managed by the Customer Care Department within NEAS. Although there Is currently no recognised definition of what is a frequent caller to 999, callers are identified on an individual basis by crews, call takers or from various multi-agency meetings that are held with a number of stakeholders including Social Services, GPs, Acute Trusts and the Police.

High Intensity users rely heavily on resources that could otherwise be delivering an emergency response to those in greater need but also they represent an ineffective use of health resources, particularly where ambulance attendance is linked to hospital attendance. Further, the high attendance may indicate a crucial unmet health need for the individual which needs addressing by the wider health and social care community.

Current cases are managed on an individual basis following on from an MDT meeting and a care pathway is developed depending on the circumstances of the individuals.

We have been working with Yorkshire Ambulance Service and the National Frequent Callers Network to establish national policy on frequent callers. Work is also taking place nationally to influence and agree common reporting of the Frequent Caller Ambulance Quality Indicator.

A definition for frequent calls was agreed at AACE, in Quarter 4 of 2013/14 and is looking to be rolled out across ambulance services as part of the change to the AQI definitions for 2014/15.

Clinical Effectiveness			
Priority 6	**2012/2013**	**Internal target for 2013/2014**	**2013/2014**
Explore with Commissioners a system and structure which supports implementation of individual treatment plans (ITPs) and new pathway developments.	Does not apply	to review 10 ITPs per month.	Update required

Our aims in this priority were to work with CCGs to plan and deliver better integration of local services to ensure that patients enjoy the highest quality, responsive, affordable and personalised services shaped directly by the patients as service users.

ITPs require an integrated system with robust governance arrangements in order to ensure quality and safety. We contribute to numerous clinical, operational, strategic and engagement meetings with various stakeholders across the region on an on-going basis as well as responding to invitation to ad hoc meetings/discussions/consultations about specific issues.

We have introduced a management system to supervise ITPs and work is on-going to prepare for the go live of an electronic system to manage ITPs during 2014/15.

Priority 7	2012/2013	Internal target for 2013/2014	2013/2014
More use of other options (other than going to an emergency department) during 2013/14 if other options are available	30.7% see and treat 4.0% hear and treat	To increase	Update required

Our aims in this priority were to respond to the demand for emergency care, but to provide clinical advice or treatment where possible to reduce conveyance.

A key issue facing the NHS is the increasing demand for emergency care. The rise in demand is unsustainable and the use of more appropriate alternative dispositions is critical at a time when costs and workforce pressures are rising.

We have a pivotal role to play in the entire urgent and emergency care system as an ambulance service. Traditionally, the ambulance service has been seen primarily as a call-handling and transportation service, encompassing some aspects of patient care. However increasingly, it is recognised as having a wider role, as a conduit to other NHS services and ensuring patients can access the right care, at the right place in the right time.

Providing clinical advice and signposting to callers - known as 'hear and treat'- treating patients at the scene -'see and treat'- and conveying patients to a wider range of appropriate care destinations other than Emergency Departments where alternative destinations are commissioned and are known to us can help ease emergency care pressures by reducing conveyance rates to Hospitals.

To increase the use of alternative dispositions other than A&E we have implemented a training programme to carry out Enhanced CARe training for a cohort of paramedics. To date, 45 paramedics have received training.

A clinical hub has been introduced in the Contact Centre and staff began work in December 2013. The clinical hub offers clinical support to the Contact Centre along with Patient Safety Support to patients. This is expected to produce an increase in the use of alternative dispositions.

We have recognised that this is a priority we want to continue to focus on in 2014/15. The role of the Enhanced CARe and Specialist Paramedic (primary care) will be considered as part of this work.

Differences in information since the 2012/2013 quality report

As far as we know, there are no differences in the information since the 2012/2013 quality report.

Complaints and compliments

We take any complaint, concern or comment we receive very seriously. We expect very high standards to be maintained in our trust, and if this is not the case we will deal with it appropriately. We do our best to fairly and thoroughly investigate every complaint we receive. We also take action to prevent the incident from happening again and improve our service where necessary.

We have a complaints policy and procedure which meets NHS complaints regulations. We work to the following principles which are set out in 'Principles For Remedy', a publication from the Parliamentary and Health Service Ombudsman, when handling complaints.

1. Getting it right
2. Being customer focused
3. Being open and accountable
4. Acting fairly and proportionately
5. Putting things right
6. Seeking continuous improvement

How we deal with complaints

When we receive a complaint, concern or comment we:

- acknowledge it within three working days, either by phone or in writing; and
- write to the person making the complaint within 25 working days (or longer if agreed), outlining the investigation we have carried out and giving our findings along with any action being taken.

What we do if we get it wrong

- We will offer an apology.
- We will review the care we provided or the way we managed the incident and reflect on what happened in a way that helps us to learn from the experience.
- We will use the experience we have gained from the incident to improve our policies and practice.
- Where appropriate, we will create a specific care plan, with the involvement and agreement of the patient involved.

Type of complaints

The most common type of complaint received is about the time taken for an ambulance to arrive after an emergency call or an 'urgent' transport booking by a healthcare professional. We have carried out a full A&E review and we will put this into practice in the coming financial year (2014/2015). The changes made are aimed at having a positive effect on the response times we achieve. Complaints about staff attitude continue to be a common theme and we have dealt with this issue in our training programme for 2013/2014.

Compliments

We receive compliments about both operational staff (for the care and treatment provided to patients) and call handlers in our Accident and Emergency Control and NHS 111 Urgent Care Service. We pass on all compliments to the staff concerned.

We need to take account of the number of calls we actually receive – **1,110,700** and incidents we respond to – **371,951**, for all services when assessing complaints and compliments received.

	2011/2012	2012/2013	2013/2014
Complaints received	289	410	tbc
Compliments received	271	337	tbc

Of the 410 complaints received, we did not take 18 any further as we did not receive the appropriate level of agreement from the relevant patients, and we closed eight complaints by discussing the problem with our investigating officer and giving feedback to the person who complained. Our complaints team investigated the following complaints and the outcomes were as follows.

- 183 (44.6%) complaints were upheld (the reason for the complaint was found to be valid, and we were at fault).
- 50 (12.2%) complaints were part upheld (an element of the complaint, but not all aspects of the complaint, were found to be valid and we were partially at fault).
- 89 (21.7%) complaints were not upheld (the reason for the complaint was found not to be our fault).
- 62 (15.1%) complaints are currently still under investigation at the time of writing this report. (This includes complaints that have been reopened due to further contact.)

Patient case studies – new ones please	
photo	**text**
photo	**text**

Feedback from our stakeholders
In line with the quality report guidance, we have asked for comments on the draft quality report from our lead commissioning primary care trusts, the Health and Wellbeing Boards and regional OSC. These comments are set out below and we have not edited them in any way.
Statement from our lead commissioner- xxx
Statement From xxx Overview and Scrutiny Committee
Statement from xxx Healthwatch
Statement from xxx Clinical Commissioning Group
Auditors limited assurance report

Statement of directors responsibilities

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

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

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

- the content of the quality report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2013/14*;
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2013 to June 2014
  - papers relating to Quality reported to the Board over the period April 2013 to June 2014
  - feedback from commissioners dated [*XX/XX/20XX*]
  - feedback from governors dated [*XX/XX/20XX*]
  - feedback from local Healthwatch organisations dated [*XX/XX/20XX*]
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated [*XX/XX/20XX*]
  - [*latest*] national patient survey [*XX/XX/20XX*]
  - [*latest*] national staff survey [*XX/XX/20XX*]
  - the head of internal audit's annual opinion over the trust's control environment dated [*XX/XX/20XX*]
  - CQC quality and risk profiles dated [*XX/XX/20XX*].

- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information in the quality report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts Regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the Board

NB: sign and date in any colour ink except black

…….Date……Chairman

…….Date……Chief Executive

Jargon buster - add any new ones and move to front of document if possible – check prescribed format

Term	Definition
AACE	The Association of Ambulance Chief Executives (AACE) provides ambulance services with a central organisation that supports, coordinates and implements nationally agreed policy. It also provides the general public and other stakeholders with a central resource of information about NHS ambulance services.
Care bundle	A care bundle is a group of between three and five specific procedures that staff must follow for every single patient. The procedures will have a better outcome for the patient if done together within a certain time limit, rather than separately.
Care Quality Commission	The independent regulator of all health and social-care services in England. The commission makes sure that the care provided by hospitals, dentists, ambulances, care homes and services in people's own homes and elsewhere meets government standards of quality and safety.
Category A8	A life-threatening 999 call that must be responded to within eight minutes for 75% of these cases.
Category A19	If a category-A patient needs transport, this should arrive, 95% of the time, within 19 minutes of the request for transport being made.
Clinical audit	A clinical audit mainly involves checking whether best practice is being followed and making improvements if there are problems with the way care is being provided. A good clinical audit will find (or confirm) problems and lead to changes that improve patient care.
Clinical effectiveness	Clinical effectiveness means understanding success rates from different treatments for different conditions. Methods of assessing this will include death or survival rates, complication rates and measures of clinical improvement. This will be supported by giving staff the opportunity to put forward ways of providing better and safer services for patients and their families as well as identifying best practice that can be shared and spread across the organisation. Just as important is the patient's view of how effective their care has been and we will measure this through patient reported outcomes measures (PROMs).
Clinical governance, quality and patient safety strategy	A strategy that defines how we will demonstrate quality in patient safety, patient experience and clinical effectiveness.
Commissioning for Quality and Innovation (CQUIN) payment framework	The Commissioning for Quality and Innovation (CQUIN) payment framework means that a part of our income depends on us meeting goals for improving quality.
Contact centre	The first point of contact for 999, 111 and patient transport services patients who need frontline

	medical care or transport.
Control environment	This relates to the system of controls we have in the trust.
Core services	Our core services are accident and emergency, NHS 111, community first responders, the patient transport service and emergency planning.
Directory of services	Once we have decided on the appropriate type of service for the patient – so that we can direct them to a service which is available to treat them – we use a system linked to a directory of services. This directory contains details of the services available, their opening times and what conditions and symptoms they can manage, within an area local to the patient.
End-of-life patients	Patients approaching the end of their life.
Enforcement action	Action taken against us by the Care Quality Commission if we do not follow regulations or meet defined standards.
e-PRF	e-PRF uses laptops to replace paper patient report forms. Ambulance staff attending calls can now download information on the way, access patients' medical histories, enter information in 'real time' and send information electronically to the accident and emergency department they are taking the patient to and to the patient's GP practice.
First responder	A first responder is a volunteer who has had training to act on behalf of the ambulance service and can respond to emergency calls when sent by the contact centre. They deal with a specific list of emergencies and give the patient support and appropriate treatment until the ambulance arrives.
Foundation trust boards	These make sure that trusts are effective, run efficiently and manage resources well and answer to the public.
Governors	Foundation trust members have elected a council of governors. The council is made up of 21 public governors and four staff governors, plus nine appointed governors.
Governance and Risk Committee	This committee gives the Board an independent review of, and assurances about: • all aspects of governing and managing risk; • our own systems for control and managing risk, to make sure they are fit for purpose, have enough resources and support our performance and reputation; • the process of governing risk, to make sure it is clear about current and future aspects of exposure to risk; • the evidence to support our reports to Monitor; and • keeping to legislation, best practice and regulations.
Governor Task and Finish Group	A group set up to identify which priority areas and risks should be included in a specific document, such as the annual plan or quality account.
Handover and	The point when all the patient's details have been passed, face-to-face, from the ambulance staff to

turnaround process	staff at the hospital, the patient is moved from the ambulance trolley or chair into the treatment centre trolley or waiting area and responsibility for the patient has transferred from the ambulance service to the hospital. Turnaround is the period of time from an ambulance arriving at hospital to an ambulance leaving hospital.
Health Act 2009	An act relating to the NHS Constitution, healthcare, controlling the promotion and sale of tobacco products, and the investigation of complaints about privately arranged or funded adult social care.
Hear and treat	A triage system designed to assess patients over the phone and to provide other options in terms of care, where appropriate, for members of the public who call 999.
Logistics desk	A logistics desk in our contact centre, which will be a point of contact for A&E crews who need guidance and advice on where to take or send non-emergency patients when the nearest A&E department is not appropriate.
Major trauma	Major trauma means multiple, serious injuries that could result in death or serious disability. These might include serious head injuries, severe gunshot wounds or road-traffic accidents.
Monitor	The independent regulator of NHS foundation trusts
National ambulance quality indicators	Measures of the quality of ambulance services in England, including targets for response times, rates when calls are abandoned, rates for patients contacting us again after initial care, time taken to answer calls, time to patients being treated, calls for ambulances dealt with by advice over the phone or managed without transport to A&E, and ambulance emergency journeys.
National clinical audit	National clinical audit is designed to improve the outcome for patients across a wide range of medical, surgical and mental-health conditions. It involves all healthcare professionals across England and Wales in assessing their clinical practice against standards and supporting and encouraging improvement in the quality of treatment and care.
National confidential enquiries	Investigations into the quality of care received by patients to assist in maintaining and improving standards.
NHS Operating Framework	Sets out the planning, performance and financial requirements for NHS organisations and the basis on which they will be held to account up to and including 2012/2013.
NHS Planning Guidance – 'Everyone Counts'	Sets out the planning, performance and financial requirements for NHS organisations and the basis on which they will be held to account from 1 April 2013.
NHS (Quality Accounts) Regulations 2010	Set out the detail of how providers of NHS services should publish annual reports – quality accounts – on the quality of their services. In particular, they set out the information that must be included in the accounts, as well as general content, the form the account should take and when the accounts should be published, and arrangements for review and assurance. The regulations also set out exemptions for small providers and primary care and community services.
NHS Foundation	Sets out the guidance on the legal requirements for NHS foundation trusts' annual report and accounts.

Trust Annual Reporting Manual 2011-12	
Pathways	A system developed by the NHS which is used to identify the best service for a patient and how quickly the patient needs to be treated, based on their symptoms. This may mean the patient answering a few more questions than previously. All questions need to be answered as we use them to make sure patients are directed to the right service for their needs. Types of service may include an ambulance response, advice to contact the patient's own GP or the out-of-hours service, visit the local minor injury unit or walk-in centre or self-care at home.
Patient experience	This includes the quality of caring. A patient's experience includes how personal care feels, and the compassion, dignity and respect with which they are treated. It can only be improved by analysing and understanding how satisfied patients are, which is measured by patient experience measures (PREMS).
Patient report forms	An up-to-the-minute record of a patient's history, assessment and treatment provided by our staff.
Patient safety	Makes sure the environment the patient is being treated in is safe and clean. This then reduces harm from things that could have been avoided, such as mistakes in giving drugs or rates of infections. Patient safety is supported by the National Patient Safety Agency 'seven steps to patient safety'.
The Pulse	The Pulse is our in-house magazine published once every two months that gives our staff information on a range of topics such as clinical issues, good-news stories, project information and sporting events. It also includes a letters page so that staff can see letters written by members of the public.
Payment by Results	The aim of Payment by Results is to provide an open, rules-based system for paying trusts. It will reward efficiency, support patient choice and diversity and encourage shorter waiting times. The Payment by Result tariffs system means funding is fair and consistent rather than relying on past budgets and the negotiating skills of individual managers.
Quality Committee	This committee gives the Board an independent review of, and assurances about, all aspects of quality, specifically clinical effectiveness, patient experience and patient safety, and monitors whether the Board keep to the standards of quality and safety set out in the registration requirements of the Care Quality Commission.
Quality dashboard	An easy-to-read, often single-page report showing the current status and historical trends of our quality measures of performance.
Research Ethics Committee	This committee helps to make sure that any risks of taking part in a research project are kept to a minimum and explained in full. Their approval is a major form of reassurance for people who are considering taking part. All research involving NHS patients has to have this approval before it can start.
Rural performance	Measuring the category-A8 response performance in all rural areas, as agreed at a local level.
Safeguarding referral	The process crews follow if they suspect a patient (whether a child or an adult) is vulnerable or at risk of harm.
See and treat	A face-to-face assessment by a paramedic that results in a patient being given care somewhere other

	than an A&E department.
Special reviews or investigations	Special reports on how particular areas of health and social care are regulated.
Urgent-care centre	Urgent-care centres help to prevent people going to hospital unnecessarily. For instance, at walk-in centres, patients can be treated for minor injuries and conditions instead of going to hospital.

Contact Details

If you would like a copy of this report in another format such as in Braille, on audio tape, in large print, in another language or any other format, please contact the following.
Email:
xxx@neas.nhs.uk
Address:
North East Ambulance Service NHS Foundation Trust
Ambulance Headquarters
Bernicia House
Goldcrest Way
Newburn Riverside
Newcastle Upon Tyne
NE15 8NY

We welcome feedback on this report. You can provide your comments and suggestions in writing.
Email:
nicola.thackray@neas.nhs.uk
Address:
Nicola Thackray
North East Ambulance Service NHS Foundation Trust
Ambulance Headquarters
Bernicia House
Goldcrest Way
Newburn Riverside
Newcastle upon Tyne
NE15 8NY

Or, visit the NHS Choices website to leave feedback at:
http://www.nhs.uk/Services/Trusts/Overview/DefaultView.aspx?id=29237

AUDIT AND GOVERNANCE COMMITTEE

15 May 2014

HARTLEPOOL BOROUGH COUNCIL

Report of: Scrutiny Manager

Subject: TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST – QUALITY ACCOUNT 2013/14 – COVERING REPORT

1. PURPOSE OF REPORT

1.1 To introduce representatives from Tees, Esk and Wear Valleys NHS Foundation (TEWV) Trust who will be in attendance at today's meeting to engage with Members in respect of their 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. Quality Accounts inform stakeholders and the public about the quality of services provided by NHS Trusts. They set out:-

- what an organisation is doing well;
- where improvements in service quality are required;
- what the priorities for improvement are for the coming year;
- how the organisation has involved service users, staff and others with an interest in their organisation in determining those priorities for improvement.

2.2 The Quality Accounts are circulated to key organisations including commissioners, patient groups and relevant overview and scrutiny committees. These groups have the opportunity to submit a statement for inclusion in the published version setting out their views on a Trust's performance and priorities.

2.3 A presentation (attached as **Appendix 1**) will be provided at the meeting on the Quality Priorities and performance against Quality Metrics.

2.4 A copy of the Quality Account is attached as **Appendix 2.** Members should consider:-

(a) The 2013/14 Priorities for Improvement and how the Trust performed against those priorities;

(b) Performance against the quality metrics; and

(c) The Quality Priorities for 2014/15.

2.5 On 3 March 2014 TEWV's Quality Account process and related information was considered by the Tees Valley Joint Health Scrutiny Committee, as the Joint Committee covers a large proportion of the population served by the Trust. It was agreed by the Committee to submit a statement of assurance in the final published version.

3. RECOMMENDATIONS

3.1 That the Audit and Governance Committee consider and comment on the TEWV's 2013/14 performance and the priorities for quality improvement in 2014/15 and that these comments are included within the statement of assurance being prepared by the Tees Valley Joint Committee

Contact Officer:- Joan Stevens – Scrutiny Manager
Chief Executive's Department – Legal Services
Hartlepool Borough Council
Tel: 01429 284142
Email: joan.stevens@hartlepool.gov.uk

BACKGROUND PAPERS

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

(a) Report and presentation delivered to the Tees Valley Joint Health Scrutiny Committee entitled 'Tees, Esk and Wear Valleys NHS Foundation Trust – Quality Account 2013-14' at the meeting of 3 March 2014

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Quality Account 2013/14

Hartlepool OSC

15th May 2014

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NHS Foundation Trust

Introduction

- The Quality Account '13/14:
  - A way of making information on quality available to the public and improving public accountability – DoH/Monitor derived format.
  - Addresses quality as a whole – safety, effectiveness and experience.
  - Looks backwards over '13/14 and forward to '14/15.
- Involving our Stakeholders:
  - In July '13, we worked with you to identify our priorities for '14/15 – the 'WHAT'
  - In Feb '14 we presented to you our agreed quality priorities for '14/15 and our draft delivery plans – the 'HOW'.

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Performance Against Quality Priorities 2013/14

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Quality Priorities 2013/14 – looking back

- **Priority 1:** Implement recommendations of **CPA** review, including improving care planning.
- **Priority 2:** Implement recommendations of **CPA** review, including improving communications between patients and staff.
- **Priority 3:** To improve the delivery of **crisis services** through implementation of the crisis review's recommendations.
- **Priority 4:** To improve clinical **communication** with GPs.

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Priorities 1 & 2: CPA

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

- Aim:
  - A standard of high quality care planning across the Trust.
  - Service users and carers reporting that they feel listened to and understood, involved in the development of their care plan and subsequent care reviews, and agree that their care plan will help them achieve their goals.
  - To reduce staff time spent on administrative tasks and increase face to face treatment time with service users.
- What we have achieved in '13/14:
  - We are 2 years into a complex and significant 3/4 year programme of change.
  - The first 2 years has focussed on the review, the identification of recommendations, the development of an implementation plan and the commencement of the CPA project to implement the plan.

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Priorities 1 & 2: CPA

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NHS Foundation Trust

- What we have achieved in '13/14:
  - The next year of the 3/4 year programme will focus on further implementing the recommendations via the CPA project.
  - The CPA project commenced with appointment of a project manager and team – in post 1st Oct '13.
  - The CPA project implementation plan was agreed in Nov '13.
  - We have established the project governance arrangements with representation from each locality / speciality and two service users.
  - We have established links with other co-dependent Trust projects e.g. recovery, model lines, GP communication, PbR, PARIS. A significant part of the CPA project will be delivered through these projects.
  - We are establishing communication links with each Local Authority via existing joint meetings & Partnership Boards.
  - We have reviewed the current CPA policy to ensure it is consistent with our plans.

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Priorities 1 & 2: CPA

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NHS Foundation Trust

- What we have achieved in '13/14 (cont.):
  - We are in the process of re-issuing to every service user on CPA a copy of their care plan on yellow paper with clear instructions on how to raise concerns, a briefing note on the CPA project and an invitation to be involved in the project. So far 2,000 of 3,000 adults on CPA received re-issue.
  - We have further developed our service user information folder which includes: a new CPA information leaflet; appointment information; community team and contact information; mental health / service fact sheet; recovery diary. It is proposed that this will be sent to all service users on CPA in 2014/15.
  - What we have to do in '14/15:
  - The next steps are reflected in quality priorities 2 & 3 for '14/15.

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Priority 3: Crisis

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NHS Foundation Trust

- Aim:
- To have a standard of high quality crisis and home treatment services across the Trust.
- To avoid unnecessary admissions to inpatient care and provide more care closer to home.
- To improve service user's experience of crisis services.
- What we have achieved in general:
- We have implemented a consistent operational policy.
- We have new shift patterns to match staff numbers to peaks and troughs in demand.
- We have introduced a new role of shift coordinator to ensure a quick response to crisis intervention and staff time is protected for intensive home treatment. During the day this is one coordinator per team, but out of hours this is one coordinator per locality covering all teams.

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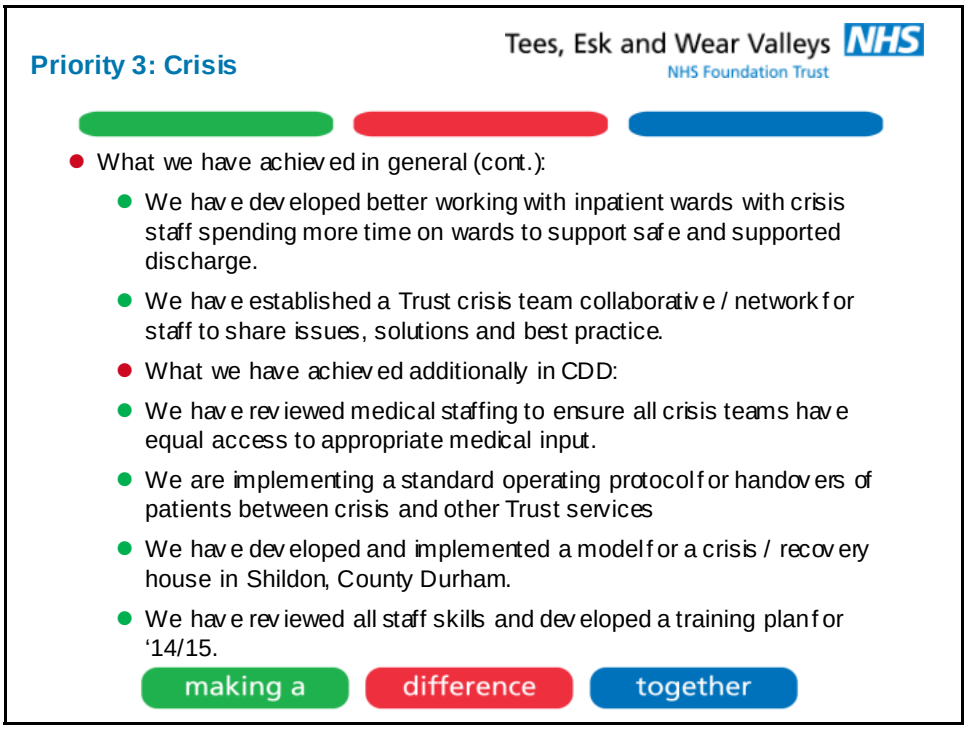
Priority 3: Crisis
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust
What we have achieved in general (cont.):
We have developed better working with inpatient wards with crisis staff spending more time on wards to support safe and supported discharge.
We have established a Trust crisis team collaborative / network for staff to share issues, solutions and best practice.
What we have achieved additionally in CDD:
We have reviewed medical staffing to ensure all crisis teams have equal access to appropriate medical input.
We are implementing a standard operating protocol for handovers of patients between crisis and other Trust services
We have developed and implemented a model for a crisis / recovery house in Shildon, County Durham.
We have reviewed all staff skills and developed a training plan for '14/15.
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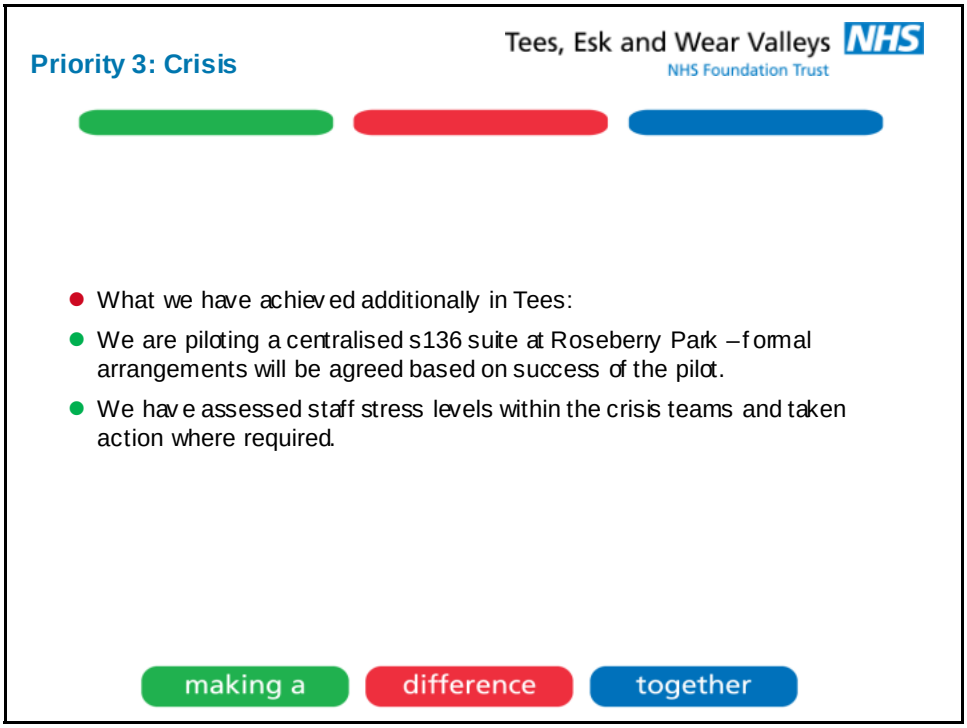
Priority 3: Crisis
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust
What we have achieved additionally in Tees:
We are piloting a centralised s136 suite at Roseberry Park – formal arrangements will be agreed based on success of the pilot.
We have assessed staff stress levels within the crisis teams and taken action where required.
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Priority 4: Communications

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

- Aim:
- To ensure a standard of high quality communication with GPs across the Trust.
- To ensure communication with GPs that is timely, focussed and highlights what they need to know.
- To ensure service users are offered copies of these communications.
- What we have achieved in '13/14 :
- The project plan was agreed in June '13 and revised in Dec '13.
- The key challenge was to develop a standard template which was compatible with historical and new versions of the CPA documentation and could be generated electronically on PARIS – this process did cause a delay but was agreed by the Trust in February '14.
- This will be tested on PARIS and implemented by Q2 '14/15 – but outside original timescales of Q4 '13/14

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Priority 4: Communications

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

- What we have achieved in '13/14 (cont.):
- We have developed a standard process for giving GPs access to quick clinical advice. This is being piloted and will be rolled-out Trust-wide in '14/15.
- In County Durham, Darlington and Tees we have developed and distributed to all GPs a service directory outlining what GPs should expect from each of our services.
- We have developed and discussed with CCGs options for effective communication with GPs e.g. emailing letters. Preferred options different for different CCGs / GP practices. This is being piloted with some GP practices in Q1 '14/15 with roll-out in '14/15.

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Performance Against Quality Metrics 2013/14

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Quality Metrics '13/14

Quality Metrics		2013/14		2012/13	2011/12	2010/11	2009/10
		Target	Actual	Actual	Actual	Actual	Actual
Patient Safety Measures							
1	Number of unexpected deaths classed as a serious incident per 10,000 open cases	< 12.00	**11.88**	15.91	12.00		
2	Number of outbreaks of Healthcare Associated Infections	0	**0**	0	0	0	0
3	Patient Falls per 1,000 admissions	< 31.04	**35.99**	34.09	37.44		

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Quality Metrics '13/14

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

	Quality Metrics	2013/14 Target	2013/14 Actual (at Feb '13)	2012/13 Actual	2011/12 Actual	2010/11 Actual	2009/10 Actual
Clinical Effectiveness Measures							
4	Percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care (validated)	> 95.00%	**97.86%**	97.14%	98.08%	98.50%	97.50%
5	Percentage of clinical audits of NICE Guidance completed	100%	**97%**	89.47%	95.20%	66.70%	75.00%
6	Average length of stay for patients in Adult Mental Health and Mental Health Services for Older People Assessment & Treatment Wards	AMH <33 MHSOP <52	**AMH: 31.72** **MHSOP: 54.08**	35	37	39	47

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Quality Metrics '13/14

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

	Quality Metrics	2013/14 Target	2013/14 Actual (at Feb '13)	2012/13 Actual	2011/12 Actual	2010/11 Actual	2009/10 Actual
8	Percentage of complaints satisfactorily resolved	> 90.00%	**79.58%**	76.36%			
National Patient Survey ctual							
9	Number of questions where our score was within 5% of the highest scored Mental Health Trusts	Improvement on 2012/3 survey	**12 (32%)**	11 (29%)	12 (32%)	18 (47%)	16 (42%)
	Number of questions where our score was within the middle 90% of scored Mental Health Trusts		**26 (68%)**	27 (71%)	23 (61%)	14 (37%)	22 (58%)
	Number of questions where our score was within 5% of the lowest scored Mental Health Trusts		**0 (0%)**	0 (0%)	3 (8%)	6 (16%)	0 (0%)

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National Targets & Regulatory Requirements '13/14

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Quality Metrics		2013/14 Target	2013/14 Actual (at Feb '13)	2012/13 Actual	2011/12 Actual	2010/11 Actual	2009/10 Actual
a	The Trust has registered with CQC with no conditions	Fully met	**Fully met**	Fully met	Fully met	Fully met	Fully met
b	Number of occupied bed days of under 18s admitted to adult wards	0	**48**	64	83	70	173
c	Retention rate substance misuse (rolling 12 months and reported 3 months behind)	=/> 92.90%	**92.45% (at Oct '13)**	89.91%	89.90%	84.40%	89.70%
d	Number of early intervention in psychosis new cases (cumulative position)	> 259	**619**	599	479	455	407
e	Number of crisis resolution home treatment episodes (cumulative position)	> 3,338	**3,725**	6,152	5,965	5,751	5,191

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National Targets & Regulatory Requirements '13/14

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Quality Metrics		2013/14 Target	2013/14 Actual (at Feb '13)	2012/13 Actual	2011/12 Actual	2010/11 Actual	2009/10 Actual
f	Percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper (validated)	> 95.00%	**97.58%**	97.35%	96.00%	97.00%	97.20%
g	Percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care (validated)	> 95.00%	**97.86%**	97.14%	98.08%	98.50%	97.50%
h	Maintain level of crisis resolution teams set out in 2003/06 planning round	Maintain	**Maintained**	Maintained	Maintained	Maintained	Maintained

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Mandatory Indicators '13/14

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Mandatory Indicators '13/14		'13/14		'12/13	'11/12	'10/11
		Target	Actual (at Feb '13)	Actual	Actual	Actual
i	Percentage of staff employed by, or under contract to, the Trust who would recommend the Trust as a provider of care to their family or friends	> 3.99 out of 5.00	3.89	3.83	3.73	
ii	Indicator score with regard to a patient's experience of contact with a health or social care worker	> 91.77	89.4	88.42	87.35	89.90
iii	Number of patient safety incidents reported within the Trust	> 7,241	6,428	5,946		
iv	Percentage of patient safety incidents resulting in severe harm or death reported within the Trust	< 1.4%	0.95%	1.4%		

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Quality Priorities 2014/15

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Quality Priorities 2014/15 – looking forward

- **Priority 1:** To have more staff trained in specialist **suicide prevention** and intervention.
- **Priority 2:** Implement recommendations of **CPA** review, including,
  - Improving communication between staff, patients and other professionals.
  - Treating people as individuals.
- **Priority 3:** Embed the **recovery** approach (in conjunction with CPA).
- **Priority 4:** Managing pressure on **acute inpatient** beds.

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Priority 1: Suicide Prevention

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

- Aim:
  - Number of staff trained and confident in specialist suicide prevention and intervention increased.
  - Care that manages risk in a way that promotes recovery and keeps our service users safe.
- The actions for '14/15 are:
  - To approve the project scope.
  - To recruit the project team and establish the project group.
  - To complete a review current practice.
  - To develop a suicide prevention framework and training / implementation plan.
  - To develop a training needs assessment and training plan.
  - To complete priority training (e.g. Crisis teams) by quarter 1 '15/16 and thereafter ongoing.

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Priority 2: CPA

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NHS Foundation Trust

- Following on from priorities 1 & 2 for '13/14.
- Aim:
  - To improve service user experience, choice and involvement in their personal recovery.
  - To ensure services are personal and meaningful to service users
  - To ensure carers feel recognised, valued and supported
  - The actions for '14/15 are:
  - To redesign CPA processes and documentation to ensure they fulfil the following:
    - Meeting mandatory requirements whilst reducing unnecessary burden on staff.
    - Ensuring the requirements of the Mental Health Act are met whilst reducing unnecessary burden on staff.

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Priority 2: CPA

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

- The actions for '14/15 are (cont.):
- To redesign CPA processes and documentation to ensure they fulfil the following (cont.):
  - Development of standard work regarding s117 after care
- Implement actions relating to CPA from Model Lines Pilot Team
- Implement regular audit and case management/ supervision systems to include monitoring of transfer processes within PARIS (electronic patient record)

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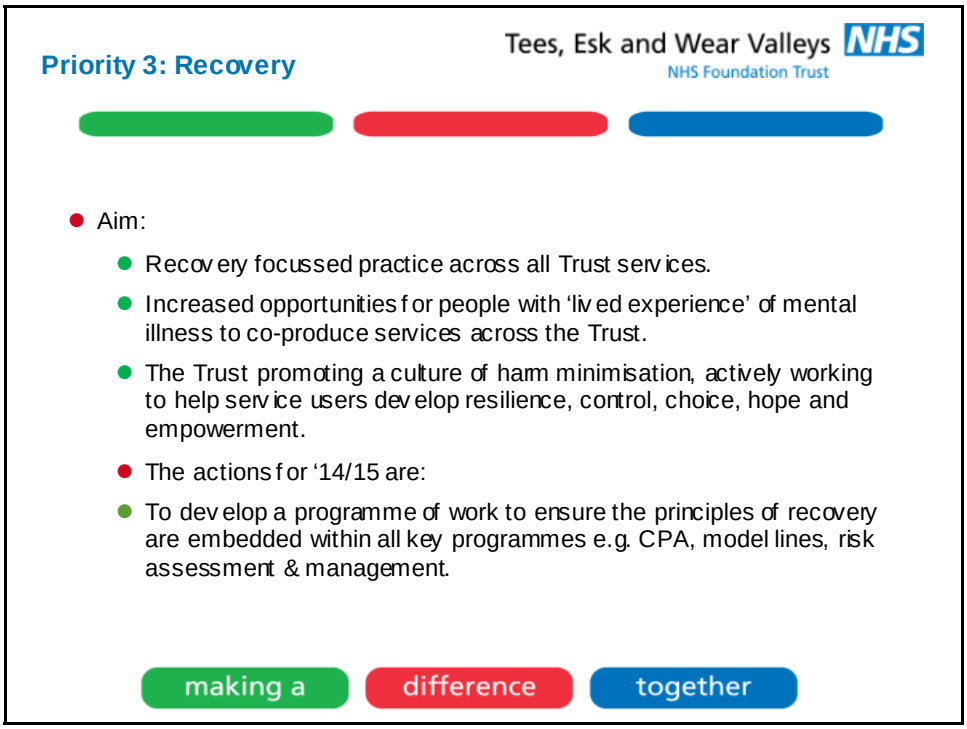
Priority 3: Recovery
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust
Aim:
Recovery focussed practice across all Trust services.
Increased opportunities for people with 'lived experience' of mental illness to co-produce services across the Trust.
The Trust promoting a culture of harm minimisation, actively working to help service users develop resilience, control, choice, hope and empowerment.
The actions for '14/15 are:
To develop a programme of work to ensure the principles of recovery are embedded within all key programmes e.g. CPA, model lines, risk assessment & management.
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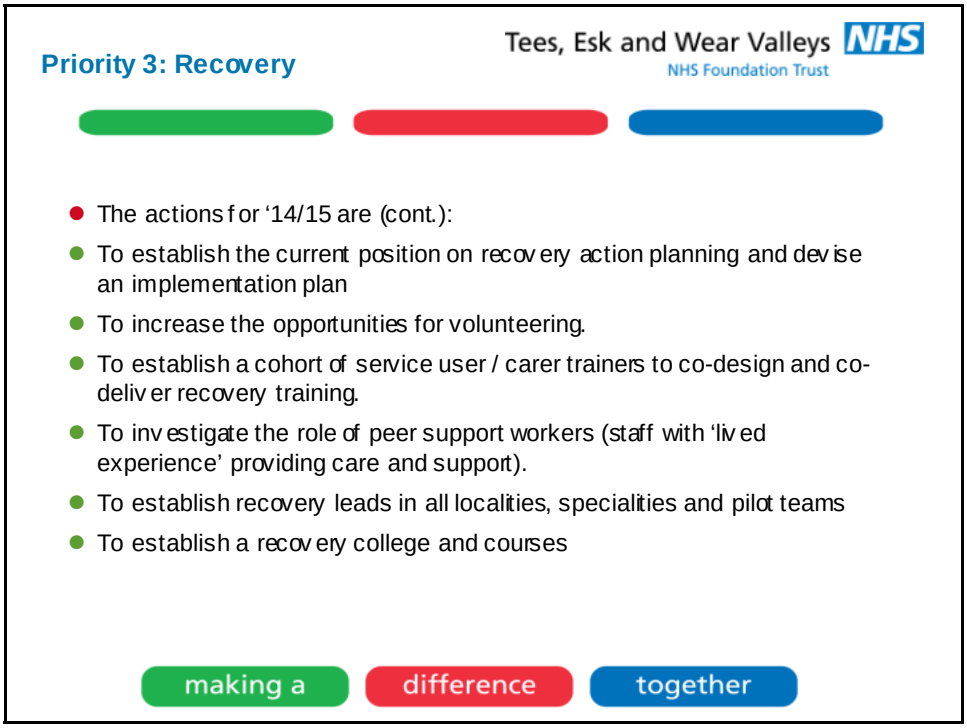
Priority 3: Recovery
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust
The actions for '14/15 are (cont.):
To establish the current position on recovery action planning and devise an implementation plan
To increase the opportunities for volunteering.
To establish a cohort of service user / carer trainers to co-design and co-deliver recovery training.
To investigate the role of peer support workers (staff with 'lived experience' providing care and support).
To establish recovery leads in all localities, specialities and pilot teams
To establish a recovery college and courses
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Priority 4: Acute beds

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

- Aim:
  - In 2014/15 we are aiming for 85% of patients being treated close to home increasing to 90% in 2015/16 and beyond
  - The actions for '14/15 are:
  - To reduce the percentage of people on community team caseloads that are admitted to inpatient care.
  - To reduce the readmission rates to inpatient care following discharge.
  - To continue to improve the skills and effectiveness of the crisis teams as gatekeepers to inpatient care.

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Content of Quality Account 2013/14

- Chief Executives Statement
- Review of Performance in '13/14
  - Quality Priorities
  - Quality Metrics
- Mandated Statements
- Priorities of '14/15
- Stakeholder Comments (included verbatim)
- Statements of Assurance

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NHS Foundation Trust

Next Steps in Quality Account 2013/14

QA '13/14 to Stakeholders	18th April '14
Stakeholder Comments Due (30 c.d.)	19th May '14
Publish	31st May '14

Question: what more could we do to support y our participation in the Quality Account process?

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Our Draft Quality Account / Report 2013/14

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PART 1: STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE OF THE TRUST

I am pleased to be able to present Tees, Esk and Wear Valley NHS Foundation Trust's (TEWV) Quality Account / Report for 2013/14. This is the sixth Quality Account / Report we have produced and it tells you a lot of what we have done to improve the quality of our services in 2013/14 and how we intend to make further improvements in 2014/15.

Please note: for the purposes of publication in the Trust's Annual Report, the Quality Account is termed the Quality Report, and therefore, is termed as both of these throughout this document.

Our Mission, Vision & Strategy

The purpose of the Trust is:

'To minimise the impact that mental illness or a learning disability has on peoples' lives'

Our vision is:

'To be a recognised centre of excellence with high quality staff providing high quality services that exceed people's expectations'

Our commitment to delivering high quality services is supported by our second strategic goal:

'To continuously improve the quality and value of our work'

This commitment is embedded within the TEWV approach *(see page 5).*

Our starting point in delivering this strategic goal was to understand what quality means to the Trust and all our stakeholders. In order to be able to demonstrate that we are delivering quality we believe our services must:

- **Provide the perfect experience** – this means that the people who use our services consider that the way we work with them ensures that they are listened to, engaged with and treated with compassion, respect and dignity.
- **Be appropriate** – this means that treatment and care should be safe, 'does no harm', be evidence-based and relevant to the needs of the individual.
- **Be effective** – this means that what we do, delivers the outcomes that we and our service users and carers expect, and makes a positive difference to people's lives.

In the 2013 NHS service user survey of community services, the Trust scored **7.5 out of 10** (sample size of 217) for 'overall care'. This was a similar score to other mental health Trusts in the survey.

In the Trust's own surveys in 2013/14, **91%** (sample size of 5,547) of service users reporting 'excellent' or 'good' to the question 'overall how would you rate the services you have received'

- **Reduce waste** – this means that we should remove or minimise any activity that does not add value to people who use our services, our staff and our other stakeholders.
- **Be built upon** the standards set by the Care Quality Commission and the other regulators we are accountable to.

To support the delivery of our vision, the Trust has developed a quality strategy which sets out our ambition for quality:

'To ensure safe, patient centred and effective high quality clinical care and treatment, delivered by valued individuals and teams'

In 2013/14, in the Family & Friends Test, the Trust scored **45** on a scale between -100 and +100 (sample size of 1,293).

This means that to the question 'would you recommend the Trust as a place to receive treatment', **87%** of patients reported 'extremely likely' or 'likely', and **5% (68 patients)** reported 'unlikely' or 'extremely unlikely'.

