AUDIT AND GOVERNANCE COMMITTEE AGENDA

HARTLEPOOL BOROUGH COUNCIL

Thursday 11 February 2016

at 10.00 am

in Committee Room B
Civic Centre, Hartlepool

MEMBERS: AUDIT AND GOVERNANCE COMMITTEE

Councillors Ainslie, S Akers-Belcher, Belcher, Cook, Lawton and Martin-Wells.

Standards Co-opted Members; Mr Norman Rollo and Ms Clare Wilson.
Parish Council Representatives: Parish Councillor J Cambridge (Headland) and Parish Councillor B Walker (Greatham).
Local Police Representative: Chief Superintendent Gordon Lang.

1. **APOLOGIES FOR ABSENCE**

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

3. **MINUTES**

   3.1 To confirm the minutes of the meetings held on 28 January, 2016 *(to follow)*

4. **AUDIT ITEMS**

   No items.

5. **STANDARDS ITEMS**

   No items.

6. **STATUTORY SCRUTINY ITEMS**

   6.1 North Tees and Hartlepool NHS Foundation Trust - Quality Account:

   (a) Covering Report – *Scrutiny Manager*
   (b) Presentation – *Associate Director of Nursing, Quality and Patient Experience (NTHFT)*

   6.2 Update Presentation - *NHS Better Health Programme (SeQIHS)* - Communication Lead, Better Health Programme.

6.3 Youth Justice Strategic Plan 2016-2017 - *Director of Child and Adult Services (Verbal Update)*

6.4 Community Safety Plan 2014-17 (Year 3) - *Director of Regeneration and Neighbourhoods*

6.5 Six Monthly Monitoring of Scrutiny Recommendations – *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 30 November, 2015.

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

No items.

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 20 November, 2015.

11. **REGIONAL HEALTH SCRUTINY UPDATE**

No items.

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

ITEMS FOR INFORMATION

Date of next meeting – Thursday 3 March, 2016 at 10.00 am in the Civic Centre, Hartlepool.

AUDIT AND GOVERNANCE COMMITTEE

MINUTES AND DECISION RECORD

28 January 2016

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

Present:

Councillor: Ray Martin-Wells (In the Chair)

Councillors: Jim Ainslie, Rob Cook and Trisha Lawton

Standards Co-opted Members:
Norman Rollo and Clare Wilson

Parish Council Representatives:
John Cambridge (Headland)

Also Present: Councillors Alan Clark and Jim Lindridge
Barry Coppinger, Police and Crime Commissioner for Cleveland
Chief Superintendant Gordon Lang
Deputy Chief Constable Simon Nickless
Eve Cooper, Adam Shillaw, Callum Reed, Caitlin Towers and Danielle Measor – Young People's Representatives

Officers: Clare Clark, Community Safety and Engagement Manager
Rachel Parker, Community Safety and Research Officer
Joan Stevens, Scrutiny Manager
Angela Armstrong, Principal Democratic Services Officer

96. Apologies for Absence

Apologies for absence were received from Councillor Stephen Akers-Belcher and Parish Council Representative Brian Walker.

97. Declarations of Interest

Councillors Jim Ainslie and John Lauderdale declared personal interests in minute 99.

98. Minutes of the Following Meetings

(i) Minutes of the meeting held on 12 November 2015 – Confirmed subject to the inclusion of Councillor Rob Cook's apologies.

(ii) Minutes of the meeting held on 10 December 2015 – Confirmed.

99. Crime and Policing Levels in Hartlepool (*Scrutiny Manager/Community Safety and Engagement Manager/Police and Crime Commissioner for Cleveland and Chief Superintendant, Cleveland Police*)

The presentation from the Community Safety and Engagement Manager had been circulated to Members prior to the meeting and Members were asked if they required any clarification or further information. A Member commented that 29% of all respondents had indicated they had no sense of belonging to their local area and clarification was sought as he understood that the residents of the Ward he represented did feel part of their local community. The Community Safety and Engagement Manager indicated that the representative sample was taken from across the whole Town and that the Community Development Team were working with local communities to identify the priorities that mattered to them. The Scrutiny Manager drew Members' attention to a letter from Hartlepool's MP, Iain Wright which was circulated to the Committee prior to the meeting. The MP had expressed concerns at the increasing pressure being placed on an under resourced and overstretched police service as well as the risk to neighbourhood policing due to the lack of funding.