To deliver this we have identified a number of priorities to be addressed in 2014/15. Section two of the Quality Account / Report sets out four quality priorities for 2014/15 that were developed and agreed with our stakeholders. Within the Trust's business plan there are additional priorities for 2014/15 and beyond which also have a focus on improving quality.

What we have achieved in 2013/14

Section two of the Quality Account / Report also sets out our progress on our four quality priorities for 2013/14. However, these quality priorities are not the only ways we have improved the quality of our services in 2013/14. The following are other notable examples of quality improvements within our services / localities in 2013/14:

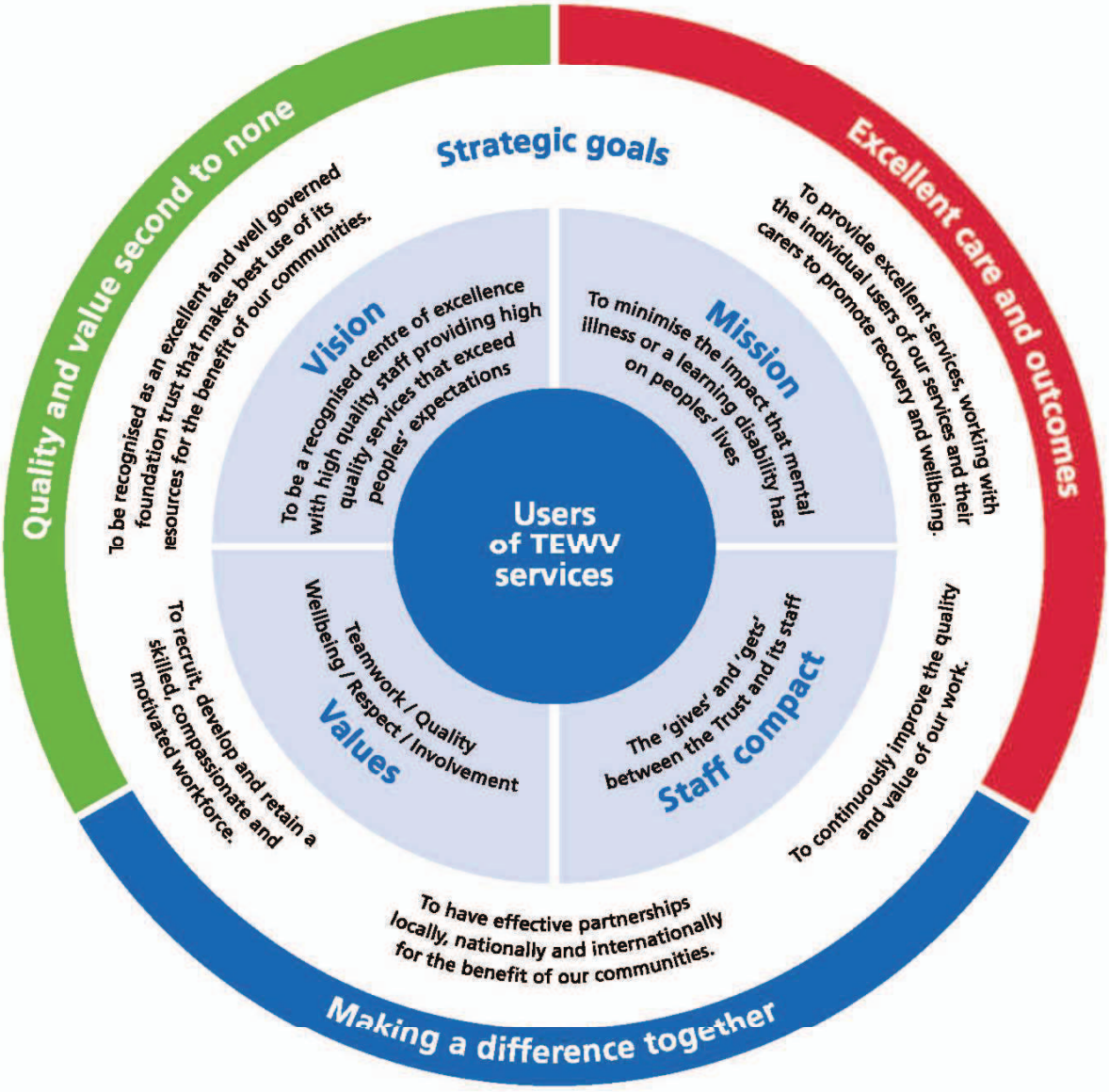
- We have continued to invest in ensuring our buildings provide appropriate and therapeutic environments. In 2013/14 we saw the completion of a brand new complex care ward at Springwood in Malton, the opening of a purpose built low secure ward for children and young people at the West Lane site in Middlesbrough, the upgrade of the lodge at Bankfields Court to support an individual package of care, and the development of a new community team base at Windsor House in Harrogate.
- We have continued to work with our commissioners to deliver new services to meet the needs of those who use our services. For example:
  - A new section 136 suite and a street triaige service in Scarborough
  - A crisis and recovery house in Shildon, County Durham.

In the 2013 NHS Staff Survey, the Trust scored **3.89 out of 5.00** (sample size of 492) for the question 'would recommend the Trust as a place to work and receive treatment'.

This was an **improvement on 2012** and within the **top 20%** of all mental health Trusts who participated in the survey.

Overall in 2013 TEWV was ranked **1st out of 57** mental health Trusts for the NHS Staff Survey

The TEWV approach



Note: The staff compact is a psychological or cultural relationship that exists between staff and the Trust. It sets out what staff should 'give' – to provide the best possible customer experience – and what staff should 'get' back from the Trust in return for this – the Trust will endeavour to be a great organisation to work for. It also describes what the Trust should 'give' and 'get' back in return.

- We have worked with our partners to improve services. For example:

  - We have worked with Dementia Forward and the Red Cross in Harrogate to develop additional activities for those with dementia outside hospital.
  - We have provided training to care home staff to promote the use of evidence-based practice.
  - We have continued to develop our liaison services to support the acute Trusts in our area to provide improved experiences for theit patients who also have mental health problems.

In the Trust's own surveys in 2013/14, **77%** (sample size of 1,109) of carers replied 'yes, always' to the question 'do you feel that you are actively involved in decisions about the person you care for'

In addition to these examples above, we have continued to drive improvements in the quality of our services through using the TEWV Quality Improvement System (QIS). This is the Trust's framework and approach to continuous quality improvement and uses tried and tested techniques to improve the way services are delivered. Some notable examples of what we achieved within our services in 2013/14 are:

- The time taken from referral to the specialist eating disorders team and acceptance for treatment by the specialist team has reduced from 43 days to **6** days.
- **100%** of service users who leave adult mental health inpatient wards in North Yorkshire now leave with a summary of their care and their discharge plan which includes their medications. This avoids the risk of duplication with multiple prescriptions.
- Harrogate dementia collaborative ran an improvement event to reduce attendance of people with dementia to the emergency department at Harrogate District Hospital. Outcomes included:

  - Creating a 'best practice' file for service users to support care homes manage their care including clear, visual representations of key support information.
  - Developing a system to support communication and action for care homes to address a deterioration of a service user's health.

- We have significantly reduced the time it takes for children to transfer to adult services when they are 18 years old.
- We have redesigned the care planning process on our low secure forensic learning disability wards which has resulted in patients experience ratings improving form 6 out of 10 to **8 out of 10**.

In the Trust's own surveys in 2013/14, **77%** (sample size of 3,000) of service users reporting 'yes always' to the question 'did you feel safe on the ward'.

The majority who felt they did not always feel safe were in wards where behaviours that challenge are more prevalent.

In 2013/14 the Trust was also recognised externally when we won or were shortlisted for a number of prestigious awards, in particular:

Eight Awards Won:	Six Awards Shortlisted:
Nursing Times Awards 2013: • Nursing in Mental Health • Nursing in Learning Disabilities National Dementia Care Awards: Best Inspiring Leader HSJ Awards 2013 Innovation in Mental Health: Learning Disability Inpatient Service in Durham NHS Leadership Awards 2013: NHS Leader of Patient Inclusivity of the Year National Service User Achievement: Service User Led Initiative for My Shared Pathway in Forensic Services Hospitality Assured Business Excellence Team of the Year Award 2013: Hotel Service Team HFMA: Finance Director of the Year	Royal College of Psychiatrists Psychiatric Team of the Year for Older Adults 2013 Nursing Times Awards 2013: • Nurse Leader • Nurse of the Year National Leadership Awards: • NHS Inspirational Leader of the Year • NHS Leadership Development Champion of the Year A carer who works with our Trust was shortlisted for the Royal College of Psychiatrists Carer Contributor of the Year Award 2013

What we have learnt in 2013/14

Of course we know we do not always get it right. The Trust is working hard to develop a culture of openness and honesty to help improve its quality. The systems of complaints, incident reporting, surveying and regulation are critical to this.

During the year we have listened to our service users and carers, staff, partner organisations and regulators. The following are some examples of the lessons we have learnt and improvements made in 2013/14:

- Improvement has been made to clinical risk assessment and management as a result of root cause analyses of serious untoward incidents.
- The Trust developed a workbook to help qualified nursing staff manage service user's physical care following concerns raised by clinical staff regarding their knowledge and skills.
- Greater effort is being made to explain the purpose of medication and assess side effects following feedback from patient surveys that this was not always done well.
- In response to feedback from carers that they were not always involved in decisions about treatment and care, in some of our services, we

In 2013/14 the Trust reported **83** serious untoward incidents. Of these **60** resulted in the death of a patient or alleged homicide.

As a result of the root cause analysis of these incidents in 2013/14, **269** action points were generated. At March 2014, **12** of these action points were outstanding beyond their originally agreed timescale.

have committed to contacting carers on a regular basis and providing drop-in sessions for carers.

- Feedback from patient surveys on an adult learning disabilities ward specifically requested a cinema room. A room was re-decorated, blinds and a projector installed and the room now operates as a cinema room.

The structure of this Quality Account / Report is in accordance with guidance that has been published by both the Department of Health and the Foundation Trust regulator, Monitor, and contains the following information:

- Section 2 – Information on how we have improved in the areas of quality we identified as important for 2013/14, the required statements of assurance from the Board and our priorities for improvement in 2013/14.
- Section 3 – Further information on how we have performed in 2013/14 against our key quality metrics and national targets.

In 2013/14 the Trust received **150** complaints. Of these **83%** were resolved satisfactorily with the complainant.

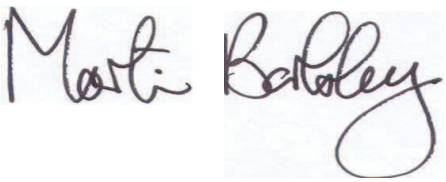
As a result of these complaints **78** action plans to learn the lessons were generated. At March 2014, **17** of these action plans were outstanding beyond the originally agreed timescale.

The information contained within this report is accurate, to the best of my knowledge.

A full statement of Directors' responsibilities in respect of the Quality Account / Report is included in **Appendix 1**. This is further supported by the signed limited assurance report provided by our external auditors on the content of the 2013/14 Quality Account / Report which is included in **Appendix 2**.

I hope you find this report interesting and informative.

If you would like to know more about any of the examples of quality improvement we have highlighted in this report, or have any feedback or suggestions on how we could improve our Quality Account / Report please do let us know by e-mailing either myself at martinbarkley@nhs.net, Chris Stanbury (Director of Nursing & Governance at chris.stanbury@nhs.net or Sharon Pickering (Director of Planning & Performance) at sharon.pickering1@nhs.net

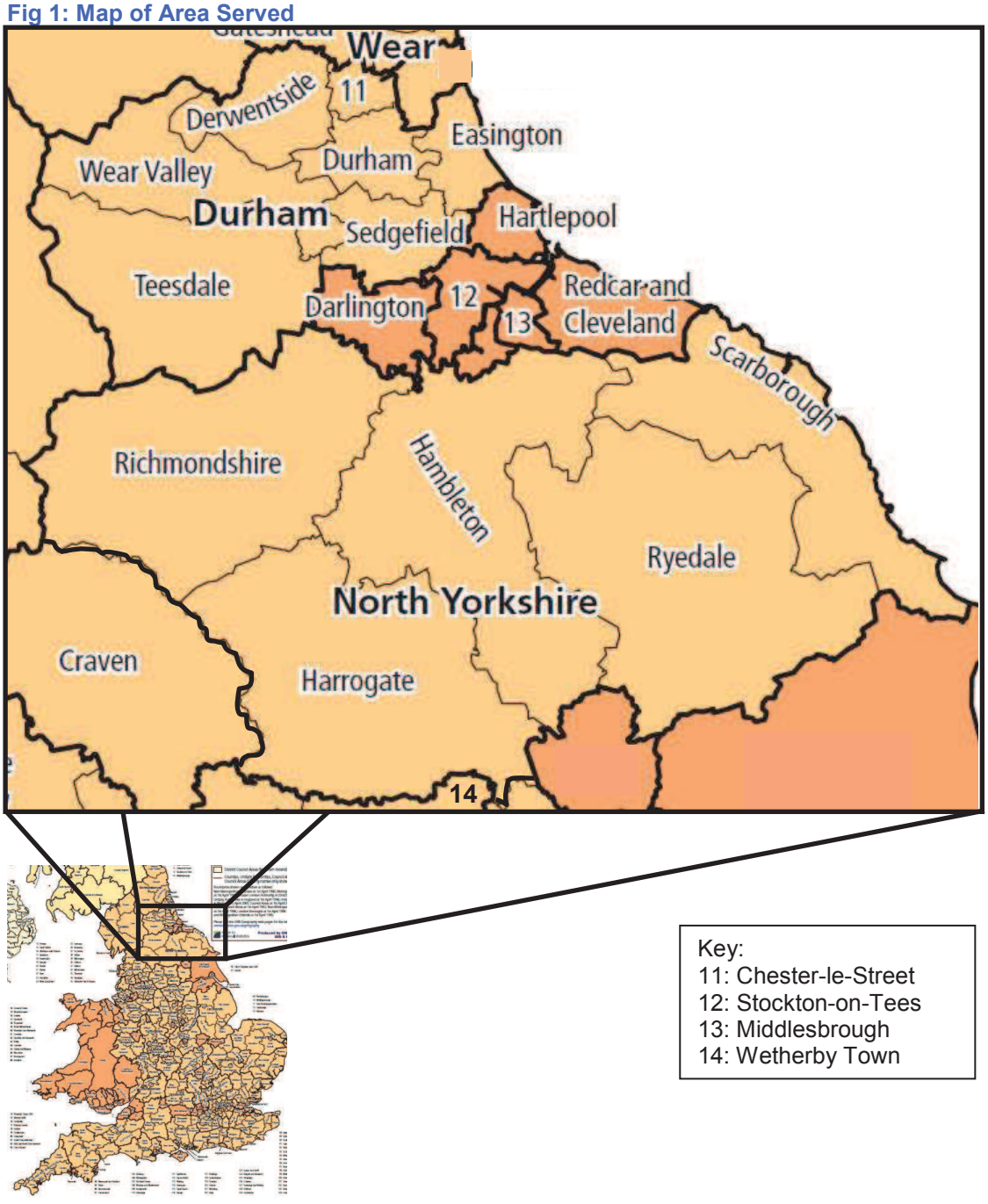


Martin Barkley
Chief Executive
Tees, Esk and Wear Valleys NHS Foundation Trust

A Profile of the Trust

The Trust provides a range of mental health, learning disability and substance misuse services for 1.6 million people across a wide geographical area of approximately 3,600 square miles. The areas covered by the Trust include County Durham and Darlington, the four Teesside boroughs of Hartlepool, Stockton, Middlesbrough and Redcar & Cleveland, the Scarborough & Whitby, Ryedale, Hambleton & Richmondshire and Harrogate districts of North Yorkshire, and Wetherby Town in West Yorkshire. The Trust also provides learning disability services to the population in Craven and some regional specialist services (e.g. specialist eating disorder services) to the North East and beyond.

Fig 1: Map of Area Served



Office of National Statistics (2011)

In 2013/14:

- Our annual income was **£286** million.
- The Trust employed **6,052** staff or **5,415** whole time equivalents (WTE), of which **4,518** staff or **4,127** WTE were clinical staff.
- These staff delivered treatment and care for **47,540** people over the year.
- **5,889** service users received inpatient care from **12** locations across the Trust.
- In the community our staff provided over **1.4** million face-to-face or telephone contacts with service users.

PART 2: PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

2013/14 Priorities for Improvement – how did we do

As part of our 2012/13 Quality Account / Report the Board of Directors agreed four quality priorities to be addressed in 2013/14.

Priority 1&2: Implement the recommendations of the Care Programme Approach review relating to:
- improving care planning.
- improving communications between patients and staff.

Priority 3: To improve the delivery of crisis services through implementation of the crisis review's recommendations

Priority 4: To further improve clinical communication with GPs

Progress has been made against these four priorities and the following section provides details.

It is important to note that the achievement of priorities should not be seen as the end point. These priorities are often a key milestone in a journey of quality improvement and further work will continue to embed good practice and deliver further improvements in experience and outcomes for our service users.

Priorities 1 & 2: Implement the recommendations of the Care Programme Approach review relating to:
- **improving care planning,**
- **improving communications between patients and staff.**

Why is this important:

We are two years into a complex and significant four year programme to improve the use of the Care Programme Approach (CPA) across the Trust. CPA is the approach we use to assess patients, plan and coordinate care, and review progress with patients who require secondary mental health services and have complex needs.

In 2012/13, the Trust performed a comprehensive review of its use the Care Programme Approach (CPA). Some key findings of this review relevant to care planning and communication were:

- The quality of assessment and care planning is variable across the Trust.
- Care coordinators spend a significant amount of time on the administration of CPA and other processes related to internal and external initiatives. This reduces the time available to spend with service users and carers to listen and discuss concerns and deliver recovery focused interventions.
- Some service users and carers believe they are removed from, and not fully involved in, the care planning process or their treatment.
- Some service users and carers report that the care documentation that is shared with them is not always clear and understandable.

- There is a lack of clarity and agreed processes regarding the management of section 117 of the Mental Health Act – the statutory duty to provide health and social care to some service users following discharge from in-patient care.

In 2013/14 the focus of this priority was to develop a plan to implement the recommendations of the review and commence the implementation of this plan via the CPA project.

The Care Programme Approach and care planning is critical to the quality of care our service users receive. The full involvement and participation of service users and carers within care planning is associated with improved outcomes and the experience of care. Addressing the issues above for service users, carers, staff and all agencies with whom we work with was a clear priority for improving the quality of the services the Trust delivers.

What benefits / outcomes our service users and carers should expect:

As the recommendations of the review are fully implemented in 2014/15 and 2015/16, our service users and carers, partners in care and staff should expect to see:

- A standard of high quality care planning across the Trust.
- Service users and carers reporting that they feel listened to and understood, that they understand and are involved in the development of their care plan and subsequent care reviews, and that their care plan will help them achieve their goals.
- A reduction in staff time spent on administrative tasks associated with care planning and more face to face treatment time with service users and carers.

What we did in 2013/14:

The following is a summary of the key things we have done in 2013/14:

Developed a detailed implementation plan.	• The development of the detailed implementation plan was deferred by the Board to quarter 3 2013/14 to allow time to recruit a project manager and agree a methodology for implementation. • The CPA project commenced with appointment of a project manager on the 1st October 2013. • The detailed implementation plan was agreed in November 2013.	Achieved

Commence the delivery of the detailed implementation plan.	• We have established the project governance arrangements with representation from each locality / speciality and two service users. • We have established links with other co-dependent Trust projects e.g. recovery, model lines (a project to develop model teams and a model way of working to provide best practice care), how we communicate with GPs, payment by results (the national project to link payment for service to outcomes delivered for patients), PARIS (the electronic patient record). A significant part of the CPA project will be delivered through these projects. • We are establishing communication links with each Local Authority via existing joint meetings & partnership Boards. • We have reviewed the current CPA policy to ensure it is consistent with our plans. • We are in the process of re-issuing to every service user on CPA a copy of their care plan on yellow paper with clear instructions on how to raise concerns, a briefing note on the CPA project and an invitation to be involved in the project. At March 2014, around **2,000** service users out of a total of **10,359** people on CPA have been re-issued with a copy of their care plan. In 2014/15 all service users on CPA within all services will be re-issued with a copy of their care plan • We have further developed our service user information folder which includes: a new information leaflet about CPA and care coordination; appointment information; community team and contact information; mental health / service fact sheet; recovery diary. The Trust is considering a proposal to send a folder to all service users on CPA in 2014/15.	Achieved

What we plan to do in 2014/15:

The next steps are reflected in quality priorities 2 & 3 for 2014/15 (*see pages 44 & 45).*

Priority 3: To improve the delivery of crisis services through implementation of the crisis review's recommendations

Why this is important:

Access to and the response from the crisis teams are central to the safety and effectiveness of the care received by service users when they are experiencing a crisis. The provision of this type of intervention at a time of great need can have a significant impact on service users' recovery as well as avoiding unnecessary admissions to inpatient care. Ensuring a consistent quality of crisis care across the Trust and at any time of day is, therefore, essential.

What benefits / outcomes our service users and carers should expect:

Through the delivery of this priority, our service users and carers, our partners in care and our staff should expect to see:

- A standard of high quality crisis and home treatment services across the Trust.
- Avoidance of unnecessary admissions to inpatient care and more care closer to home.
- Service users and carers reporting an improvement in their experience of crisis services.

What we did in 2013/14:

Two projects in County Durham & Darlington and Tees were used to implement the recommendations of the crisis review in 2013/14. This priority did not include North Yorkshire as the organisational review in 2012/13 was limited to County Durham & Darlington and Tees. There has been, however, a review of community mental health teams including crisis services in North Yorkshire during 2013/14.This work has taken the recommendations of the crisis review in County Durham & Darlington and Tees and developed a model of care suited to the North Yorkshire locality. It is expected that the revised model for crisis services in North Yorkshire will be implemented alongside the recommendations for the wider community mental health services in 2014/15.

The following is a summary of the key things we have done in County Durham & Darlington and Tees in 2013/14:

Implement recommendations from the crisis review – for both County Durham & Darlington and Tees	• We have implemented a consistent operational policy. • We have developed new shift patterns to match staff numbers with peaks and troughs in demand. • We have introduced a new role of shift coordinator to release front-line staff to focus on delivering care. This has ensured a quick response to crisis intervention whilst also protecting time for intensive home treatment. During the day each team has a shift coordinator. Out of hours the teams within each locality come together with one shift coordinator covering each locality. • We have developed better joint working with inpatient wards resulting in crisis staff spending more time on wards to facilitate safe, prompt and supported discharge. • We have established a Trust crisis team collaborative / network for staff to share issues, solutions and best practice. The first formal meeting of the group will be in April 2014.	Achieved

Implement recommendations from the crisis review – specifically in County Durham & Darlington	• We have reviewed medical staffing to ensure all crisis teams have equal access to appropriate medical input. • We are implementing a standard operating protocol for handovers of patients between crisis services and other Trust inpatient and community services. • We have developed and implemented a model for a crisis / recovery house in Shildon, County Durham. • We have reviewed all staff skills and developed a training plan for '14/15.	Achieved
Implement recommendations from the crisis review – specifically in Tees	• We are piloting a centralised s136 suite at Roseberry Park – formal arrangements will be agreed based on success of pilot. • We have assessed the levels of staff stress within the crisis teams and taken action where required.	Achieved

What we plan to do in 2014/15:

The crisis services have not been chosen specifically as a priority for 2014/15. However, the quality priority for 2014/15 on managing the pressure on inpatient beds *(see pages 46 & 47)* will involve crisis services.

Priority 4: To further improve clinical communication with GPs

Why this is important:

The needs of an individual with mental ill-health and/or a learning disability are always unique and often complex. As partners in care, the Trust and its local GPs must work together to maximise our combined efforts to meet these needs. How effectively we communicate our roles, our actions and what we expect of each other is critical to this partnership, and ultimately the outcome and experience of service users and carers.

Our view of our communication with GPs was that it was variable approach across the Trust and we did not always focus on providing what GPs and service users and carers needed to know. This conclusion was borne out by the feedback we received from GPs.

What benefits / outcomes our service users and carers should expect:

Through the delivery of this priority, our service users and carers, our partners in care and our staff should expect to see:

- A standard of high quality communication with GPs across the Trust.
- GPs reporting that the Trust's communication regarding the care of service users is timely, focussed and highlights what they need to know.
- Service users and carers reporting that they are offered copies of communications between the Trust and the GP

What we did in 2013/14:

The following is a summary of the key things we have done in 2013/14:

Agree a draft standard template for clinical communications with GPs (e.g. discharge plans).	• A draft standard template was approved by the Trust in June 2013.	Achieved
Agree a business case for the implementation of the standard template.	• A business case for the implementation of the standard template was approved by the Trust in September 2013.	Achieved
Create a standard patient information / front sheet and free text template for clinical communications with GPs on PARIS.	• A key challenge was to ensure that the standard electronic template was compatible with historical and new versions of the Care Programme Approach (CPA) documentation and could be generated electronically on PARIS (the electronic patient record). • This issue created a delay and a revised project plan was agreed by the Trust in December 2013 to defer this action from quarter 2 to quarter 4 2013/14. • A final standard electronic template for clinical communications with GPs was agreed by the Trust in February 2014.	Achieved
Ensure the electronic version of the standard template on PARIS functions effectively within clinical situations.	• Given the delay in agreeing the final standard template, testing the template on PARIS did not commence until quarter 4 2013/14. • The Trust agreed in the revised project plan to defer this action to be completed by quarter 2 2014/15. • Testing is now in progress and is on track for completion by quarter 2 2014/15, however, this is outside the originally reported timeframe of 2013/14.	Not Achieved in '13/14 but on track for revised deadline of Q2 '14/15
Establish Trust wide use of the standard template for clinical communications with GPs.	• Given completing the testing of the final standard electronic template on PARIS was deferred to quarter 2 2014/15, implementing the template Trust-wide will not happen until this time. • The Trust agreed in the revised project plan to defer implementation to quarter 2 2014/15, however, this is outside the originally reported timeframe of '13/14. • In the meantime each locality is on track to develop a training and roll out plan which will support the implementation of the standard template Trust-wide by quarter 2 2014/15.	Not Achieved in '13/14 but on track for revised deadline of Q2 '14/15

Develop a standard process for telephone and email access for clinical advice.	• We have developed a standard process for giving GPs access to quick clinical advice. GPs are given a single named contact for each service. When a GP calls for clinical advice, details are logged, the best person to provide advice is identified, advice is given within 48 hours of contact, the response given is logged. • We are piloting the standard process with GPs and will roll this out across the Trust in 2014/15. • In County Durham, Darlington and Tees we have developed and distributed to all GPs a service directory outlining what GPs should expect from each of our services. These include the names and contact details of all clinical and management leads in each of the services. A similar approach is being considered for GPs in North Yorkshire.	Achieved
Establish lines of communication most effective for GP practices - e.g. emailing 'letters'	• This action was superseded by the CQUIN target agreed with local Clinical Commissioning Groups (CCGs): to develop an improved method of delivering discharge information through electronic measures. • We scoped and identified potential options for the transfer of information based on GP requirements and respective system capabilities. • We have developed solutions for these options and discussed these with CCGs and GP practices. The outcome was that different CCGs and GP practices had different preferred options. • It is expected that a pilot with GP practices will commence in quarter 1 2014/15 with full roll out in 2014/15.	Achieved

Update on 2012/13 quality priorities

In last year's Quality Account / Report we reported on our progress with our quality priorities for 2012/13. Within this we also noted some further actions for 2013/14. In some cases, these actions were to be embodied within the quality priorities for 2013/14, and therefore, are reported within this Quality Account / Report. In other cases, these quality priorities were discontinued in the Quality Account / Report but remained a priority for the Trust. The following is a brief summary of our progress with the quality priorities that were discontinued.

To improve how we gain feedback from patients on their experience and improve our services and the feedback we receive	• In 2013/14 we extended our survey work into children & young people's services and services for adults with learning disabilities • In 2013/14 we received responses from **6,051** *(at Feb '14 – to update at end May)* service users and carers about their experience compared to **3,820** in 2012/13. This is a **58%** increase on the previous year and shows we are continuing to seek feedback on the experience of care within all our services.
To sustain an improvement in all transfers of care with standard work practices and improved communication between professionals	• A re-audit of services in 2013/14 rated the Trust **AMBER** (i.e. compliant for 50% to 79% of transfers). As a result service-level action plans have been agreed and are being implemented.
To develop broader liaison arrangements with acute Trusts around physical health needs of mental health patients.	• In 2012/13 the Trust reported that the two projects to extend acute liaison services to older people in County Durham & Darlington and Tees had been completed. It was noted that in 2013/14 a full evaluation of the projects would be performed. It was also noted that work would continue in North Yorkshire with commissioners to explore opportunities for establishing acute liaison. • In County Durham and Darlington the high visibility of the service within the hospitals has resulted in a significant increase in the number people being supported during the period of their admission, and with a reduction in urgent referrals. Over the 12 month period from October 2012 to September 2013 the service received **2,211** referrals for patients aged over 65. This is more than double the previous year, with face-to-face contacts for this period increasing by over **400%**. The average length of stay for older people in acute wards was between **0.9** and **3.2** days shorter than before the service was extended. The total number of acute hospital bed-days saved is estimated at between **1,990** and **7,075** in a full year. The economic evaluation suggested that the £2m p.a. invested in the service is more than outweighed by the cost of bed days in acute hospital care and continuing social care provision that was required prior to the service being in place. • In Tees, the service was not operational until April 2013, and therefore, the 12-month evaluation is not expected until quarter 1 2014/15.

To develop broader liaison arrangements with acute Trusts around physical health needs of mental health patients (cont.)	• In North Yorkshire, the Trust has worked with its commissioners to develop opportunities for mental health liaison including input into acute Trusts. Business cases for three services in Scarborough, Northallerton and Harrogate have been agreed. It is anticipated that these services will commence in 2014/15.

Statement of Assurances from the Board 2013/14

The Department of Health and Monitor require us to include our position against a number of mandated statements to provide assurance from the Board of Directors on progress made on key areas of quality in 2013/14. These statements are contained within the blue boxes. In some cases additional information is supplied and where this is the case this is provided outside of the boxes.

Review of services

During 2012/13 TEWV provided and/or sub-contracted **7** relevant health services.

TEWV has reviewed all the data available to them on the quality of care in **7** of these relevant health services.

The income generated by the relevant health services reviewed in 2012/13 represents **100%** per cent of the total income generated from the provision of the relevant health services by TEWV for 2013/14.

Our seven services are:

- Adult Mental Health Services
- Mental Health Services for Older People
- Children & Young Peoples Mental Health and Learning Disability Services
- Adult Learning Disability Services
- Forensic Mental Health Services
- Forensic Learning Disabilities Services
- Substance Misuse Services

The review of services is undertaken by the Quality and Assurance Committee and includes a six-monthly report from each clinical division. This report includes information on:

- Patient safety – including information on incidents, serious untoward incidents, levels of violence and aggression, medication incidents, implementation of safety alerts.
- Clinical effectiveness – including information on the implementation of National Institute for Clinical Excellence (NICE) guidance and the results of clinical audits.
- Patient experience – including information on complaints, claims, contacts with the Trust's patient advice and liaison service, results from the service user surveys and visits from the service user and carer led teams.
- Care Quality Commission – compliance with the essential standards of safety and quality and any risks to compliance or the quality of services.

In addition to the formal report, the services deliver a presentation on any particular areas of work that have been undertaken to improve quality and invite service users

and carers to talk to the Trust's Quality and Assurance Committee on the experience they have had and what they think we could do to improve.

The data reviewed as described above covers the three areas of patient safety, clinical effectiveness and patient experience. However, the Quality and Assurance Committee recognises that some of the data is more available and robust than others. The data on standard clinical outcomes in mental health is still limited.

The Board also undertakes monthly visits, and the Executive Management Team bi-monthly visits, to our wards and teams across the Trust. They listen to what service users, carers and staff think and feel about the services we provide. A key part of the Board visit is the production of a report and action plan which is then presented to the Board at its next formal meeting for approval and subsequent monitoring.

On a monthly basis, all the services review their quality and clinical assurance performance. The information collated includes:

- Patient safety – a thematic analysis of serious incidents, actions taken for improvement, safety alerts, infection prevention and control audit and incident data, medicines management review, safeguarding audits and an action plan update for children and adults.
- Care Quality Commission compliance – details of monthly Quality Risk Profile reports and feedback from Care Quality Commission inspections and reviews.
- Patient experience – details of lessons learned from complaints, patient feedback / surveys and patient reported outcomes.
- Clinical audit and evidence based practice information.

On a quarterly basis we have clinical quality and risk governance meetings with commissioners.

Participation in clinical audits and national confidential inquiries

During 2013/14, **6** national clinical audits and **1** national confidential inquiry covered the relevant health services that TEWV provides.

During 2013/14, TEWV participated in **100%** of national clinical audits and **100%** of national confidential inquiries of the national clinical audits and national confidential inquiries which it was eligible to participate in.

The national clinical audits and national confidential inquiries that TEWV was eligible to participate in, and did participate in, during 2013/14 are as follows:

- National Audit of Schizophrenia.
- Prescribing Observatory in Mental Health (POMH) UK topic 13a – prescribing for attention deficit hyperactivity disorder (ADHD).
- POMH UK topic 7d – monitoring of patients prescribed lithium.
- POMH UK topic 4b – prescribing anti-dementia drugs.
- POMH UK topic 10c – use of antipsychotic medicine in children and young

peoples mental health services (CAMHS).
- National Audit of Psychological Therapies (NAPT) in adult mental health.
- National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH).

NB: For POMH UK Topics 13a, 7d, 4b and 10c above the Trust has adopted a local audit approach.

The national clinical audits and national confidential inquiries that TEWV participated in, and for which data collection was completed during 2013/14, are listed below alongside the number of cases submitted to each audit or inquiry as a percentage of the number of registered cases required by the terms of the national audit or inquiry.

Audit Title	Cases Submitted	% of the number of registered cases required
National Audit of Schizophrenia	100	100%
POMH UK topic 13a – prescribing for ADHD	35	100%
POMH UK topic 7d – monitoring of patients prescribed lithium	868	100%
POMH UK topic 4b – prescribing anti-dementia drugs	***	100%
POMH UK topic 10c – use of antipsychotic medicine in CAMHS	***	100%
National Audit of Psychological Therapies (NAPT) in adult mental health	4,241****	100%
National Confidential Inquiry into Suicide & Homicide by People with Mental Illness	n/k*	97%**

* Cases are submitted confidentially and directly by individual consultants, and therefore, the number of cases submitted is not known.

** Extract from National Confidential Inquiry Annual Report July 2013: for the final year of the patient suicide and homicide analysis we estimated the final number of cases based on data completeness in previous years. Projected figures are based on the average annual return of inquiry questionnaires in England, i.e. for suicide 97% and for homicide 98%. Page 11 Para 2 National Confidential Inquiry.

*** POMH Topic 4b and Topic 10c are currently underway and the reports are anticipated by the end of March 2014 and July 2014 respectively. It should be noted that there has been a delay in the publication of the national report for POMH topic 4b by POMH-UK.

**** The NAPT clinical audit is a retrospective case record audit of people who completed therapy between 1st July 2012 and 31st October 2012.

The reports of **3** national clinical audits were reviewed by the provider in 2013/14 and TEWV intends to take the following actions to improve the quality of healthcare provided:

- POMH UK topic 13a – prescribing for attention deficit hyperactivity disorder (ADHD).

  Actions:

  - The physical healthcare group to consider access to percentile and

growth charts via the electronic patient record system.
- The clinical audit report to be presented to the children's and adult mental health services development groups and distributed to all relevant teams.
- The clinical audit report to be presented to the drug and therapeutics committee

- POMH UK topic 7d – monitoring of patients prescribed lithium.

  Actions:

  - To disseminate the clinical audit results to clinical directors, heads of service, team managers and lithium register designated links.
  - Action plans for ensuring pre-treatment checks are performed to be requested from the Chester-le-Street, Ripon and Whitby adult mental health teams.
  - Action plans for ensuring annual weight/BMI/waist circumference are recorded to be requested from all teams.
  - To share the clinical audit results with the Drug and Therapeutics Committee.
  - To set up three monthly exception reporting of pre-treatment checks.

- National Audit of Psychological Therapies (NAPT) in Adult Mental Health.

  Actions:

  - The localities to review their local reports, develop and implement action plans to improve clinical practice where identified as necessary.
  - To look at attrition rates across the speciality and identify any potential improvements to address this area which was below the national average.

The reports of **81** local clinical audits (**186** individual audits) were reviewed by the provider in 2013/14 and TEWV intends to take the following actions to improve the quality of healthcare provided. **Appendix 4** includes a selection of **9** key themes from these local clinical audits reviewed in 2013/14.

In addition to those local clinical audits reviewed (i.e. those that were reviewed by the Trust's Quality and Assurance Committee), the Trust undertook a further **65** clinical audits in 2013/14.

All the clinical audits referenced above were included in the annual internal forward audit programme for reasons of quality assurance, service improvement or professional development. The forward audit programme is agreed every year with the clinical services to include 'must do' national or Trust-wide audits and those requested by services as part of their quality assurance or quality improvement plans. The audits vary in focus – some monitor compliance against an internal policy or procedure and others measure the variance of current practice against national standards, such as NICE guidance. A number are designed to provide evidence of

the outcomes from a service initiatives or new practice, particularly the quality improvement initiatives agreed as CQUINs.

The findings from these audits are reported to the Trust Quality and Assurance Committee, with any risks from findings escalated through the management systems. Any learning and recommendations from the audit results are expressed as actions for the services to implement to achieve further improvement. Many of the actions are simply to prompt and remind staff about existing guidance and some result in change to processes and systems. Audit findings are regularly used in other quality improvement projects to plan where to focus change and development.

The delivery of actions is monitored through the Trust governance systems and delays in achievement are escalated. At the end of March 2014 there were **16** *(at Feb 2014 – to update at end May)* action points that were overdue beyond their originally agreed timescales. Topics are re-audited to monitor that improvement actions have been effective.

Participation in clinical research

The number of patients receiving NHS services provided or subcontracted by TEWV in 2013/14 that were recruited during the period to participate in research approved by a research ethics committee was **1,411**.

Of the **1,411, 1,049** were recruited to National Institute for Health Research (NIHR) portfolio studies. This compares with **536** patients involved as participants in NIHR research studies during 2012/13 and **433** in 2011/12. This is a key indicator of the Trust's rapidly increasing involvement with large scale, often complex, national research across clinical disciplines such as psychosis, attention deficit hyperactivity disorder, addictions, drug safety, forensic mental health, dementia, affective disorders and personality disorder.

The Trust's growing participation in clinical research through 2013/14 reflects our firm commitment to improving the quality of care we provide, as well as contributing to the broader goals of mental health research.

Examples of how we have continued our participation in clinical research include:

- We were involved in conducting **92** clinical research studies during 2013/14. This compares with **104** in 2012/13. **46** of these studies were supported by the NIHR through its networks and **22** new studies approved through its coordinated research approval process.
- **73** members of our clinical staff participated as researchers in studies approved by a research ethics committee, with **42** of these in the role of principal investigator for NIHR supported studies.
- **19** researchers from outside the organisation were granted access under the National Research Passport Scheme to perform research with us compared to **9** in 2012/13.

- We have continued to develop our collaborative partnership with Durham University across a number of areas of shared interest including primary care mental health, evaluation of psychological interventions in young people and prescribing quality and safety. This year we celebrated five years of this partnership. Of more than **20** high impact publications resulting from this collaboration, findings from a study involving people with schizophrenia who can't or won't take antipsychotic drug treatment were published in the Lancet. This ground breaking research involving Trust participants suggests that cognitive therapy without medication could be safe and effective in reducing psychotic symptoms.
- 2013/14 saw a rapid growth in Trust support of large scale dementia research. In response to the Prime Minister's Challenge on Dementia, the Trust is scoping development of a research pharmacy capability, consolidating plans for further collaboration with pharmaceutical industry in dementia research. Over **80** participants have been recruited this year to dementia studies which included recognition of the Trust as the highest performer nationally in recruiting to a study of the prevalence of visual impairment in dementia.
- The Trust is one of five NHS Trusts across the UK hosting a trial which aims to establish whether lamotrigine, a mood stabiliser, is an effective treatment for borderline personality disorder. There are currently no medicines licensed for the treatment of borderline personality disorder, which affects between 0.5% and 2% of the population. So far over **20** participants have been randomised to the trial across a spread of services including those from Harrogate and Ripon. The study delivery is overseen locally by a study steering group whose composition includes two users of services to ensure that all study governance and delivery is properly informed from patient perspective.
- An important study of an oral health intervention for people with serious mental illness has been undertaken, successfully engaging all Trust early intervention in psychosis teams.
- Commercially sponsored research remains a priority for government, our network funders and our Trust's research and development growth strategy. This year we submitted a number of expressions of interest for participation in pharmaceutical company sponsored research. Notable was a Lundbeck sponsored observational study involving patients with schizophrenia treated with anti psychotic injections. Recruitment targets have been exceeded with agreement of the sponsor.

We have also developed processes to ensure research has led to improvements in quality of care. This has been achieved by ensuring that the design, delivery and findings of research are communicated and discussed by research interest groups. We also support and nurture lead researchers within clinical specialties in order that the research and development activity is aligned with the skills and knowledge needs articulated by the services.

Goals agreed with commissioners

Use of the Commissioning for Quality and Innovation Payment Framework (CQUIN)

A proportion of TEWV's income in 2013/14 was conditional upon achieving quality improvement and innovation goals agreed between TEWV and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation Payment Framework (CQUIN).

As part of the development and agreement of the 2013/14 mental health contract, discussions were held between the Trust and each of its commissioners to agree a set of goals and indicators that both parties felt were appropriate and relevant to local and national strategies. Indicators linked to patient experience, patient safety and clinical effectiveness were key to both provider and commissioner. These are monitored at meetings every quarter with our commissioners.

An overall total of **£5,948,598** was available for CQUIN to TEWV in 2013/14 conditional upon achieving quality improvement and innovation goals across all of its CQUINs, and a total of **£5,884,071 (98.92%)** *(at Feb 2014 - to update figure at end May)* was received for the associated payment on 2013/14. This compares to £5,938,580 (100%) and £3,744,990 (99.9%) received in 2012/13 and 2011/12 respectively.

Some examples of CQUIN indicators which the Trust made progress with in 2013/14 were:

- To improve access to support for service users and carers from the point of diagnosis of dementia to support them in coming to terms with the impact of the condition and the losses they experience. In quarter 4 2012/13 the Trust reported that between **3%** and **15%** of service users surveyed had received the relevant information leaflets on diagnosis, medication, support of carers, etc. By quarter 4 2013/14 this had increased to between **73%** and **98%** depending on leaflet and locality and above the target set by commissioners of **20%**.
- To deliver improvement in the level of falls using data from NHS Safety Thermometer. In quarter 3 2013/14, **70%** of mental health services for older people inpatient staff and **97%** of community learning disabilities staff were trained in the falls pathway against a year-end target of **60%** and **80%** respectively. An audit has confirmed that all older people admitted to inpatient care and all people with learning disabilities open to caseload are now screened for their risk of falls with all those at high risk receiving a falls intervention plan.
- Patients with a learning disability and epilepsy who experience prolonged or serial seizures have an epilepsy rescue medication protocol in place. At quarter 3 2013/14 it was reported that across County Durham, Darlington and Tees **80%** of people identified had a rescue plan in place against a year end target of **75%**.
- **100%** of all children and adolescent mental health service patients have a transition care plan in place by the age of 17.5 years.

However, we did not always make such good progress throughout the whole year. Delays have meant that the following CQUINs were not on track in 2013/14.

- To improve the implementation of the pathway of care in A&E services by improving the implementation of the borderline personality disorder integrated care pathway. Progress with the plan has been delayed, in particular, with gaining service user involvement and joint working with the emergency departments within acute Trusts.
- To have achieved a minimum agreed response rate for uptake of the inpatient survey ensuring data is maintained of those who refuse to participate. Although progress has been made in most areas, response rates in several services and localities (for example North Yorkshire adult mental health 77%; Durham mental health services for older people 79%) are below the target of 80%.

What others say about the provider

Registration with the Care Quality Commission (CQC) and periodic / special reviews

TEWV is required to register with the Care Quality Commission and its current registration status is **registered to provide services with no conditions attached**.

The Care Quality Commission has **taken one** enforcement action and raised **one moderate concern** and **one minor concern** against TEWV during 2013/14.

TEWV has participated in **13** special reviews or compliance inspections by the Care Quality Commission relating to the following areas during 2013/14:

- Two inspections at **Auckland Park, Bishop Auckland** – a unit providing care and treatment for older people's mental health inpatient care, day care and outreach services. There are three wards on site which have 12 beds each.
- **Tunstall Ward, Lanchester Road Hospital, Durham** – a 20 bed acute admission ward for female patients only and accommodates patients both detained under sections of the Mental Health Act 1983 (MHA) and informal patients who are not detained under the Act.
- **West Lane, Middlesbrough** – an inpatient service with three wards for young people. One ward provides assessment and treatment, one ward is a low secure facility, and the third ward is an inpatient eating disorder service.
- **Dental Suite Ridgeway, Roseberry Park, Middlesbrough** – this service is provided within the Health Centre at Roseberry Park Hospital. It provides services to patients within the low and medium secure wards at the hospital. The provider uses the facilities of the health centre which are maintained by the Trust. The management of appointments is maintained by staff working within the health centre.
- **Trust Headquarters, West Park – two community teams** – for the Care Quality Commission (CQC) purposes, Trust Headquarters is registered as the central location for the main community services of the Trust. CQC visited a sample of two community teams. This included teams delivering support for

those with psychosis and affective disorder.

- **Trust Headquarters, West Park – clozapine and lithium clinics** – the CQC visited a sample of outpatient clinics for this inspection. At a previous inspection in 2012/13, CQC found concerns with the Trust's arrangements for medicines. CQC carried out this inspection to check whether action had been taken to address these concerns. They found that improvements had been made.
- **Bankfields Court, Middlesbrough** – Bankfields Court provides an assessment and treatment, rehabilitation and respite service for adults with learning disabilities from the Teesside area who also have associated mental health problems, challenging behaviour or severe epilepsy. There are two units with six beds each and a converted house with one bed for assessment and treatment; six rehabilitation flats and eight respite beds.
- **Thornaby Road, Middlesbrough** – a small home providing personal and nursing care for five people with learning disabilities and additional support needs.
- **Lanchester Road Hospital, Durham** – five learning disability and forensic learning disability assessment and treatment wards.
- **163 Durham Road, Stockton** – two five-bedded assessment and treatment wards providing services for adults with a learning disability and associated challenging behaviours, autism, and epilepsy, and a respite service for adults with a learning disability who can have complex needs or present with challenging behaviours.
- **Ridgeway, Roseberry Park, Middlesbrough** – forensic learning disability wards – although the CQC visited these wards in 2013/14 the report on these visits is not due until 2014/15.
- There was one review for **HMP Holme House** for which the Trust is sub-contracted to provide specialist mental health care by the lead contractor Care UK. As such, the outcome of this review is within the Quality Account / Report for Care UK.

The CQC also undertook a review of health services for looked after children and safeguarding operating in the areas of the Trust served by Stockton Borough Council. A recommendation for TEWV as a result of this inspection was to ensure that practitioners are assessing and describing the risk to children and families when making referrals to children's social care to enable social workers to make informed decision. A further recommendation was to assess the training requirements of practitioners working in a supporting role to ensure that they are accessing safeguarding training at a level commensurate with their duties

TEWV has also participated in **38** Mental Health Act inspections by the Care Quality Commission to the following ward areas during 2013/14:

Ward	Service Type	Locality
Abdale House	Adult Mental Health Rehab	Harrogate
Bankfields	Learning Disabilities Assessment & Treatment	Middlesbrough
Bedale	Adult Mental Health Psychiatric Intensive Care	Middlesbrough
Bek	Learning Disabilities Assessment & Treatment	Durham
Bilsdale	Adult Mental Health Assessment & Treatment	Middlesbrough

Ward	Service Type	Locality
Binchester	Older Peoples Mental Health Challenging Behaviour	Bishop Auckland
Birch	Adult Mental Health Assessment & Treatment	Darlington
Bransdale	Adult Mental Health Assessment & Treatment	Middlesbrough
Cedar	Adult Mental Health Assessment & Treatment	Harrogate
Ceddesfeld	Older Peoples Mental Health Challenging Behaviour	Bishop Auckland
Danby	Adult Mental Health Assessment & Treatment	Scarborough
Earlston House	Adult Mental Health 24 Hour Nursed Care	Durham
Evergreen	Children's Eating Disorders	Middlesbrough
Farnham	Adult Mental Health Assessment & Treatment	Durham
Fulmar	Non Forensic Mental Health Low Secure	Middlesbrough
Kirkdale	Non Forensic Mental Health Low Secure	Middlesbrough
Langley	Forensic Learning Disabilities	Durham
Lincoln	Adult Mental Health Assessment & Treatment	Hartlepool
Lustrum Vale	Adult Mental Health 24 Hour Nursed Care	Stockton
Mandarin	Forensic Mental Health Low Secure	Middlesbrough
Maple	Adult Mental Health Assessment & Treatment	Darlington
Merlin	Forensic Mental Health Medium Secure	Middlesbrough
Mulberry House	Adult Mental Health 24 Hour Nursed Care	Easington
Newberry	Children's Mental Health Assessment & Treatment	Middlesbrough
Oakwood	Forensic Learning Disabilities Rehab	Middlesbrough
Picktree	Older Peoples Mental Health Assessment & Treatment	Durham
Primrose Lodge	Adult Mental Health 24 Hour Nursed Care	Chester-le-Street
Ramsey	Learning Disabilities Assessment & Treatment	Durham
Roseberry	Older Peoples Mental Health Assessment & Treatment	Durham
Rowan	Older Peoples Mental Health Assessment & Treatment	Harrogate
Springwood	Older Peoples Mental Health Continuing Care	Malton
Talbot	Learning Disabilities Assessment & Treatment	Durham
The Dales	Learning Disabilities Assessment & Treatment	Stockton
Tunstall	Adult Mental Health Assessment & Treatment	Durham
Ward 14	Older Peoples Mental Health Assessment & Treatment	Northallerton
Ward 15	Adult Mental Health Assessment & Treatment	Northallerton
Westerdale (S)	Older Peoples Mental Health Assessment & Treatment	Middlesbrough
Westwood	Children's Mental Health Low Secure	Middlesbrough

The CQC Mental Health Act Commissioners also undertook an inspection to look at the arrangements for assessment and application for detention that operate in the areas of the Trust served by Durham County Council Social Services and Darlington Borough Council. The primary action was for the two local authorities to address conveyance / transport issues. However the Trust was requested to identify and progress action to reduce the time that police are waiting at Section 136 suites.

The reports following these inspections highlighted that all but two services met full compliance requirements. The following outlines the two services which required action.

Auckland Park, Bishop Auckland: during August 2012, the CQC raised one moderate concern and one minor concern impacting on compliance and requiring

improvement actions. Following a further inspection in April 2013 an enforcement action and moderate concern was raised. Whilst the CQC did not indicate that there were any issues in terms of the quality of the care provided at Auckland Park, they did find that some processes on the ward were not tailored to meet individual assessments of the needs of the patients.

TEWV took the following actions to address the conclusions or requirements reported by the Care Quality Commission. TEWV has made the following progress by 31st March 2014 in taking such actions.

Auckland Park, Bishop Auckland

Outcome 1 (Regulation 17): respecting and involving people who use services.
Enforcement Action: essential standard not met – the provider had not provided appropriate opportunities, encouragement and support to people who used the service in relation to their autonomy and independence.

Actions and Progress

- Bedroom and en-suite doors are now not locked unless there are:
  - Unmanageable risk issues identified in the individual intervention plans that describe the risk management, or
  - Documented patient / carer wishes for the doors to be locked.
- Staff ensure individual views are considered and risks assessed relating to autonomy and independence and document the assessment outcomes giving a rationale for the decisions made. Outcomes of assessments are recorded in the electronic patient record (PARIS).
- All staff have participated in retraining and a discussion on the principles of regulation 17, the related patient outcome, and positive risk taking approaches developed for Auckland Park
- Capacity to make decisions about care and treatment for every individual is assumed unless there is evidence to indicate that there is compromise to their level of capacity to make those decisions. Individual capacity assessments are carried out when patients are involved in decisions about their care.
- When patients have been assessed to have a reduced capacity to make decisions about their care, then families, carers and advocates are involved to represent the patient's view. Referral requests for an Independent Mental Capacity Advocate and notes from involvement discussions are recorded in the PARIS record.
- Staff assess individual views and risks and document the assessment outcomes to give the rationale for the risk management plan agreed and decisions made.
- On admission / transfer to the ward, patients and carers are advised that bedrooms and en-suite bathrooms are usually left unlocked. Their wishes in relation to this and the plan agreed are recorded in the case note section of the PARIS record. An information leaflet and standard process checklist has been developed for this process.

- Health records include decisions to give patients individual bedroom keys and take account of individual patients' capacity, best interests, risks and wishes. A standard process checklist has been developed for this process.
- Decisions about the need to lock bedrooms are reviewed on a weekly basis as a minimum, at the time the intervention plan is reviewed and a case note entry is made to reflect this.
- Doors leading to Ceddsfield Ward and Hamsterley Ward gardens are unlocked during daylight hours.
- Changes to signage recommended by the Stirling audit (a tool for assessing the environment within which people with dementia are cared for) have been implemented e.g.:

    - Signs have been placed at low height.
    - Black/blue font on yellow background is used.
    - Pictorial and word content are both used.

- A range of communication strategies for those who no longer are able to understand the written word have been developed. These include sharing best practice from other services.
- A standard care plan has been implemented for all patients on admission to Auckland Park that identifies the essentials required for person centred care within a positive risk framework. The care plan describes the specific individual needs and wishes of the individual patient.

Outcome 2 (Regulation 18) : consent to care and treatment
Moderate Concern: essential standard not met – the provider had not suitable arrangements in place to obtain and act in accordance with the consent of people who used the service.

Actions and Progress

- The Trust's policy for controlling access to in-patient areas (including the locking of ward doors) has been implemented. Individual intervention detailing risk assessment and risk management plans identifies the ward egress and access level for each patient.
- Where it is assessed that an informal patient should not be allowed to leave the ward unaccompanied for reasons relating to risk, the team consider whether a liberty has been deprived. It is then considered how that deprivation should be authorised, either via the Mental Health Act or Mental Capacity Act, and then follow the appropriate policy and document in the patient's notes.
- An individually meaningful picture that assists a patient in distinguishing their room is used on bedroom doors as well as the person's name.
- There are clear procedures and guidelines in place for the use of mental capacity assessments. These are being implemented appropriately.
- All staff are up to date with Mental Capacity Act and deprivation of liberty training and are competent in the application of the legislation.
- Ward managers have agreed suitable environmental improvements with advice from staff trained in implementing the recommendations of the Stirling

audit. Environmental improvements consider the needs and abilities of patients and are culturally and generationally appropriate.

- Cognitive stimulation boxes are available for all patients and stored appropriately following discussion with the patient and their carers and in accordance with their capacity, risks and wishes.
- Where patients cannot manage free access, cognitive stimulation boxes are accessible as described in the individual intervention plan to promote positive therapeutic access.
- Training in the use of the Malnutrition Universal Screening Tool (MUST) has been provided to each of the wards and the tool has been implemented for every patient on all wards at Auckland Park.

163 Durham Road, Stockton

Outcome 4: care and welfare of people who use the service.
Minor concern: people should get safe and appropriate care that meets their needs and supports their rights.

Actions and Progress

- Although the inspection was completed in March 2014, the report was received on the 15th April 2014. *Actions and progress to add in May.*

The enforcement action and moderate concern raised for Auckland Park was removed following a further re-inspection in August 2013.

During this inspection the CQC found that:

- The Trust had fully implemented the improvement plans, and had achieved compliance in both essential standards.
- The improvements meant Auckland Park Hospital had in place appropriate opportunities, encouragement and support to people who used the service in relation to their autonomy and independence.
- Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.
- Where people did not have the capacity to consent, the Trust had acted in accordance with legal requirements.

The family members that the CQC spoke with were extremely complimentary about the service and staff. They told the CQC that this was the best service their relatives had used and that all the staff were extremely skilled and competent. Comments from relatives included:

"I have absolutely no complaints about the hospital and staff. All the staff are absolutely marvellous and the care is second to none. I don't know why anyone would not consider the service to be first class.", and

"The service is excellent. It really is marvellous."

Quality of data

TEWV submitted records during 2013/14 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data: *(figures at Dec 2014 – to update at end May)*

- Which included the patient's valid NHS number was: **99.50%** for admitted patient care; **99.80%** for outpatient care.
- Which included the patient's valid General Medical Practice Code was **95.05%** for admitted patient care; **97.26%** for outpatient care.

TEWV Information Governance Assessment Report overall score for 2013/14 was **88%** and was graded **satisfactory**.

The Information Governance Toolkit measures the Information Security and Caldicott Functions of the Trust.

It is important to patients because it demonstrates that the Trust has safe and secure processes in place to protect the sensitive personal information that we process. It demonstrates that our staff have robust training in areas such as confidentiality and the Trust carries out its legal duties under the Data Protection Act 1998, Freedom of Information Act 2000 and aspects of the Human Rights Act.

88% (satisfactory) means that we achieved at least the level 2 standard on all elements of the toolkit, however, in a significant number of elements we met the level 3 (the highest score). This is an improvement on the 2012/13 score of **85%.**

TEWV was **not** subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

Monitor, the regulator of Foundation Trusts, at the end of 2013 issued draft guidance for the coming financial year. This requires organisations to implement outcome measurement as a key requirement of developing Mental Health Payment by Results. The areas for development are:

- **Clinically Reported Outcome Measure (CROM)**: this will be the Health of the Nation Outcome Score (HoNOS) and reported via the Mental Health Minimum Data Set.
- **Patient Reported Outcome Measure (PROM)**: the Trust is currently testing as part of a scale pilot a patient reported wellbeing measure, the Warwick-Edinburgh Mental Well-being Scale (WEMWBS), as recommended in the Monitor 2014/15 currency and tariff development guidance.

- **Patient Reported Experience Measure (PREM)**: This will be the Friends and Family Test *(Mental Health Guidance for PbR: 2012/13: section 7.1).* Specifically, the percentage of service users surveyed during the reporting period who would recommend the Trust as a provider of care to their family or friends.

In response to this guidance, the Trust is developing its approach to recording and reporting these measures. The testing of these measures will form part of the payment by results contract with commissioners in 2014/15 and will be a step towards future mandated requirements.
The Trust has and continues to play a significant national role in these developments. We are undertaking national work on behalf of the Department of Health to analyse pilot data on HoNOS and in relation to the PROM and PREM developments.

At end of March 2014 *(end Feb - to update at end May):*

- **94.8%** of service users on the adult mental health and mental health services for older people caseload were assessed using the mental health clustering tool. The clustering tool is the nationally agreed approach for categorising patients' needs and is the basis for payment by result.
- **89.9%** of service users on the adult mental health and mental health services for older people caseload were reviewed within the guideline timeframe.

At the time of publication, there is limited national benchmarking data to compare against the Trust reported figures.

Further work for 2014/15 includes:

- The inclusion of key payment by results development metrics as part of routine performance management.
- Embedding the new metrics into clinical services.
- Further development of the Integrated Information Centre within the Trust to assist reporting of payment by results data.

TEWV will be taking the following actions to improve data quality:

- We have a data quality improvement group chaired by the Director of Finance and Information which meets on a monthly basis and addresses data quality issues in terms of patient, staff, financial and risk information.
- We have a data quality strategy and scorecard to monitor improvement. The strategy aims:
    - To maximise the accuracy, timeliness and quality of all our data wherever and however it is recorded.
    - To ensure that every member of our staff understands that data quality is the responsibility of everyone and an integral part of their role.
    - To ensure we achieve compliance with all our statutory and regulatory obligations.

- We have established regular reports on key elements of data which show how well data is being recorded on the various information systems, particularly the patient information system and the staff information system.
- In 2014/15, the Trust is continuing to implement an Integrated Information Centre. Within this there is a data quality engine that will enable services and teams to assess and improve the quality of their data in real time.
- Regular reports are available to all services so that they can target improvement work on areas where problems occur. Data quality is a key item for discussion in the monthly performance meetings that are held between the services and the Chief Operating Officer, the Director of Finance and Information and the Director of Planning and Performance.

Mandatory quality indicators

The following are the mandatory quality indicators relevant to mental health trusts, issued jointly by the Department of Health and Monitor and effective from February 2013.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127382/130129-QAs-Letter-Gateway-18690.pdf.pdf
For each quality indicator we have presented a mandatory statement and the data on the NHS Information Centre (NHSIC) for the most recent and the previous reporting period available.

Care Programme Approach 7 day follow-up

The data made available by the Health and Social Care Information Centre (NHSIC) with regard to the percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period.

TEWV Actual Quarter 4 2013/14	***TEWV Actual Quarter 3 2013/14***	**** National Benchmarks in Quarter 3 2013/14***	***TEWV Actual Quarter 2 2013/14***	***TEWV Actual Quarter 1 2013/14***
Trust Final Reported: **97.83%** Trust Reported to Monitor: **97.83%** *(at Feb 2014 – to update at end May)*	Trust Final Reported and figure reported to Monitor: **97.95%** NHSIC Reported: **98.20%**	NHSIC Reported: National Average MH Trust = **96.70%** Highest/Best MH Trust = **100%** Lowest/Worst MH Trust = **77.20%**	Trust Final Reported: **98.62%** Trust Reported to Monitor: **98.64%**	Trust Final Reported and figure reported to Monitor: **97.68%**

* latest benchmark data available on NHSIC at quarters 3 2013/14

TEWV considers that this data is as described for the following reasons:

- The discrepancy between the Trust final reported figure and the figure reported to Monitor in quarter 2 2013/14 is due to the fact the Trust final figure is refreshed throughout the year to reflect a validated position as data quality issues are resolved. The figure reported to Monitor is the position at quarter end and is not refreshed after submission.
- The discrepancy between the NHSIC and the Trust / Monitor figure is due to the fact the NHSIC data is submitted at a Clinical Commissioning Group (CCG) level, and therefore, excludes data for patients from CCGs outside the Trust area or where the CCG is unspecified in the patient record.
- The few actual breaches, **37** in total in 2013/14 *(as at Feb '14 – to update at end May)*, were a result of:
    - Services users not attending the follow-up appointment despite efforts of the service to contact the patient, and
    - Failure in communication between the discharging ward and the community team.

TEWV **has taken** the following actions to improve this percentage, and so the quality of its services, by:

- Monitoring this key performance indicator via the Trust's dashboard at service and board level on a monthly basis.
- Investigating all breaches and identifying lessons learnt at director and service level performance meetings.
- Reviewing how the services maintain contact with the patient in the days following discharge to eliminate non-attendance at the follow-up appointment.
- Proactively contacting other agencies with whom the patient is in contact where there is a greater risk of non-attendance at follow-up (e.g. homelessness).
- Implementing a standard process to ensure patients discharged to other services (e.g. 24 hour care unit) are not overlooked.
- Reminding staff regarding procedures for follow-up when patients are on leave from the ward or the care coordinator is on annual leave / holiday.
- Continuously raising awareness and reminding staff at ward / team meetings of this national requirement, the need to follow the standard procedure and the need to record data accurately.

Crisis Resolution Home Treatment Team acted as a gatekeeper

The data made available by the Health and Social Care Information Centre (NHSIC) with regard to the percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period.

TEWV Actual Quarter 4 2013/14	*TEWV Actual Quarter 3 2013/14*	** National Benchmarks in Quarter 3 2013/14*	*TEWV Actual Quarter 2 2013/14*	*TEWV Actual Quarter 1 2013/14*
Trust Final Reported and figure reported to Monitor: **97.58%** *(at Feb 2014 – to update at end May)*	Trust Final Reported and figure reported to Monitor: **97.67%** NHSIC Reported: **98.3%**	NHSIC Reported: National Average MH Trust = **98.6%** Highest/Best MH Trust = **100%** Lowest/Worst MH Trust = **85.50%**	Trust Final Reported and figure reported to Monitor: **97.84%**	Trust Final Reported and figure reported to Monitor: **96.63%**

* latest benchmark data available on NHSIC at quarters 3 2013/14

TEWV considers that this data is as described for the following reasons:

- The discrepancy between the NHSIC and the Trust / Monitor figures is due to the fact the NHSIC data is submitted at a Clinical Commissioning Group (CCG) level, and therefore, excludes data for patients from CCGs outside the Trust area or where the CCG is unspecified in the patient record.
- The few actual breaches, **36** in total in 2013/14 *(as at Feb '14 – to update at end May)*, were a result of failure to follow the standard procedure.

TEWV **has taken** the following actions to improve this percentage, and so the quality of its services, by:

- Monitoring this key performance indicator via the Trust's dashboard at service and board level on a monthly basis.
- Investigating all breaches and identifying lessons learnt at director and service level performance meetings.
- Reviewing crisis services in 2012/13, acknowledged the lessons from breaches and building these lessons into standard work which was implemented across all crisis services in 2013/14.
- Continuously raising awareness and reminding staff at ward / team meetings of this national requirement, the need to follow the standard procedure and the need to record data accurately.

Staff Friends and Family Test

The data made available by the Health and Social Care Information Centre (NHSIC) with regard to the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.

TEWV Actual 2013	*National Benchmarks in 2013*	*TEWV Actual 2012*	*TEWV Actual 2011*
3.89 out of 5.00 (sample size of 492)	National Average MH Trust = **3.55 out of 5.00** Highest/Best MH Trust = **4.04 out of 5.00**	**3.83 out of 5.00** (sample size of 519)	**3.73 out of 5.00** (sample size of 536)

TEWV considers that this data is as described for the following reasons:

- The figure is derived from the NHS staff survey.
- The 2013 result, **3.89 out of 5.00**, is a small improvement on the 2012 and 2011 results and is in the top 20% of all mental health Trusts.
- This improvement is linked to the five areas in the 2013 survey that the Trust achieved its best scores, four of which were the best score for all mental health Trusts in England.

    - Work pressure felt by staff: **2.80 out of 5.00** compared to national average of **3.07** (NB: lower better).
    - Staff job satisfaction: **3.85 out of 5.00** compared to national average of **3.67**.
    - The percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver: **83%** compared to national average of **77%**.
    - The percentage of staff feeling they are able to contribute towards improvements at work: **79%** compared to national average of **72%**.
    - Fairness and effectiveness of incident reporting procedures: **3.68 out of 5.00** compared to national average of **3.52**.

TEWV **has taken** the following actions to improve this percentage, and so the quality of its services:

- Annual Trust and directorate level action plans are developed in response to the NHS Staff Survey. Some areas for improvement work in 2013/14 were:

    - Continuation of the work to try to improve the health and wellbeing of the Trust's staff. This included trying to gain a better understanding of the causes of stress. Stress assessment tools have been considered and several staff engagement workshops have taken place in both adult mental health services at Roseberry Park and learning disability forensic services.
    - The Trust reviewed and updated its policy for positive approaches to supporting people whose behaviour is described as challenging.
    - The Trust introduced more ways of anonymously reporting concerns. Staff can now use a form on the intranet or leave a message on the concerns line.

Patient's experience of contact with a health or social care worker

The data made available by the Health and Social Care Information Centre (NHSIC) with regard to the Trust's "patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.

TEWV Actual 2013	*National Benchmarks in 2013*	*TEWV Actual 2012*	*TEWV Actual 2011*
NHSIC Reported: **89.40** (sample size of 217)	NHSIC Reported: National Average MH Trust = **85.80** Highest/Best MH Trust = **90.90** Lowest/Worst MH Trust = **80.90**	NHSIC Reported: **88.42** (sample size of 230)	NHSIC Reported: **87.35** (sample size of 223)

Notes on metric

This indicator is a composite measure, calculated by the average weighted (by age and sex) score of four survey questions from the community mental health survey. The four questions were:

Thinking about the last time you saw this NHS health worker or social care worker for your mental health condition…

…Did this person listen carefully to you?
…Did this person take your views into account?
…Did you have trust and confidence in this person?
…Did this person treat you respect and dignity?

TEWV considers that this data is as described for the following reasons:

- The figure is derived from the NHS service user survey.
- The Trust's score for 2013 was **89.4.** The Trust's score in 2013 is an improvement on 2012 and 2011 and is closer to the best mental health Trust score of **90.9** compared to 2012.
- The individual scores that this figure is based on were:
    - Did this person listen carefully to you: **9.1 out of 10**, and better than the national average.
    - Did this person take your views into account: **8.7 out of 10**, and better than the national average.
    - Did you have trust and confidence in this person: **8.5 out of 10**, similar to the national average.
    - Did this person treat you respect and dignity **8.7 out of 10**, and better than the national average.

TEWV **has taken** the following actions to improve this percentage, and so the quality of its services:

- Annual Trust and directorate level action plans were developed and implemented in response to the NHS Service User Survey for community services. However, a key part of our approach to improvement was the implementation of the recommendations of the review of the Care Programme Approach outlined in the quality priorities for 2013/14 and 2014/15. A benefit expected from these priorities will be a reduction in staff time spent on administrative tasks and more face to face time to listen to, understand and gain the confidence of service users and carers.
- In addition to the feedback from the national survey, the Trust's local surveys include the questions similar to those used nationally. In 2013/14, **6,051** *(at Feb '14 – to update in May)* service users were surveyed locally on these questions. It is the act of continuously surveying the experience of service users and responding to the feedback which ensures that the Trust continuously improves on this metric.

Patient safety incidents including incidents resulting in severe harm or death

The data made available by the Health and Social Care Information Centre (NHSIC) with regard to the number of patient safety incidents, and percentage resulting in severe harm or death, reported within the Trust during the reporting period.

TEWV Actual Quarters 3&4 2013/14	***TEWV Actual Quarters 1&2 2013/14***	***TEWV Actual Quarters 3&4 2012/13***	**** National Benchmarks in Quarters 3&4 2012/13***
Trust Reported to NRLS: **2,841** incidents reported of which **19** (**0.67%**) resulted in severe harm or death *(at Feb 2014 – to update at end May)* NB: NRLS reported figure not available until 2014/15	Trust Reported to NRLS: **3,285** incidents reported of which **36** (**1.10%**) resulted in severe harm or death NRLS Reported: **?** incidents reported of which **?** (**?%**) resulted in severe harm or death *(NRLS data not yet available)*	Trust Reported to NRLS: **3,027** incidents reported of which **41** (**1.4%**) resulted in severe harm or death NRLS Reported: **3,048** incidents reported of which **41** (**1.4%**) resulted in severe harm or death	NRLS Reported: National Average MH Trusts: **2,041** incidents reported of which **27** (**1.3%**) resulted in severe harm or death Lowest MH Trust: **3** incidents reported of which **1** resulted in severe harm or death Highest MH Trusts: **6,737** incidents reported of which **170** (**2.5%**) resulted in severe harm or death

* latest benchmark data available on NRLS

TEWV considers that this data is as described for the following reasons:

- The Trust reported and National Reporting & Learning System (NRLS) reported data for 2013/14 differ because the Trust's definition of a patient safety incident is wider than that of the NRLS.

- There is currently no nationally agreed or regulated approach to reporting, categorising and validating patient safety incidents. Different Trusts may choose to apply different approaches. For example, the approach taken to determine a classification such as those 'resulting in severe harm' will often rely on clinical judgement which may, acceptably, differ between professionals. The classification of an incident may also be subject to a potentially lengthy investigation which may result in the classification being changed. The change may not be reported externally and the data held by a Trust may not be the same as that held by the NRLS.
- The number of incidents reported by TEWV to the NRLS for quarters 3 and 4 2012/13 is above the national average. The percentage resulting in severe harm or death is similar to the national average. However, it is not possible to use this data to comment of the Trust's culture of incident reporting or the occurrence of incidents. The absolute numbers of incidents reported is a factor of the relative size of Trusts and the complexity of their case-mix. Similarly, the percentage of incidents reported as severe harm or death is a factor of the different methodologies used by Trusts to identify incidents and categorise their severity and therefore comparisons between Trusts are inconclusive. We can say, however:

    - The reporting of patient safety incidents in the Trust is increasing year on year.
    - Amongst the most common themes are disruptive / aggressive behaviour, accidents (including falls) and self harming behaviours which account for three-quarters of all incidents leading to harm.

TEWV **has taken** the following actions to improve this position, and so the quality of its services, by:

- Analysing all patient safety incidents. These are reported and reviewed by the Trust's Quality and Assurance Committee via the quarterly Patient Safety Report and the six-monthly review of services, and with commissioners via the Clinical Quality Review Process.
- Introducing a web-based reporting system that enables timely and service-specific analysis and a transparent corporate overview.
- Analysing areas of low reporting and trends in high risk incident categories. These are reviewed monthly by the responsible service with action plans developed and monitored as appropriate to address warning signs.
- Subjecting all serious untoward incidents (i.e. those resulting in sever harm or death) to a 'root cause analysis'. This is a robust and rigorous approach to understanding how and why each incident has happened, to identify any causal factors and to implement any lessons for the future.
- Raising awareness of staff, through clinical team leads, of the importance and value of reporting and reviewing 'near misses'.

2014/15 Priorities for Improvement

The Trust's Quality and Assurance Committee is responsible, on behalf of the Board of Directors, for ensuring that appropriate structures, systems and processes are in place to deliver safe, high quality effective care, which is continuously improving. In doing so it also takes responsibility for recommending to the Board the key quality priorities for any given year to ensure that we continue to improve the quality of services we deliver.

The process of identifying the key priorities for 2014/15 involved a number of our stakeholders. The process was as follows:

- An internal review was undertaken on the findings of serious untoward incidents, other incidents / 'near misses', complaints, patient advice and liaison service contacts and audit findings to identify common themes for improving quality.
- These were discussed with the Trust's Quality and Assurance Committee, and together with the views of the other locality and specialty-specific quality groups across the Trust, a set of key themes for improving quality were developed.
- An event was held in July 2013 where these findings and key themes were shared with our stakeholders to get feedback on where they think the quality of our services needs to be improved.
- Representatives from the following stakeholders agencies were invited to attend:

    - Clinical Commissioning Groups (x9)
    - Local Authority Overview & Scrutiny Committees and Directors of Social Services (x7)
    - Healthwatch (x7)
    - Trust Governors – Public (x33)
    - Trust Governors – Elected (x14)

- From this workshop **13** key quality themes were selected and these were presented to the Board of Directors in October 2013.
- At its formal meeting in November, the Board of Directors agreed the **four** quality priorities for 2014/15 from the **13** key quality themes identified by our stakeholders. The remaining themes identified by the stakeholders were fed into the business planning process and are included within the Trust's Business Plan for 2014/17.
- For each quality priority a lead Director was identified who developed the key actions that would be taken to address the priority in 2014/15.
- A second stakeholder workshop, with the same invitees as shown above, was held in February 2014 where our four quality priorities and proposed plans to deliver these were shared.
- The stakeholders gave comments on our plans and were asked to consider what benefits / outcomes they would expect for our service users and carers from these priorities. Their ideas were captured and taken into account in our final action plans for each priority as described below.

Our four priorities for 2014/15 are:

Priority 1: To have more staff trained in specialist suicide prevention and intervention.
Priority 2: Implement recommendations of Care Programme Approach (CPA) review, including,
- Improving communication between staff, patients and other professionals.
- Treating people as individuals.

Priority 3: Embed the recovery approach (in conjunction with CPA).
Priority 4: Managing pressure on acute inpatient beds.

Priority 1: To have more staff trained in specialist suicide prevention and intervention

Why this is important:

From 1981 to 2007, age-standardised suicide rates in the North East of England reduced year on year to a low in 2007 of 10.5 per 100,000 of the population. This was significantly higher than the rate for England in 2007 of 9.5. Since 2007 the rate in the North East of England has increased and was 12.0 per 100,000 of the population in 2012 and similar to levels seen in the first few years of the decade. Again the rate in the North East of England in 2012 remained significantly higher than the rate for England of 10.4. It is therefore a priority that the recent upward trend is reversed and the gap between the North East of England and the rest of England is reduced. However, it is recognised that the suicide rate is influenced by many social and economic factors which are beyond the control of the Trust. The Trust, therefore, aims to play its part by improving how staff recognise the warning signs and intervene early to prevent avoidable suicides.

What benefits / outcomes our service users and carers should expect:

- The number of staff trained in specialist suicide prevention and intervention will have increased.
- Staff who have received specialist training will be confident in suicide prevention and intervention.
- Care will be provided in a way that manages risk whilst promoting recovery and keeping our service users safe.

What we will do in 2014/15:

We will:
• Approve the project scope by quarter 1 2014/15.
• Recruit the project team and establish the project group to take this forward by quarter 1 2014/15.
• Review current practice within the Trust by quarter 1 2014/15.

We will:

- Develop a suicide prevention framework and training and implementation plan that describes what training is required, who will provide it and what other support is necessary for staff to provide effective suicide prevention and intervention by quarter 2 2014/15.
- Develop a training needs assessment and training plan which will describe who will receive training and how this will be rolled out across the Trust by quarter 3 2014/15.
- Commence training for priority staff (e.g. crisis teams) by Q4 2014/15 (to be completed for all relevant staff in 2015/16)

Priority 2: Implement recommendations of the Care Programme Approach (CPA), including:

- Improving communication between staff, patients and other professionals
- Treating people as individuals

Why this is important:

The Care Programme Approach (CPA) and care planning is critical to the quality of care our service users receive. The full involvement and participation of service users and carers within care planning is associated with improved outcomes and the experience of care. Addressing these issues for service users, carers, staff and all agencies with whom we work with is a clear priority for improving quality within the Trust.

What benefits / outcomes our service users and carers should expect:

- Improved service user experience, choice and involvement in their personal recovery.
- Services that are personal and meaningful to service users.
- Carers will feel recognised, valued and supported.

What we will do in 2014/15:

We will:

- Implement actions relating to CPA from model lines pilot team by quarter 2 2014/15.
- By quarter 4 2014/15, redesign CPA processes and documentation to ensure they fulfil the following:
  - meeting mandatory requirements whilst reducing unnecessary burden on staff.
  - ensuring the requirements of the Mental Health Act are met whilst reducing unnecessary burden on staff.
  - development of standard work regarding section 117 of the Mental Health Act – the statutory duty to provide health and social care to some service users following discharge from in-patient care.
- Implement regular audit and case management / supervision systems to include monitoring of transfer processes within PARIS (the electronic patient record) by quarter 4 2014/15.

It is anticipated that further work to fully implement the recommendation of the CPA review will continue into 2015/16. In 2015/16 the following actions will be delivered:

- Implement core competency frameworks to identify the competencies needed by staff to implement the revised CPA processes and documentation.
- Implement a work based competency tool to assess competency and appraises' / supervisors' performance of assessment and care planning skills.
- Implement systems and standards for training, supervision and case management of care co-ordinators and lead professionals.
- Start the development of a revised Trust / multi-agency CPA policy.

Priority 3: Embed the recovery approach (in conjunction with CPA).

Why this is important:

Many people who have experienced mental health related problems have shown us that it is possible to maintain or re-establish their wellbeing, meaning, value and purpose in life. But, despite advances in mental health care, too often people are still left feeling disconnected from themselves, from friends and family, from the communities in which they live, and from meaning and purpose in life. Clearly this can have a devastating and long-term life changing effect. It is, therefore, important that the services we provide do not just focus on alleviating the symptoms of mental ill-health, but also are provided within a culture that in every way promotes recovery where recovery is defined as:

'A deeply personal, unique process of changing one's attitudes, values, feelings and goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. Recovery from mental illness involves much more than recovery from the illness itself'.

Recovery from mental illness: the guiding vision of the mental health system in the 1990s (Anthony), Psychosocial Rehabilitation Journal, 16(4), April 1993, 11-23.

What benefits / outcomes our service users and carers should expect:

- Recovery focussed practice across all Trust services.
- Increased opportunities for people with 'lived experience' of mental illness to co-produce services across the Trust.
- The Trust promoting a culture of harm minimisation, actively working to help service users develop resilience, control, choice, hope and empowerment.

What we will do in 2013/14:

We will:

- Develop a programme of work to ensure the principles of recovery are embedded within all key programmes e.g. CPA, model lines, risk assessment & management (ongoing).
- Establish the current position on recovery action planning and devise an implementation plan by quarter 2 2014/15.
- Increase the opportunities for volunteering by quarter 4 2014/15.
- Establish a cohort of service user / carer trainers to co-design and co-deliver recovery training by quarter 4 2014/15.
- Investigate the role of peer support workers (staff with 'lived experience' providing care and support) by quarter 4 2014/15.
- Establish recovery leads in all localities, specialities and pilot teams by quarter 4 2014/15.
- Establish a recovery college and courses by quarter 2 2014/15.

Priority 4: Managing pressure on acute inpatient beds

Why this is important:

Wherever possible we try to help people to receive care close to home so they do not need to be admitted into a hospital bed. However, sometimes, people do need to spend time in hospital. When this is necessary it is important that they are admitted to the ward that has been identified as serving that community, unless they choose to go to a different unit, or there are clinical reasons to support this. This is important as it means that service users receive their inpatient care close to home and their families and carers and also it helps ensure better engagement from the community team that will support them when they leave the ward. Currently 22% of patients do not receive care at their 'local' inpatient unit.

What benefits / outcomes our service users and carers should expect:

- In 2014/15 we are aiming for 85% of patients being treated close to home increasing to 90% in 2015/16 and beyond.

What we will do in 2013/14:

We will:

- Reduce the percentage of people on community team caseloads that are admitted to inpatient care by quarter 4 2014/15.
- Reduce the readmission rates to inpatient care following discharge by quarter 4 2014/15.
- Continue to improve the skills and effectiveness of the crisis teams as gatekeepers to inpatient care by quarter 4 2014/15.

In addition to these key actions, there are a number of other projects aimed at improving services that will impact indirectly on the Trust's ability to manage pressure of beds. For example:

- Work with community mental health teams to improve the quality of home treatment, crisis and care planning.
- Building on the work of rapid process improvement workshops in 2013/14 to improve the quality and efficiency of discharge planning.
- Evaluating the opportunity for using rehabilitation as a step-up facility from home treatment as well as a step-down facility from acute inpatient care.
- Working with commissioners to develop new services that prevent admissions and shorten lengths of stay when inpatient care is necessary e.g. street triage, crisis beds, GP liaison services.

Monitoring Progress

We will monitor formally our progress against all of the above priorities on a quarterly basis. A quarterly Quality Account / Report Performance Report, outlining performance against the overall aims, progress with the delivery of our planned actions and any corrective action required, will be shared with the Trust's Quality and Assurance Committee and Council of Governors.

In November 2014, we will also share the quarter 2 2014/15 update report with all our stakeholders as a mid-year report to facilitate our stakeholder's review of our Quality Account / Report at year end.

A key way for delivering the priorities for 2014/15 will be the use of the various tools within the Trust's Quality Improvement System. As outlined earlier, the Trust's Quality Improvement System is the Trust's framework and approach to continuous quality improvement and has within it standardised processes for monitoring progress and improvement.

PART 3: OTHER INFORMATION ON QUALITY PERFORMANCE 2013/14

Our performance against our quality metrics

The following table provides details of our performance against our set of agreed quality metrics for 2013/14.

These metrics are the same as those we reported against in our Quality Account / Report, 2012/13 which allow us to monitor progress. However, in some cases, the exact definitions in 2012/13 and 2013/14 have changed from 2009/10 and 2010/11 as we have learned lessons on what is more meaningful to quality. These are:

- The 'number of unexpected deaths' reported in 2009/11 (metric 1) was changed in 2012/13 to the 'number of unexpected deaths classed as a serious incident per 10,000 open cases'. This is because using a rate is a valid approach for making comparisons across the years even if activity within the Trust increases.
- The 'number of patient falls per 100,000 occupied bed days' reported in 2009/11 (metric 3) has been changed to the 'number of patient falls per 1,000 admissions' as experience has shown this indicator is more closely linked to new admissions rather than occupied bed days.
- The 'number of complaints per 100,000 patients' reported in 2009/11 (metric 8) has been changed to the 'percentage of complaints satisfactorily resolved' as experience has shown that it is more important to measure the satisfaction of our response to complaints as opposed to the absolute number of complaints. The latter we encourage as important feedback to the Trust on the quality of our services.