The representatives from Cleveland Police jointly gave a detailed and comprehensive presentation which examined the crime levels in Hartlepool, the Funding/Planning Assumptions for 2016/17 and the further development of Local Policing towards 2020, including neighbourhood policing.

A Member highlighted specific incidents which led to a particularly high rate of crime over a short period of time, such as one person damaging over 50 cars in one night. The Chief Superintendant reiterated the value of Police Community Support Officers and their role in engaging with local communities particularly with regard to gathering intelligence to investigate such incidents. In response to a question from a Member, the Chief Superintendant confirmed that all resources were deployed using a scientific formula which examined the social economic factors within communities as well as the level of anti-social behaviour and crime and was based on the level of threat, risk and harm to that community. A discussion ensued on the extremely valuable work undertaken by Neighbourhood Policing Teams. Concerns were expressed about the Government's proposals for all emergency services to join forces. The Police and Crime Commissioner commented that closer more collaborative working across all emergency services should ensure the best possible response was provided for all incidents.

The Chief Superintendant and Deputy Chief Constable provided clarification on a number of areas where detailed statistics had been provided within the presentation. The Deputy Chief Constable commented that dealing with organised crime was a priority for Cleveland Police and would be followed up by community cohesion work and education for the longer term approach.

It was noted that there appeared to have been an increase in sexual offences and clarification was sought on this. The Deputy Chief Constable commented that as a result of a report received from Her Majesty's Inspectorate, Cleveland Police had reviewed the crime figures back to 2011 to ensure that all crimes were recorded correctly and reassigned them were appropriate. In addition to this, a number of people had come forward reporting historic offences due to a recent change in public attitude resulting in increased confidence that something would be done. The Deputy Chief Constable commented that in the past serious sex offences and violence had been under reported but was confident that the figures now included realistic reporting and this was assisted through close working with the Council's Safeguarding Team.

A Member sought clarification on the provision of Victim Support Services. The Police and Crime Commissioner indicated that Safe in Tees Valley was the chosen provider for this service across Cleveland and Durham when devolved to the responsibility of the Police and Crime Commissioner on 1 April 2016. It was highlighted that there was an event organised in February this year to enable Safe in Tees Valley to outline their proposals for the provision of victim services and further details of this event will be forwarded to Members. The Police and Crime Commissioner indicated that a further update on the provision of this service would be submitted to future meeting of the Committee. The Deputy Chief Constable emphasised that crime reporting was the foundation of performance and would also ensure victims receive the most appropriate service as well as ensuring resources were managed to effectively deal with risk, threat and harm.

It was noted that the increase in some of the reporting figures had been the result of the previous year's figures being at an all time low along with the changes made to reporting methods to ensure there was more accurate recording. In addition, the Chief Superintendant commented that from August, there was a slight downturn in these figures with a projection of a 13% reduction in crimes associated with anti-social behaviour. The Chief Superintendant provided further clarification on a number of queries regarding the crime statistics provided within the presentation.

In response to a question from a co-opted member, the Deputy Chief Constable commented that a lot of work was being undertaken to support offenders and with young people within schools to ascertain the reasons why crimes were happening in the first place, including cyber crime and fraud. A Member commented on the great work being undertaken with offenders within Holme House Prison through the victim offender/restorative justice process and clarification was sought on what support was in place to protect vulnerable people within Hartlepool. The Deputy Chief Constable commented that protecting vulnerable people, including physical and online abuse, was a priority and started with education including within schools, youth groups etc.

The Chair questioned the level of policing resources allocated to Hartlepool

and the Chief Superintendant confirmed that there were 24 officers within neighbourhood teams across the Town and the overall level of Police Officers serving Hartlepool would be maintained. In addition to this, a new shift pattern had been developed which would hopefully drive the effectiveness and efficiency of the force.