Table 2: Quality Metrics

	Quality Metrics	2013/14 Target	2013/14 Actual *(at Feb '13)*	2012/13 Actual	2011/12 Actual	2010/11 Actual	2009/10 Actual
Patient Safety Measures							
1	Number of unexpected deaths classed as a serious incident per 10,000 open cases	< 12.00*	**11.88**	15.91	12.00		
2	Number of outbreaks of Healthcare Associated Infections	0	**0**	0	0	0	0
3	Patient Falls per 1,000 admissions	< 31.04	**36.46**	34.09	37.44		
Clinical Effectiveness Measures							
4	Percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care (validated)	> 95.00%	**97.86%**	97.14%	98.08%	98.50%	97.50%
5	Percentage of clinical audits of NICE Guidance completed	100%	**97%**	89.47%	95.20%	66.70%	75.00%
6	Average length of stay for patients in Adult Mental Health and Mental Health Services for Older People Assessment & Treatment Wards	AMH <33 MHSOP <52	**AMH: 31.72** **MHSOP: 54.08**	35	37	39	47
Patient Experience Measures							
7	Delayed Transfers of Care	< 7.50%	**1.89%**	2.07%	1.60%	1.60%	2.90%
8	Percentage of complaints satisfactorily resolved	> 90.00%	**83.33%**	76.36%			
National Patient Survey							
9	Number of questions where our score was within 5% of the highest scored Mental Health Trusts	Improvement on 2012/3 survey	**12 (32%)**	11 (29%)	12 (32%)	18 (47%)	16 (42%)
	Number of questions where our score was within the middle 90% of scored Mental Health Trusts		**26 (68%)**	27 (71%)	23 (61%)	14 (37%)	22 (58%)
	Number of questions where our score was within 5% of the lowest scored Mental Health Trusts		**0 (0%)**	0 (0%)	3 (8%)	6 (16%)	0 (0%)

* The number shown here is the maximum level of unexpected deaths that we would expect to see rather than a target number we are trying to achieve

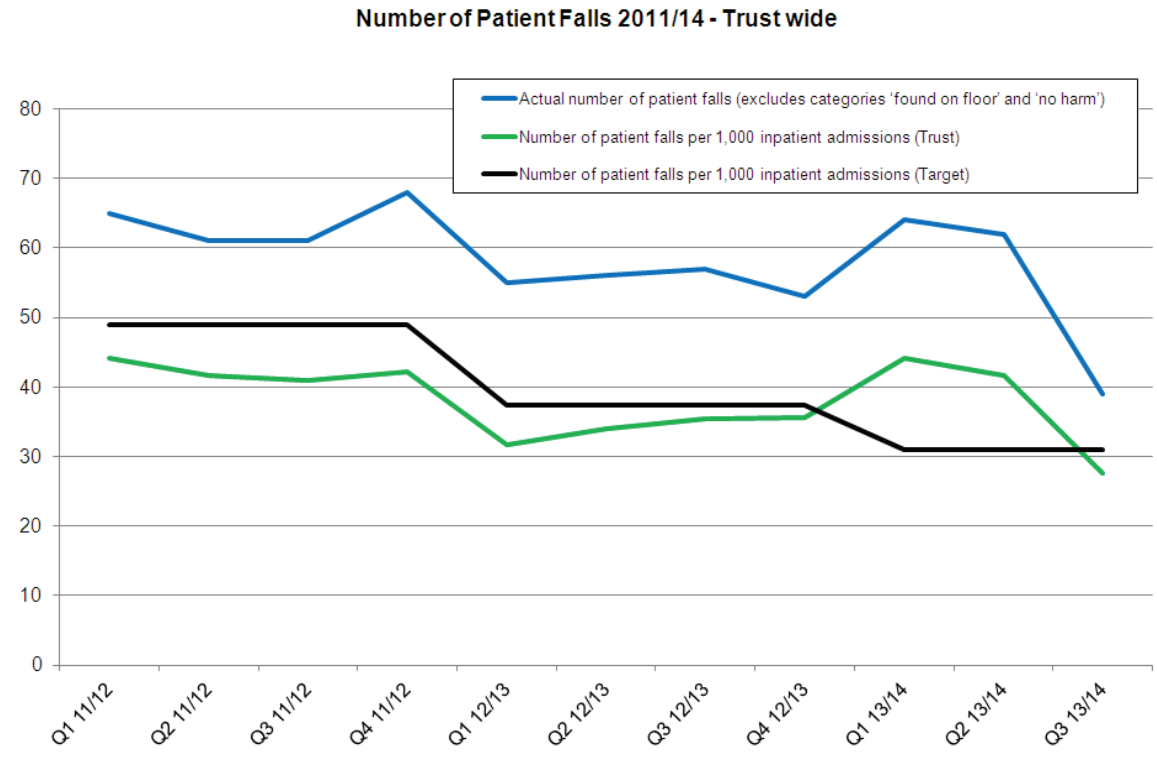
Notes on selected metrics

1. Data for this metric is taken from Incident Reports which are then reported via the National Strategic Executive Information System (STEIS).
2. Outbreaks of healthcare associated infections relates to those of MRSA bacteraemia and C Difficile. The Infection Prevention and Control Team would be notified of any outbreaks direct by the ward and that would then be recorded on an 'outbreak' form before being reported externally.
3. Patient falls excludes the categories 'found on floor' and 'no harm'. Data for this metric is taken from Incident Reports which are then reported via the Trust's Risk Management System, DATIX.
4. Data for CPA 7 day follow up is taken from the Trust's patient systems and is aligned to the national definition.
5. The percentage of clinical audits of NICE Guidance completed is based on the number of audits of NICE guidelines completed against the number of audits of NICE guidelines planned. Data for this metric is taken from audits undertaken by the Clinical Directorates supported by the Clinical Audit Team.
6. Data for average length of stay is taken from the Trust's patient systems.
7. Delayed transfers of care are based on Monitor's definition and therefore exclude children and adolescent mental health services. Data for this metric is taken from the Trust's patient systems.
8. The percentage of complaints satisfactorily resolved is based on the number of complaints where the complainant did not report dissatisfaction with the Trust's response expressed as a percentage of the total number of resolution letters sent out. Please note, if the complainant did not respond to the resolution letter it was assumed that the complainant was satisfied with the Trust's response.
9. The National Patient Survey for 2012/13 is not directly comparable to previous Community Surveys. Also the National Patient Survey for 2009/10 is an inpatient survey which is not directly comparable to the community surveys. The metrics previously reported previously were categorised as follows:
    a. Number of questions where our score was within the top 20% of Mental Health Trusts
    b. Number of questions where our score was within the middle 60% of Mental Health Trusts
    c. Number of questions where our score was within the lowest 20% of Mental Health Trusts

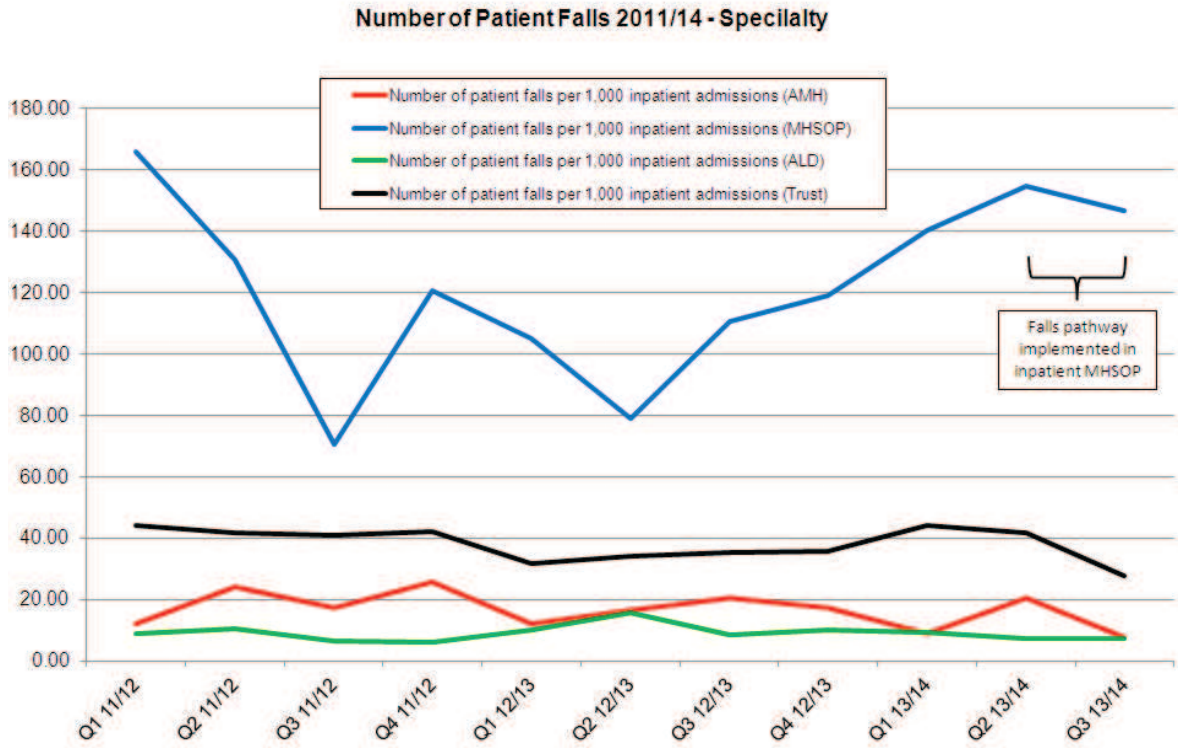
Comments on Areas of Under-Performance

Metric 3: Patient falls per 1,000 admissions

The number of falls reduced significantly in quarter 3 2013/14. The rate was **27.6** per 1,000 admissions against a target of **< 31.04** and was the lowest quarterly rate in two years. However, overall for 2013/14 the rate was **36.46** and above target due to higher falls rates in quarters 1 and 2 2013/14. The following graph shows the rate by quarter over the last two years:



Further analysis shows that the increase in 2013/14 was influenced mostly by an increase in falls in mental health services for older people services. The reduction in quarter 3 2013/14 reflects the implementation of the revised falls pathway in older people's inpatient services. It is expected, therefore, the rate will continue to fall in 2014/15 as the falls pathway is further implemented within older people's community services.



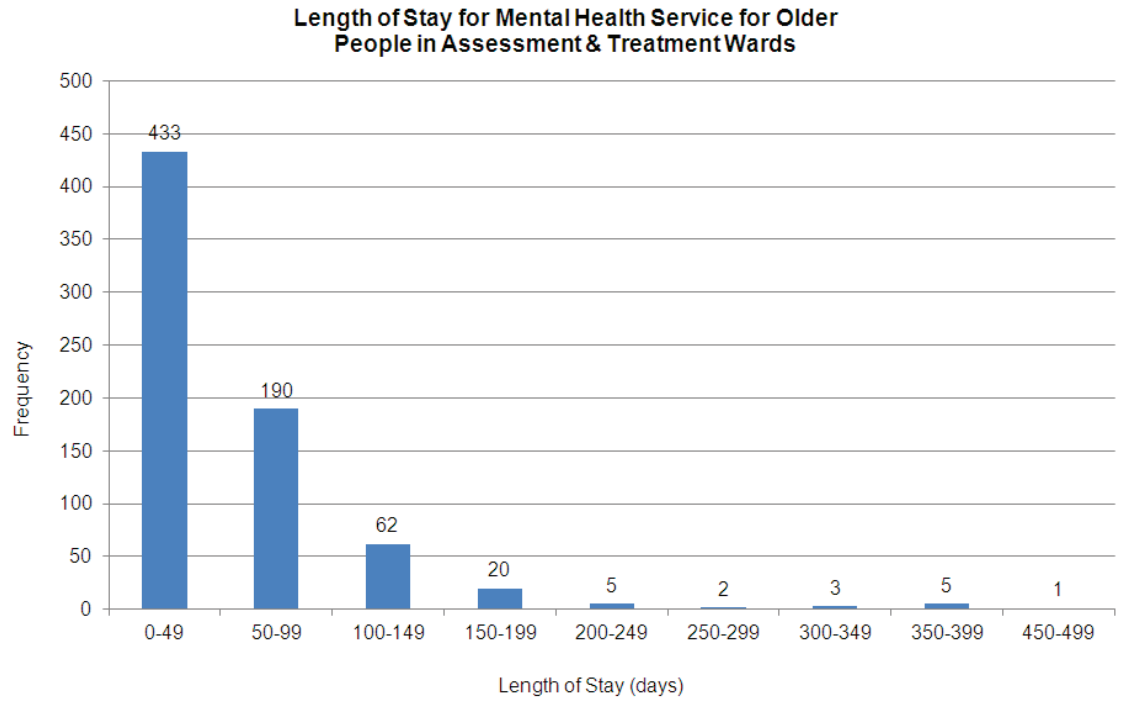
Metric 5: Percentage of clinical audits of NICE Guidance completed

In 2013/14, **97%** (35 out of 36) of NICE clinical audits planned for completion in 2013/14 were completed. The remaining one NICE clinical audit that was planned for completion but not completed in 2013/14 was undertaken and the action plan is awaiting final sign-off in quarter 1 2014/15.

Metric 6: Average length of stay for patients in adult mental health and mental health services for older people assessment & treatment wards

The average length of stay for adults has remained steady and below the target for 2013/14 and is, therefore GREEN. The average length of stay for older people was within target for quarters 1 and 2 but increased from 50/51 days to **56** days in quarter 3 2013/14 which is above the target of < 52 days, and therefore RED.

The following table shows the actual lengths of stay for **722** older people discharged in 2013/14. Whilst the average length of stay for patients on mental health services for older people assessment and treatment wards was **54** days, the average was skewed by a few long stay patients. In fact **16** patients in 2013/14 had stays over 200 days. If the stays of these **16** patients were capped at 200 days, the average length of stay would be **51.9** days and within the target of < 52 days.



Metric 8: Percentage of complaints satisfactorily resolved

Complaints are monitored by the Quality Assurance Committee and are thoroughly investigated. Both the Patient Experience Department and Patient Advice and Liaison Services (PALS) strive to resolve as many concerns/complaints as possible informally.

Table 3 below shows the resolution rate of complaints by service. This indicates that those 10 complaints not satisfactorily resolved were all in adult mental health.

Table 3: Complaints Resolution

Service	Locality	Total number of complaints resolution letters sent	Percentage (numbers) satisfactorily resolved*
Adult Mental Health	Durham & Darlington	21	76% (16)
	Tees	13	77% (10)
	North Yorkshire	3	33% (1)
Mental Health Services for Older People	Durham & Darlington	3	100% (3)
	Tees	4	100% (4)
	North Yorkshire	1	100% (1)
Children's & Young Peoples Services Mental Health & Learning Disabilities	Durham & Darlington	1	100% (1)
	Tees	3	100% (3)
	North Yorkshire	0	n/a
Adult Learning Disabilities	Durham & Darlington	1	100% (1)
	Tees	1	100% (1)
	North Yorkshire	1	100% (1)
Forensic Services	Trust-wide	7	100% (7)
Other	Trust-wide	1	100% (1)
Total		**60**	**83.33% (50)**

* The percentage of complaints satisfactorily resolved is based on the number of complaints where the complainant did not report dissatisfaction with the Trust's response expressed as a percentage of the total number of resolution letters sent out. Please note, if the complainant did not respond to the resolution letter it was assumed that the complainant was satisfied with the Trust's response.

Our performance against national targets and regulatory requirements

The following table demonstrates how we have performed against a wide range of targets set for us by the Department of Health, our regulator Monitor and our commissioners.

Table 4: National Targets & Regulatory Requirements

Indicators		2013/14		2012/13	2011/12	2010/11	2009/10
		Target	Actual (at Feb '13)	Actual	Actual	Actual	Actual
a	The Trust has registered with CQC with no conditions	Fully met	**Fully met**	Fully met	Fully met	Fully met	Fully met
b	Number of occupied bed days of under 18s admitted to adult wards	0	**48**	64	83	70	173
c	Retention rate substance misuse (rolling 12 months and reported 3 months behind)	=/> 92.90%	**92.45%**	89.91%	89.90%	84.40%	89.70%
d	Number of early intervention in psychosis new cases (cumulative position)	> 259	**619**	599	479	455	407
e	Number of crisis resolution home treatment episodes (cumulative position)	> 3,338	**3,725**	6,152	5,965	5,751	5,191
f	Percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper (validated)	> 95.00%	**97.52%**	97.35%	96.00%	97.00%	97.20%
g	Percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care (validated)	> 95.00%	**97.86%**	97.14%	98.08%	98.50%	97.50%
h	Maintain level of crisis resolution teams set out in 2003/06 planning round	Maintain	**Maintained**	Maintained	Maintained	Maintained	Maintained

Notes on national targets and regulatory requirements

b) Retention rate is the percentage of people who misuse substances who stay within treatment for the duration of the course of treatment. The information is subject to a 3-month delay in reporting, therefore, the figure shown is the position reported in the January 2013 report which covers November 2012 to October 2013.

e) The number of crisis home treatment episodes in 2013/14 is significantly less than previous years. This is due to a change in the definition of the indicator where multiple linked contacts are now counted as a single episode rather than individual episodes.

Comments on Areas of Under-Performance

Indicator b: Number of occupied bed days of under 18s admitted to adult wards

There were **48** occupied bed days for the 'under 18s admitted to adult wards' in 2012/13. This relates to **10** patients.

It is important to note that all of these admissions were clinically appropriate. For example, an admission of an adolescent aged 17 years and 10 months for an episode that is likely to last more than two months avoids an unnecessary transition to adult mental health later. Or, where the clinical need of the service user would be best met on an adult ward.

Indicator c: Retention rate substance misuse (rolling 12 months and reported 3 months behind)

The percentage of people who misuse substances and stay within treatment for the duration of the course of treatment is **92.49%** at Oct 2013 and below the target of **92.90%.** *To update at in May*.

External Audit

For 2013/14, our external auditors have to provide a limited assurance report on whether two mandated indicators included in the Quality Account / Report have been reasonably stated in all material respects. In addition the Council of Governors have the option to choose one further local indicator for external assurance. The three indicators which have been included in the external assurance of the Quality Account / Report 2013/14 are:

- The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care.
- The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper.
- Percentage of complaints satisfactorily resolved.

The full definitions for these indicators are contained in **appendix 5.**

Our stakeholders' views

The Trust recognises the importance of the views of our stakeholders as part of our assessment of the quality of the services we provide and to help us drive change and improvement. How we involve and listen to what our stakeholders say about us is critical to this process. In producing the Quality Account / Report 2013/14, we have tried to improve how we involved our stakeholders in assessing our quality in 2013/14.

The following are some positive comments we received from our stakeholders following the two events we held in July 2013 and February 2014:

- *Honest and open with data presented – as always.*
- *Good to have an opportunity to discuss the issues.*
- *Group work was useful and wide ranging.*
- *No facilitation and leading on issues – good listening.*
- *Good quality discussion.*
- *Very positive attitude to create progress.*
- *Good pre-event reading / informative material (i.e. Information Pack).*
- *Mix of ideas and participants.*
- *Good to be part of the development of the Quality Account / Report and see where our work fits in.*

The following are the comments from our stakeholders on things we could do better in our Quality Account / Report:

- *Try to increase attendance and encourage wider participation e.g. GPs, people with direct patient contact.*
- *Try running two events to avoid peak holiday time.*
- *No chance to network as work groups stayed the same.*
- *A long afternoon – could have been done in less time if presentations shorter.*
- *Get views from people not in the room – websites, twitter, facebook.*

In response the Trust will continue to make the production of the Quality Account / Report an open and transparent process and encourage participation through its stakeholder events and systems for reporting quality and assurance to its stakeholders.

In line with national guidance, we have circulated our draft Quality Account / Report for 2013/14 to the following stakeholders:

- NHS England – Area Teams (x2)
- Clinical Commissioning Groups (x9)
- Health & Wellbeing Boards (x7)
- Local Authority Overview & Scrutiny Committees (x7)
- Local HealthWatch (x7)

All the comments we have received from our stakeholders are included verbatim in **Appendix 3**.

The following are the general themes received from stakeholders in reviewing our Quality Account / Report for 2013/14:

- *To add end May.*

Our stakeholders did raise a number of points of clarity and, where possible, these have been addressed in the document before publication. However, the Trust will write to each stakeholder addressing each comment made following publication of the Quality Account / Report 2013/14 and as part of an annual lessons learnt exercise in preparation for the Quality Account / Report 2014/15.

In response to many stakeholders' requests, the Trust has agreed to continue providing all stakeholders with a half-year update in November 2014 on the Trust's progress with delivering its quality priorities and metrics for 2014/15.

Appendix 1

2013/14 STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY ACCOUNT / REPORT

The Directors are required under the Health Act 2009 and the National Health Service (Quality Account) Regulations 2010 to prepare Quality Accounts / Report for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Account / Report (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Account / Report.

In preparing the Quality Account / Report, Directors are required to take steps to satisfy themselves that:

- the content of the Quality Account / Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14;

- the content of the Quality Account / Report is not inconsistent with internal and external sources of information including:

    - Board minutes and papers for the period April 2013 to June 2014;
    - Papers relating to Quality reported to the Board over the period April 2013 to June 2014;
    - Feedback from the commissioners dated May 2014;
    - Feedback from Governors dated 19th March & 7th April 2014;
    - Feedback from Local Healthwatch organisations dated May 2014;
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated ?nd May 2014
    - The latest national patient survey published on 17th September 2013;
    - The latest national staff survey published on 25th February 2014;
    - The Head of Internal Audit's annual opinion over the Trust's control environment received by the Audit Committee on ?th May 2014;
    - Care Quality Commission quality and risk profiles dated 8th April 2014.

- the Quality Account / Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;

- the performance information reported in the Quality Account / Report is reliable and accurate;

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account / Report, and these controls are subject to review to confirm that they are working effectively in practice;

- the data underpinning the measures of performance reported in the Quality Account / Report is robust and reliable, conforms to specified data quality

standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Account / Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Account / Report regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Account / Report (available at: www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275)

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

By order of the Board

Date: Chairman

Date: Chief Executive

Appendix 2

2013/14 LIMITED ASSURANCE REPORT ON THE CONTENT OF THE QUALITY ACCOUNTS / REPORT AND MANDATED PERFORMANCE INDICATORS

To add end May

Appendix 3

FEEDBACK FROM OUR STAKEHOLDERS

The following responses to our stakeholders were received from our stakeholders (in alphabetical order):

To add end May

The following stakeholders were given the opportunity to comment on our draft Quality Account / Report for 2013/14 and made a short comment by email:

- *To add end May*

The following stakeholders were given the opportunity to comment on our draft Quality Account / Report for 2013/14 but chose to offer no comments:

- *To add end May*

Appendix 4

KEY THEMES FROM 81 LOCAL CLINICAL AUDITS (186 INDIVIDUAL AUDITS) REVIEWED IN 2013/14

Audit Theme	Summary of Actions
Infection Prevention and Control (IPC) audits (77 individual audits of ward / team areas)	• All infection prevention and control audits are continuously monitored by the IPC team and required actions are rectified collaboratively with the IPC team and ward staff.
Clinical audit of NICE guidance on autism (2 local clinical audits)	• The findings of the audit are to be used to inform an adult autism rapid process improvement workshop (RPIW) and rapid pathway development workshop (RPDW) scheduled in 2014/15. • The audit results are to be cascaded across adult mental health services to encourage participation in autism training in 2014/15.

Clinical audit of NICE guidance on bipolar disorder (2 local clinical audits)	• The findings will be highlighted in the audit bulletin to improve awareness of the specific requirements to:
	  ◦ Consider alternative options if there has been no response to a combination of preventative medications.
	  ◦ Further encourage patient involvement in relapse prevention and self help support groups.
	  ◦ Further encourage family/carer involvement in support groups.
	• The results to be discussed in all consultant groups, specifically to:
	  ◦ Increase awareness to ensure physical health checks are completed fully, routinely and recorded on PARIS (the electronic patient record).
	  ◦ Further ensure that when medication is changed, a clear statement should be entered on PARIS of the factors considered including psychiatric factors, physical health and patient preference.
	  ◦ Further ensure that a statement is entered on PARIS (at least annually) about the patient's views of their treatment.
	  ◦ Further ensure the most appropriate referral route for obtaining a second opinion for people with treatment resistant bipolar disorder.
	  ◦ Further ensure that the risk of suicide/self harm is documented regularly (at least at each review for stable low risk patients).
	• To be re-audited with new audit tool in 2014/15.

Audit Theme	Summary of Actions
Clinical audits of supervision (local clinical audits across 4 service areas)	• Team / ward managers / clinical leads to ensure a high standard of supervision in line with the Trust's supervision policy, including: ◦ All staff to have identified their own clinical supervisor within one month of start date or change of supervisor ◦ A copy of all clinical supervision contracts to be retained in staff personal files ◦ Increasing the number of staff encouraged to participate in a minimum of eight one- hour clinical supervision sessions and four one-hour managerial supervision sessions per year ◦ Ensuring supervision logs are kept up-to-date. ◦ Ensuring supervision to address work pressures e.g. sickness absence, stress management, caseload management ◦ Where appropriate establish monthly peer group supervision sessions.
Clinical risk assessment and management audits (local clinical audits across 7 service areas)	• Audit results to be disseminated to teams and individuals highlighting key themes where further improvement can be made. • A key facts bulletin to be developed and published to all staff to encourage further improvement on risk assessment and management. • Feedback sessions to be held with the Team managers for the individual cases where data was not recorded sufficiently. • Refresher training to be provided to staff on specific areas including: the responsibilities of the 'lead professional' role; the use of SAMURAI risk assessment tool; recording risk assessments on PARIS; ensuring risk assessment information is linked to the care plan. • A re-audit of cases highlighted as not meeting the standard to be performed following refresher training. • Deputy medical directors to have discussion with clinical directors regarding sign off of risk assessments by consultants. • Ensure that risk assessment and management is routinely discussed as part of clinical supervision.
Clinical audit of safer lithium monitoring audits (3 local clinical audits)	• Audit results to be shared with the safe medication practice group and fed back to prescribers in teams. • Key areas for further improvement to highlight: ◦ Ensuring lead professionals / care co-ordinators continue to document efforts made for monitoring and record outcome of discussion with patient on PARIS. ◦ Ensuring prescribers continue to discuss monitoring with patient, and if patient is not aware of this then letter to GP should reflect this. ◦ Ensure all patients are given/offered a lithium alert card and this is documented on PARIS. ◦ Ensuring staff continue to document PARIS what monitoring has been done / offered. • To explore possibility of reviewing lithium visual display boards to include key headings (e.g. BMI etc).

Audit Theme	Summary of Actions
Suicide prevention audits (3 local clinical audits across 5 service areas)	• Individual inpatient ward and community team action plans were produced at the time of auditing. Action plans will be monitored via the appropriate locality governance routes. • The findings from the audit shall be used as evidence within the quality priority for 2014/15: to have more staff trained in specialist suicide prevention and intervention *(see page 47 & 48)*.

Transfers of care audits (local clinical audits across 5 service areas)	• The audit report will be shared with the relevant service governance groups and with care pathway work streams to build findings into standard operating procedures.
	• The audit report to be discussed with the Trust's CPA project lead to further embed standards of best practice into care coordination practice.
	• Key areas for services to further improve transfers include:
	  ◦ Ensuring the staff record a narrative on forensic history including stating where no forensic history exists.
	  ◦ Further ensuring that staff review care plans within one month of discharge and provide patients/carers with a written copy of their care plan.
	  ◦ Ensuring that for patients who have transferred from mental health inpatients services, the receiving care coordinator documents the outcome of the 7 day follow-up, including FACE risk assessment.
	• Ward and team managers will randomly spot check at least two discharges per month and report findings to the relevant service governance groups.

Safeguarding children audits (3 local clinical audits)	• Audit lead to produce lessons learned briefing for all the safeguarding team and link professionals which includes a summary of the audit and identified areas for improvement. • Link professionals and safeguarding team to use the lessons learned bulletin to further support the training provided to staff with a focus on the improvement areas identified. • The senior nurse to remind safeguarding children supervisors of the importance of ensuring records identify the date and findings of when the child was last seen and, if appropriate, spoken to. • Clear explanations of consent for child protection, child in need and common assessment framework referrals to be included on Trust's webpage on safeguarding children and in safeguarding children training. • Perform a mapping exercise to look at who the current link professionals are, what areas they cover and where the gaps are. • Following identification of gaps, senior managers to be informed and asked to address this by identifying link professionals. • E-bulletin notice to inform staff of who their named nurse and doctor are for safeguarding children, and also the role of the safeguarding team and link professionals.

Appendix 5

QUALITY PERFORMANCE INDICATOR DEFINITIONS

Percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care

Data definition:

All patients discharged to their place of residence, care home, residential accommodation, or to non psychiatric care must be followed up within 7 days of discharge. All avenues need to be exploited to ensure patients are followed up within 7 days of discharge*. Where a patient has been discharged to prison, contact should be made via the prison in-reach team.

Exemptions:

- Patients who die within 7 days of discharge may be excluded.
- Where legal precedence has forced the removal of the patient from the country.
- Patients transferred to NHS psychiatric inpatient ward.
- CAMHS (children and adolescent mental health services) are not included.

The 7 day period should be measured in days not hours and should start on the day after discharge.

Accountability:

Achieving at least 95% rate of patients followed up after discharge each quarter.

* Follow up may be face-to-face or telephone contact, this excludes text or phone messages

The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper*.

Data definition:

Gate-keeping: in order to prevent hospital admission and give support to informal carers, crisis resolution home treatment teams are required to gate-keep all admission to psychiatric inpatient wards and facilitate early discharge of service users. An admission has been gate-kept by a crisis resolution team if they have assessed** the service user before admission and if the crisis resolution team was involved in the decision making-process, which resulted in an admission.

Total exemption from crisis resolution home treatment teams gate-keeping:

- Patients recalled on a Community Treatment Order.
- Patients transferred from another NHS hospital for psychiatric treatment.
- Internal transfers of service users between wards in the Trust for psychiatry treatment.
- Patients on leave under Section 17 of the Mental Health Act.

- Planned admission for psychiatric care from specialist units such as eating disorder unit.

Partial exemption:

Admissions from out of the Trust area where the patient was seen by the local crisis team (out of area) and only admitted to this trust because they had no available beds in the local areas. Crisis resolution home treatment teams should assure themselves that gate-keeping was carried out. This can be recorded as gate-kept by crisis resolution home treatment teams.

* This indicator applies to patients in the age bracket 16-65 years and only applies to CAMHS patients where they have been admitted to an adult ward.

** An assessment should be recorded if there is direct contact between a member of the team and the referred patient, irrespective of the setting, and an assessment made. The assessment should be face-to-face and only by telephone where face-to-face is not appropriate or possible

Percentage of complaints satisfactorily resolved

Numerator:

From the number of resolution letters sent during the month the number where there is no indication that the complainant indicates they are not happy with the response and wants further action following receipt of the resolution letter.

Denominator:

Number of resolution letters sent within the month.

Indicator format:

Standard percentage.

Appendix 6

GLOSSARY

Affective Disorders: are mental disorders reflected in disturbances of mood. They may be regarded as lying along the affective spectrum a grouping of related psychiatric and medical disorders which may accompany bipolar, unipolar, and schizoaffective disorders at statistically higher rates than would normally be expected.

Antipsychotic Medication: an antipsychotic (or neuroleptic) is a psychiatric medication primarily used to manage psychosis (including delusions, hallucinations, or disordered thought), particularly in schizophrenia and bipolar disorder, and is increasingly being used in the management of non-psychotic disorders.

Attention Deficit Hyperactivity Disorder (ADHD): one of the most common childhood disorders and can continue through adolescence and adulthood. Symptoms include difficulty staying focused and paying attention, difficulty controlling behavior, and hyperactivity (over-activity).

Autistic Spectrum Disorders: describes a range of conditions including autism, Asperger syndrome, pervasive developmental disorder not otherwise specified (PDD-NOS), childhood disintegrative disorder, and Rett syndrome, although usually only the first three conditions are considered part of the autism spectrum. These disorders are typically characterized by social deficits, communication difficulties, stereotyped or repetitive behaviors and interests, and in some cases, cognitive delays.

Bipolar disorder: is a mental illness typically classified as a mood disorder. It is characterized by episodes of an elevated or agitated mood known as mania, usually alternating with episodes of depression.

Body Mass Index (BMI): is a measure for human body shape based on an individual's mass and height

C Difficile: a species of bacteria of the genus Clostridium that causes severe diarrhea and other intestinal disease when competing bacteria in the gut flora have been wiped out by antibiotics.

Care Programme Approach (CPA): describes the approach used in specialist mental health care to assess, plan, review and co-ordinate the range of treatment care and support needs for people in contact with secondary mental health services who have complex characteristics. It is a called “an approach” rather than just a system because the way that these elements are carried out is as important as the actual tasks themselves. The approach is routinely audited.

Care Quality Commission (CQC): the independent regulator of health and social care in England who regulate the quality of care provided in hospitals, care homes and people's own homes by the NHS, local authorities, private companies and voluntary organisations, including protecting the interests of people whose rights are restricted under the Mental Health Act.

Clinical Commissioning Groups (CCGs): NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. CCGs are clinically led groups that include all of the GP groups in their geographical area. The aim of this is to give GPs and other clinicians the power to influence commissioning decisions for their patients. CCGs are overseen by NHS England.

Clozapine: is an atypical antipsychotic medication used in the treatment of schizophrenia.

Commissioning for Quality and Innovation (CQUIN): is a payment framework such that a proportion of NHS providers' income is conditional on quality and innovation. Its aim is to support the vision set out in *High Quality Care for All* of an NHS where quality is the organising principle.

Council of Governors: the Council of Governors is made up of elected public and staff members, and also includes non elected members, such as the Prison Service, Voluntary Sector, Acute Trusts, Universities, Primary Care Trusts and Local Authorities. The Council has an advisory, guardianship and strategic role including developing the Trust's membership, appointments and remuneration of the Non Executive Directors including Chairman and Deputy Chairman, responding to matters of consultation from the Trust Board, and appointing the Trust's auditors.

Divisions: services in TEWV are organised around six Divisions: Adult Metal Health Services, Substance Misuse Services, Mental Health Services for Older People, Adult Learning Disability Services, Children & Young Peoples Services, Forensic Services – see also Localities

FACE Risk Assessment: a portfolio of assessment tools designed for adult and older people's mental health settings. Risk is assessed using the FACE Risk Profile based on four factors: violence; self-harm / suicide; and self neglect / vulnerability.

Forensic Services: forensic mental health and learning disability services work mainly with people who are mentally unwell or who have a learning disability and have been through the criminal justice system. The majority of people are transferred to secure hospital from prison or court, where their needs can be assessed and treated. These services are intended to see that people with severe mental illness or learning disability who enter the criminal justice system get the care they need.

Health Care Associated Infections (HCAIs): treatment-resistant infection contracted as a consequence of being in contact with healthcare services, predominantly MRSA and c-difficile.

Healthwatch: local bodies made up of individuals and community groups, such as faith groups and residents' associations, working together to improve health and social care services. They aim to ensure that each community has services that reflect the needs and wishes of local people.

Hospital Episode Statistics (HES): is the national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere. HES is the data source for a wide range of healthcare analysis for the NHS, Government and many other organisations and individuals.

Information Governance Toolkit & Assessment Report: is a national approach that provides a framework and assessment for assuring information quality against national definitions for all information that is entered onto computerised systems whether centrally or locally maintained.

Lithium: lithium carbonate is a medicine which is used in depression, mania, bipolar disorder, self-harming behaviour and treating aggressive behaviour.

Localities: services in TEWV are organised around three Localities (i.e. County Durham & Darlington, Tees, North Yorkshire) and one Directorate (i.e. Forensic Services) – see also Divisions.

Mental Capacity Act: is a framework to provide protection for people who cannot make decisions for themselves. It contains provision for assessing whether people have the mental capacity to make decisions, procedures for making decisions on behalf of people who lack mental capacity and safeguards. The underlying philosophy of the MCA is that any decision made, or action taken, on behalf of someone who lacks the capacity to make the decision or act for themselves must be made in their best interests.

Mental Health Research Network (MHRN): is part of and funded by the National Institute for Health Research and provides the NHS infrastructure to support commercial and non-commercial large scale research in mental health including clinical trials.

Monitor: the independent economic regulator for NHS Foundation Trusts.

MRSA: is a bacterium responsible for several difficult-to-treat infections in humans. MRSA is especially troublesome in hospitals, prisons and nursing homes, where patients with open wounds, invasive devices, and weakened immune systems are at greater risk of infection than the general public.

National Audit of Psychological Therapies (NAPT): funded by the Healthcare Quality Improvement Partnership (HQIP) and is an initiative of the College Centre for Quality Improvement (CCQI). Aims to promote access, appropriateness, acceptability and positive outcomes of treatment for those suffering from depression and anxiety.

National Confidential Inquiries (NCI) and National Clinical Audit: research projects funded largely by the National Patient Safety Agency (NPSA) that examine all incidents of, for example suicide and homicide by People with Mental Illness, with the aim is to improve mental health services and to help reduce the risk of these tragedies happening again in the future. Supported by a national programme of audit.

NHS Service User Survey: the annual survey of service users' experience of care and treatment received by NHS Trusts. In different years has focussed both on inpatient and community service users.

NHS Staff Survey: an annual survey of staffs' experience of working within NHS Trusts.

National Institute for Clinical Excellence (NICE): NHS body that provides guidance, sets quality standards and manages a national database to improve people's health and prevent and treat ill health. NICE works with experts from the NHS, local authorities and others in the public, private, voluntary and community sectors - as well as patients and carers - to make independent decisions in an open, transparent way, based on the best available evidence and including input from experts and interested parties.

National Institute for Health Research (NIHR): an NHS research body aimed at supporting outstanding individuals working in world class facilities to conduct leading edge research focused on the needs of patients and the public.

National Reporting and Learning System (NRLS): an NHS led central database of information on patient safety incidents used to identify and tackle important patient safety issues at their root cause.
National Research Passport Scheme: a scheme to streamline procedures associated with issuing honorary research contracts or letters of access to researchers who have no contractual arrangements with NHS organisations who host research, and who carry out research in the NHS that affects patient care, or requires access to NHS facilities.

National Strategic Executive Information System (STEIS): a new Department of Health system for collecting weekly management information from the NHS.

Near Misses: an event or circumstance that could have resulted in unnecessary damage, loss or harm such as physical or mental injury to a patient, staff, visitors or members of the public which was averted through intended or unintended action.

Overview & Scrutiny Committees (OSCs): statutory committees of the Local Authority provided to scrutinise the development and progress of strategic and operational plans of multiple agencies within the Local Authority area. One such OSC is for Health & Wellbeing.

PARIS: the Trust's electronic care record, product name PARIS, designed with mental health professionals to ensure that the right information is available to those who need it at all times

Patient Advice & Liaison Team (PALs): the team working with the Trust that provides advice and information about Trust services or signposting people to other agencies, and manages service users' and carers' comments, concerns or complaints.

Payment by Results (PBR): a new system being implemented across the NHS, and piloted in mental health Trusts, to provide a transparent, rules-based system for paying NHS Trusts. The system aims to reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions. Payment will be linked to activity, adjusted for case-mix, and outcomes. Importantly, this system aims to ensure a fair and consistent basis for hospital funding rather than being reliant principally on historic budgets and the negotiating skills of individual managers.

Personality Disorder: class of personality types and enduring behaviours associated with significant distress or disability, which appear to deviate from social expectations particularly in relating to other humans.
Prescribing Observatory in Mental Health (POMH): a national agency, led by the Royal College of Psychiatrists, that aims to help specialist mental health services improve prescribing practice via clinical audit and quality improvement interventions.

Psychosis: is the term used to describe a type of mental health issue that seriously affects the way that a person thinks or feels and where the person can lose contact with reality.

Quality and Assurance Committee (QuAC): sub-committee of the Trust Board responsible for quality and assurance.

Quality and Assurance Groups (QuAG): Locality / divisional groups within the Trust responsible for quality and assurance.

Quality Risk Profile Reports: The Care Quality Commission's (CQC) tool for providers, commissioners and CQC staff to monitor provider's compliance with the essential standards of quality and safety.

Rapid Process Improvement Workshop (RPIW): a technique for improving quality within the overall TEWV Quality Improvement System (QIS)

Root Cause Analysis (RCA): a technique employed during an investigation that systematically considers the factors that may have contributed to the incident and seeks to understand the underlying causal factors.

Schizophrenia: is a mental disorder characterized by a breakdown in thinking and poor emotional responses. Common symptoms include delusions, such as paranoia; hearing voices or noises that are not there; disorganized thinking; a lack of emotion and a lack of motivation.

Section 136 of the Mental Health Act: is the law which can be used to admit a person to hospital for assessment and/or treatment for a mental illness. The police can use section 136 of the Mental Health Act to take a person to a place of safety when they are in a public place. They can do this if they think the person has a mental illness and are in need of care. A place of safety can be a hospital or a police station. The police can keep the person under this section for up to 72 hours. During this time, mental health professionals can arrange for a Mental Health Act assessment.

Serious Untoward Incidents (SUIs): defined as an incident that occurred in relation to NHS-funded services and care, to ether patient, staff or member of the public, resulting in one of the following: unexpected / avoidable death, serious / prolonged / permanent harm, abuse, threat to the continuation of the deliver of services, absconding from secure care.

TEWV Quality Improvement System (QIS): the Trust's framework and approach to continuous quality improvement based on Kaizen / Toyota principles.

Unexpected Death: a death that is not expected due to a terminal medical condition or physical illness.

Visual Control Boards: a technique for improving quality within the overall TEWV Quality Improvement System (QIS).

AUDIT AND GOVERNANCE COMMITTEE

15 May 2014

HARTLEPOOL BOROUGH COUNCIL

Report of: AUDIT AND GOVERNANCE COMMITTEE

Subject: DRAFT FINAL REPORT – INVESTIGATION INTO CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

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1. PURPOSE OF REPORT

1.1 To present the draft findings of the Audit and Governance Committee following its investigation into Chronic Obstructive Pulmonary Disease (COPD).

2. BACKGROUND

2.1 The Audit and Governance Committee met on the 27 June 2013 to consider their Work Programme and agreed that the Committee would in 2013/14 focus on COPD as the health topic for investigation.

2.2 COPD is a chronic disabling disease which causes a gradual decline in lung function, with increasing episodes of chest infections and exacerbations as the condition progresses. It is a general term which includes chronic bronchitis and emphysema. It mainly affects people over the age of 40 and risk increases with age. Smoking is the main cause in the vast majority of cases.

2.3 COPD is incurable but treatments help to slow down the decline in the lung function therefore early diagnosis and support for effective self-management and self-care can help patients live an active life. About 835,000 people in the UK are currently diagnosed with COPD and an estimated 2.2 million people have the condition but do not know it. COPD is the fourth biggest killer in the UK, the second most common cause of emergency admissions to hospital and one of the most costly in-patient conditions treated by the NHS. In Hartlepool, there is a decreasing trend in the number of deaths from COPD but the number of people with COPD is increasing, placing additional demand on services[1].

[1] Hartlepool Joint Strategic Needs Assessment – www.teesjsna.org.uk

2.4 The key issues, as identified in Hartlepool's Joint Strategic Needs Assessment (JSNA), relating to COPD are as follows:-

(a) The estimated prevalence of COPD in Hartlepool is 4.3% but only 2.7% of the population has been diagnosed. This suggests that about 1,250 people with COPD remain undiagnosed.
(b) There is a lack of community awareness of COPD and its risk factors.
(c) There are high numbers with undiagnosed COPD that may lead to increased complications, ill health and health inequalities and inefficiency.
(d) The number of people with COPD is increasing, placing additional demand on services.
(e) There are variations in the quality of diagnosis and management of COPD among general practices.
(f) The COPD emergency admission rate in Hartlepool is higher than the England average.
(g) The capacity and capability of current services to cope with the projected increase in the number of people with COPD, from a recorded prevalence of 2.7% in 2010 to 4.4% in 2020.
(h) There is low awareness of lung health and COPD in communities that are at high risk, for example, current and ex-smokers and women.

(i) There is inequitable access to high quality spirometry in primary care and Community settings.

3. OVERALL AIM OF THE SCRUTINY INVESTIGATION

3.1 The overall aim of the Scrutiny investigation was to examine the effectiveness of the services and pathways available to people diagnosed with COPD and explore how awareness of COPD can be increased to aid early diagnosis and prevention.

4. TERMS OF REFERENCE FOR THE SCRUTINY INVESTIGATION

4.1 The Terms of Reference for the Scrutiny investigation were as outlined below:-

(a) To gain an understanding of COPD and the pathways available to people diagnosed with COPD (including the causes; signs and symptoms; prevention; and treatment);

(b) To consider the numbers of people with COPD in Hartlepool and examine the impact of unplanned emergency admissions on service provision;

(c) To identify the services available in Hartlepool for those diagnosed with COPD and ensure effective partnership working to encourage / increase early diagnosis and positive treatment outcomes;

(d) To examine the quality of diagnosis and management / treatment of COPD across GP practices and NHS services in Hartlepool;

(e) To explore how community awareness of COPD can be increased, in particular to those people / communities who are 'seldom heard, seldom seen' and to people / communities that are at high risk, for example, current and ex smokers and women;

(f) To seek the views of COPD patients and their families and carers; and groups / bodies who provide services for people diagnosed with COPD

5. MEMBERSHIP OF THE AUDIT AND GOVERNANCE COMMITTEE

5.1 The membership of the Scrutiny Forum was as detailed below:-

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

6. METHODS OF INVESTIGATION

6.1 Members of the Audit and Governance Committee met formally from 22 August 2013 to 2 May 2014 to discuss and receive evidence relating to this investigation. A detailed record of the issues raised during these meetings is available from the Council's Democratic Services.

6.2 A brief summary of the methods of investigation are outlined below:-

(a) Setting the Scene presentation from the Public Health Team

(b) Presentation and verbal evidence received from North Tees and Hartlepool NHS Foundation Trust

(c) Presentation and verbal evidence received from the Hartlepool and Stockton-on-Tees Clinical Commissioning Group

(d) Presentation and verbal evidence received from the British Lung Foundation

(e) Presentation and verbal evidence received from Stockton and Hartlepool Stop Smoking Service

(f) Presentation, written and verbal evidence received from Tees Valley Public Health Shared Service

(g) Focus Group held on 10 December 2013

(h) Written evidence received from the COPD Exercise Group

(i) Presentation from Hartlepool Families First

(j) Report of HealthWatch Hartlepool entitled 'Listening to the Seldom Heard'

7. FINDINGS

WHAT IS COPD AND WHAT ARE THE PATHWAYS AVAILABLE TO PEOPLE DIAGNOSED WITH COPD (INCLUDING THE CAUSES; SIGNS AND SYMPTOMS; PREVENTION; AND TREATMENT)

7.1 Members at their meeting of 3 October 2013 received a setting the scene presentation from the Council's Specialty Registrar in Public Health to gain an understanding of COPD and the pathways available to people diagnosed with COPD (including the causes; signs and symptoms; prevention; and treatment).

Signs, Symptoms and Causes of COPD

7.2 Members were informed that COPD is the name for a collection of lung diseases including chronic bronchitis and emphysema.

7.3 The principal cause of COPD is smoking. At least four out of five people who develop the disease are, or have been, smokers. Exposure to certain types of dust and chemicals at work, including grains, isocyanates, cadium and coal, have been linked to the development of COPD, even in people who do not smoke. The lining of the airways becomes inflamed and permanently damaged by smoking. This damage cannot be reversed. There is a rare genetic tendency to develop COPD called alpha-1-antitrypsin deficiency which causes COPD in about 1% of cases.

7.4 Members were interested to know about the numbers of people suffering with COPD who had not smoked but had been diagnosed with the disease and the potential causes other than smoking. The Public Health Registrar confirmed that not all people diagnosed with COPD were smokers or ex-smokers, and that people could have contracted the disease through environmental factors. Although looking at the population as a whole, the vast majority of COPD is smoking related.

7.5 The symptoms of COPD usually develop over a number of years and many people are unaware that they have the condition. COPD does not usually become noticeable until after the age of 35. Some of the signs include:-

- increasing breathlessness when exercising or moving around
- a persistent cough with phlegm that never seems to go away
- frequent chest infections, particularly in winter
- wheezing
- weight loss
- tiredness and fatigue
- swollen ankles

Prevention, Diagnosis and Treatment of COPD

7.6 Being diagnosed early allows for appropriate treatment and advice and help to stop or slow the progression of COPD. In order to assess how well the lungs work a spirometry breathing test is carried out, which measures the volume of air a person can breathe out in one second. A comparison is then carried out with normally expected readings to indicate whether airways are obstructed.

7.7 The Committee was informed that early identification of COPD and reducing the numbers that presented to Accident and Emergency departments was a major target. Members acknowledged that identifying sufferers before they presented to Accident and Emergency would be extremely difficult. Twenty percent of all Accident and Emergency attendances related to COPD. Members questioned whether other venues such as the One Life Centre would be able to treat people during an exacerbation, which is a flare up of symptoms, but it was pointed out that during an exacerbation treatment by specialist respiratory team was the most appropriate response.

7.8 COPD causes about 25,000 deaths a year in the UK, progression to severe COPD can be prevented by making lifestyle changes. Stopping smoking is the single most effective way to reduce the risk of getting the condition. Early detection leads to improved outcomes and health and wellbeing.

7.9 There is no cure for COPD, but treatment can help slow the progression of the condition and reduce the symptoms. Treatments help to slow down the decline in the lung function, so early diagnosis and support for effective self management and self care can help patients live an active life. If a person smokes, the best way to prevent COPD from getting worse is for the person to seek help to stop smoking.

7.10 The main aims of therapy are to improve symptoms such as breathlessness and help prevent an exacerbation. Inhaled bronchodilators are generally the first therapies that should be offered to people with COPD. Inhaled bronchodilators and inhaled steroids are used to reduce breathlessness and the chance of an exacerbation.

Numbers of people living with COPD in Hartlepool

7.11 The following diagram illustrates those people diagnosed with COPD compared to those that are undiagnosed across the Tees Valley.

Locality	**Reported Diagnosed COPD - GP disease register aged 16+, 2010/11)**	**Estimated Undiagnosed - 'missing numbers' - with COPD (based on GP registered population aged 16+, 2010/11)**
Hartlepool	2,578	1,602

Middlesbrough	3,828	5,208
Redcar & Cleveland	3,643	2,246
Stockton	4,032	5,544
Tees Total	14,081	14,600

8. SERVICES AVAILABLE IN HARTLEPOOL FOR THOSE DIAGNOSED WITH COPD AND EFFECTIVE PARTNERSHIP WORKING TO ENCOURAGE / INCREASE EARLY DIAGNOSIS AND POSITIVE TREATMENT OUTCOMES

8.1 The Committee at their meeting of 2 May 2014 welcomed evidence from Hartlepool and Stockton-on-Tees Clinical Commissioning Group (CCG) and North Tees and Hartlepool NHS Foundation Trust (NTHFT) in relation to service provision. The Chair of the CCG informed Members that:-

- Acute services are provided via NTHFT
- There is a pulmonary rehabilitation service for stage 1-2 patients and stage 3 and 4 patients
- Community services are provided via NTHFT, which includes a Community Respiratory Assessment and Management Service (CRAMS)
- Oxygen assessment is provided

8.2 The Consultant Respiratory Physician from NTHFT explained the service pathways for patients with COPD. Members were informed that patients can use self referral via the Single Point of Access at the One Life Centre to the CRAMS team. In addition to this there is a nurse led clinic at Hartlepool and Peterlee once a month, and daily at the One Life Centre. Patients can also be referred by their GP to the weekly delivered service at the One Life Centre and the CRAMS Team.

8.3 There is also a pulmonary rehabilitation service available to COPD patients. This programme includes a physical exercise programme and advice on lung health and coping with breathlessness. It is a gold standard programme which has proven benefits for up to 18 months afterwards. It can be accessed via GPs or via the CRAMS service. The programme is based in hospital or in the community and locations are Seaham, Peterlee and Hartlepool. It is a rolling programme with no waiting list. A member of the public who attended the Committee reported that the programme does work and is very beneficial. Members recognised that pulmonary rehabilitation is a service that is effective and very helpful to COPD patients. Members

questioned whether there was anything that the Committee could do to help its success and suggested widely promoting the service.

8.4 Members were informed that a new pilot programme had recently been developed and was running from Hartlepool Hospice. The programme is a breathlessness support group and is being funded by the CCG. It is to help patients and carers with anxiety when patients become breathless. A member of the public who was present at the meeting when this programme was discussed, reported that the programme was very beneficial, as the biggest problem for COPD sufferers was managing breathlessness. It was questioned whether more could be done through GPs on how to manage breathlessness. Representatives from the CCG said that there are educational projects for GPs and nurses to roll out the lessons from such pilots. There is also a patient education programme delivered via the CRAMS service.

Partnership Work

8.5 The Committee heard that many partnerships are in place to aid early diagnosis and these include ongoing work with the Local Authority / the Public Health Team and the Area Team. There is a COPD screening programme carried out in GP practices, where all patients aged 35 or over who smoke are invited to attend for screening and practices have signed up to provide Healthy Lung checks. The CCG will also continue its partnership working with the voluntary and community sector.

8.6 The Council, through the GP Referral Co-ordinator run a weekly exercise programme for COPD patients. The group completed a questionnaire and the results highlighted that six out of ten people had reduced their need for hospital visits since they had been involved in the exercise programme. Examples of some of the comments from the group are as follows:-

"It gives you the motivation to continue to do the exercises and also helps to keep you mobile"

"Feel a lot better in my mobility; feel relaxed and more energetic after class. My balance has improved. Enjoy the class very much".

Access to Services

8.7 Members were informed that the CCG are looking at the ideal pathway between GP practices and community/hospital services, as everyone wants the best possible experience of health services. The Better Care Fund plans to try and move care from hospital into the community. The respiratory pathway and associated services are under review and further work is being undertaken to improve direct access to services.

8.8 HealthWatch Hartlepool and COPD patients reported that the CRAMS service had developed a very good reputation with patients. However, throughout this investigation, it become apparent to the Committee that

access to the CRAMS service, since the introduction of the single point of access is extremely difficult. COPD patients and family / carers reported that access to respiratory nurses used to be direct, for example patients could contact a respiratory nurse by calling him/her direct, but now access is via the single point of access number. A message is then passed onto the respiratory nurses. Both NTHFT and the CCG were aware of these problems and the Lead Respiratory Nurse at NTHFT reported that a Task and Finish Group had been set up to investigate the problems. The Group are due to meet in June to evaluate the practices and procedures. Further work is being undertaken to improve access and response times, for example, appointment times when visiting respiratory nurses have been extended and a late clinic is due to be piloted one day a week to see if this helps improve access.

8.9 The Committee was pleased to hear that there is more support for patients attending the One Life Centre as volunteers now work within the One Life Centre to escort patients to the COPD Clinic. It was acknowledged that patients have lost a little faith with the CRAMS services, and this faith needs to be restored. That is why direct access to nurses/consultants is being reviewed and a new pathway of care being developed. The Lead Respiratory Nurse commented that the satisfaction surveys that she sent out to COPD patients highlighted that patients were not happy with access to the service. A leaflet is also being collated with key contacts and patients will be asked to evaluate it to see if it will help improve access and the information provided to patients.

8.10 Members raised concerns about access to GPs and how there are problems with people not being able to get appointments. The Chair of the CCG commented that there are new changes to GP contracts, from 1 April 2014, which means that COPD patients, over 75, have a named responsible GP, in addition to their 'family' GP. Members were informed that this is an additional service that will provide speedier access to GP services. There is also a telephone line for patients to call. The CCG want to make sure that this service enhances links with patients. In order to further help links between patients and GPs, the CCG are looking to advertise using media methods such as Sky TV and Smart TVs.

8.11 The CCG sought views on health services through a 'Call to Action' questionnaire. HealthWatch Hartlepool gathered views, using the questionnaire from under-represented groups. One of the sections in the questionnaire related to long term conditions and the top three answers in relation to what is most important to you were, services are easy to access, services are available at weekends and there are good public transport links. In relation to how services could be improved, a sample of the comments are listed below:-

- 'people with long term conditions together with their carers need to be made aware of local support groups'
- Planned follow-up with continuity of care i.e contact with the same doctor

- A better phone service – bring back direct contact with respiratory unit
-

8.12 Members received information from Hartlepool's Families First in relation to the Health Bus. The Health Bus offers a range of health advice and health checks. The Bus used to offer spirometry tests, however, the Committee was informed that the spirometry equipment was removed for use by the NTHFT community teams and was not returned. Members were informed by the Lead Respiratory Nurse that national best practice is saying that spirometry testing should be carried out by GPs and respiratory nurses. Therefore, it was suggested that the use of the COPD questionnaire was appropriate to use in locations, such as the Health Bus, to direct people to the GP if they were showing signs of COPD.

Challenges for Commissioners and Service Providers

8.13 Members were interested to hear about the challenges that both Commissioners and Service Providers face. The CCG, as Commissioner, highlighted that their challenges are as follows:

(a) Managing the increasing demand for services, with patients with multiple conditions which means increased reliance on care and costs;

(b) Improving the commissioned provision to allow patients to avoid admission;

(c) Ensure that the service review is robust enough to meet the future demands and does not need to be repeated in the near future; and

(d) Integration across health and social care

8.14 The challenges facing the service provider NTHFT, include the volume of patients, although the statistics were high it was better to have identified those patients than not. Another challenge was the low uptake of extremely effective interventions, for example, the pulmonary rehabilitation programme.

8.15 In order to improve service provision further, Members were informed that improvements to the enhanced care team and the single point of access would contribute to an improved service. Along with improving patient self referral into the CRAMs service.

8.16 The Chair of the CCG outlined further changes which will help improve services including closer links in health and social care to ensure that patients can be supported to avoid hospital admission and quickly discharged, when appropriate. Also, effective reduction in the numbers who smoke, and early diagnosis will mean fewer patients to be treated and managed in the longer term.

8.17 The Chair of the CCG highlighted to the Committee that COPD hardly happens if you do not smoke and it is about encouraging people not to

smoke or stop as soon as possible or if people cannot stop then to reduce the amount they smoke.

9. QUALITY OF DIAGNOSIS AND MANAGEMENT / TREATMENT OF COPD ACROSS GP PRACTICES AND NHS SERVICES IN HARTLPEOOL

9.1 Members received a presentation from NTHFT and the CCG at their meeting on 2 May 2014 which explained how quality of diagnosis and management of COPD is measured. Hartlepool has a higher proportion of people diagnosed with COPD but Hartlepool GP practices perform better than others in the CCG area, which is better than the National average. However, work still needs to continue to diagnose people with COPD. The Committee was informed that there was a new programme, which involves a team visiting GP practices to do comprehensive assessments of diagnosis and management of COPD, to see what is happening at a 'grass roots level'. Contracts with providers include quality measures and clinical quality review meetings.

9.2 In primary care there is a standardised criteria for diagnosis of COPD and there is ongoing clinical training, for example lunch and learn sessions.

9.3 Members were informed that NTHFT provide a rolling education programme for primary care staff, which includes COPD courses for practice nurses (there is a demand for this type of training) and COPD study days. There are new guidelines on providing COPD care and NTHFT are looking towards a gold standard management of COPD.

9.4 The review of COPD pathways currently being conducted is expected to result in, improved access; reduction in emergency admissions; and services closer to home with patients being seen in either an acute or community setting.

10. IMPACT OF UNPLANNED EMERGENCY ADMISSIONS ON SERVICE PROVISION

10.1 Members received evidence in relation to the impact of unplanned admissions on service provision. Every exacerbation that a COPD patient has reduces lung function. Representatives from NTHFT informed Members that unplanned admissions have a significant impact on COPD patients and also on NHS services. The rate of admission is 144.9 per 1000 COPD patients. Approximately six patients per week have a length of stay of one day of less, which is a cost of £160,000. The total number of beds days in 2012/2013 was 6517 with the cost of hospital interventions being £298,164 per 1000 COPD patients.

10.2 NTHFT informed Members that NTHFT was improving the enhanced care team. This service aims to reduce hospital admissions and shorten the length of stay. The service will be consultant led and will include a nurse delivered 'hospital at home' for patients with COPD. It will be a fully comprehensive service, including respiratory consultant input for every

patient. Rather than a patient coming into hospital, the patient would be visited by a specialist nurse, which would be able to provide packs, antibiotics, nebuliser etc and a follow up would be provided for five days. This will be backed up by rapid access to a GP, if needed.

10.3 Members discussed the use of rescue packs, which are packs that are kept at home with the patient that can help control an exacerbation and help prevent deterioration, which in turn avoids hospital admission. Members queried whether these packs were still available and it was confirmed by the Chair of the CCG that rescue packs were still available, however, the process for distributing them to people seems to have changed. The Committee recognised that these packs really help people with COPD and should be made readily available.

11. RAISING AWARENESS OF COPD AND BENEFITS OF EARLY DETECTION

11.1 The Committee focussed on the benefits of early detection of COPD and also how awareness can be raised of COPD at their meeting on 20 February 2014. Members received evidence from the British Lung Foundation, the Smoking Cessation Service and the Tees Valley Public Health Shared Service.

Evidence from the British Lung Foundation

11.2 The Committee welcomed evidence from Bev Wears, the Service Development Manager at the British Lung Foundation, who provided a very informative presentation outlining awareness of COPD and early detection of COPD.

11.3 Members were informed that respiratory disease is the third commonest cause of death but was not prioritised for treatment services. Members were astounded that mortality rates in the UK were twice the European average and lung cancer survival rates were also significantly lower than those in the USA.

11.4 The British Lung Foundation is the only UK charity for all lung conditions and the charity support people affected by lung disease, so that no one has to face it alone. The charity also promotes greater understanding of lung disease and the charity campaign for change in the nations' lung health. In addition to this the charity also funds vital research so that new treatments and cures can help save lives.

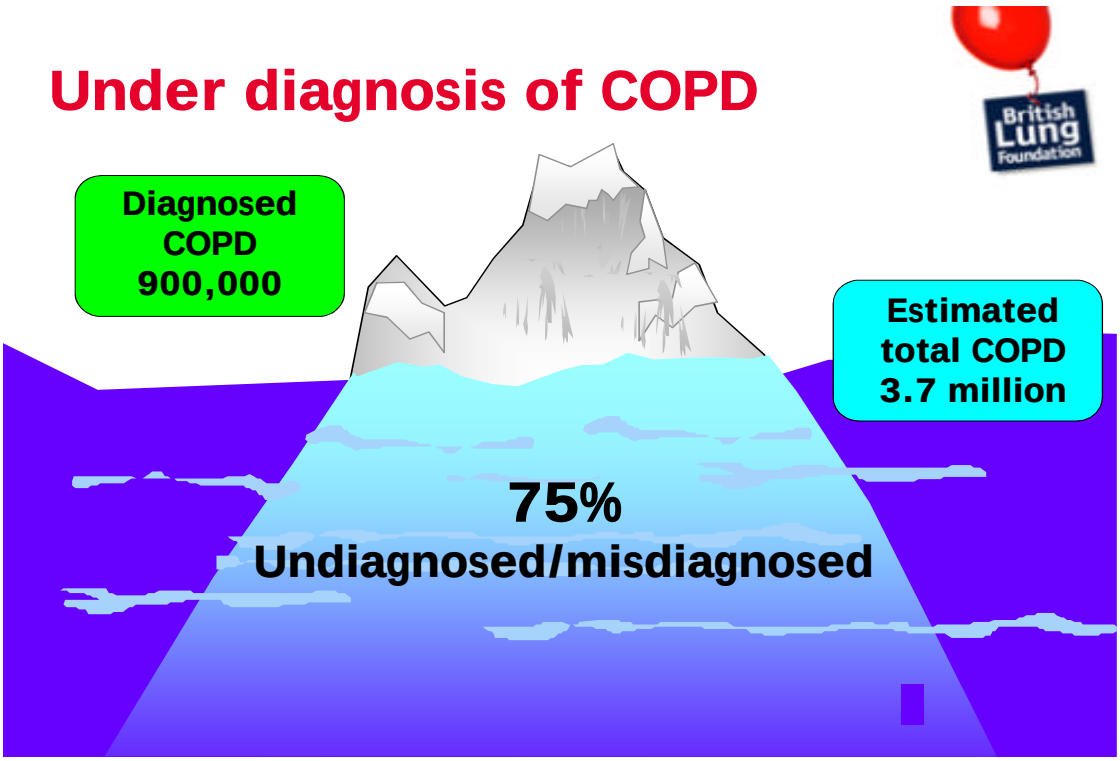
11.5 The Foundation in their Invisible Lives report mapped areas most at risk of future COPD hospital admission and found COPD hotspot areas across UK and the Foundation predict these communities are most likely to contain the 'missing millions'. The following identifies the top ten areas within the North East who have the highest proportion of people at risk of COPD:-

NORTH EAST - Top ten PCTs with highest proportion of people at risk of COPD

• South Tyneside	62% higher than UK average
• Gateshead	54%
• Sunderland Teaching	51%
• **Hartlepool**	**42%** ★
• County Durham	37%
• Middlesbrough	35%
• Newcastle	34%
• Redcar and Cleveland	28%
• North Tyneside	28%
• Darlington	11%

www.blf.org.uk

11.6 It was reiterated to the Committee that the number of people under diagnosed with COPD was extremely high and an area for concern. The diagram below illustrates the 'missing millions'.



11.7 In Hartlepool the estimated prevalence of COPD is 3.41 (% attributed populated) and the England average is 2.93%. The recorded prevalence in Hartlepool is 2.42 (% GP practice lists) against an England average of 1.69. The prevalence of undiagnosed COPD is 28.5 (% estimated with COPD).

11.8 The Committee was informed of a recent targeted awareness campaign at North Tyneside. The British Lung Foundation, CCG and North Tyneside Council worked together to deliver the awareness campaign. The campaign involved outbound calling to 5,000 'at risk' households, 6 public awareness events were held and promotion was carried out.

11.9 The Committee questioned if a targeted campaign had been undertaken in Hartlepool and they were informed that one had not happened in Hartlepool. However, the British Lung Foundation indicated they would be happy to run such a campaign subject to funding. It was highlighted that there was a systemic approach to screening for people over 35 who were or had been smokers. However, Members did raise concerns at the levels of screening undertaken by different GP surgeries as not all appeared to be proactive on COPD.

11.10 On 13 February 2014, results of a 20 year study led by researchers at Plymouth University Peninsula Schools of Medicine and Dentistry were published and found that:-

- doctors are missing chances to diagnose COPD earlier in up to 85% of cases
- 5 years before diagnosis, 85% of patients had visited their GP or hospital at least once with lower respiratory symptoms
- Opportunities were missed in 58% in 6-10 years before diagnosis and 42% in 11-15 years before diagnosis

11.11 The Committee questioned whether there is any good practice around the region that could be utilised in Hartlepool to try and help diagnose people with COPD. Overall, there is a large amount of good work being promoted around the region and within the community. However, there was variation in the work, with some excellent examples and some requiring improvement.

11.12 In relation to the resourcing services, the British Lung Foundation representative indicated that there was no uniform service delivery, therefore some areas were better resourced than others. Members thought that working with GP surgeries did limit the target group to those who visited the GP, however, wider campaigns had been carried out in the community, for example at supermarkets.

11.13 One of the key messages is around earlier diagnosis and lifestyle changes in order to increase early diagnosis of COPD. These lifestyle changes include stopping smoking and regular exercise. Other factors that need to be considered post diagnosis include good quality information at the time of diagnosis, self management options, which include written plans; educational programmes to reduce hospital admissions, improve quality of

life, improve exercise endurance and reduce depression. Also, post rehabilitation long term exercise with a trained instructor prolongs functional and emotional benefits. Of benefit are also integrated patient support groups, for example Breathe Easy Groups.

11.14 The Committee was informed about how to help manage COPD and the British Lung Foundation has developed pathways of good practice based on Nice Quality Standards. There is also a range of information produced which includes British Lung Foundation free publications, helpline and online web community, penpals and Breathe Easy Groups, living well with COPD DVD, exercise handbook and information packs available at diagnosis.

11.15 Self management plans are available which include a range of information to help manage the condition and help and contacts. A patient record book is available which contains information that will be very useful to those who treat patients.

Evidence from the Smoking Cessation Service

11.16 Representatives from the Stockton and Hartlepool Stop Smoking Service attended the meeting of the Audit and Governance Committee on 20 February 2014 to provide information on active case finding of lung ill health.

11.17 The Committee was informed that the Stop Smoking Service aimed to help people stop smoking and not only did they identify people through the GP practices but also did so within the wider community, who may not realise they were showing symptoms of COPD.

11.18 The service informed Members that they had developed a Lung Health Questionnaire with five basic questions that could lead to an individual being referred to their GP for a spirometry test. The roll out of this questionnaire to local pharmacies was also being explored. Members thought that the use of the questionnaire was very beneficial as it was a means of directing people with potential symptoms of COPD into their GP practice for screening. The Committee agreed that this questionnaire should be promoted and distributed in as many places as possible. It was noted by Members that the British Lung Foundation used a similar set of questions in its publicity and it was suggested that a consistent approach may help spread the message.

11.19 Members were supportive of advertising campaigns but were concerned that the messages are being delivered but are not having an effect, as some people with COPD are still smoking. It was suggested that educational campaigns in schools may help distribute the message.

11.20 Members highlighted that one of the areas that needed to be addressed was young people who smoked. Advertising campaigns, such as ‘every breath you take’ and ‘stobtober’ have played a major role in highlighting the dangers of smoking and helping people understand how early diagnosis of COPD can make a significant difference. One of strong messages that featured in the ‘stoptober’ campaign was the amount of money people could save if they

quit smoking, for some people this could equate to £250 per month. The Committee was of the view that as well as highlighting the chronic debilitating effects of smoking, maybe by highlighting the financial saving this would have the most effect.

11.21 The Stop Smoking Service concluded that it is about balancing prevention and treatment approaches, detecting COPD early, using the stop smoking service as a gateway and reducing NHS costs and improving quality of life.

Evidence from the Tees Valley Public Health Shared Service

11.22 Dr Ononeze, Public Health Registrar attended the Audit and Governance Committee on 20 February 2014 to provide details on the Tees COPD Screening programme. There is a Tees COPD Screening Programme called 'the missing thousands', which is about systematic early identification of patients with undiagnosed long term conditions, which is key to improving health and reducing health inequalities. It is important to reduce variations in the management of patients with long term conditions and also important in reducing emergency hospital admissions. All Hartlepool GP practices have signed up to the campaign, which started in January 2013. The funding for this programme is non-re-occuring. It is important to find people who have COPD because it is key to improving health, reducing health inequalities and reducing hospital admissions

11.23 The Committee was interested to know the numbers of people screened and diagnosed, the diagram below illustrates.

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

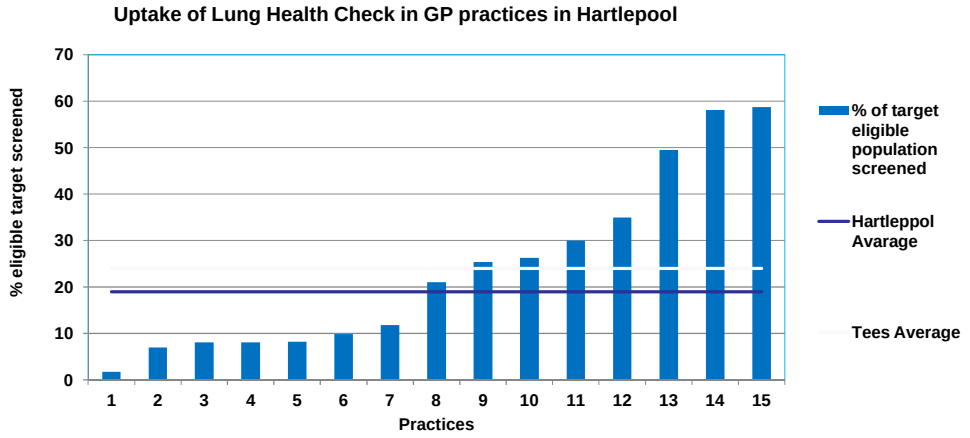
TEES VALLEY PUBLIC HEALTH SHARED SERVICE

	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%)

11.24 Members raised concerns about the variations of people diagnosed with COPD across the GP practices in Hartlepool and questioned why screening should differ significantly from one surgery to the next. Although, some areas will have higher levels of COPD, (as around 13% of those diagnosed from the current screening programme were from deprived communities) some GP practices may be more proactive in determining the illness than others. Members were of the opinion that it would be valuable for the community to know the number of screenings taking place at the various GP surgeries in Hartlepool. This would then assist people in comparing their surgery to others to determine whether to move to another surgery that was more proactive in determining illness. Dr Ononeze commented that those figures may be published in the future. The below diagram illustrates the uptake of Lung Health Checks in GP practices in Hartlepool

TEES VALLEY PUBLIC HEALTH SHARED SERVICE

Percentage of eligible target population screened by GP practices: Jan - Dec 2013



11.25 The Committee considered the cost of emergency admissions for those people with no previous COPD diagnosis and were provided with the below information:

Case for screening (2): emergency COPD admissions* in those with no previous COPD diagnosis

TEES VALLEY PUBLIC HEALTH SHARED SERVICE

	2010/11		2011/12	
Activity	**Hartlepool**	**Stockton**	**Hartlepool**	**Stockton**
Total number of patients admitted as emergency for COPD	467	717	443	689
No. of patients with no previous COPD	158	243	114	212
% of patients with no previous COPD	33.8%	33.9%	25.7%	30.8%
Cost of patient's admissions with no previous COPD	£ 309,144	£ 464,984	£ 239,976	£ 386,355

•Data relate to all Finished Consultant Episodes where the primary or secondary diagnosis was coded with a COPD ICD10 code (J40-J449). Excludes TEWV patients (provider = RX3) and MRCCS patients, NHS Tees Information Services, 2012

Darlington · Stockton-on-Tees · Middlesbrough moving forward · Hartlepool · Redcar & Cleveland

11.26 Dr Ononeze concluded her presentation by informing the Committee of the future plans, which are to embed the programme in general practices, undertake public health campaigns to raise awareness of lung health checks and explore how to implement lung health checks in appropriate community venues in order to improve availability and increase access.

12. VIEWS OF COPD PATIENTS AND THEIR FAMILIES AND CARERS AND GROUPS / BODIES WHO PROVIDE SERVICES FOR PEOPLE DIAGNOSED WITH COPD

12.1 The Committee recognises that COPD can affect daily life in many ways and by keeping healthy, being as active as possible, learning breathing techniques, and taking medication as prescribed can help to reduce the symptoms of COPD. The Committee held a focus group for COPD patients and their families and carers on 10 December 2013 to explore patient pathways and experiences.

12.2 The following summarises the key issues that were raised during the focus group session:-

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.

12.3 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.

13. CONCLUSIONS

13.1 The Audit and Governance Committee concluded that:-

(a) Early diagnosis leads to improved outcomes and improved health and wellbeing:

(b) That stopping smoking is the most effective way to reduce the risk of COPD and targeting young people could help to reduce the numbers of young people smoking;

(c) Exercise programmes, such as pulmonary rehabilitation are an extremely effective intervention and need to be widely prompted to encourage people to attend;

(d) Work needs to continue to try and diagnosis the 'missing thousands'. The Committee was supportive of the 'missing thousands campaign';

(e) The service provision that is provided to COPD patients and their families is very good, however, patients are finding it difficult to access services and it is hoped that the review of the COPD pathways, including a review of the single point of access, will result in better direct access to services and to GP appointments;

(f) That COPD rescue packs are very beneficial to COPD patients and should be widely available to people with COPD;

(g) Overall, there is a large amount of good work being promoted around COPD, however, there is variation in the work, with some excellent examples and some requiring improvement;

(h) The level of screening undertaken by different GP surgeries varies and it appears that not all surgeries are proactive on COPD screening;

(i) There are a variety of questionnaires used to direct people who may have COPD to their GP for screening. The Committee agreed that the questionnaires were very beneficial but would be helpful if a consistent approach across organisations could be developed, with the use of a single questionnaire.

14. RECOMMENDATIONS

14.1 The Audit and Governance Committee has taken evidence from a wide variety of sources to assist in the formulation of a balanced range of recommendations. The Forum's key recommendations to the Health and Wellbeing Board are as outlined below:-

(a) That the Health and Wellbeing Board develop a strategic approach to COPD to ensure that inequality is not worsened by:-

(j) monitoring the review of the single point of access to establish whether the changes have had a positive impact on COPD patients and their families

(ii) ensuring that any changes to service provision are appropriately evaluated to provide assurance that these changes are effective from an evidence and cost perspective

(b) That the Health and Wellbeing Board explores ways to promote COPD support programmes, such as the pulmonary rehabilitation programme, to encourage people to attend;

(c) That the Health and Wellbeing Board, through an integrated and co-ordinated approach, work in partnership with relevant organisations and groups to promote a consistent message on COPD through the use of a single questionnaire;

(d) That the Health and Wellbeing Board raises community awareness of COPD by placing the COPD questionnaire in community and health venues across Hartlepool to find those people with undiagnosed COPD;

(e) That the Health and Wellbeing Board explores the development of a targeted COPD awareness campaign for young people to raise awareness of the long term implications of smoking;

(f) That the Health and Wellbeing Board explores whether the number of COPD screenings taking place at various GP surgeries across Hartlepool can be publicised, as it would be valuable for the community to be aware of the variations in practices in order to aid patient choice and help to alleviate variations across GP surgeries.

COUNCILLOR KEITH FISHER
CHAIR OF THE AUDIT AND GOVERNANCE COMMITTEE

ACKNOWLEDGEMENTS

The Forum is grateful to all those who have presented evidence during the course of our investigation. We would like to place on record our appreciation, in particular of the willingness and co-operation we have received from the below

named:-

Hartlepool Borough Council:

Councillor Carl Richardson – Chair of the Health and Wellbeing Board

Louise Wallace – Director of Public Health

Andy Graham – Public Health Registrar

Lorraine Harrison – GP Referral Co-ordinator

External Representatives:

Hartlepool residents

Healthwatch Hartlepool

Hartlepool's Breathe Easy Group

Bev Wears – Service Development Manager, British Lung Foundation

Pat Marshall – Stop Smoking Service Manager, Stockton and Hartlepool Stop Smoking Service

Dr Victoria Ononeze – Public Health Specialist, Tees Valley Public Health Shared Service

Dr Monaghan - Consultant, NTHFT

Dr Elmer - NTHFT

Sandra Stych – Nurse Co-ordinator Lung Health, NTHFT

Dorothy Wood – Lead Respiratory Nurse, NTHFT

Sally Thompson, Assistant Director for Anaesthetics and Emergency Care, NTHFT

Dr Posmyk – Chair, Hartlepool and Stockton-on-Tees Clinical Commissioning Group

Deborah Ward - Hartlepool and Stockton-on-Tees Clinical Commissioning Group

Paul Thompson – Hartlepool Families First

Evidence provided to the Committee

The following evidence was presented to the Audit and Governance Committee throughout the course of the investigation into COPD:-

Date of Meeting	**Evidence Received**
22 August 2013	Scoping Report – *Scrutiny Support Officer*
3 October 2013	Setting the Scene Presentation – *Speciality Registrar in Public Health.*
10 December 2013	Focus Group with COPD patients
20 February 2014	Presentation and verbal evidence from:- - Smoking Cessation Service - Tees Valley Public Health Shared Service - British Lung Foundation
2 May 2014	Presentation and verbal evidence from:- - North Tees and Hartlepool NHS Foundation Trust - Hartlepool and Stockton on Tees Clinical Commissioning Group - Hartlepool Families First Feedback from the COPD Exercise Group

AUDIT AND GOVERNANCE COMMITTEE

HARTLEPOOL BOROUGH COUNCIL

Report of: Audit and Governance Committee

Subject: DRAFT FINAL REPORT – RE-OFFENDING INVESTIGATION

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1. PURPOSE OF REPORT

1.1 To present the draft findings of the Audit and Governance Committee following its investigation into re-offending in Hartlepool.

2. BACKGROUND

2.1 The Audit and Governance Committee met on the 27 June 2013 to establish its Work Programme for 2013/14. In doing so, the Committee agreed to select one investigation topic from within each of the areas covered by its statutory scrutiny responsibilities.

2.2 Given its role as the Councils Crime and Disorder Committee, the Audit and Governance Committee welcomed suggestions from a variety of sources in relation to potential community safety / crime and disorder topics. Information provided, highlighted the essential role of the Safer Hartlepool Partnership in reducing crime and disorder, anti-social behaviour, substance misuse and re-offending in Hartlepool and drew particular attention to the issue of re-offending and the activities being undertaken to reduce it.

2.3 Following consideration of quarterly performance reports from the Safer Hartlepool Partnership, the Committee noted the success of the activities of the Partnership and its partners in reducing the re-offending rate in Hartlepool. Prolific and young offenders reducing by 48% and 52% respectively. Members commended the improvements made but were concerned that despite the work undertaken, Hartlepool currently still has the second highest re-offending rate in the country, with adult re-offending a significant factor.

2.4 The Committee was astounded to find that the financial cost to the taxpayer of re-offending was estimated to be within the region of £9.5 billion to £13 billion per year). However, of equal concern were the other less quantifiable costs, many of which have a devastating and long-term effects on the most vulnerable in society, i.e.:

- Victims, their families and whole communities; and

- Families of re-offenders.

2.5 Given the importance of the re-offending issue and its wide ranging effects, the Committee welcomed the development of a local Reducing Re-offending Strategy to tackle high rates of re-offending. The Committee felt strongly that it could play a beneficial role in the development of the strategy, and on this basis select the issue of re-offending as its 'crime and disorder' investigation in 2013/14. The Safer Hartlepool Partnership supported the selection of re-offending by the Audit and Governance Committee as its chosen topic and welcomed input in to the strategy.

3. OVERALL AIM OF THE SCRUTINY INVESTIGATION

3.1 The overall aim of the Scrutiny investigation was to explore the level and impact of re-offending in Hartlepool and gain an understanding of the complexity of associated issues and services.

4. TERMS OF REFERENCE FOR THE SCRUTINY INVESTIGATION

4.1 The Terms of Reference for the Scrutiny investigation were as outlined below:-

(a) To ascertain the level, impact of re-offending nationally, regionally and locally and gain and understanding of the complexity of key factors which influence / impact upon it;

(b) To gain an understanding of the role and responsibilities of the local authority, and its partners, in reducing re-offending levels;

(c) To explore:-

i) National and local strategies / rehabilitation programmes in place to reduce re-offending rates and consider if they are being effectively implemented and resourced; and

ii) The services provided in Hartlepool to reduce / prevent re-offending and gain and understanding of how partners work together in the provision of these services.

(d) To explore any good practice being implemented elsewhere and consider the potential effectiveness of its use in Hartlepool; and

(e) To seek the views of service users (re-offenders and their families) in relation to their experience of services and potential improvements.

5. MEMBERSHIP OF THE AUDIT AND GOVERNANCE COMMITTEE

5.1 The membership of the Audit and Governance Committee was as detailed below:-

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

6. METHODS OF INVESTIGATION

6.1 Members of the Audit and Governance Committee met formally from 20 September 2013 to 17 April 2014 to discuss and receive evidence relating to this investigation. A detailed record of the issues raised during these meetings is available from the Council's Democratic Services.

6.2 A brief summary of the methods of investigation are outlined below and **Appendix A** to this report:-

(a) Feedback on:

- Visit to Holm House Prison
- Hartlepool Business Forum Event 'A Chance 4 Change – Exploding the Myths of Employing Ex-Offenders'

(b) 'Setting the Scene' presentation from the Community Safety Team

(c) Presentations and evidence from:

- Tees, Esk and Wear Valley NHS Foundation Trust
- North Tees and Hartlepool Foundation Trust
- Youth Offending Service (Hartlepool Borough Council)
- Hartlepool and Stockton-on-Tees Clinical Commissioning Group
- Durham Tees Valley Probation Trust
- National Offender Management Directorate (NOMS)
- Cleveland Police

(d) Written and verbal evidence from:

- Jobcentre Plus
- Member of Parliament for Hartlepool
- Cleveland Police and Crime Commissioner
- Chair of Hartlepool's Neighbourhood Services Policy Committee

(e) Offenders / Re-offenders and their families

(f) Evidence from Voluntary and Community Sector Groups:

- West View Advise and Resources Centre

FINDINGS

7. AN INTRODUCTION TO RE-OFFENDING

7.1 As a starting point for the investigation, the Committee felt that it was important to obtain a clear understanding of the issue in terms of:

- How re-offending is defined and measured; and
- The level and impact of reoffending.

7.2 How is Re-offending Measured and Defined?

7.2.1 The Committee was informed that six different measures had historically been used to record offending and re-offending rates. However, with the identification of re-offending rates as one of the main Ministry of Justice measures, for use by communities to hold local services providers to account, it became apparent that the establishment of a single measure was required. Subsequently, in 2011, a single unified measure of proven re-offending was created to bring all 6 measures in line and align the calculation / cohort. As part of the measure:-

i) Proven re-offending is defined as 'Where an offender is convicted at court or receives a caution for an offence committed within the follow-up period (12 months) and then disposed of within either this follow-up period, or waiting period (a further 6 month period)'.

ii) The cohort now includes all individuals that re-offend, including those who:

- Receive a caution, reprimand or warning;
- Receive a court conviction other than immediate custody;
- Were discharged from custody;
- Tested positive for Class A drugs on arrest
- Within a rolling 12 month period

iii) Proven reoffending is broken down by various elements, of particular interest were those by:

- Local Authority
- Probation Trust
- Youth Offending Service
- Drug Action Team
- Prison Establishment

7.2.2 Members supported the creation of a SINGLE measure of proven re-offending as a logical development, to provide information on a rolling 12 month basis, making effective comparison and service development easier. It was, however, acknowledged that the length of the data gathering process means that the data published, albeit on a quarterly basis, is nearly 2 years old. The Committee expressed concern that this makes it very difficult to develop tailored strategies for the future to effectively meet need.

7.2.3 These issues had also been recognised by Officers and the Committee commended the Community Safety Partnership, in partnership with Durham Tees Valley Probation Trust, on the implementation of a process for the collection and evaluation of up to date local data to supplement the 'SINGLE Measure' data. Details of this data were presented to the Committee as part of the evidence gathering process and have been utilised in the formulation of this report and the conclusions/recommendations contained within it.

7.3 **What is the Level and Impact of Re-offending?**

7.3.1 The Committee recognised the importance of gaining an understanding of baseline national and local offending/re-offending information, in order to effectively consider the success or otherwise of activities / services to reduce re-offending in Hartlepool. This information was presented to the Committee by the Community Safety Partnership, and Durham Tees Valley Probation Trust, at the meeting held on the 31 October 2013.

The National Position

7.3.2 Members noted with interest that on a national basis, whilst the number of offenders going to court (and overall crime rates) continued to reduce, an increasing number of those who commit crime were now receiving prison sentences. Recent figures showed that in the year up to September 2011:

- More than 400,000 crimes were committed by those who had broken the law before;

- Of those sentenced to less than 12 months, 58.5% have gone on to reoffend within 12 months of release; and

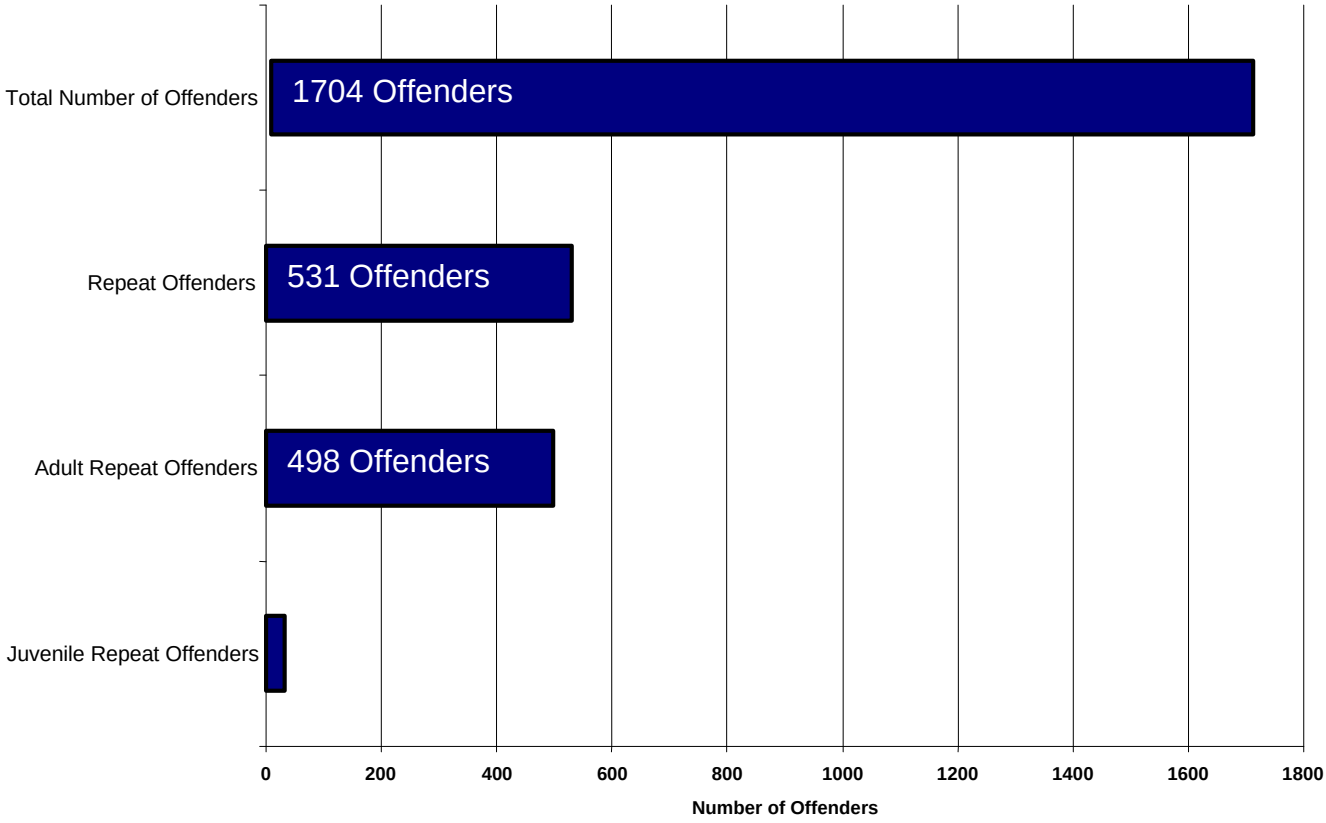
- The cost of this to the taxpayer is estimated to be £9.5 billion to £13 billion per year.