A Member sought clarification on how the positive image portrayed within this presentation would be promoted to the residents of Hartlepool. The Police and Crime Commissioner indicated that Cleveland Police's basic model of policing was sustainable and affordable and explored ways of making more efficiencies wherever practical. The ongoing work of the Neighbourhood Policing Teams was a key element to promoting the positive image and engaging with local communities to ensure they feel safe and break down any barriers. The continuation of the partnership working between all services, including the Local Authority was key to , sharing intelligence, making progress and reducing crime.

A Member commented that he was pleased to note the more accurate reporting methods for crimes but did express some concerns that victims were still too afraid to report crimes for fear of retaliation. The Police and Crime Commissioner commented that people should be encouraged to report crime anonymously through Crime Stoppers if they were afraid of reporting a crime.

Members welcomed the recent recruitment process being undertaken and the commitment given here today for the future of neighbourhood policing in Hartlepool.

The Chair thanked the Police representatives for their attendance and for answering Members' questions.

Recommended

The presentation and questions and discussion that followed were noted.

100. Minutes from Tees Valley Health Scrutiny Joint Committee held on 14 October 2015

Received.

101. North East Joint Health Scrutiny Committee Update

The minutes of the meeting held on 1 October 2015 were received. The Scrutiny Manager informed the Committee that at the meeting of the North East Joint Health Scrutiny Committee on 6 January, the Learning Disability Partnership Transformation Project was considered. A number of recommendations were made by the Committee, including the addition of Elected Member representation on the Learning Disabilities Transformation

Board. The Scrutiny Manager indicated that should any Members require any further information, that they could contact her direct.

Recommended

1) The minutes of the meeting held on 1 October 2015 were received.
2) The update provided on the outcome of the meeting held on 6 January 2016 was noted.

102. Any Other Items which the Chairman Considers are Urgent

None.

The meeting concluded at 4.00 pm

CHAIR

AUDIT AND GOVERNANCE COMMITTEE

11 February 2016

HARTLEPOOL BOROUGH COUNCIL

Report of: Scrutiny Manager

Subject: NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST – QUALITY ACCOUNTS 2015/16

1. PURPOSE OF REPORT

1.1 To:

i) Introduce representatives from North Tees and Hartlepool NHS Foundation Trust (NTHFT) who will be in attendance at today's meeting to assist and inform discussions in relation to the Trust's Quality Accounts for 2015/16; and

ii) Seek views / comments from the Committee for inclusion in the Committee's draft Third Party Declaration in relation to the Trust's Quality Account for 2015/16.

2. BACKGROUND INFORMATION

2.1 The Health Act 2009 (Part 1/Chapter 2/Section 8) requires that all providers of NHS healthcare services produce an annual Quality Account, containing prescribed information relevant to the quality of the services they provide.

2.2 As part of the process for the development of these accounts, there is a legal requirement to involve Overview and Scrutiny Committees from each local authority in the formulation, and submission, of third party declarations. The NTHFT's Quality Account's have been considered annually by the Audit and Governance Committee (A&G) and under revised Constitutional arrangements by Full Council on the 16 February 2015. Details of the comments made by Council in relation to the Quality Account for 2014/15 are attached at **Appendix A** for Members information.

2.3 Responsibility for the formulation of the Councils third party Declaration has now returned to the remit of the Audit and Governance Committee and in taking forward the formulation of the Draft Declaration, a presentation will be given at today's meeting by representatives from NTHFT. The presentation to:

i) Reflect on NTHFT's Quality Account for 2014/15 leading into 2015/16; and

ii) Engage with Members of the Committee in terms of the Trust's Quality Account for 2015/16, outlining details of:

- The key priorities;
- The Quality Account Marketplace Event;
- Timescales; and
- Lessons from previous years.