The Position in Hartlepool

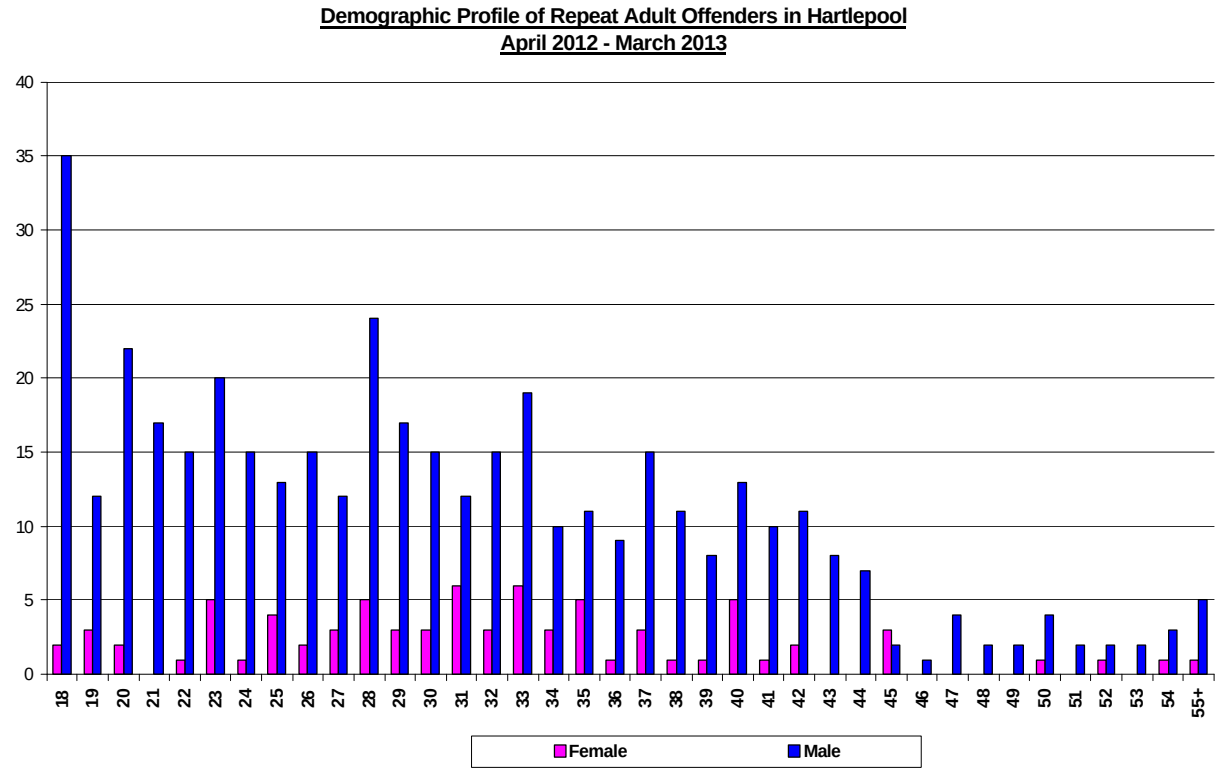
7.3.3 The Committee reiterated concern that Hartlepool currently has the second highest re-offending rate in the country, with re-offending accounting for more than two thirds of crime, and adult re-offending a significant factor within that.

7.3.4 As a starting point Members gained and understanding of the level and make up, of re-offended activity in Hartlepool and noted with interest that there are currently 1704 offenders in Hartlepool. Of this figure, 93% are adult offenders and 8% juvenile offenders. Breaking these figures down further, it became apparent to the Committee that of these 1704 offenders 500 are categorised as 'repeat offenders', and concern was expressed regarding both aspects of the composition of this figure. Whilst Members were concerned to find that the largest proportion (92% - 498) were adults, they were particularly concerned that 8% were juveniles.

7.3.5 A graphical representation of this is shown below.



7.3.6 Given the high proportion of adult re-offenders in Hartlepool, Members explored with interest the gender demographic profile of the re-offender cohort, as illustrated in the table below.



7.3.7 Members noted with concern the prevalence of male re-offenders and drew particular attention to the spike in the 18 year age group. With this in mind, Members expressed concern regarding the effectiveness of transition services between juvenile (up to the age of 17) and adult service (commencing at 18).

7.3.8 The Committee found of interest that the majority of the 498 adult re-offenders had committed offences that did not require Probation Service intervention and the figures provided broke down as follows:

- 7% are currently Prolific and Priority Offenders (PPO)
- 7% are currently High Crime Causers
- 2% are known to Team around the Household
- 34% tested positive for Class A drugs (nearly 4 out every 10)
- 35% are known to local drug & alcohol treatment services

7.3.9 Information considered by the Committee also provided an understanding of the types of crimes committed by re-offenders, as detailed below.

RE-OFFENDERS KNOWN TO PROBATION	**RE-OFFENDERS NOT KNOWN TO PROBATION**
26% Shoplifting **12%** Violence – 35% Domestic Violence related **8%** Burglary **7%** Drug Offences **7%** Driving Offences	**22%** Shoplifting **17%** Violence – 34% Domestic Violence related (majority assault without injury) **8%** Drunk & Disorderly **7%** Criminal Damage - (mainly to dwellings)

GENDER SPLIT (those known to Probation)	
FEMALE **35%** Known to Probation **36%** Tested Positive for Class A **57%** Known to Treatment Services **10%** High Crime Causers **4%** Team around the Household **39%** Shoplifting	**MALE** **43%** Known to Probation **38%** Tested Positive for Class A **32%** Known to Treatment Services **8%** PPO's **7%** High Crime Causers **1%** Team around the Household **22%** Shoplifting **12%** Violence **7%** Burglary

7.3.10 It was noted with interest that, local and national data suggests that those who receive short prison sentences are at the greatest risk of re-offending. On this basis, the Committee felt strongly that partnership working to identify those offenders who present the most risk to their communities, ensuring early intervention to prevent the escalation of offending and providing community based support to address needs, is essential.

7.3.11 The Committee considered the information provided in detail and was surprised to find that the level of Prolific Priority Offenders (PPO) and high crime causers makes up a relatively low proportion of the re-offending figures. Looking in more detail at the top 10 offenders, Members found that only one was classified as a PPO and supported the view that this demonstrated the effectiveness of offender management in Hartlepool.

7.3.12 Members were also surprised to find that whilst the majority of re-offenders live in the more deprived neighbourhoods they do offend in their own home areas (as demonstrated in **Appendix B**). This contradicted the perception that offenders gravitate to more affluent areas and avoid their local area.

Offender	Age	Gender	Probation	Order	PPO	HCC	Class A	Treatment	Shoplifting	Violence	Crim Dam	Vehicle Crime	Theft	D&D	Stolen Goods	Motoring	Public Order
Offender 1	30	Male		Community Order													
Offender 2	38	Male															
Offender 3	27	Female		Community Order				?									
Offender 4	38	Male		Community Order													
Offender 5	34	Male															
Offender 6	31	Male		Community Order													
Offender 7	40	Male		Community Order													
Offender 8	20	Male		Community Order													
Offender 9	21	Male		Community Order													
Offender 10	37	Male															

7.3.13 Taking into the consideration the information provided, concern was, however, expressed that:-

i) Acquisitive crime accounts for the highest proportion of re-offences; with shoplifting accounting for more than half of these (nearly 40% of women and over 20% of men are convicted for shoplifting offences).

ii) Drugs are becoming a major issue in the town, with opiate misuse a key driver in the occurrence of acquisitive crime (a high proportion of those arrested tested Positive for Class A drugs / known to drug treatment services):

- Female (36% Tested Positive for Class A drugs, 57% Known to Treatment Services); and

- Male (38% Tested Positive for Class A drugs, 32% Known to Treatment Services).

iii) The level of violent crime (in particular the prevalence of domestic violence, with statistics showing that 34% of overall violent crime in Hartlepool is domestic violence related).

iv) Offenders are often the most socially exclude and have complex and deep rooted health and social problems, such as substance misuse, mental health, housing and debt, family and financial problems. A significant concern was the impact of welfare reform and the potential increase in acquisitive (i.e. shoplifting) and violent crimes, impacting further on the most vulnerable communities and individuals.

8. THE COMPLEXITY OF KEY FACTORS WHICH INFLUENCE RE-OFFENDING

8.1 The Committee learned that a wide range of factors contribute significantly to the likelihood of an individual re-offending and these are known as the criminogenic needs of offender and the 'pathways out of offending'. These were refined in 2004 in the National Re-offending Action Plan and added to as a result of the review undertaken by Baroness Corston in 2010:

- Accommodation and Support
- Education, Training and Employment
- Mental and Physical Health
- Drugs & Alcohol
- Finance, Benefits and Debt
- Children and Families
- Attitudes, Thinking and Behaviour
- Women affected by sexual exploitation and rape
- Women affected by domestic violence

8.2 The Committee noted that the provision of accommodation and employment/education/training are the two most significant pathways out of re-offending and queried what, if any, are the differences between the criminogenic needs of offenders and those who go on to re-offend. Members noted with interest that those who re-offend have a significantly greater need for support in 4 key areas, as detailed below.

CRIMINOGENIC NEEDS OF RE- OFFENDERS	
Employability Needs	92% more
Drugs Misuse	83% more
Accommodation	79% more
Financial Management	79% more

8.3 Members supported the view that the provision of services that meet the complex and deep rooted needs of offenders, in relation to health and social problems, is essential to the provision of pathways out of offending, reducing crime and breaking the cycle of offender behaviour across generations.

8.4 The Committee welcomed an assurance that the provision of services that focus on these needs is a priority for the Council and its partners and the structure and effectiveness of the services provided were discussed in greater detail as part of the investigation.

9. NATIONAL AND LOCAL STRATEGIES / REHABILITATION PROGRAMMES IN PLACE TO REDUCE RE-OFFENDING RATES

9.1 The Committee gained an understanding of national and local strategies and programmes in place to reduce re-offending rates. Members noted with interest the recently published "Transforming Rehabilitation: A Strategy for Reform" strategy, which is the Government's response to the consultation document "Transforming Rehabilitation: a revolution in the way we manage offenders". Evidence provided highlighted to the Committee the Government's plans to transform the way in which offenders are managed in the community in order to bring down reoffending rates.

9.2 Members learned that the key aspects of the reforms are as follows:

- A new public sector National Probation Service will be created, working to protect the public and building upon the expertise and professionalism which are already in place.

- For the first time in recent history, every offender released from custody will receive statutory supervision and rehabilitation in the community. We are legislating to extend this statutory supervision and rehabilitation to all 50,000 of the most prolific group of offenders – those sentenced to less than 12 months in custody.

- A nationwide 'through the prison gate' resettlement service will be put in place, meaning most offenders are given continuous support by one provider from custody into the community. We will support this by ensuring that most offenders are held in a prison designated to their area for at least three months before release.

- The market will be opened up to a diverse range of new rehabilitation providers, so that we get the best out of the public, voluntary and private sectors, at the local as well as national level.

- New payment incentives for market providers to focus relentlessly on reforming offenders will be introduced, giving providers flexibility to do what works and freedom from bureaucracy, but only paying them in full for real reductions in reoffending.

9.3 Members welcomed the development of new strategies, however, concern was expressed that whilst the proposed reforms are changing the face of services, measures could place additional burdens on services at a time of financial restraint. These concerns were compounded by the need to protect services and potential impacts of the privatisation of the probation service.

9.4 The Committee was particularly interested in the Community Payback and Restorative Justice schemes and their use / potential impact in Hartlepool. Details of the basis of each being:

- Community Payback (Provides offenders with the opportunity through a court order to put something back into the community).

- Restorative Justice (An approach to justice that focuses on the needs of the victims and the offenders, as well as the involved community, instead of satisfying abstract legal principles or punishing the offender).

9.5 On a local basis, the Committee learned about the importance of the development of a Local Reoffending Strategy, with the aim of 'ensuring that local services are co-ordinated in a manner that meets the needs of offenders, whilst at the same time ensuring local communities remain safe'. Members supported the importance of a single Reducing Re-offending Strategy as the most effective means of identifying gaps, learning more about non-statutory offenders and offender health and wellbeing needs.

10. THE ROLE AND RESPONSIBILITIES OF THE LOCAL AUTHORITY, AND ITS PARTNERS, IN REDUCING RE-OFFENDING

10.1 Having obtained an understanding of re-offending levels and activity, the Committee explored the roles and responsibilities of the local authority and its partners in reducing re-offending.

10.2 Evidence provide outlined statutory responsibilities under the Crime and Disorder Act 1998 to work together to reduce crime, disorder, substance misuse and re-offending:

- Local Authority (Safer Hartlepool Partnership - SHP)
- Police
- Fire Brigade
- Clinical Commissioning Group
- Probation

10.3 The Local Authority (through the Community Safety Partnership) has a commitment to dealing with offending / re-offending in Hartlepool, with its inclusion as a key strategic objective within the 3 year Community Safety Strategy (2011/14). It has also been established as a priority for 2013/14, with the aim of 'tackling offending and re-offending behaviour through a combination of prevention, diversion and enforcement activity underpinned by a strong multi agency approach'.

10.4 As indicated earlier in the report, considerable progress has been made in terms of reducing prolific and youth offending, however, Hartlepool's performance in relation to the Single Proven Re-offender Measure remains high. The Committee welcomed indications that, as part of its responsibilities, the Partnership is developing a local Reducing Re-offending Strategy to tackle high rates, whilst being mindful of anticipated changes as part of the Governments Transformation of Rehabilitation Strategy.

10.5 It was noted that re-offending has over the years had differing priorities and that local partners have had differing understanding. In light of these comments, the Committee welcomed a move towards improved partnership working and emphasised the need to focus on the embedding of a offender centric approach to:

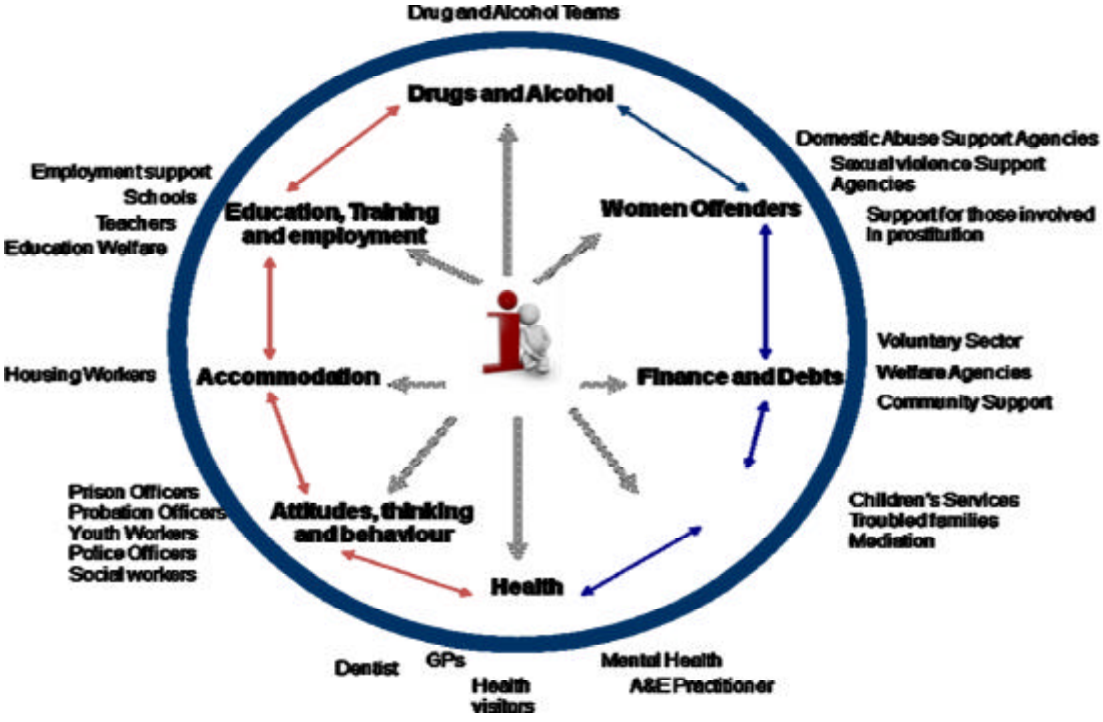
- Improve pathways out of re-offending by shaping current services to meet the needs of offenders.
- Provide appropriate support to offenders to keep them on the right track and break the cycle of re-offending.
- Improve a shared understanding of the complexities of offending behaviour on individuals and our communities.

11. SERVICES PROVIDED IN HARTLEPOOL TO REDUCE / PREVENT RE-OFFENDING

11.1 The Committee learned that services to offenders, in an effort to prevent re-offending are provided across the following organisations / partners:

Police / Police and Crime Commissioner
Prison Service
Probation Service
Health Services
Youth Offending Service
Local Authority (Family Services - Early intervention / adult care)
Employment and Benefits
Housing Services
Voluntary and Community Sector

11.2 A summary of the services are outlined below.



11.3 Evidence provided helped to demonstrate to the Committee the cross cutting nature of the services re-offenders access and during the course of the investigation each organisation was asked a number of key questions:-

i) What are the key issues connected to / influencing reoffending
ii) How and what services are provided both in and outside prisons;
iii) How effective are services;
iv) How are services co-ordinated across the responsible authorities;
v) What are the strategic aims and how are they implemented / communicated;
vi) What are the challenges facing providers (including potential impact of Welfare reform); and
vii) What could be changed?

11.4 In asking these questions the Committee was particularly interested in how services are provided in response to the primary issues / factors that influence and impact re-offenders i.e. employment, financial management, family support, mental health and drug / alcohol services.

Prison Services

11.5 At the meeting on the 23 January 2014, the Committee received evidence from National Offender Management Service (NOMS) and Association of North East Councils in relation to joint working between prisons and local authorities to reduce re-offending.

11.6 Members were interested to learn about the background of the Reoffending Project in looking at services that currently exist around the nine resettlement pathways, who delivers these services now and how we can avoid duplication and improve co-ordination in the future. Members noted the results of the project in that:

- The process of sending an offender to prison costs £60,000, excluding the £16,500 prison costs for a six month detention in a male local prison.

- There were 1200 prisoners at Holme House Prison, with around 4500 men a year being housed there.

- NOMS had found that local authorities and prisons weren't always aware of service providers and there was significant duplication.

- The Hartlepool Team around the Household – was seen as a positive multi-agency approach, addressing behaviour of persistently problematic households.

- Housing, was an area that needed further development – access to social housing was described as “an administrative nightmare” for someone with a background of offending. There was local anecdotal evidence that offenders were often poorly when applying for social housing, excluding them based on outdated lists of all previous convictions etc.

- If offenders had good secure accommodation there was a 20% reduction in reconviction rates.

- More than three quarters of prisoners who reported being homeless before entering custody were reconvicted within a year.

- Offenders are repeatedly found to experience multiple problems including substance misuse, homelessness and poor mental health. When combined, these problems could perpetuate a cycle of sustained offending behaviour, punctuated by short periods of detention, and significant barriers faced on release.

- Strong links need to be built with prisons so that work can start early to build motivation and plan for release.

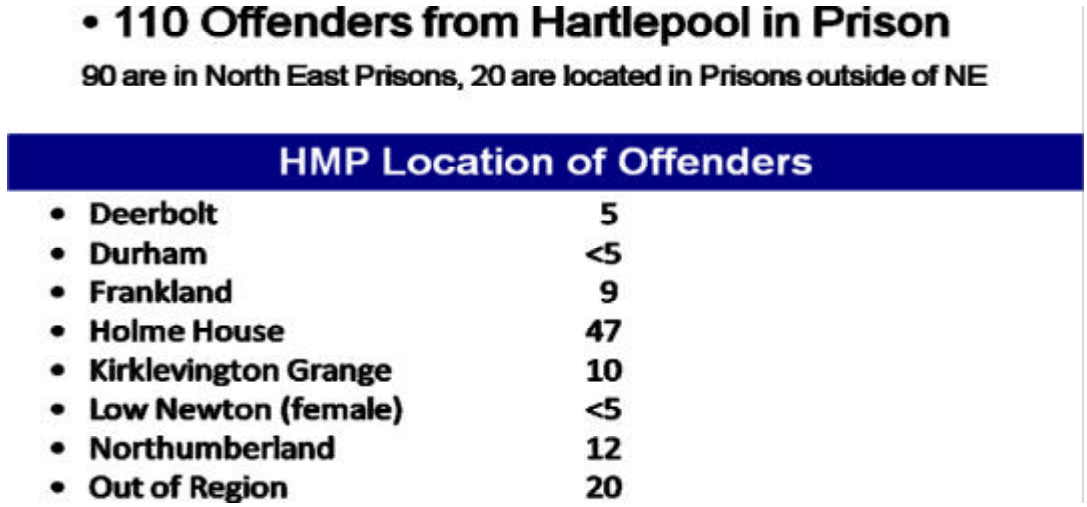
- 11 people in custody were on remand and 16 were serving less than 12 months. Under the current processes, these individuals would not be receiving the support services and interventions that were available to those serving longer sentences. Under the government's Transforming Rehabilitation reforms this would change and those serving less than 12 months would be receiving supervision and support.

- The Regional Reducing Reoffending Project, through the Gate Housing Service had commissioned NOMS NE and RHG – to work with multiple needs offenders. A NE Region Prisons Resettlement Group and a NE Offender Housing Forum had been established and were developing an action plan of regional priorities. This would mean big changes for how services for offenders were delivered.

11.7 Members welcomed recognition of the positive work being undertaken in Hartlepool by the Team around the Household, as a multi-agency approach, identifying and addressing behaviour of persistently problematic households. This approach was effective at removing barriers and strengthening engagement, leading to improved outcomes.

11.8 It was noted that 20% reduction in reconviction rates among offenders who had secure accommodation. The Committee was of the view that housing is an area that needs further development, with access to social housing described as an administrative nightmare for someone with a background of offending. Members also supported the view that more partnership working around housing and expressed concern regarding anecdotal evidence that Housing Options teams can treat offenders poorly, excluding them based on outdated lists of all previous convictions, etc.

11.9 In terms of the location of offenders and its impact on family relationships, the picture is outlined over the page.



- **110 Offenders from Hartlepool in Prison**

90 are in North East Prisons, 20 are located in Prisons outside of NE

HMP Location of Offenders	
• Deerbolt	5
• Durham	<5
• Frankland	9
• Holme House	47
• Kirklevington Grange	10
• Low Newton (female)	<5
• Northumberland	12
• Out of Region	20

11.10 Whilst the majority of Hartlepool offenders are detained at the local prison Holme House, a number are not and the Committee was keen to make sure that this is taken into consideration in terms of the potential impact that may be having on offender's families. Given that it is estimated that approximately 45% of prisoners lose touch with their families, it is particularly important to support families in their ability to visit given the long distance to travel, affordability, etc. This is particularly important given the importance of maintaining good family relationships to help reduce reoffending and the support of families on release.

11.11 From the evidence provided, the Committee:

- Supported the need in the future to:

i) Strengthen strategic partnerships and improve partnership working
ii) Have the Prison Service needs to be at the heart of the local offender management approach
iii) Identify barriers and develop solutions
iv) Develop Through the Gate services

- Commended the activities of the Regional Reducing Reoffending Project in:

i) Commissioning Through the Gate Housing Service (NOMS NE & RHG – to work with multiple needs offenders)
ii) Establishing a NE Region Prisons Resettlement Group
iii) Establishing a NE Offender Housing Forum (all partners) and working up an action plan of regional priorities

Probation Service

11.12 The Committee at its meeting on the 23 January 2014, received a presentation from the Durham Tees Valley Probation Trust (the Trust) outlining the work of the Trust.

11.13 Members were advised that currently, the Hartlepool Offender Management Unit is responsible for 386 offenders and the Hartlepool Integrated Offender

Management Scheme for a further 98; giving a total of 484 Hartlepool offenders as at 6 January 2014. It was noted that under the new government Transition Programme for Probation Services the National Probation Service would be responsible for 86 high risk prisoners with a further 390 becoming the responsibility of the new Community Rehabilitation Company. The total of 476 prisoners was based on the figures as at 11 November 2013 which had been submitted to government.

11.14 The presentation reiterated the criminogenic factors that had been instrumental in leading probation offenders to reoffend in relation to employment, training and education (92%), drug misuse (83%), accommodation (79%) and financial management and Income (79%). In addition to these factors, the impact alcohol was also highlighted as a significant factor in relation to violent reoffending.

11.15 The Trust representatives outlined for the Committee's information a case study of a 27 year old male re-offender who had been given a 12 month Community Order and a 6 months Drug Rehabilitation Order (DRR). The case study highlighted the impact of family circumstances and particularly the lack of supported accommodation with wrap around services to support the drug rehabilitation in particular. A multi-agency approach was required to support such offenders particularly when they had chaotic lifestyles and had frequently drifted into homelessness. It also highlighted that, if services were front-loaded with offenders when they came back into the community, they could have greater long term pay-offs. However, it was acknowledged that there were more successes with low-risk offenders than the high-risk offender that was the subject of the case study.

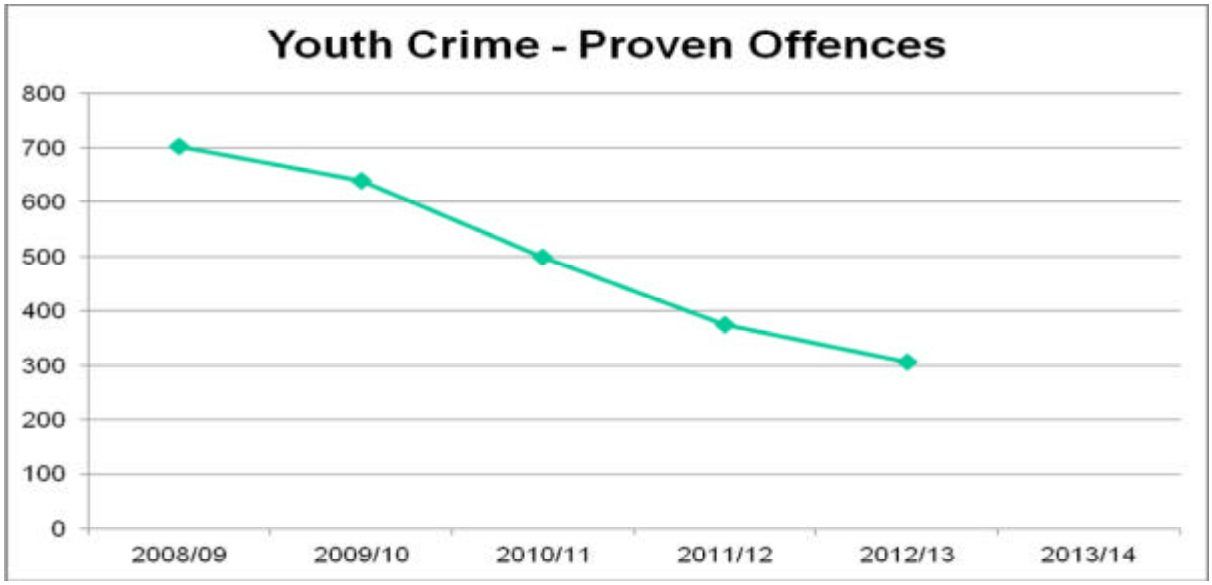
11.16 Of major concern to the Committee was the transition of services to the government's new approach of payment by results, with the case study probably written off as a failure to allow capacity to concentrate on the easier to manage offenders that would create income. At present all offenders were referred to the Probation Trust but with the payments by results system there was the potential for services to become fragmented and some offenders falling through the gaps.

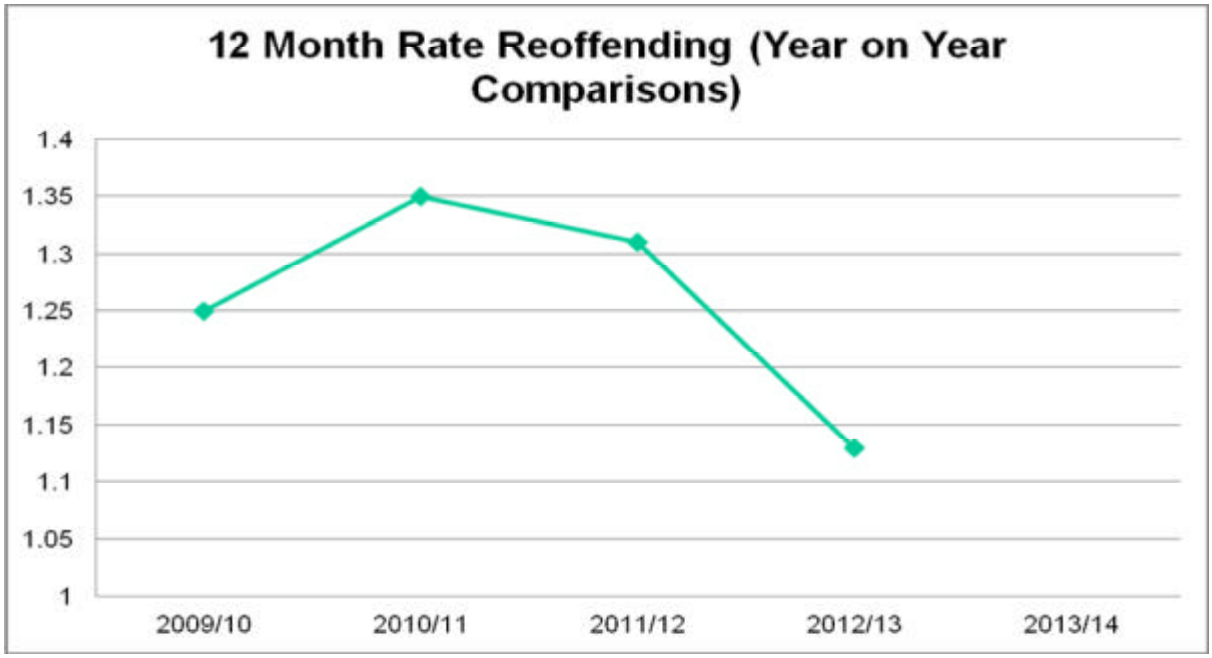
11.17 The Chair thanked the representatives of the Probation Trust for their evidence and commented that he was unsupportive of the payments by results approach to probation services particularly for the reasons highlighted in the presentation. Members echoed the comments and noted that the view was also supported by the Police and Crime Commissioner in Section 14.9 of the report.

Youth Offending Service

11.18 The Committee at its meeting on the 23 January 2014, obtained an understanding of the background to the establishment of the Hartlepool Youth Offending Service (YOS), following the introduction of the Crime and Disorder Act 1998. The primary functions of Youth Offending Services are to prevent offending and re-offending by Children & Young People and reduce the use of custody.

11.19 As a multi-agency service, it is made up of representatives from the Council's Children Services, Police, Probation, Health, Education and the voluntary/community and sits within the Local Authorities broader Youth Support Service. Demonstrating the strength of partnership working that already exists with the ability to respond to the needs of young offenders and their families in a comprehensive and coordinated way. The success of the service demonstrated below.





11.20 In recent years, the average number of young people who go on to re-offend in Hartlepool has reduced from 40% to 35% in recent years. The majority of re-offences are undertaken by a small minority of young people whose offending behaviour could be deemed repetitive and prolific. Offences committed by young people in recent years tend to be grouped around acquisitive crime and public order offences including violent assaults (often on other young people).

11.21 In looking a 'What Works', Members acknowledged and supported the importance of:

- A Holistic Assessment of need,
- Engagement with Education, Employment or Training
- Restorative work to develop victim understanding and empathy
- Interventions to reduce substance misuse
- Cognitive behavioural interventions
- Support to parents/carers
- Consistency and perseverance (Deter Young Offenders Programme)

11.22 The Committee, however, noted with concern the challenges facing the service in the future in relation to:

- Funding reductions at both a national and local level.
- Proposed changes to Probation Services that require new models of working.
- The decision to re-locate Youth Court listings to Middlesbrough has the potential to penalise young people (and their families) who do not have the means to travel to and from Middlesbrough (and is likely to place a greater pressure on the Youth Offending Service).

11.23 Attention was also drawn to the triage system, used in conjunction with the Police for dealing with young people who had been arrested, and its success in diverting many young people away from the court system and had a 78% success rate. This had led to the PCC rolling out the triage system to the other Cleveland policing districts. Chief Inspector Beeston commented that were it not for the triage system, many first time offenders would have received a Police Caution and then received no further support. The triage system provided the opportunity through the Youth Offending Service to divert those young people away from further offending and the court system. The Police viewed the system as being a positive means of keeping young people out of court and from further offending. It did have resource implications but they were worth the success of the scheme.

11.24 The Committee supported the view in relation to the move of the Youth Court to Middlesbrough, and whilst the success of the service in reducing reoffending was very commendable concern was expressed that the move of the youth court would make dealing with persistent re-offenders more difficult. The move would penalise the innocent, as well and was likely to significantly increase the numbers of young people failing to attend court. Concern was expressed regarding the lack of consultation with the local authority as a major oversight and the Committee had formally expressed its concerns in light of the excellent partnership working that had been developed over recent years was now being fundamentally undermined by the removal of the Youth Court.

Local Authority Services

11.25 The Committee explored the services provided by the local authority in terms of Integrated Offender Management, Team around the Household, Troubled Families Initiative and Community Payback Initiative.

11.26 **Team around the Household** - The Committee noted that some 290 families had initially been involved with the initiative, with positive results from input into 201 of those families. The input was, however, intensive and involved close working with many agencies to deliver results. Drug misuse was prevalent within these families but so too was domestic violence. The team aimed to provide intensive support to families to break the cycle of reoffending and anti-social behaviour and stop it occurring with new generations in the families. In some cases the support had to protect children first and foremost and there had been occasions where young children had been removed due to persistent drug dealing within a family for example.

<u>The Model</u>

11.27 Members noted that a Probation Officer was seconded from the Durham Tees Valley Probation Trust to the Team to provide intensive multi-agency support to families identified as needing this kind of support. This required a high level of multi-agency support but support of this type had considerable benefits in braking the cycle of reoffending and anti-social behaviour.

11.28 In conjunction with the trend forming throughout the investigation, it was noted that worklessness is one of the biggest issues for these families, alongside domestic abuse and drug abuse. Members were keen to highlight that the problems experienced by these families on released should not be underestimated and whilst they may have a home to go back to but re-integrating back into family life could be very difficult and often traumatic for

younger children. Conversely, it was noted that those in drug rehabilitation programmes often found those services seamless when they left prison. Prisoners who had been in prison long-term, 24 months or more, often commented that they found switching back to the pace of normal life very difficult.

11.29 Members, however, noted concerns that there was a need for greater coordination of services when prisoners were released particularly between the different agencies. More planning was also needed for the reintroduction of prisoners into their families. There had been a tendency in the past to work with the family and assume the family member in prison was being looked after. The prisoner needed to be an integral part of the work if it was intended that they would return to the home.

11.30 Evidence of the effectiveness of the initiative was provided from practitioners as follows:

- 89% said partnership working good or excellent
- 93% reported communication between agencies good or excellent
- 96% reported quality of data sharing as good or excellent
- 83% reported both the speed and quality of responses of other agencies was good or excellent
- Agency staff reported that the Team approach delivers greater accountability, increased officer responsibility beyond departmental silos, and increased staff knowledge of other service areas.
- The Lead Practitioner in a co-ordinating role is key to this success. It has prevented inter-agency tensions about which organisation should lead on a multi-agency case.

11.31 The Committee welcomed the 'Team Around' as an excellent example of how various agencies could come together in a targeted approach. The majority of families that received this approach were very thankful for the support they received. There were still some offending but others were working hard to gain some 'normality'.

Think Families, Think Communities (Troubled Families)

11.32 Members explored the background to the "Troubled Families" programme, which had been set up by government in April 2012, with a clear definition of a troubled family:

- A member of the family involved in criminal behaviour or anti social behaviour;
- Children not attending school – either poor attendance or excluded; and
- Parent/s not in employment.

11.33 Evidence provided showed that in addition to one or two of the above criteria, families in Hartlepool are also monitored in relation to domestic violence and substance misuse.

11.34 It was reiterated that there are approximately 290 families in Hartlepool meeting the required criteria and the Committee was pleased to find that a number of these families already have a significant number of people working with them due to the complexities of the family's issues.

11.35 An offer had been extended to some of the families who in the service to participate in the investigation, but, given the sensitive nature of the issue this had not been possible. The Committee, however, put forward a number of questions which were put to around to around twenty families outside the meeting:

- What did you find the hardest to deal with when you (or your family member) left prison (i.e. no money, no home, no family support, no job, health (drugs and alcohol issues), social pressure, etc)?
- How easy was it to get the help you (or your family member) needed on leaving prison to deal with these problems?
- Did the help you need continue when you (or your family member) left prison?

11.36 The following responses were received and a number of issues and problems identified from the consultation.

Responses

"It's OK, but at times I just wanted to be left alone"

"They helped put a roof over my head and sorted my benefits which was a nightmare"

"The worker tried hard to help me and I'm grateful for their support"

"I really want to work but it's all confusing me, go here, go there, sign this, sign that, I just want a job"

"We all found it hard when he came out, especially the kids but with the support it's getting better slowly"

Issues / Problems

- Benefits arranged upon release – set up and in place in the community upon release
- Accessing employment training programmes
- Housing/Accommodation issues
- Setting up drug treatment
- Rebuilding trust with family members
- Social/peer/community pressures: offenders being released with good motivation to change but then returning to communities with strong influences which are hard to resist

11.37 Members commended officers, and partners, on the aims and aspirations of the programme, as a means of exploring creative and innovative ways of working with difficult families to support an improvement in outcomes and

reduce reliance of high cost services. The Committee welcomed the activities of the team, in co-ordination with lead practitioners to move towards the development of a one family plan, with all required plans sitting within this. Members felt that this is the way forward, in assisting all families to lead themselves through their plans, with support and challenge as needed to ensure that children's lives are improved.

Employment and Benefits Services

11.38 The Committees attention was drawn to the results of an analysis of the impact of employment on re-offending following release from custody, using Propensity Score Matching (undertaken by the Ministry of Justice (MoJ) in March 2013).

11.39 Members noted with interest, that whilst employment has been shown to reduce the likelihood of re-offending, offenders leaving custody face significant barriers to finding and staying in work.

Re-offending rates by P45 employment status in the year after release from custody in 2008. Length of custodial sentence	One year proven re-offending rate	
	P45 employment spell after release	No P45 employment spell after release
Less than one year	32%	69%
1 year or more	18%	43%

11.40 Attention was drawn to the importance of ensuring that offenders receive specialist support as soon as possible after release from custody, with the Department for Work and Pensions and the Ministry of Justice fast-tracking offenders leaving custody into the Work Programme. In addition to this, Members learned that:

- From early 2012, Jobcentre Plus advisers started to take claims for Jobseeker's Allowance in prison, to start entitlement on release and to facilitate mandatory referral to the Work Programme.
- Any prison leaver claiming Jobseeker's Allowance within 13 weeks of leaving custody now has a mandatory referral to the Work Programme.
- The MoJ is committed to working with businesses to significantly increase work activity undertaken by offenders in custody, which in addition to repaying society, aims to ensure that offenders are motivated to work and return to their lives outside prison, better prepared for employment.

11.41 It was acknowledged that, although it is thought that employment has a positive effect on offenders, it is difficult to make firm conclusions about the direct impact of employment on re-offending from the majority of the published literature.

11.42 The Committee, however, discovered that after release from custody offenders tend to have employment levels well below the general population with barriers to work for offenders including a range of other factors such as health problems; substance misuse; housing problems and homelessness; poor basic skills; low levels of qualifications, self-confidence and motivation to find work; and lack of work experience.

11.43 Local Authority Services - Looking at service provision in Hartlepool, the Committee considered the activities of the Economic Regeneration Team to remove barriers and support ex-offenders back into employment. Delivering, through services that are centred on independent information advice and guidance, work trails, volunteering opportunities and in-work mentoring. The Committee also noted with interest the support offered to both businesses through a series of different programmes.

11.44 Services provided include:

- Core Offer to Employers – partnership with Jobcentre Plus, National Careers Service and National Apprenticeship Service.
- Hartlepool Works Consortium;
- Self employment support via Hartlepool Enterprise Centre
- Core Offer to Employers
- Construction Skills Certification Scheme (CSCS) Test Centre.
- Hartlepool Youth Investment Project
- Connect to Work (NEET programme)
- Youth Engagement and Support (YES) Project;
- Youth Contract
- FamilyWise (linked to Troubled Families team).

11.45 The Committee considered information in relation to the effectiveness of the service and noted that 80% of customers have been supported into a positive outcome. Looking in more detail, this equated in 2012/13 to:

- 101 into Employment
- 343 into Training
- 1,007 Business Assisted
- 88 New Business Start-ups
- 262 Jobs Created

11.46 In relation to the co-ordination of services, the Committee welcomed indications that the team work closely with Durham and Tees Valley Probation, Hartlepool Youth Offending Team, Jobcentre Plus, Think Families / Think Communities and all of the Tees Valley Local Authorities through the Tees Valley Local Enterprise Partnership.

11.47 Members noted the information provided and welcomed assurances that the provision of support for all working age adults to secure long term sustainable employment is a key priority for the Council; with ex-offenders identified are a priority group. The Committee felt strongly that this continued commitment would be essential for the future of the reducing re-offending agenda and noted the challenges facing service provision in relation to:

- Hartlepool currently has 6.8% or 3,961 of working age adults are out of work which is more than double the national average.
- According to research over 17% of the UK population between the ages of 18 and 52 have a criminal conviction.
- Local labour market – availability and quality of jobs.
- Employer discrimination – employers may need educating.
- Lack of qualifications, including low levels of literacy and numeracy.
- Motivation, confidence and reliability of offenders.
- Too far removed from the labour market unlikely to get jobs – low skills, no or little work experience.
- Others issues such as poverty and debt, housing, health, substance misuse but also life, social and thinking skills.
- Lack of funding.

11.48 In terms of the potential for change the Committee noted suggestions that the way forward could be:

i) Investment in the provision of intensive 1-2-1 interventions and support to address barriers to employment, education and training.

ii) Closer working with key partners in line with the Troubled Families model which aims to create a culture of empowerment rather than dependency.

iii) Sustaining current levels of services to:

- Ensure that offenders returning to the area after a custodial sentence have access to a specialist Employment Adviser.
- Be able to continue to work with providers to strengthen pathways out of offending into education, employment and training.
- Expand on specialist provision to ensure re-offenders are able to maintain engagement with the Council.

11.49 <u>Department of Work and Pensions (DWP)</u> – The Committee at its meeting on the 17 April 2014, received evidence from Job Centre Plus in relation to the support they provided to offenders upon release from custody/prison. These services including the provision of a designated advisor to work with local partners i.e. the Probation Service to identify any barriers for claimants with a view to preventing reoffending.

11.50 In response to concerns regarding difficulties encountered with ex-offenders in terms of processing benefit claims, Members welcomed indications that advisors are now located within prisons with a view to establishing claims prior to offenders leaving prison. It was clarified that whilst the DWP's focus is predominantly on the benefits side, taking advanced claims ensuring that payments are in place for those released from prison to negate the need to commit crime to support them financially. In addition to this, the Committee was pleased to find that Probation work also took place with families inside the prison prior to release.

11.51 It was highlighted that housing / homelessness is also a fundamental cause of re-offending and access to benefits and the Committee received clarification that arrangements are in place to support individuals in these situations. Members were assured that a 'care of' address is acceptable, or alternatively claimants can register at the Job Centre daily. Some concerns were expressed by Members regarding the practicalities of registering at the Job Centre on a daily basis as well as the impact on individuals as a result.

11.52 With regard to access to employment opportunities and benefits following release from prison, a query was raised as to whether information was shared with family members and the Committee assured that extensive work is undertaken in relation 'to post' release support. In response, it was reported that there was some uncertainty as to whether to whether information of this type was shared with family members.

11.53 The Committee welcomed confirmation of the existence of good working relationships between the Council and Job Centre Plus and was pleased to find that a number of key activities are available, including national apprenticeship schemes and national careers schemes. Member were, however, concerned that a key challenge facing a number of agencies was supporting individuals with access to employment following release from prison. It was noted that nationally only 5 out of 100 people have secure employment.

11.54 The Committee highlighted the proposal under the new regime to reduce the number of job search facilities in the Job Centre and were concerned regarding the potential impact on job seekers. Members welcomed confirmation that access to free wifi was to be made available in Job Centres in the coming months as an alternative and noted that Job Centre Plus shared the concerns expressed throughout the presentation in relation to the potential impact of the changes to the Probation Service. Of particular concern was the role of work programme providers and payment by results process.

Housing Services

11.55 As discussed during the course of the investigation, evidence from Housing Hartlepool reinforced Members concerns regarding the importance of the provision of suitable accommodation and support as one of the most important pathways in reducing the risk of re-offending.

11.56 Members were very concerned to discover that locally, practitioners had highlighted a particular problem with regards the lack of suitable accommodation for low to medium risk offenders in Hartlepool. Members were also aware that the standard of accommodation was often low and Members were pleased to find that work is being undertaken with one local private landlord who had provided a multi-occupancy house for ex-offenders that was working well.

11.57 Evidence provided by a range of organisations, utilising the OASys assessment tool, clarified that the level of housing need in Hartlepool (as at 30th September 2013) equated to:

- 36% (137) of offenders were assessed as having a criminogenic need associated with accommodation linked to their risk of re-offending.
- 71% (97) of offenders were assessed as medium risk.
- 14% (19) of offenders were assessed as low risk.
- 86% (118) of offenders were male.

11.58 The Committee was advised that in terms of the most problematic and chaotic offenders managed by the Hartlepool Integrated Offender Management (IOM) Team, more than half (52%) of those who were assessed had a criminogenic need associated with accommodation linked to their risk of re-offending. Based on the information provided, Members noted that the ten offenders recently released from prison had been unable to access suitable accommodation in Hartlepool upon their release. Members were very concerned to find that of these ten offenders, five were placed in temporary accommodation outside of Hartlepool, with four of them gravitating back to Hartlepool without securing accommodation.