2.4 The NTHFT representatives present will be available to provide clarification and assistance, as required, and in considering the information provided the Committee is asked to formulate views and comments for inclusion in the draft Third Party Declaration. The draft declaration will then be utilised in conjunction with the draft version of the NTHFT Quality Accounts (2015/16), timetabled for March 2016, to finalise the Committee's Third Party Declaration. Given the timescale for the development and submission of the declaration, following today's presentation approval is sought for the finalisation of the draft declaration to be delegated to the Chair of the Committee in consultation with the Scrutiny Manager.

2.5 To assist the Committee, as copy of the current Quality Account (2014/15) has been provided for information. Given the size of the document, copies can be found in the Members room and on line with the papers for this meeting.

3. RECOMMENDATIONS

3.1 That the Audit and Governance Committee:-

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

(ii) Formulate comments on the information presented at today's meeting, which will be used to contribute to the formulation of the third party declaration.

(iii) Delegate finalisation of the draft declaration to the Chair of the Committee in consultation with the Scrutiny Manager

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) Minutes of the meetings of Full Council held on 16 February 2015

(b) Minutes of the meetings of the Audit and Governance Committee held on 3 September 2015

(c) The Health Act 2009 (Part 1, Chapter 2, Section 8)

Appendix A

COUNCIL – 16 FEBRUARY 2015 - QUALITY ACCOUNT COMMENT

1) There is a need to be able to drill down survey results on a locality basis to show the financial cost to family and friends of a hospital stay. Whilst it is noted that this cannot be done as part of the 'friends and family' survey element of the Quality Account, it is suggested that the collection of this information be undertaken through the Travel and Transport Group.

2) A resident queried the in-patient discharge procedures at UHNT and, in particular, instances that resulted in elderly patients being discharged out of hours / in the early hours of the morning, with no way of getting home other than expensive taxi fares. Council questioned public awareness of financial assistance available to pay for transport in these instances and identified the need to better publicise the availability of this funding.

North Tees and Hartlepool NHS
NHS Foundation Trust

Quality Accounts
2014 – 2015

Quality Report – Annual Quality Report 2014-15

ANNUAL QUALITY REPORT (Quality Accounts) 2014-15

Part 1: Statement on quality from the Chief Executive

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

I am pleased to introduce the North Tees and Hartlepool NHS Foundation Trust Quality Accounts for 2014-15 which demonstrates our continued commitment to strive for excellence and high performance in order to deliver care of the highest quality. The report focuses on our performance over the last year as well as our key priorities for 2015-16.

2014-15 has proved again to be a very busy and successful year where we continued to achieve high standards across the Trust.

This reporting year we once again met the challenging Clostridium difficile target which was set by our commissioners of no more than 40 hospital acquired cases. The report will outline the actions taken to achieve this improvement.

The main challenge for 2014-2015 relates to our increasing Hospital Standardised Mortality Ratio (HSMR) and summary hospital-level mortality indicator (SHMI) mortality values. This is a complex issue and we continue to look at the reasons for this, such as the care for people with pneumonia and gaining a greater understanding of how patients' long term medical conditions and those on the palliative care pathway are recorded. We are also working in collaboration with local GPs to assess the wider community health that affects the Trust, and how this in turn affects the HSMR and SHMI values. We continually work with external bodies to ensure as an organisation we have third party assurance on the work we are undertaking.

As always we continue to appreciate the excellence of our staff, and this reporting period our staff have been particularly recognised for their achievements throughout the year, having been nominated for a number of awards. These have included a number of staff receiving professorships and the chief health professions officers award for clinical leadership; a national award for the falls team, and a Queens Nurse award, where staff are recognised for their outstanding efforts. It is not only our staff that deserve recognition for their hard work, but also all of our volunteers, members, governors and other partners and stakeholders.

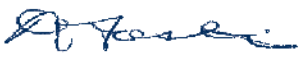
The Trust continues to receive regular comments and reviews from patients, carers and family members on NHS Choices; the two sites are currently rated at:

University Hospital of North Tees is rated at **4.0** out of 5 star services on NHS choices and University Hospital of Hartlepool is rated at **5.0** out of 5.

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

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

To the best of my knowledge the information contained in this document is an accurate reflection of outcome and achievement.



Alan Foster MBE
Chief Executive

What is a Quality Report/Accounts?

Quality Accounts are annual reports to the public about the quality of healthcare services that we provide. They are both retrospective and forward looking as they look back on the previous year's data, explaining our outcomes and, crucially, look forward to define our priorities for the next year to indicate how we plan to achieve these and quantify their outcomes.

Our quality pledge

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

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

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

This approach of unannounced visits at varied times will continue during 2015-2016.

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

Quality standards and goals

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

Listening to patients and meeting their needs

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

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

Over the last year we have spoken with over 20,000 patients. We have spoken to them in their own homes, community clinics, and our inpatient and outpatient hospital wards as well as our departments. We always ask patients how we are doing and what we could do better.

We understand from patients that great healthcare is defined in the way that we treat patients, family members, carers and staff. As a result of this we continue to promote our **RESPECT** nursing and midwifery strategy which was developed by staff, patients, governors and stakeholders. Compassion in Practice is the new three year vision and strategy for nursing, midwifery and care staff drawn up by the Chief Nursing Officer. The strategy encompasses the fundamental elements of what we believe underpins great patient care. These are:

Unconditional CQC Registration

During 2014-2015 the Trust met all standards required for **successful and unconditional registration with the Care Quality Commission (CQC)** for services across all of our community and hospital services.

Achievements

Shining stars

Team of the year

Infection prevention and control team. The Trust's MRSA rates have been very low for the last six years and the Clostridium difficile rate is now very low. The Trust compares very favourably with other Trusts in our region.

Developing excellent services

Specialist deep cleaning team for implementing a fantastic range of services that no other Trust in the country have in place. They have done a huge amount of work to help tackle the Trust's Clostridium difficile levels.

Commitment to equality and diversity

Community identified the need for a specialised hospital antenatal clinic for pregnant women who have a substance misuse problem and are considered a high risk group for pregnancy.

Outstanding contribution to volunteering

Diabetes nurse specialist Marie Presgrave for setting up Carlton Activity Residential Diabetes Stay for young people with diabetes giving them essential diabetes education, and helping them make friends along with a fun holiday.

Leadership award

Matron for the elective care unit Linda Wildberg; Linda worked tirelessly to maintain the highest standard possible and is constantly striving to improve patient care. Linda was described as an inspirational leader by her nominee.

Top hospitals awards

The Trust's maternity care was shortlisted for an award for excellence earlier this year.

Healthcare intelligence expert CHKS shortlisted 15 NHS Trusts for excellence in maternity care, as part of its top hospitals programme awards.

Compassion in Practice Awards – Finalist 2014

6Cs team for putting Compassion in Practice into ways of working, shortlisted as one of three teams for the award.

Park Mark award

The Trust was presented with the Park Mark award for the safety and quality of car parking facilities at both of its hospital sites.

The Specialist deep cleaning team.

Part 2:

Part 2a: 2014-2015 priorities for improvement

Part 2 of the Quality Account provides an opportunity for the Trust to report on progress against quality priorities that were agreed with external stakeholders in 2013-2014. We are very pleased to be able to report some significant achievements during the course of the year.

Consideration has also been given to feedback received from patients, staff and the public.

Presentations have been provided at various staff groups with the opportunity for staff to comment on and a feedback form is provided for patients views.

Progress is described in this section for each of the 2014-2015 priorities.

Stakeholder priorities 2014-2015

The quality indicators that our external stakeholders said they would like to see reported in the 2014-2015 Quality Accounts were:

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

"My experience of care was excellent. At all times staff were considerate and courteous. I feel that I could not have had better care. A very unpleasant treatment and procedure was made tolerable by the great consideration given to me by all the medical staff. " [sic]

Priority 1: Patient Safety

Mortality

1. Mortality

Rationale: To reduce avoidable deaths within the Trust by reviewing all available mortality indicators.