11.59 Members explored the number of request received from offenders for Sheltered Accommodation and were advised that between October 2013 and December 2013, 23 offenders had approached Shelter to access support. It was, however, highlighted that as a result of housing shortages in Hartlepool, Shelter had been required to refer a large number of their clients to out of area provisions.

11.60 In relation to other support services, it was noted that 'Through the Gate' referrals services had been provided to eight offenders in Hartlepool between October 2013 and December 2013. The Committee welcomed the availability of this service and the level of service provided to re-offenders, with a comparison of other neighbouring Authorities showing that Hartlepool has the highest number of offenders accessing the service in Cleveland. Concern was, however, expressed that for same time period, numbers remained low in terms of accommodation secured and referrals made to Hartlepool Housing Options Service. This was supported by data from the Housing Options Service which indicated that referral numbers in terms of prison leavers are low and account for less than 2% of referrals.

11.61 The Committee was reassured to find that the Safer Hartlepool Partnership's Local Offender Housing Needs Group recognised the importance of gaining an insight into the following issues and was exploring solutions to strengthening the accommodation pathway to break the cycle of re-offending:

- The accommodation needs of offenders;
- Existing locally commissioned accommodation and support services relating to offenders;
- Evidence of unmet need; and
- Shared good practice.

11.62 It was highlighted that the Local Offender Housing Needs Group had in fact agreed, with its partners, the following priorities for action to address the accommodation needs of offenders:

- Housing Liaison Post
- Housing Directory
- Single Assessment Form
- One Stop Shop
- Compass Application
- Team around the Offender
- Hostel with Licensed Tenancies

11.63 The Committee supported the progression of these priorities and in relation to the establishment of a Housing Liaison Post, considered further information in relation to the initiative from Sunderland Council. This information was considered at the meeting on the 17 April and details of discussions are outlined in Section 12 of this report.

Voluntary and Community Sector Services (Financial Services)

11.64 The Committee welcomed evidence from the West View Advice and Resource Centre (WVARC) on their work in providing support for offenders referred to the Community. Advice provided being as follows:

- Welfare Benefits advice,
- Employment advice,
- Housing advice,
- General support with consumer queries, Debt advice/support,
- Appeals support/advice.

11.65 It was noted that WARC services are provided by centre visits, outreach locations, home visits, Macmillan support visits (home /residential care facility). The Committee noted concerns that problems had been experienced following the release of offenders on Fridays, with no access to benefits. Ex-offenders often find themselves having to go to several different agencies in different buildings and places simply to access the services they needed and this could be challenging for some of them in the immediacy after their release from prison. The development of a 'one-stop shop' approach was viewed by WARC as a significant development in bringing benefits directly to offenders on their release from prison. The Committee supported this view.

11.66 WARC was asked to comment in relation to potential issues for the future and the Committee noted that:

- Waiting Times can impact on the time without income, whilst awaiting benefit claims to be processed / waiting times for debt appointments etc.

- Effective support and financial management delivered to the partners of those in prison can reduce issues when the offender is released from prison.

11.67 The Committee noted the issues / concerns raised.

Health Services

11.68 The Committee expressed concern at the propensity for mental health problems among offenders and was concerned that this was not being tackled appropriately within the wider services to re-offenders. The Committee went on to received evidence in relation to services provided through the national commissioning arrangements for prisons, and secure training centres in the region.

11.69 Members ascertained that services are provided in relation to prisoners' general health care and secondary health care services including substance misuse. Information provided the Committee with details of the health issues facing offenders, summarised as follows:

- 90% of prisoners have substance misuse problems, mental health problems or both;
- 72% of male prisoners and 70% of female prisoners suffer from two or more mental health disorders;
- 20% of prisoners have four or five major mental health disorders;
- 83% of prisoners smoke (averaging 16 cigarettes per day);
- 9% of prisoners suffer from severe and enduring mental health illness;
- 10% of prisoners have a learning disability;
- up to 50% of new prisoners are estimated to be problem drug users;
- 40% of prisoners declare no contact with primary care prior to detention;
- People who have been in prison are up to 30 times more likely to commit suicide (in the first month after discharge from prison) than the general population;
- 20% of male and 37% of female sentenced prisoners have previously attempted suicide;
- There is commonly poor continuity of health care information on admission to prison, on movement between prisons and on release;
- 49% of male, sentenced prisoners were excluded from school (2% in general population).

11.70 Further evidence provided by the Tees Esk and Wear Valleys NHS Foundation Trust, at the meeting on the 17 April 2014, detailed the Trusts role in the provision of the following services, the aim of which is to impact, affect and influence re-offending:

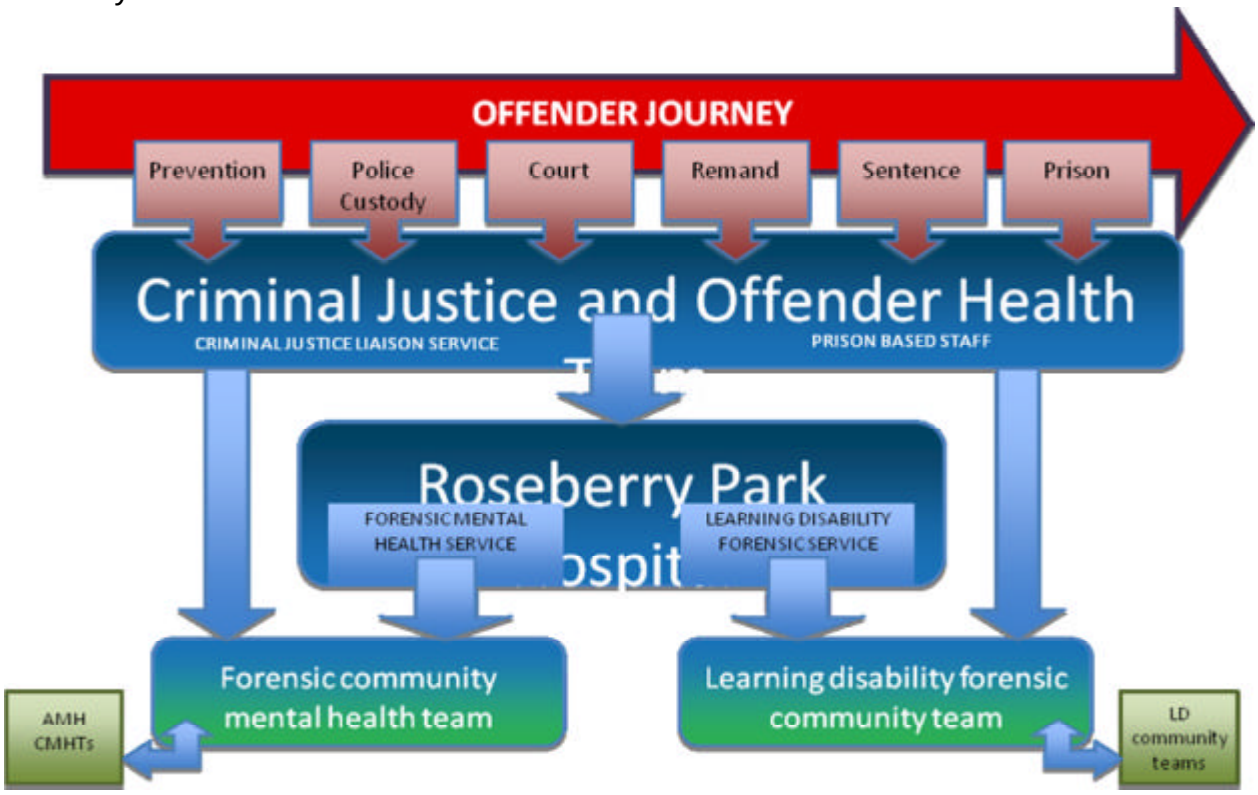
i) The Prison Mental Health Contract:

- 7 prisons (total population 5,500, every category)
- Women's prison health (HMP Low Newton)
- Women's DSPD - Primrose project
- PIPE (Psychologically informed planned environment)

ii) Community Offender Health Services:

- Criminal Justice Liaison Team
- Integrated Offender Management Unit Nurse
- Probation Personality Disorder Psychology Service
- Street Triage Team
- All-age Liaison & Diversion Service

11.71 Members noted with interest the breadth of services provided and the offender journey that offenders make through criminal justice and offender health system.



11.72 As part of its investigation, the Committee considered further information in relation to the services provided.

All Age Liaison and Diversion Service

11.73 The Committee gained an understanding of the aim of the Liaison and Diversion service to improve health and criminal justice outcomes for children, young people and adults who come into contact with the youth and criminal justice systems. It was noted that the service provides assessments, and liaison, for people with mental health problems who are either currently in the criminal justice system, or at risk of entering the criminal justice system. The focus of the services is very much towards the early part of the offender pathway.

11.74 In terms of the role of the service, it was noted that the priorities are around Advice and support to Criminal Justice Staff, Assessment of both mental state and risks and to provide Access to appropriate services. Key outcomes being:

- Improved access to health and social care services
- Improved health outcomes for individuals
- Improved criminal justice system outcomes
- Improved criminal justice outcomes for individuals
- Reduction in the number of first time entrants to the youth justice system
- Reduction in offending and re-offending by individuals passing through Liaison & Diversion services as measured by a national minimum data set

11.75 Members were advised that Government funding of £25m had been allocated for the establishment of a Liaison and Diversion Service and of that funding allocation, £800,000 had been awarded for the development of a local site at Middlesbrough. Whilst funding for the Liaison and Diversion service was substantially less than anticipated, potential benefits for Hartlepool as a result of the establishment of the site in Middlesbrough were welcomed by the Committee. Indications that discussions were currently ongoing with the Police and Crime Commissioner with a view to securing additional funding, to extend the hours of operation of services, was also welcomed by the Committee. Members were of the view that the provision of services should be extended to 24 hours a day 7 days a week.

11.76 Members supported the aims and objectives of the service with individuals to be treated and managed within a whole care pathway approach, with services working collaboratively to ensure that individuals receive a coordinated approach to address their health and social care needs and their offending behaviour. The Care Programme Approach (CPA) process will underpin service delivery and Members felt that this is an example of the type of holistic service delivery necessary to reduce re-offending in the future.

Criminal Justice Liaison Service

11.77 Members learned that the Criminal Justice Liaison Service is heavy focused on early intervention, liaison and diversion, providing an inclusive service to ensure that persons within the criminal justice system and carers receive a high quality, competent and effective range of interventions. The service delivery includes liaison, prevention and ultimately equitable access to mental health services across the trust. The service promotes social inclusion and acceptance of service users within mental health provision who have offended, or are likely to re-offend to enable them to live a more productive, positive and fulfilling life.

11.78 The Committee supported the concept of the liaison service as an integrated part of mainstream services, ensuring easy access to psychiatric assessment and advice, creating robust multi-agency working. Whilst the service is predominantly for adults, with recognition of the need for age sensitive services, in the Cleveland area a service is offered to 16-17 year olds from the CAMHS services.

11.79 If during a mental health assessment a learning disability is suspected this is brought to the attention of the custody staff, and although the CJLS team do not have specialist skills in this area they do have a general awareness and would follow the principles of Green Light and would signpost to the most appropriate service.

Street Triage Team

11.80 The Committee was advised that as part of the National Development Programme, a funding opportunity arose for TEWV to develop a business case for enhancements to the current Liaison and Diversion Services. It had been found that there was an increase in the number of persons brought to a place of safety under Section 136 MHA 1983, who were later released as not having mental problems. It had been shown that in Cleveland Police a high proportion of people were detained under the Mental Health Act and whilst they may not need some level of intervention the use of the place of safety as an intervention was not always proportionate, nor did it meet their needs.

11.81 With the basic cost of detention calculated at £1,780 per person, it was estimated that if the number of people picked up by police, and subsequently released without any intervention, had been identified by the Street Triage Team then there could be projected savings of around £690,000 in a twelve month period. A Triage Team now operates two nurses on duty at any one time between the hours of 12pm and 12am 7 days a week, who respond to calls from the police and attend the scene to assess a person's mental state and advise best course of action.

11.82 The Committee was impressed by the work of the Team, across the Cleveland area, and its results in achieving more timely interventions by mental health professionals, avoiding unnecessary detentions either in a police station or hospital. This equated to a better experience for individuals as well as achieving a substantial cost saving for those services.

11.83 Members learned that the main challenge facing Offender Health Services is funding and commended providers on the efforts being made to work smarter and leaner than ever before, reconfiguring services and looking at joint working and integrated working where possible. It was, however, noted that one of the ways to further strengthen the services position would be to explore further joint commissioning of services.

Drug and Alcohol Services

11.84 In relation to the provision of drug and alcohol services, the Committee learned that nationally the number of individuals accessing drug treatment has fallen by 1.1%, however, in Hartlepool numbers have <u>increased by 5.5%</u> (and drug related offences have reduced by 6.5%).

11.85 It was highlighted that the Safer Hartlepool Partnership had recognised the need to enhance the enforcement and support aspect offered by Probation and the Police, with the need to engage the offenders in effective treatment to reduce the need to offend to feed a substance misuse addiction. Subsequently, in 2008, the Criminal Justice Integrated Team (CJIT) was created, with the co-location of the Probation Service, Police and Recovery support to maximise the opportunities to capture and engage offenders in effective treatment. A subsequent review of the work of the CJIT team, the importance of multi-agency working had been clearly identified. This required the movement of disciplines out of 'silos' and had been driven from the top of the organisations involved.

11.86 To put the services provided in to context, two case studies were considered.

Case Study 1 - L is male and 35 years of age. He is a heroin user and between 2006 and 2012 he had been arrested and drug tested on 20 occasions, the last 12 for burglary. He was constantly in and out of the prison system. A referral from HMP Wealston was received in May 2013. He was assessed by a recovery worker. He was engaged in treatment and his care plan concentrated on the reduction of his drug use, remaining in treatment, supplying negative drug tests, accessing alternative activities and looking for employment opportunities.

L is identified as a Prolific and Priority Offender (PPO) and is on license from June 2013 to December 2014. L realised that he had come to a time in his life where he wants to make positive changes and was engaged by the CJIT. L had a good family support and they are now fully engaged in his recovery. In regard to his alternative activities L has been referred to Lifeline to look at getting support in getting back to work. He attended groups and worked on completing job searches and building his CV.

L was supported to access the CAB and the Food bank. He was also supported with his benefits and ensuring that he maintains his treatment regime. The recovery worker met with him weekly to look at triggers, relapse prevention, motivation to change and consequences of drug usage using mind mapping interventions. These maps provide a visual image of issues and looks at how they can be resolved. L engaged well with all agencies involved in his care and his self esteem has visibly grown.

Today L is now in full time employment. He has not re-offended since leaving prison and has addressed his drug problem.

Case Study 2 - S is female and 30 years of age. She is a heroin user and has been in treatment for a period of 7 years. Her offending had escalated recently and she had worked intensively to look at the root causes of her addiction and offending with her keyworker to identify the best options for her recovery. She started to reduce her substitute medication with a view to going into a detoxification and Rehabilitation facility.

S was awaiting her court appearance, which would, if she was convicted, jeopardise her opportunity to go into rehab. The court worker who is part of the CJIT team was informed of the situation and she met with S on the court landing. She discussed the offence of theft with S and her solicitor at length so that the solicitor was aware of the threat to her recovery should she be sentenced.

Any fine imposed would cause some difficulties as she would be contributing to her rehab placement through her benefits. The solicitor approached the bench during the case and appraised the magistrates. The worker was able to explain to them the intense engagement work that S would have to complete before entering the rehab and what the effects would be for her if she was unable to access the treatment option which best met her needs. The bench sentenced S to a 12 month conditional discharge and no costs which enabled her to commence her programme.

She is drug free and doing well in the rehab.

11.87 To achieve recovery, offenders need to understand the root cause of their addiction. The psychosocial interventions undertaken are aimed at changing mindsets and building recovery capital in the community. The support offered in Hartlepool is continually developing to meet those needs. Members supported the move for all partner organisations to sign up to these multi-discipline intervention teams and were pleased to discover that Hartlepool is a long way down the road to delivering of services through effective multi-agency working.

12. EXAMPLES OF GOOD PRACTICE

12.1 The Committee requested further information in relation to two areas of best practice.

Housing Liaison Post – Sunderland City Council

12.2 Further to evidence provided in Paragraph 11.62, Members noted that statistics had fluctuated in relation to offenders being unable to access mainstream accommodation as a result of their behaviour. As a result of a scrutiny investigation, an initiative had been introduced in Sunderland to create a Housing Liaison post to work between the custody setting and local housing teams/landlords. The aim of the post being to help offenders find tenancies in advance of release date and work with offenders and families to understand their behaviour.

12.3 Members reiterated concerns expressed throughout the investigation in relation to the impact of the Homelessness Amendments Act. The results of the Act being that prisoners are released on a Friday afternoon and are not treated as a priority for housing accommodation, with difficulties often encountered by Advisors in prisons determining the nature of the housing issue which contributed to this problem. Whilst it was noted that there is no longer a statutory requirement for an Access to Housing service, Members were particularly impressed by the introduction of the role, and its outcomes, and voiced their support for the creation of a similar post in Hartlepool. Even if the funding was only short-term, it was felt that the post may lead to the development of new approaches to the housing of offenders that could be carried forward.

Hartlepool Business Forum Event 'A Chance for Change Exploding the Myths of Employing Ex-Offenders'

12.4 Members of the Committee attended the Hartlepool Business Forums Event on the 3 April 2014, called 'A Chance for Change'. From the plethora of information provided at the event, the Committee drew attention to work being undertaken in the HM Prison Service to make offenders 'work ready', including:

- employability strategies,
- careers guidance,
- curriculum vocational skills,
- Practical skills and high quality training opportunities.

12.5 Particular attention was drawn to the Change for Change scheme operated at Dearbolt Prison, whereby businesses are being championed to proactively recruit ex-offenders and be involved in mentoring programmes in prisons. Members were very supportive of this scheme and it was suggested that the potential for local authorities to lead by example in encouraging the provision of employment / apprentice opportunities for ex-offenders should be explored.

13. THE VIEWS OF SERVICE USERS IN RELATION TO THEIR EXPERIENCE OF SERVICES AND POTENTIAL IMPROVEMENTS.

13.1 The Committee felt that it was important to explore the views of re-offenders and their families as part of the investigation and in doing so extended an invitation to families involved with the Team around the Family to participate. Given the sensitive nature of the issue, a number of questions were put to around twenty families and the views obtained are outlined in Section 11.36.

13.2 In addition to this information, the Committee undertook a visit to Holme House Prison on the 14th February 2014 to look at the prisoner location areas (wings) and speak in person to Hartlepool offenders. The visit offered Members a real insight into an offender's journey in the custody setting and an overview of the services provided.

13.3 As part of discussions with offenders, Members notes with interest responses to the following questions:-

1) What will you find the hardest to deal with when you leave prison (i.e. no money, no home, no family support, no job, health (drugs and alcohol issues), social pressure, etc)?

2) Is it easy to get the help you need in prison to help you with these problems?

3) Do you know if this help will continue when you leave prison?

13.4 Members welcomed the opportunity to speak to prisoners and felt that it had provided a very useful insight, with the key issues raised by prisoners outlined as follows:-

i) Housing is particularly key – services to help with housing start 8 weeks before release which prisoners were saying isn't enough time to sort housing out. Services can be accessed by prisoners before this on request. It was suggested maybe a three month period before release would be more suitable.

ii) Employment didn't appear to be a big issue, as the prisoners had undertook courses and had employment plans after release and services were in place in prison and on release to provide support. However, success of securing a job was dependent on finding housing.

iii) Benefits were raised as an issue, as it could often take up to six weeks before the first payment, benefits needed to start as soon as possible after release.

iv) Prisoners weren't aware of their local Councillors and how they could help. The Members who attended were supportive of prisoners who had been released contacting them if they needed help / advice.

v) Drug / alcohol services continued when prisoners were released – no problems were raised in relation to this.

13.5 The Committee highlighted that all of the prisoners had raised the issue of benefits and housing as major issues on release from prison. Particular concern was expressed regarding:

- The acute impact of benefit delays on prisoners released on Fridays, in that they are left with no means to access benefits or advice until the following Monday.

- Being pushed down the housing waiting list as soon as it became apparent they were an ex-offender.

- Services in relation to housing advice and help only starting in two weeks before their release date, with the potential for additional stress for prisoners as they prepare for release.

13.6 In light of the concerns raised, it was suggested that the provision of greater flexibility and the ability for housing services needed to be explored to respond more appropriately to those offenders who may wish to avoid returning to the community where their past offending had been centred.

13.7 The Committee was surprised to discover that in talking to prisoners employment wasn't one of their major issues. Whilst the Durham Tees Valley Probation Trust has a target for offenders achieving employment of 30% before the end of their supervision period, it was acknowledged that for prisoners with the array of complex issues, employment may not one of their highest priorities. Homelessness and access to drug rehabilitation programmes could be much more pressing.

13.8 Members were very grateful to prisoners for agreeing to participate and felt that the public perception of prisons was not always accurate. It was clear from the feedback from the prisoners that there was a need to break the cycle of reoffending and much was simply down to them having sufficient money to get by and somewhere to live.

14. VIEWS FROM KEY INDIVIDUALS

14.1 The Committee welcomed evidence in relation to its re-offending investigation, from the following key individuals, at its meeting on the 23 January 2014.

Councillor Jackson, Chair of the Neighbourhood Services Committee Chair

14.2 Members welcomed Councillor Jackson's input into the meeting and noted the Neighbourhood Services Committee's role in relation to the activities of the Community Safety Team and the strategic content of the Community Safety Plan and Domestic Violence Strategy.

14.3 In recognition of the connection between areas of disadvantaged and re-offending levels, Councillor Jackson reinforce the need to reducing re-offending levels and, in doing so, the importance for the Council and its partners of addressing unemployment and poor educational attainment issues in disadvantaged areas. The Committee supported this view and shared concerns that offenders released from custody, returning home to the same issues that had driven them to offend in the first place, had little chance of changing their behaviour.

14.4 Members were interested to hear that the Neighbourhood Services Committee had recently supported the implementation of a Community Payback scheme in the town. The team delivering the project was facilitated by the Council and had been quite effective on schemes such as graffiti removal and horticultural projects. Whilst it was noted that there had been some issues for council staff, the Committee supported Councillor Jackson's view that the way forward was the provision of staff training in how to deal with offenders in these situations.

14.5 During the course of discussions, the issue of motivation / aspiration was highlighted as a major issue for re-offenders, with long term worklessness a significant problem for communities. Support was also expressed for the role of such schemes as Community Payback as an opportunity to foster / promote a work ethic for the future and extend accountability past conventional prison sentences. Concern was, however, expressed that sanctions must be included as part of schemes and where there is failure to meet the requirements sanctions must be carried through. Schemes must not be viewed as easy alternatives to accountability.

Chief Inspector Lynn Beeston, Cleveland Police

14.6 Chief Inspector Lynn Beeston's attendance at the meeting was welcomed by Committee and attention dawn to the police role in relation to enforcement. Members were assured that Police representatives take an active part in many joint teams and often "had a foot in both camps".

14.7 Concerns regarding the prevalence of drugs and alcohol as the two main drivers behind the majority of crime in Hartlepool were shared, especially in relation to the impact of 'family background' on offending, with many offenders growing up in households with parents and other relatives that offended. Emphasis was placed on the merits of schemes that looked to divert people away from the courts system and thereby a criminal record.

14.8 Particular attention was drawn to the success of the Triage system as a means of diverting young people out of the court system and commended it as an excellent example of partnership working, with significant and beneficial effects. Attention was also drawn the benefits of restorative interventions as a pre triage intervention with young people and whilst it only applies to young people in Hartlepool at the moment, its successful implementation for adults in Durham was highlighted. Members supported this view and suggested that the extension of the scheme in Hartlepool should be explored.

Barry Coppinger, Cleveland Police and Crime Commissioner

14.9 Members welcomed written evidence from the Police and Crime Commissioner. The Committee noted his continued support for the Government's sustained aim of driving down the rate of reoffending, providing better value for the taxpayer and noted his concerns regarding:

- Loss of accountability for protecting the public
- These proposals threaten local collaboration and partnerships
- Risks of serious disruption to services during the transition period
- Uncertainty over the future regulation of professional standards
- Inclusion of those released from short term prison sentences in management and supervision
- Cost Implications

Iain Wright, Member of Parliament for Hartlepool

14.10 The Committee welcomed written evidence from Iain Wright (MP), details of which are as follows:-

i) One of the best ways to reduce crime, the number of victims and the cost of our criminal justice system is by cutting down on reoffending. The rate of reoffending in Hartlepool, which I believe is now the second highest in the country, is far too high and I welcome the focus brought by this investigation.

ii) I think it is important that the Committee be fully aware of the challenges posed by the Government's privatisation of the Probation Service. Through its Transformation of Rehabilitation Strategy the Government intends to abolish local Probation Trusts and allow non-public providers to manage low and medium-risk offenders. In my view this approach risks fragmenting probation services, reducing their quality and will ultimately make the task of the Safer Hartlepool Partnership more difficult. I have raised this matter in Parliament and have held meetings with staff from Durham Tees Valley Probation Service to discuss their concerns.

iii) There are two areas of risk from this policy that I would point to.

- First, the new approach to probation does not take account of the fact that many offenders fluctuate between the different risk levels. Contrary to assurances given by Ministers, private companies are clearly going to be put in charge of some of the most dangerous

offenders and any lapse in supervision could put the public at risk. Agencies will need to respond quickly if risk level accelerates but if this is to involve a change in responsibility from the private sector to the public sector the inevitable bureaucracy could make this a difficult process.

- Second, I am concerned about the introduction of payment by results (PBR) in probation for the new private providers. This is an approach untested anywhere in the world but it is now being rolled out across the country without proper piloting. My impression is that this will create an incentive for agencies to focus their attention primarily on those offenders easiest to rehabilitate and neglect the more difficult cases.

14.11 The Committee shared the Police and Crime Commissioners concerns regarding the proposals set out in the Government paper, in relation to the provision of probation services and the effectiveness of Payment by Results (PBR) mechanisms.

15. CONCLUSIONS

15.1 The Committee concluded that:-

a) The complexity of the issues facing, and factors influencing, re-offenders can not the underestimated, along with the considerable level of social, economic and operational challenges that face local authorities and their partners.

b) The availability of accurate, and up to date, data is essential to the development of effective services, and on this basis the Safer Hartlepool Partnership was congratulated on the development of processes in partnership with the Durham Tees Valley Probation Trust for the production of accurate local data.

c) Reform to improve the delivery of re-offending service are welcomed, however, changes to the delivery of probation services, being implemented through the Governments Transformation of Rehabilitation Strategy, may potentially have a detrimental impact on service delivery in terms of duplication of activities, effectiveness and consistency of provision.

d) The development and delivery of ‘’holistic’ / offender centric services to meet the complex mix of needs/issues experienced by re-offenders, and robust partnership working, is an essential to the provision of pathways out of offending.

e) It is clear that prison does not work for many offenders and as such Restorative and other alternative interventions have a role to play in the offending punishment process. This does not, however, mean that a ‘soft’ approach is being taken and the inclusion of sanctions, that are acted upon where required, is essential.

f) Given the success of triage services for young people, the potential of extending its provision to include adults could be beneficial.

(g) The Community Payback scheme has been effective on schemes such as graffiti removal and horticultural projects in terms of encouraging a work ethic and raising esteem and aspirations. In order to progress the scheme further, emphasis must be placed on the importance of the provision of training to equip staff to interact effectively with ex-offenders in a work environment.

(h) The 'Team Around' model worked well and is an excellent example of how various agencies can work together in a targeted approach. The majority of families that received this approach were very thankful for the support they received. There were still some offending but others were working hard to gain some 'normality'.

(i) There is a clear need in respect of the provision of suitable accommodation for offenders in Hartlepool, especially in terms of our most chaotic and prolific offenders.

(j) A situation exists in relation to the release of offenders on Fridays, with ex-offenders often finding themselves having to go to several different agencies in different buildings and places to access the services and benefits they need. A 'one-stop shop' approach would be a beneficial development in bringing benefits directly to offenders on their release from prison.

(k) There is significant concern regarding the movement of the Youth Court from Hartlepool to Middlesbrough and the significant impact it will have on the effectiveness of the Youth Offending Team in reducing / preventing re-offending.

(l) The Council needs to lead by example in encouraging ex-offenders in to work and training.

(m) The establishment of a local Reducing Re-offending Strategy to tackle high rates of re-offending is commended and in progressing its development, consideration must be given to:-

i) The development of drug, housing and employment services as a priority for the future to meet the criminogenic needs of offenders in Hartlepool.

ii) The importance of addressing unemployment and poor educational attainment in disadvantaged areas, to raise aspirations and challenge the cycle of offender behaviour across generations.

iii) The Committee supported this view and shared concerns that offenders released from custody, returning home to the same

issues that had driven them to offend in the first place, had little chance of changing their behaviour.

iv) The development of improved partnership working around housing, with checks in place to ensure that there is no stigma applied to offenders in the allocation of housing.

v) Improvement in the provision of services in relation to:

- Housing advice starting earlier than two weeks before the release date for prisoner.

- The provision of greater flexibility and the ability for housing services to respond more appropriately to those offenders who may wish to avoid returning to the community where their past offending had been centred.

vi) Pressures placed on the community through the welfare reforms and their potential impact on the issues and factors that influence/ effect re-offending.

vii) The importance of family relationships to offenders and the potentially negative impact of prison placements outside the area on the maintenance of these relationships.

16. RECOMMENDATIONS

16.1 The Committee recommended that:-

Operational Issues

a) The extension of the triage service to include adults be explored.

b) The Community Payback scheme be supported, and in taking it forward additional training be provided for staff to equip them to effectively interact with ex-offenders in a work environment.

c) In recognition of problems experienced by ex-offenders released on Friday's regarding the need to access services and benefits provided by different agencies, the introduction of a 'one-stop shop' approach be explored to bring services and benefits together directly to offenders on their release.

d) In line with the priorities identified by the Local Offender Housing Needs Group, the establishment of a Housing Liaison post, similar to that in place in Sunderland, be explored.

e) That the potential for the Council to be involved in schemes similar to the 'Change for Change' scheme operated at Dearbolt Prison, leading by example in encouraging the provision of employment / apprentice opportunities for ex-offenders, be explored.

f) The Mental Health Criminal Justice Liaison and Diversion Service be developed in Hartlepool and options explored for the joint commissioning of the service in the future.

Contributions to the Reducing Re-offending Strategy

g) The establishment of a local Reducing Re-offending Strategy is supported and in progressing its development, consideration be given to:-

i) The continued development and delivery of ''holistic' / offender centric plans and services to meet the complex mix of needs/issues experienced by re-offenders, and robust partnership working,.

ii) The adoption of the Team Around/IOM principles as a template for the provision of holistic / offender centric re-offending prevention services.

iii) The role of restorative and other alternative interventions in the offending punishment process and s part of this the importance of sanctions that are acted upon where required.

iv) The prevention of duplication in service deliver, and loss of the positive outcomes already achieved, following the implementation of the Reform to improve the delivery of re-offending service are welcomed, however, changes to the delivery of probation services, being implemented through the Governments Transformation of Rehabilitation Strategy, may potentially have a detrimental impact on service delivery in terms of duplication of activities, effectiveness and consistency of provision.

v) The development of drug, housing and employment services as a priority for the future to meet the criminogenic needs of offenders in Hartlepool.

vi) The importance of addressing unemployment and poor educational attainment in disadvantaged areas, to raise aspirations and challenge the cycle of offender behaviour across generations.

vii) The development of improved partnership working around housing, with checks in place to ensure that there is no stigma applied to offenders in the allocation of housing.

viii) Improvement in the provision of services in relation to:

- Housing advice starting earlier than two weeks before the release date for prisoner.

- The provision of greater flexibility and the ability for housing services to respond more appropriately to those offenders who may wish to avoid returning to the community where their past offending had been centred.

ix) Pressures placed on the community through the welfare reforms and their potential impact on the issues and factors that influence/ effect re-offending.

x) The importance of family relationships to offenders and the potentially negative impact of prison placements outside the area on the maintenance of these relationships.

COUNCILLOR KEITH FISHER
CHAIR OF THE AUDIT AND GOVERNANCE COMMITTEE

ACKNOWLEDGEMENTS

The Committee is grateful to all those who have presented evidence during the course of our investigation. We would like to place on record our appreciation, in particular of the willingness and co-operation we have received from the below named:-

Hartlepool Borough Council:

Louise Wallace, Director of Public Health
Karen Clark, Service Delivery Manager, Drugs and Alcohol
Clare Clark, Neighbourhood Manager, Central
Julie Keoy, Criminal Justice Integrated Team (CJIT) Manager
Roni Checksfield, Youth Inclusion Custody Coordinator
Lisa Oldroyd, Community Safety Research and Development Coordinator
Caron Auckland, Project Officer – Employability
Rachel Parker, Community Safety Research Officer
Neil Harrison, Head of Service
Mark Smith, Head of Integrated Youth Support Services
Lisa Taylor, Service Manager, Offender Health

External Representatives:

Barry Coppinger, Cleveland Police and Crime Commissioner
Iain Wright, MP
Libby Griffiths, Tenancy Relations and Enforcement Manager, Housing Hartlepool
Lucia Saiger-Burns, Director of Offender Services, Durham Tees Valley Probation Trust
Julie McShane, Probation Officer, Durham Tees Valley Probation Trust
Jan Dobson, Manager, PATCH Family Support
Chief Inspector Lynn Beeston, Local Policing Area Commander for Hartlepool
Anthony Lowes, Reducing Reoffending Project Manager, National Offender Management Service, North East
Tabitha Falcus, Reducing Reoffending Project Manager, Association of North East Councils
Kevin Parry and Julie Keay, Durham Tees Valley Probation Trust
Stephen Thomas and Zoe Sherry, Hartlepool Healthwatch
Andrew Tweed and Deborah Duffy, Job Centre Plus
Peter Smith, Sunderland City Council
Dorothy Wood, NHS Foundation Trust
David Brown, Tees Esk and Wear Valleys NHS Foundation Trust
Paul Cartmell, Tees Esk and Wear Valleys NHS Foundation Trust

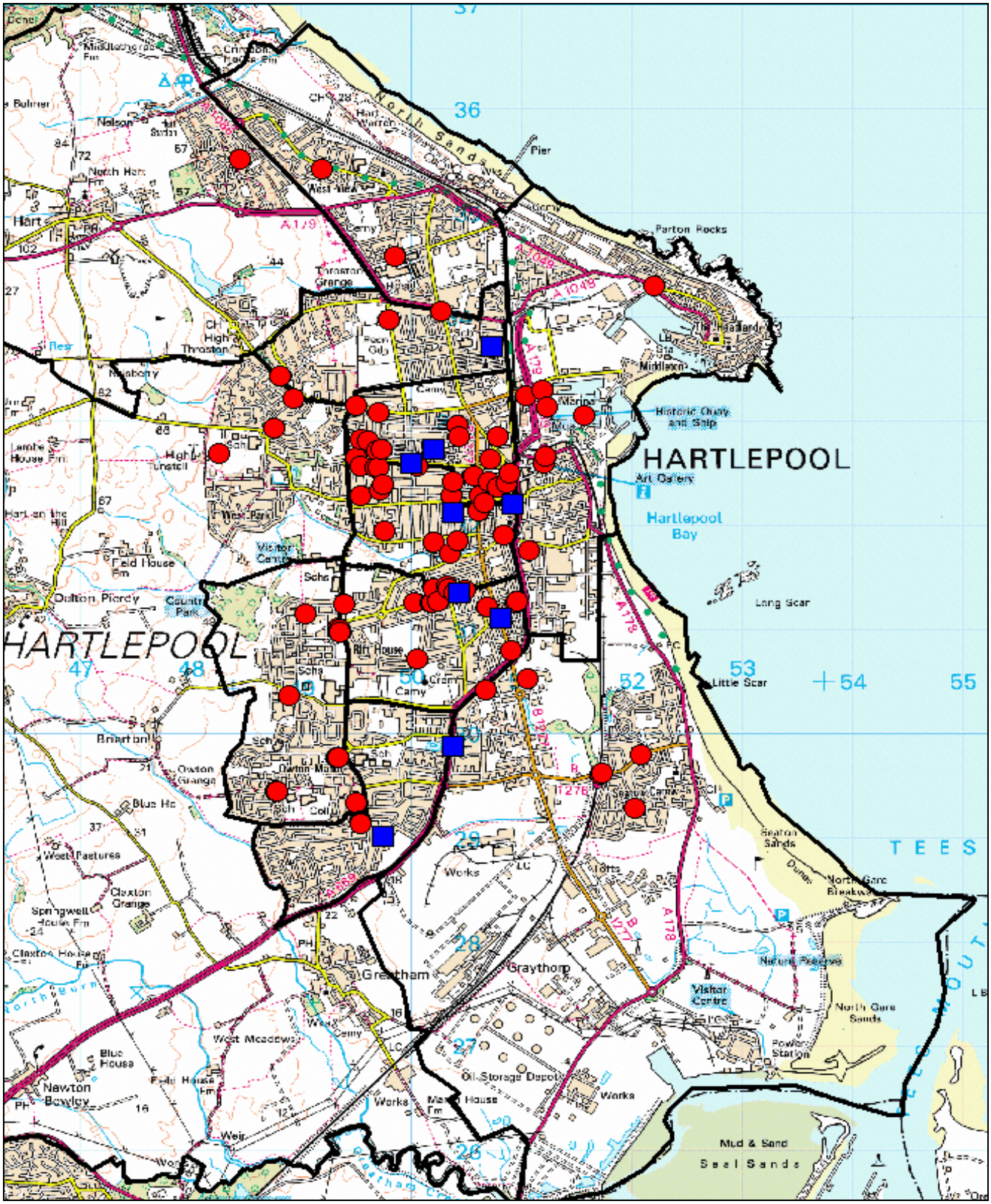
Appendix A

Evidence provided to the Forum
The following evidence was presented to the Audit and Governance Committee throughout the course of the investigation into 'Re-offending':-

Date of Meeting	**Evidence Received**
20 September 2013	Scoping Report – *Scrutiny Manager*
31 October 2013	i) Setting the Scene Presentation – *Community Safety Team and Durham Tees Valley Probation Trust* ii) Re-offender Health Provision (Presentation) – *Public Health and NHS England*
23 January 2014	Evidence from:- i) The Chair of Hartlepool's Neighbourhood Services Committee ii) Written evidence from the Police and Crime Commissioner and Hartlepool's MP iii) The National Offender Management Service (NOMS) iv) The Youth Offending Service (Hartlepool Borough Council) v) Cleveland Police
14 February 2014	Visit to Holme House Prison
6 March 2014	Evidence in relation to the provision of the following services for Re-offenders:- i) Family Support Services (Team Around the Household / Team Around the Family) ii) Housing Service (Housing Hartlepool / Tees Valley Probation Trust)

	iii) Employment Services (Economic Development Team – Hartlepool Borough Council) iv) Financial Management Services – Voluntary and Community Sector (West View Advice and Resource Centre)
3 April 2014	Hartlepool Business Forum Event 'A Chance for Change Exploding the Myths of Employing Ex-Offenders'
17 April 2014	Evidence in relation to the provision of the following services for Re-offenders:- i) Mental Health Services (North Tees and Hartlepool Foundation Trust / Tees, Esk and Wear Valley NHS Foundation Trust) ii) Employment / Benefit Services (Job Centre Plus iii) Best Practice – Sunderland City Council iv) Feedback Forum Business Forum Event – 3 April 2014

APPENDIX B



Blue squares - Offender's residence

Red dots - Offences.

AUDIT AND GOVERNANCE COMMITTEE

15 May 2014

HARTLEPOOL BOROUGH COUNCIL

Report of: Scrutiny Manager

Subject: CONSULTATION ON HOW THE CARE QUALITY COMMISSION REGULATE, INSPECT AND RATE SERVICES

1. PURPOSE OF REPORT

1.1 To provide information to the Audit and Governance Committee on the Care Quality Commission's (CQC) consultation on how they regulate, inspect and rate services.

2. BACKGROUND INFORMATION

2.1 On the 9 April 2014 the CQC launched an eight week consultation to find out what people think about how they are planning to change the way in which they regulate, inspect and rate care services including the things they look at on an inspection, how they judge what 'good' care looks like, and how they can use information better to help the CQC to decide when and where to inspect.

2.2 The plans cover a range of services including hospitals, GPs and Adult Social Care. The main changes are:

(a) introducing new ways to inspect services, with Chief Inspectors and more specialist teams that include members of the public.

(b) using a new system of intelligent monitoring to help us decide when, where and what to inspect.

(c) listening to people's experiences of care and using the best information across our monitoring system.

2.3 The CQC plan to base their judgements and ratings on the five key questions they ask of all services:

- Are they safe?

- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

2.4 The CQC are consulting using provider handbooks and the handbooks cover:-

1) NHS Acute Hospital Services
2) Specialist Health Services
3) Community Health Services
4) NHS GP Practices and GP out of hours services
5) Equality and Human Rights

The Handbooks can be viewed at http://www.cqc.org.uk/public/get-involved/consultations/consultation-how-we-regulate-inspect-and-rate-services or hard copies are available on request from Laura Stones on 01429 523087.

2.5 The handbooks that fall within the remit of the Audit and Governance Committee are 'hospitals' and 'GP practices and GP out of hours services'. An overview of these handbooks is attached as **Appendix 1** and **Appendix 2**. The consultation questions for each handbook are set out below:-

Hospital Consultation Questions

1. In addition to inspecting core services, we are also considering focusing on specific patient groups during an inspection, for example people with a learning disability mental health condition, diabetes or dementia. We would assess whether the provider understands and meet the needs of these specific groups. Do you agree that this is the right approach?

2. Do you feel confident that the key lines of enquiry and the list of prompts will help our inspectors judge how safe, effective, caring, responsive and well-led NHS acute hospitals are? Is there anything we are missing? We have provided examples of evidence we may collect during our inspections. Do you agree that this is the right kind of evidence for us to look at? Is there other evidence we could use?

3. Do you agree that the characteristics of 'outstanding' (in appendix C of the handbook) are what you would expect to see in an outstanding acute hospital service? Do you agree that the characteristics of 'good' (in appendices B and C of the handbook) are what you would expect to see in a good acute hospital service? Do you agree that the characteristics of 'requires improvement' (in appendix C of the handbook) are what you would expect to see in an acute hospital service that required improvement? Do you agree that the characteristics of 'inadequate' (in appendix C of the handbook) are what you would expect to see in an acute hospital service that was inadequate?

4. Our key lines of enquiry, prompts and ratings characteristics are generic. Do you agree that they can be applied to all of the core services? Do you feel confident that a generic approach covers the issues most important for each core service? Is there anything missing?

5. We want to know whether you agree with our approach to human rights. Please see our separate human rights approach document, in which we are asking a number of questions. We would also like your comments on our equality and human rights duties impact analysis.

6. How best do you think we can ensure that providers improve the way they conform with both the wider Mental Capacity Act and the Deprivation of Liberty Safeguards? a) Make sure we give sufficient weighting to this in our characteristics of good? b) If providers do not meet the requirements of the MCA and the Deprivation of Liberty Safeguards, apply limiters (meaning a service could not be better than requires improvement) in a proportionate way to ratings at key question level? c) In other ways?

7. During our inspections of NHS acute hospitals, we will use a number of methods to gather information from the public about their views of the services provided. Do you agree that the proposed methods of doing this are the right ones to use? Will they enable us to gather views from all of the people we need to hear from?

8. Are there ways in which we could promote learning between providers and services, particularly where we have identified outstanding care?

9. Do you agree that the grounds on which trusts can challenge their inspection reports and ask for a review of their ratings?

10. Do you agree that providers should be able to apply for a single focused inspection to recognise where improvements have been made?

11. Do you agree that the five key questions are equally important and should be weighted equally in our aggregation method?

12. Do you agree that in general the core services should be weighted equally, the only exception being where a core service at a trust is particularly small?

13. Do you agree with the guidelines for aggregating ratings? Are there any that you disagree with? Is there anything else that we should include?

14. Do you agree that CQC should use key pieces of information as described? What pieces of information would you recommend that we should use?

General Practice Consultation Questions

1. We have identified the population groups that we will inspect and rate during our inspections of NHS GP practices. Do you agree that these are the right groups for us to look at? Do you understand what we mean by these

population groups? If not, what is unclear? Do you agree that we should rate and report on each of these population groups for GP practices?

2. Do you feel confident that the key lines of enquiry and the list of prompts will help our inspectors judge how safe, effective, caring, responsive and well-led NHS GP practices and GP out-of-hours services are? Is there anything we are missing?
   Do you agree that the key things we have highlighted for each population group are the right things for our inspectors to consider when they are inspecting GP practices?

3. Do you agree that the characteristics of 'outstanding' (in appendix C of the handbook) are what you would expect to see in an outstanding NHS GP practice or GP out-of-hours service?
   Do you agree that the characteristics of 'good' (in appendices B and C of the handbook) are what you would expect to see in a good NHS GP practice or GP out-of-hours service?
   Do you agree that the characteristics of 'requires improvement' (in appendix C of the handbook) are what you would expect to see in an NHS GP practice or GP out-of-hours service that
   required improvement? Do you agree that the characteristics of 'inadequate' (in appendix C of the handbook) are what you would expect to see in an NHS GP practice or GP out-of-hours service that was inadequate?

4. We want to know whether you agree with our approach to human rights. Please see our separate human rights approach document, in which we are asking a number of questions. We would also like your comments on our equality and human rights duties impact analysis.

5. How best do you think we can ensure that providers improve the way they conform with the Mental Capacity Act? a) Make sure we give sufficient weighting to this in our characteristics of good? b) If providers do not meet the requirements of the MCA, apply limiters (meaning a service could not be better than requires improvement) in a proportionate way to ratings at key question level? c) In other ways?

6. How confident are you that the sources of information we plan to look at will identify risks of poor quality care and good practice?

7. During our inspections of NHS GP practices and GP out-of-hours services, we will use a number of methods to gather information from the public about their views of the services provided. Do you agree that the proposed methods of doing this are the right ones to use? Will they enable us to gather views from all of the people we need to hear from?

8. Are there ways in which we could promote learning between providers and services, particularly where we have identified outstanding care?

9. Do you agree that with the grounds on which practices and services can challenge their inspection reports and ask for a review of their ratings?

10. Do you agree that the five key questions are equally important and should be weighted equally in our aggregation method?

11. Do you agree that in general the population groups should be weighted equally?

12. Do you agree with the principles for aggregating ratings? Is there anything else that we should include?

3. RECOMMENDATIONS

3.1 That the Audit and Governance Committee consider the consultation questions as outlined in this report and formulate a response to the consultation.

Contact Officer:- Joan Stevens – Scrutiny Manager
Chief Executive's Department – Legal Services
Hartlepool Borough Council
Tel: 01429 284142
Email: joan.stevens@hartlepool.gov.uk

BACKGROUND PAPERS

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

(a) Care Quality Commission consultation documents: -
http://www.cqc.org.uk/public/get-involved/consultations/consultation-how-we-regulate-inspect-and-rate-services

CareQuality Commission

Overview to the provider handbooks for hospitals

For consultation

The Care Quality Commission is the independent regulator of health and adult social care in England

Our purpose:

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

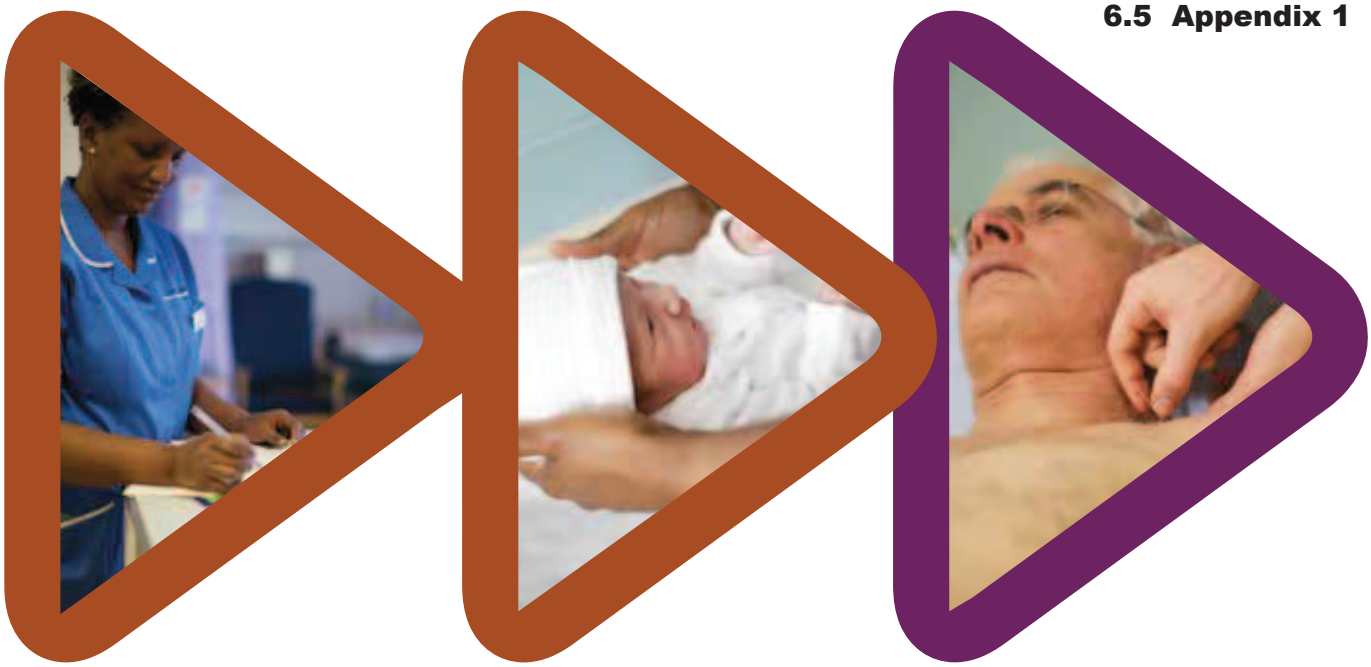
Our role:

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care.

Our principles:

- We put people who use services at the centre of our work
- We are independent, rigorous, fair and consistent
- We have an open and accessible culture
- We work in partnership across the health and social care system
- We are committed to being a high performing organisation and apply the same standards of continuous improvement to ourselves that we expect of others
- We promote equality, diversity and human rights

Contents



Foreword – Professor Sir Mike Richards

During the past year we have set out a new vision and direction for CQC in our strategy for 2013-2016, Raising standards, putting people first and in our 2013 consultation, A new start, which proposed radical changes to the way we regulate health and social care services.

In my role as Chief Inspector of Hospitals, I am responsible for overseeing the regulation and inspection of a wide range of healthcare services. This covers four broad sectors:

- Acute hospitals
- Specialist mental health services
- Community healthcare services
- Ambulance services.

Our work on implementing our new approach in each of these sectors is progressing to different timelines. We started testing our approach to NHS acute hospitals in September 2013 and have just finished two waves of inspections in which we tested and developed our proposed methodology.

For both mental health services and community healthcare services, we have just finished the initial pilot wave of inspections and will be carrying the learning from these into further pilot inspections that are due to start shortly. Our proposals for ambulance services and others, such as substance misuse services, will follow later this year.

We are developing all of these new approaches to regulation and inspection by working closely with our partners, providers, key stakeholders and, most importantly, with the public and people who use services to make sure we get this right. We will continue to evolve our model and seek input on how to improve it.

We are now at the stage where we need views and feedback on the detail that underpins our different approaches. I am pleased to publish for consultation our draft handbooks for acute hospitals, specialist mental health services and community healthcare services. The handbooks are for providers to use – to understand how we will regulate and inspect in each sector, from registration and monitoring through to inspection and ratings. They relate to both NHS and independent providers.

However, since we started our approach for acute providers in the NHS only, and have not yet started rating ambulance services, I am also publishing this month two signposting documents to engage these providers on how we will extend the approach to them. We will consult later in

the year on detailed proposals for ambulance providers. We will keep open the possibility of a further consultation for independent acute providers if need be, but in the meantime I encourage both NHS and independent providers to respond to the current consultations.

We are also consulting on our human rights approach. Human rights have underpinned our development work all the way through. We know this is fundamental to everyone's lives.

I would like to signpost one further consultation that we will launch in June. This will cover both the guidance that will underpin the new regulations and our enforcement policy. The regulations will come into force in October 2014. Our inspectors will use the guidance to determine where services are in breach of the regulations, and the enforcement policy to guide what action we take in response.

Please take the time to respond to the current consultation. We would like your views by 4 June 2014. Your views are important in helping us to evolve and develop our models for each sector, and getting them right.

Professor Sir Mike Richards
Chief Inspector of Hospitals

What are the key changes we are making?

As we have developed our new approach we have been focused on people and making sure they are at the heart of everything we do.

We will ask five key questions about services, are they:

- Safe?
- Effective?
- Caring?
- Responsive to people's needs?
- Well-led?

To make sure we ask those questions in the right way, with people's views and experiences at the heart of our approach, we have developed:

- The services, groups and/or pathways that we will focus on in each sector and how we define them.
- Key lines of enquiry (KLOEs) as the overall framework for a consistent and comprehensive approach by our inspection teams during inspections.
- Things for our inspection teams to consider under each KLOE.
- Characteristics of ratings that describe different levels of quality for each of the five key questions – and most importantly, what 'good' looks like.

We are consulting on this framework in three provider handbooks we have published with this document. The handbooks describe the elements of our regulatory model as they apply to mental health services, community health services and NHS acute hospitals:

- Registration
- Local relationships (how we keep in regular contact with providers, local partners and local representative groups)
- Intelligent monitoring (information we will gather and analyse to inform our regulatory work)
- Inspections
- Judgements and ratings
- Reporting, quality control and action planning.

Which services are covered in this consultation?

This consultation covers the following provider handbooks:

1. Acute services handbook

For now, this relates to NHS acute hospital trusts only.

We have been working with acute specialist trusts to understand how the overall approach contained within the handbook can be applied to them. We will include more detail on our approach to specialist NHS trusts in September.

We have also been working with independent organisations that provide acute services to develop our proposals for how we will regulate and inspect these services. These discussions are at early stages but nonetheless we encourage independent providers to take part in the current consultation, in order to identify any early risks to a fair playing field.

2. Specialist mental health services handbook

These services are for people with mental health needs, learning disabilities and autism and include care, treatment and support provided in hospital and in the community. The handbook for consultation is for both NHS and independent sector providers.

We are also developing our new approach to inspecting substance misuse treatment services. We will be producing a separate consultation handbook for inpatient, residential and community substance misuse services later this year.

3. Community health services handbook

By community health services we mean the range of universal, enhanced and specialist services for adults and children delivered in a community setting. This includes care in people's homes, community-based clinics, community hospitals and special schools.

Equality and human rights

Alongside the handbook we have also published:

- Our approach to human rights
- An equalities impact assessment
- A regulatory impact assessment.

We would like your views and comments on all of these documents. They each contain a number of consultation questions, and all the questions are repeated at the end of this document.

NHS acute services

We are advanced in testing our model for regulating and inspecting NHS acute hospital trusts, having now completed two waves of inspection. The first was from September to December 2013 (to pilot the approach and, in three cases, ratings) and the second was from January to March 2014 (to refine the approach, with shadow ratings for all inspected trusts).

This has involved wide and intensive engagement and support from all stakeholders and representative groups in the NHS acute sector. We are grateful for the time and commitment people have shown in giving us their expert views and helping us to shape our new approach.

In February, we published the findings from our Wave 1 pilot inspections. We learned a great deal from this first wave, and it showed that we were broadly moving in the right direction. The greater expertise that we've brought into the larger inspection teams – both from clinical specialists and from experts and from Experts by Experience – has been invaluable. Inspection teams throughout Wave 1 were able to get to heart of good care and poor care in a way that was not possible under the previous approach.

As a result of the learning from Wave 1, we made a number of changes to the Wave 2 pilot inspections and we are carrying out further evaluation.

In our February report, we outlined three challenges for us in the new approach:

- It is important that we have a consistent approach in both how we assess services and how we make judgements about quality.
- Senior expert representation on the inspection teams is vital and we need to make sure we access the right level of expertise and ensure we have high-quality training in place for our inspection teams.
- We need to improve and refine our processes, such as doing more to prepare for the main inspection and improving the logistics of organising the inspection.

We are busy addressing these and other areas for development of the model. We are strongly committed to learning and continuous improvement, which we are doing all the time.

We continue to engage widely with a wide range of stakeholders, through:

- An acute reference group of major stakeholders, chaired by the Chief Inspector of Hospitals.
- Targeted 'task and finish group' activity across different specialties and services to discuss specific areas of the new approach, such as the key lines of enquiry
- Engagement with the relevant network groups from, among others, NHS Confederation, Foundation Trust Network and the Royal Colleges.
- Ongoing activity with our online community of providers, including document reviews and live Q&A discussions.
- Regular engagement with stakeholder organisations, patient representative and consumer 'voice' organisations, and a wide range of voluntary sector groups.

With their help we have worked on the detail of our new approach to the regulation and inspection of acute hospital trusts, and this detail is set out in the draft provider handbook.

The handbook includes what we mean by the different core services we will inspect, our key lines of enquiry that will direct the focus of the inspections, and the characteristics of care at the

four rating levels as they apply to acute hospital services.

It is a reflection on our current thinking. We will continue to work with the public, people who use services, providers, professionals and organisations with an interest in our work to develop our thinking further. We will publish an update of this guidance with our final approach in September 2014.

We welcome your feedback on all the things set out in the handbook. We also welcome feedback on how well we have designed the handbooks for acute, mental health and community services to work together for combined providers.

Specialist mental health services

We are committed to developing changes to how we monitor, inspect and regulate in partnership.

Since we published our document *A Fresh Start* in November, which set out our plans for specialist mental health services, we have been discussing our ideas for change with a range of stakeholders including people who use services, providers, voluntary sector organisations, our staff and other interested individuals and groups to help develop our thinking.

We have continued to work with our expert Advisory Group to develop our proposals. We have engaged members of this group and other colleagues in detailed discussions on quality in mental health, which services to inspect, how to involve people who use services in our new inspections, indicators for our intelligent monitoring for mental health and ratings for mental health services.

People who use services are represented on the Advisory Group, as well as in the smaller group projects, but we are also working with specific groups to discuss aspects of our new approach. These include our Service User Reference Panel of people with experience of detention, local Healthwatch groups, foundation trust governors from NHS trusts that provide specialist mental health services, and representatives from local and national advocacy organisations.

We have also:

- Held bi-monthly meetings of the mental health reference group. The group consists of a mix of providers, professionals, stakeholders and Experts by Experience from across the sector.
- Worked with targeted 'task and finish' groups to discuss specific areas of the new approach, such as the key lines of enquiry.
- Set up a learning disability and autism expert reference group. Members of the group include professionals, stakeholders, Experts by Experience and carers with a specialist interest in learning disabilities or autism.
- Held workshops and online discussions with members of the learning disability reference group to help with work such as the key lines of enquiry and specialist tools for inspections of learning disability services.
- Hosted a workshop with the Independent Mental Health Services Alliance to discuss the developing model for independent providers.
- Met with Mind, Mental Health Foundation, Re-think and the Centre for Mental Health.
- Engaged with the relevant network groups from a range of bodies including NHS Confederation, Foundation Trust Network and the Royal Colleges.
- Posted document reviews and held live Q&A discussions with our online provider community.

Worked with people who have experience of mental health crises and access to services to design and deliver a first care pathway based review of services. At the heart of our new approach is our commitment to tailor our inspections on the issues that matter in each sector. We have just finished testing our new approach in five NHS trusts providing specialist mental health services (Wave 1 inspections). We will incorporate our learning and experience from those first inspections into further testing during Wave 2, which takes place from April to September 2014 and will include both NHS trusts and independent sector hospitals.

In *A Fresh Start*, we set out the main changes that we planned to make to the way we regulate and inspect specialist mental health services. These include:

- The integration of regulation and some Mental Health Act (MHA) monitoring activities
- Making greater use of information from people who use services, employing new methods to do so and learning from best practice.
- Complaints made by people who use services will form a key source of information within our new model.
- Expert inspectors, with specialists and Experts by Experience as part of inspection teams.
- A consistent focus on core services across all providers where there are known inequalities, or where people are in especially vulnerable circumstances
- Focus on transitions, care pathways and joint working, including where people move between services and where care is provided in an integrated way.
- How national standards and guidance relate to the five key questions we ask of services, with people's experience of services at the core.
- Ratings and frequency of inspections based on ratings.
- A greater focus on community-based services – especially the experience of those on community treatment orders
- Better use of data and intelligence – including information from whistleblowers and the findings of others, such as Healthwatch and third sector organisations, and national surveys.

The draft handbook sets out much of the detail to underpin these changes. It is for both NHS and independent sector providers of specialist mental health services.

It includes what we mean by the core services we will inspect and our different approaches to inspecting each of them, our key lines of enquiry that will direct the focus of the inspections, and the characteristics of care at the four rating levels as they apply to mental health services.

In addition, consultation feedback has emphasised the importance of us taking a care pathway approach and focusing on transitions between services as part of our inspection of specialist mental health services. This could include for example an acute care pathway, or a care pathway for people with dementia. The handbook outlines options for how we could include care pathways within our inspection approach. We would welcome feedback on the best approach to adopt.

The draft handbook is a reflection on our current thinking and will be refined as we test it further between April and September 2014. We will continue to work with the public, people who use services, providers and organisations with an interest in our work to develop our thinking further, and we welcome your feedback.

Community health services

Since we published our document *A Fresh Start* in December, which set out our plans for community health services, we have been busy engaging with a wide range of stakeholders and with their help working on the detail that is set out in the draft provider handbook.

We have just finished our Wave 1 testing of our new approach. This consisted of inspections of five community health service providers between January and March 2014. We will incorporate our learning and experience from those first inspections into further testing during Wave 2, which takes place from April to September 2014.

The approach we set out is relevant to all community health providers; large and small, NHS and independent sector. Our initial focus has been on large, complex organisations that provide a range of NHS community services to people in a local area. We will apply this in an appropriate and proportionate way other providers and, over the coming months, we will be looking at how it should be adapted for smaller community healthcare providers.

We intend to publish 'shadow' ratings for a small number of community health service providers during Wave 2 and we will continue to evaluate

our approach. We intend to formally roll out ratings for community health care providers from October 2014.

Like the other sectors, we have been engaging widely with providers, stakeholders and public representatives about our new approach:

- Bi-monthly meetings of the community health reference group, chaired by the Chief Inspector of Hospitals. The group consists of a mix of providers, professionals, stakeholders and voluntary groups from across the sector
- Working with targeted groups to discuss specific areas of the new approach, such as the key lines of enquiry.
- Engagement with the relevant network groups from a range of bodies including NHS Confederation, Foundation Trust Network and the Royal Colleges.
- In *A Fresh Start*, we set out the main changes that we planned to make to the way we regulate and inspect community health services. These include:
- Inspecting a greater number of services and have better coverage across all areas of care handled by a provider.
- Have a greater focus on services provided in community clinics or in people's homes, which is where most people receive care, as well as locations where care is directly provided, such as in community hospitals.
- Set a clear expectation about what good-quality care looks like in this sector.
- Be more consistent in how we gather views from people who use community health services, their families and carers as well as staff before and during inspections.
- Improve our understanding of how well services are governed across widely dispersed locations and teams.

The draft handbook sets out much of the detail to underpin these changes. These include what we mean by the different core services we will inspect and our different approaches to inspecting each of them, our key lines of enquiry that will direct the focus of the inspections, and the characteristics of care at the four rating levels as they apply to community health services.

We want your feedback on all the things set out in the handbook.

Conclusion

We have been working hard to develop the new regulatory approaches and take forward the ideas we have set out in our earlier signposting documents.

We know there is much more to do and we are enormously grateful for the help and support people have given us in co-producing each new approach.

Whether you've helped us get this far or not we are interested in hearing everyone's views. Please do take the time to respond.

Consultation questions and how to respond to this consultation

This section repeats the consultation questions we have asked throughout the provider handbook, human rights approach and impact assessments.

You can give us your views and comments by post, email or via our website using the addresses below, by **Wednesday 4 June 2014**.

Consultation questions

1. In addition to inspecting core services, we are also considering focusing on specific patient groups during an inspection, for example people with a learning disability mental health condition, diabetes or dementia. We would assess whether the provider understands and meet the needs of these specific groups.

   Do you agree that this is the right approach?

2. Do you feel confident that the key lines of enquiry and the list of prompts will help our inspectors judge how safe, effective, caring, responsive and well-led NHS acute hospitals are? Is there anything we are missing?

   We have provided examples of evidence we may collect during our inspections. Do you agree that this is the right kind of evidence for us to look at? Is there other evidence we could use?

3. Do you agree that the characteristics of 'outstanding' (in appendix C) are what you would expect to see in an outstanding acute hospital service?

   Do you agree that the characteristics of 'good' (in appendices B and C) are what you would expect to see in a good acute hospital service?

   Do you agree that the characteristics of 'requires improvement' (in appendix C) are what you would expect to see in an acute hospital service that required improvement?

   Do you agree that the characteristics of 'inadequate' (in appendix C) are what you would expect to see in an acute hospital service that was inadequate?

4. Our key lines of enquiry, prompts and ratings characteristics are generic.

Do you agree that they can be applied to all of the core services?

Do you feel confident that a generic approach covers the issues most important for each core service? Is there anything missing?

5. We want to know whether you agree with our approach to human rights. Please see our separate human rights approach document, in which we are asking a number of questions.

   We would also like your comments on our equality and human rights duties impact analysis.

6. How best do you think we can ensure that providers improve the way they conform with both the wider Mental Capacity Act and the Deprivation of Liberty Safeguards?

   a) Make sure we give sufficient weighting to this in our characteristics of good?

   b) If providers do not meet the requirements of the MCA and the Deprivation of Liberty Safeguards, apply limiters (meaning a service could not be better than requires improvement) in a proportionate way to ratings at key question level?

   c) In other ways?

7. During our inspections of NHS acute hospitals, we will use a number of methods to gather information from the public about their views of the services provided.

   Do you agree that the proposed methods of doing this are the right ones to use?

   Will they enable us to gather views from all of the people we need to hear from?

8. Are there ways in which we could promote learning between providers and services, particularly where we have identified outstanding care?

9. Do you agree that the grounds on which trusts can challenge their inspection reports and ask for a review of their ratings?

10. Do you agree that providers should be able to apply for a single focused inspection to recognise where improvements have been made?

11. Do you agree that the five key questions are equally important and should be weighted equally in our aggregation method?

12. Do you agree that in general the core services should be weighted equally, the only exception being where a core service at a trust is particularly small?

13. Do you agree with the guidelines for aggregating ratings? Are there any that you disagree with? Is there anything else that we should include?

14. Do you agree that CQC should use key pieces of information as described? What pieces of information would you recommend that we should use?

How to respond to this consultation

You can respond to our consultation in the following ways. Please send us your views and comments by **Wednesday 4 June 2014**.

Online

Use our online form at:
www.cqc.org.uk/InspectionsConsultation

By email

Email your response to:
CQCchanges.tellus@cqc.org.uk

By post

Write to us at:
CQC consultation:
How we inspect, regulate and rate
CQC National Customer Service Centre
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

6.5 Appendix 1

How to contact us

Call us on: **03000 616161**
Email us at: **enquiries@cqc.org.uk**
Look at our website: **www.cqc.org.uk**
Write to us at: **Care Quality Commission**
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Follow us on Twitter: **@CareQualityComm**

Read more and download this report in other formats at: **www.cqc.org.uk**.
Please contact us if you would like a summary of this report in another language or format.

CareQuality Commission

Overview to the provider handbook for general practice

For consultation

The Care Quality Commission is the independent regulator of health and adult social care in England

Our purpose:

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role:

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care.

Our principles:

- We put people who use services at the centre of our work
- We are independent, rigorous, fair and consistent
- We have an open and accessible culture
- We work in partnership across the health and social care system
- We are committed to being a high performing organisation and apply the same standards of continuous improvement to ourselves that we expect of others
- We promote equality, diversity and human rights

Contents

Foreword – Professor Steve Field

In December, I set out CQC's early thinking on how we will monitor, inspect and regulate GP practices and GP out-of-hours services, and our priorities for the sector. The document was called A fresh start.

I was clear that I wanted to develop all of these changes by working closely with our partners, people working in general practice, key stakeholders and, most importantly, with the public and people who use services to make sure we get this right.

Since then, we have been working with a lot of people – a wide range of external stakeholders and our own staff – to get feedback on our thinking and to co-produce our new approach.

It is still early days and we will do much more engagement and discussion between now and October, as we continue to evolve our model and seek input on how to improve it. We also want to test and evaluate this approach to see if it works for general practice and for patients and the public.

We will shortly be starting to test our proposed methodology in GP practices in our 'Wave 1' inspections: between April and June we will be inspecting 200 GP practices within 12 CCG areas.

We have already been testing our approach to GP out-of-hours services, and will be applying our learning from these from April.

At the same time as we start to test our new approach, I am pleased to publish our draft GP practice and GP out-of-hours inspection handbook for consultation. The handbook is for providers to use – to understand how we will regulate and inspect GP practices and GP out-of-hours services, from registration and monitoring through to inspection and ratings.

The evidence and input from both the consultation and Wave 1 inspections will help us to refine our approach to GP practices for Wave 2 inspections, which will start in July. We will then refine and improve our approach and fully implement it from 1 October 2014.

We are also consulting on our human rights approach. Human rights have underpinned our development work all the way through. We know this is fundamental to everyone's lives and this is something which is important to me, personally.

We have a further consultation to run in the summer. That will be on the guidance that will underpin the new regulations, as well as on our enforcement policy. The regulations will also come into force in October 2014. Our inspectors will use

the guidance to determine where services are in breach of the regulations, and the enforcement policy to guide what action we take in response.

Please take the time to respond to the current consultation. We would like your views by 4 June 2014. It is important and we need your help to get it right. Many people have helped us to get this far, and I'm really grateful to them.

Professor Steve Field
CBE FRCP FFPHM FRCGP
Chief Inspector of General Practice

What are the key changes we are making?

As we have developed our new approach we have been focused on people and making sure they are at the heart of everything we do. We will ask five key questions about practices and services, are they:

- Safe?
- Effective?
- Caring?
- Responsive to people's needs?
- Well-led?

To make sure we ask those questions in the right way, with people's views and experiences at the heart of our approach, we have developed:

- Key lines of enquiry (KLOEs) as the overall framework for a consistent and comprehensive approach by our inspection teams.
- Things for our inspection teams to consider under each KLOE.
- Characteristics of ratings that describe the different levels of quality for each of the five key questions.

We are consulting on this framework in the provider handbook we have published with this document. The handbook describes the elements of our regulatory model as they apply to GP practices and GP out-of-hours services:

- Registration
- Local relationships (how we keep in regular contact with practices, services and local representative groups)
- Intelligent monitoring (information we will gather and analyse to inform our regulatory work)
- Inspections
- Judgements and ratings
- Reporting, quality control and action planning.

Which services are covered in this consultation?

The handbook for consultation covers NHS GP practices and GP out-of-hours services. We will consult later in 2014 on our plans for the other services that fall within the remit of the Chief Inspector of General Practice (for example, dentists). This is with a view to launching our new approach to them early in 2015.

Alongside the handbook we have also published:

- Our approach to human rights
- An equalities impact assessment
- A regulatory impact assessment.

We would like your views and comments on all of these documents. They each include consultation questions, and all the questions are repeated in a single list at the end of this document.

Our approach to co-production

In A fresh start we said that we would develop the changes by working closely with our partners, providers, key stakeholders, and the public and people who use services.

We have used a model of 'co-production' which has meant people have shaped our thinking as we have progressed.

We have created a GP Advisory Group, the purpose of which is to advise the Chief Inspector about key aspects of the new model as it is developed. Members include COGPED, the General Medical Council, the Medical Defence Union, NHS England, Royal College of GPs, Royal College of Nursing, Medical Protection Society, NICE, NHS Health and Social Care Information Centre, Nursing and Midwifery Council, Parliamentary and Health Service Ombudsman, BMA, General Practice Council – BMA, Healthwatch England and Public Health England

We have also set up a GP Reference Group, through which we engage with experts from the GP sector. This group supports us by providing expert advice, opinion and challenge to the design and development of our methods. Members include NHS England area teams, CCGs, LMCs, working GPs, the Family Doctor's Association, NHS Alliance, BMA and the Department of Health.

We also have a GP out-of-hours task and finish group. This group helps to support us by focusing on specific areas of out-of-hours services that need in-depth work. It includes CCGs, out-of-hours providers, NHS Alliance, BMA, NHS

England, Primary Care Foundation and the National Audit Office.

All three groups have worked with us on a number of things including:

- The overall approach to inspecting and regulating GP practices and GP out-of-hours services
- The key lines of enquiry
- What is 'good' general practice
- Intelligent Monitoring.

We have chaired two stakeholder/engagement events:

- With patient representative groups and GP stakeholders looking at 'what does good look like in primary care'.
- With key national organisations including the General Medical Council, NHS England and the Royal College of GPs, focusing on 'How we jointly respond to poor performing practices'.

We have continued to engage with patients, public and a wide range of stakeholders across England. We will continue with this engagement.

As well as working with the co-production group to inform our lines of enquiry and characteristics of ratings, we have incorporated the existing evidence base produced by other organisations, such as the Department of Health, the Royal College of GPs and NICE.

Our priorities

In A fresh start we set out our top 10 changes we wanted to take forward. We have made good progress with many of the things we set out.

Below is a summary of what we are proposing in each of the key areas. More detail is included in the handbook.

Better, more systematic use of people's views and experiences, including suggestions and complaints

The handbook sets out more detail about how we will use people's views and experiences in making judgements about the quality of care.

In all inspections, we will gather information about people's experiences from a number of sources including national patient surveys and individual comments that we receive from the public, partner organisations that hold information about people's views, local voluntary and community organisations, local Healthwatch, patient participation groups and carer groups and local NHS complaints advocacy service. We will also test approaches to gathering views from the public, including focus groups and listening events, questionnaires and surveys of local organisations. We will use the media to publicise our inspections.

We will also look at how practices gather the views of staff, patients and the public and how they respond to these views to continually improve these services. We expect practices to have effective complaints handling arrangements and to respond properly to patient concerns, staff concerns and whistleblowers.

New expert inspection teams including trained inspectors, clinical input led by GPs, nurses and practice managers

Inspections will be led by specialist inspectors, with clinical input led by GPs. The teams will usually include specialist inspectors, GPs, nurses and/or practice managers. The team may also include GP Registrars so they can get a better understanding of a range of GP surgeries. While they are part of the team asking questions, we also hope that this will help us to create a sustainable workforce of GPs for inspections for the years ahead. Teams will vary in size, to reflect the size of the practice or out-of-hours provider.

An inspection manager will lead the inspections across a CCG area, and will be the main point of contact with the CCG and the area team throughout the inspection, supported by a GP.

Teams may also include Experts by Experience, who are people who use or care for someone who uses a GP or out-of-hours service. How we use Experts by Experience forms part of the pilot work.

A programme of inspections carried out systematically in each CCG area across England

This is set out in our handbook. We will check the quality of NHS GP services within each clinical commissioning group (CCG) area. Over a two-year period, we will inspect a number of GP practices in each CCG every six months. We are not inspecting the clinical commissioning group itself.

Inspections will usually be announced. We will announce which CCG area we are visiting at least four weeks before starting inspections in that area. And we will usually give GP practices at least two weeks' notice of the date of their inspection. We will test whether this works between now and October. We will also carry out some unannounced inspections, for example if we have concerns about a practice or if we are following up on concerns identified in a previous inspection.

Inspections of GP out-of-hours services to be incorporated into CCG area programmes

We have already started testing our new approach to inspecting in GP out-of-hours services. These began in January. From April, out-of-hours services will be included in the programme set out above, of inspections within each CCG area.

We will publish an overview of our findings in the summer.

A focus on how general practice is provided to key patient groups, including vulnerable older people and mothers, babies and children

As we set out in A fresh start, we intend to look at how well services are provided for specific groups of people and what good care looks like for them. The groups are:

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

By looking at services for these groups of people, we can make sure our inspections look at the outcomes of care provided for all people, including those who are particularly vulnerable.

We have provided more detailed definitions of these population groups in the handbook. We want to know whether you agree that these are the right groups for us to look at, and whether we are focusing on the right things for these population groups.

Tougher action in response to unacceptable care, including where necessary closing down unsafe practices

We know that the majority of people receive good quality care from their GP. However, where we find poor or unacceptable care, we will use the full range of our enforcement powers to make sure they improve. This will include, where necessary, stopping a practice from providing services or prosecuting it. We will work closely with NHS England Area Teams when responding to poor practices.

We will be consulting on the full details of our enforcement policy in summer 2014, and we will welcome your views at that time.

Ratings of all practices to help drive improvement and support people's choice of surgery

Our approach to ratings of GP practices and out-of-hours services is covered in the consultation handbook. Our ratings will be awarded on a four point scale; outstanding, good, requires improvement and inadequate.

We will roll out ratings formally from October 2014 for both GP practices and GP out-of-hours services. Before we do this, we want to thoroughly test and refine our approach to ratings and this consultation forms part of that development.

From April 2014, we will start to test our approach to how we will decide ratings for GP practices and GP out-of-hours services. From October 2014 we will fully implement our approach to rating GP practices and GP out-of-hours services, including formal ratings.

We will consider whether we can award shadow ratings as we get closer to October. Shadow ratings are ratings which we will award following an inspection and will be included in the inspection report, but which are subject to change as we develop and improve our approach.

We have already carried out some early tests of our approach in GP out-of-hours services. From July 2014, we will provide shadow ratings for all GP out-of-hours services.

By April 2016, we will have inspected and rated all NHS GP practices and GP out-of-hours in England.

Better use of data and analysis to help us to identify risk and target our efforts

'Intelligent monitoring' is how we describe the processes we use to gather and analyse information about the risk to the quality and safety of care. Together with local insight and other factors, this information helps us to decide when, where and what to inspect. By gathering and using the right information, we can make better use of our resources by targeting activity where it is most needed. It also means that we can anticipate, identify and respond more quickly to practices at risk of providing unsafe care.

The handbook sets out the sources of information we have identified in our initial scoping work. We would like to know whether these indicators are the right sources for us to draw our information from.

We will be carrying out additional testing and engagement to determine the most useful indicators to inform our inspections and ratings.

Clear guidance to underpin the five key questions we ask of services

The handbook sets these out in detail. We have developed key lines of enquiry for each of the five questions: is the practice or service safe, effective, caring, responsive and well-led? We have also developed descriptors that set out the characteristics of each rating level (outstanding, good, requires improvement and inadequate) for each of the five questions.

We want your feedback on whether the KLOEs are the rights things for our inspectors to look at, and whether the characteristics properly reflect each rating level.

Close collaborative working CCGs and Area Teams of NHS England, to avoid duplication of activity

We continue to work closely with NHS England nationally, and with CCGs and Area Teams locally.

Our proposed model of inspecting NHS GP practices and GP out-of-hours services will only be successful if we have good, ongoing relationships with NHS Area Teams as commissioners of NHS GP practices. We also need good, ongoing relationships with clinical commissioning groups, as they have a duty to support quality improvement in general practice. This will help ensure that improvements are made following our inspections.

Communication and information sharing with CCGs and Area Teams will be a key part of every inspection. It will take place every time we visit practices in each CCG area.

More information on this is in the handbook.

The Primary Medical Services (PMS) directorate

From 1 April 2014, we have a settled structure for our new Primary Medical Services Directorate within CQC. The Directorate not only involves general medical practice but also dentistry,

children and health & justice, integrated care and medicines management.

Under the Chief Inspector of General Practice, there will be four Deputy Chief Inspectors – one for each region: North, Central, London and the South. A range of senior managers will work to the Deputies, four of whom (one for each region) will be focused on general practice.

There will be 28 inspection managers under the Heads of General Practice.

The General Practice inspection managers will manage around 200 General Practice inspectors.

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Under the Chief Inspector of General Practice, there will be four Deputy Chief Inspectors - one for each region: North, Central, London and the South. A range of senior managers will work to the Deputies, four of whom (one for each region) will be focused on general practice.

There will be 28 inspection managers under the Heads of General Practice.

The General Practice inspection managers will manage around 200 General Practice inspectors.

Conclusion

Since we published A fresh start in December, we have been working hard to develop the new regulatory approach and take forward the ideas we set out.

We know there is much more to do and we are enormously grateful for the help and support people have given us in co-producing the new approach.

Whether you've helped us get this far or not we are interested in hearing everyone's views. Please do take the time to respond.

Consultation questions and how to respond to this consultation

This section repeats the consultation questions we have asked throughout the provider handbook, human rights approach and impact assessments.

You can give us your views and comments by post, email or via our website using the addresses below, **by Wednesday 4 June 2014**.

Consultation questions

1. We have identified the population groups that we will inspect and rate during our inspections of NHS GP practices.

   Do you agree that these are the right groups for us to look at?

   Do you understand what we mean by these population groups? If not, what is unclear?

   Do you agree that we should rate and report on each of these population groups for GP practices?

2. Do you feel confident that the key lines of enquiry and the list of prompts will help our inspectors judge how safe, effective, caring, responsive and well-led NHS GP practices and GP out-of-hours services are? Is there anything we are missing?

   Do you agree that the key things we have highlighted for each population group are the right things for our inspectors to consider when they are inspecting GP practices?

3. Do you agree that the characteristics of 'outstanding' (in appendix C) are what you would expect to see in an outstanding NHS GP practice or GP out-of-hours service?

   Do you agree that the characteristics of 'good' (in appendices B and C) are what you would expect to see in a good NHS GP practice or GP out-of-hours service?

   Do you agree that the characteristics of 'requires improvement' (in appendix C) are what you would expect to see in an NHS GP practice or GP out-of-hours service that required improvement?

Do you agree that the characteristics of 'inadequate' (in appendix C) are what you would expect to see in an NHS GP practice or GP out-of-hours service that was inadequate?

4. We want to know whether you agree with our approach to human rights. Please see our separate human rights approach document, in which we are asking a number of questions.

   We would also like your comments on our equality and human rights duties impact analysis.

5. How best do you think we can ensure that providers improve the way they conform with the Mental Capacity Act?

   a) Make sure we give sufficient weighting to this in our characteristics of good?

   b) If providers do not meet the requirements of the MCA, apply limiters (meaning a service could not be better than requires improvement) in a proportionate way to ratings at key question level?

   c) In other ways?

6. How confident are you that the sources of information we plan to look at will identify risks of poor quality care and good practice?

7. During our inspections of NHS GP practices and GP out-of-hours services, we will use a number of methods to gather information from the public about their views of the services provided.

   Do you agree that the proposed methods of doing this are the right ones to use?

   Will they enable us to gather views from all of the people we need to hear from?

8. Are there ways in which we could promote learning between providers and services, particularly where we have identified outstanding care?

9. Do you agree that with the grounds on which practices and services can challenge their inspection reports and ask for a review of their ratings?

10. Do you agree that the five key questions are equally important and should be weighted equally in our aggregation method?

11. Do you agree that in general the population groups should be weighted equally?

12. Do you agree with the principles for aggregating ratings? Is there anything else that we should include?

How to respond to this consultation

You can respond to our consultation in the following ways. Please send us your views and comments by **Wednesday 4 June 2014**.

Online

Use our online form at:
www.cqc.org.uk/InspectionsConsultation

By email

Email your response to:
CQCchanges.tellus@cqc.org.uk

By post

Write to us at:
CQC consultation:
How we inspect, regulate and rate
CQC National Customer Service Centre
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

6.5 Appendix 2

How to contact us

Call us on: **03000 616161**
Email us at: **enquiries@cqc.org.uk**
Look at our website: **www.cqc.org.uk**
Write to us at: **Care Quality Commission**
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Follow us on Twitter: **@CareQualityComm**

Read more and download this report in other formats at: **www.cqc.org.uk**.
Please contact us if you would like a summary of this report in another language or format.

Extract from the minutes of the Finance and Policy Committee on 25 April 2014 relating to Public Health

250. School Nursing Services (*Director of Public Health)*

Type of decision

Key Decision – Test (i) and (ii) apply – Forward Plan Reference PH/03.

Purpose of report

To seek approval from the Finance and Policy Committee to secure a school nursing service, funded through the ring fenced Public Health Grant to commence 1 April 2015.

Issue(s) for consideration

The report provided the background to Local Authorities assuming the accountability for the commissioning of school nursing services. Details of the current school nursing provision were included in the report. A new national model for School Nursing had been published by the Department of Health that aimed to reduce health inequalities amongst children and young people and it was intended that the Council's procurement process commence in October 2014 with a view to the successful provider being mobilised to begin operation no later than April 2015. The financial considerations were detailed in the report including the need to commit resources for the procurement of a school nursing service from the 2015/16 ring fenced public health grant. The Director of Public Health indicated that communication with the current provider of the service was ongoing as a service review was undertaken.

Decision

(i) That the content of the report be noted.
(ii) That the development of a new service specification during 2014/15 based on the national model and taking into consideration local needs and view from the engagement process was approved.
(iii) It was agreed to secure a provider for a school nursing service funded by the ring fenced public health grant in 2015/16.

252. Defibrillation Units (Director of Public Health)

Type of decision

Non key.

Purpose of report

To inform Members of an opportunity for the Council to contribute to reducing deaths in Hartlepool due to sudden cardiac arrest, by installing easy to use

defibrillation units at key sites for both staff and members of the public.

To obtain Members' views on the location of the defibrillation units and gain support to help raise awareness and knowledge of the units among Hartlepool residents and Council employees.

A demonstration for Members of the preferred defibrillator had taken place prior to the meeting.

Issue(s) for consideration

The report provided the background to the support provided by the British Heart Foundation (BHF) and the North East Ambulance Service (NEAS) to install defibrillator units in remote locations and key community sites in the UK. It had been identified in conjunction with NEAS that Hartlepool Borough Council had a number of sites that could warrant hosting a defibrillator unit and these were identified in the report. It was noted that some Council leisure services sites already had units in place and were checked and replaced as appropriate and funded through departmental budgets. A training schedule would be developed for host sites to include designated first aiders, Members, staff, caretakers and other staff/volunteers however, it was reiterated that anyone on the scene can use the device in an emergency.

The financial implications were detailed in the report and it was noted that the total cost per unit would be £849 plus approximately £100 per year in maintenance costs.

Members were fully supportive of the proposals and requested that wider promotion of the installation and location of these devices be undertaken including through the Council's Hartbeat magazine as the importance of raising awareness was reiterated.

In response to Members' concerns, the Workplace Health Improvement Specialist indicated that the units can be procured with anti-vandal boxes which were operated by a key code provided from the Emergency Services Control Room. However, the Director of Public Health commented that the risk of vandalism needed to be weighed up against the risk of saving a life and this was the opportunity for Members to do something practical in their leadership role for public health within the community.

It was suggested that consideration should be given to the purchase of more of the defibrillator units as and when such additional funding became available. During the discussions that followed, it was suggested that consideration be given to the location of defibrillator units within the local villages surrounding Hartlepool. This could be done in partnership with the local Parish Councils. In addition, it was suggested that additional defibrillator units be installed where the Council had staff employed such as lifeguards at the local beaches or possibly within refuse collection wagons.

In response to a query from a Member, the Workplace Health Improvement Specialist confirmed that the North East Ambulance Service had produced statistical information on the position of defibrillator units in the north east and the number of times the units had been used. There had also been a number of high profile cases nationally.

Decision

(i) That resources be identified from the ring-fenced public health grant (circa £10k) to meet the costs of the defibrillator units and ongoing maintenance.
(ii) That the installation of the defibrillator units be promoted and communicated widely across Hartlepool including through the Council's Hartbeat magazine.
(iii) That further consideration be given to locating defibrillator units within the local villages surrounding Hartlepool working in partnership with local Parish Councils, at local beaches where lifeguards operated and in places where other Council staff would have access to them such as on refuse collection wagons.
(iv) That should any additional funding become available, consideration be given to the purchase and installation of more defibrillator units.