Overview of how we said we would do it

- We will review clinical care of patients who have died in our care to obtain information about the quality of care provision.
- We will use Healthcare Evaluation Data (HED) benchmarking tool to monitor and interrogate the data to determine areas that require improvement
- Improve current processes involving palliative care, documentation and coding process

Overview of how we said we would measure it

- We will monitor mortality within the Trust using the two national measures:
- HSMR (Hospital Standardised Mortality Ratio)
- SHMI (Summary Hospital-level Mortality Indicator)
- Care Quality Commission – intelligent Monitoring Report (IMR)
- Utilise nationally / regionally agreed tools to assist in assessing levels of clinical care.

Overview of how we said we would report it

- Report to Board
- Report quarterly to the commissioners
- Report to Keogh Operational Group

Completed and reported?

- Reported to Board ✔
- Reported to Commissioners ✔
- Reported to Keogh Operational Group ✔

The Board is aware and has an understanding of the higher than expected values of both Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) and as a priority objective the emphasis is on demonstrable progress to reducing avoidable deaths in and (where possible influencing progress) out of hospital.

In reflecting on the progress within mortality performance and governance and on the renewed national emphasis, the Trust established a Keogh Delivery Group to address a root and branch review of Professor Sir Keogh's eight recommendations / indicators, which in turn impact on mortality levels. This is now a substantive group, Keogh Delivery Group.

The Trust, while using national mortality measures as a warning sign, is investigating more broadly and deeply the quality of care and treatment provided. Further progress this year will be supported by:

- Strengthening leadership, governance and assurance at specialty level, reinforced by an appropriate resource infrastructure
- Clinical record reviews of patients who have died in our care
- Regional and national networking and peer review to enable a continuous learning and sharing cycle, specifically in understanding and tackling regional anomalies
- Targeted trigger alerts to mortality positioning in sub categories, enabling proactive deep dives
- Clinical audit to support the demonstrable reduction in avoidable deaths
- Examining data and information relating to clinical quality and outcomes to develop key lines of enquiry and integrate appropriate indicators of safe care into practice
- Correlation of pertinent data and information to further understand the quality and safety perspectives of care, including:
  - Patient experience information, including Staff & Patient Experience and Quality Standards (SPEQS) and Friends and Family, NHS Choices and feedback from Matron intentional rounding
  - Staff feedback, including staff forums, supervision and mentoring
  - Safety of care delivery, utilising objective data sources and clinical observation
  - Workforce positioning, including talent management, staff to patient ratios, transparency in sharing workforce and staffing information, succession planning
  - Clinical and operational effectiveness, utilising benchmarking comparators
  - A Rapid Process Improvement Workshop (RPIW) was undertaken for respiratory pathway

The Trust continues to be involved in the Community Acquired Pneumonia Project, which has been set-up by North East Quality Observatory System (NEQOS), with the IT support from Clarity Informatics.

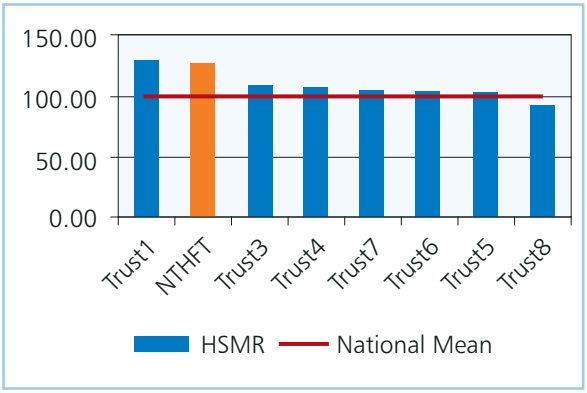
The Trust will continue to work with partner GPs and the CCGs to examine patient pathways into and out of hospital to tackle overall improvements in end of life pathway delivery and safe discharge processes.

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

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

Hospital Standardised Mortality Ratio (HSMR) March 2014 to February 2015

Healthcare Evaluation Data (HED) reporting period of March 2014 to February 2015 – Hospital Standardised Mortality Ratio (HSMR) measures the Trust as **126.40** against a national mean of 100.



The above HSMR graph demonstrates the Trust's 12 month HSMR value throughout the reporting period of March 2014 to February 2015, benchmarked against the other *North East Trusts*.

The Trust's 12-month average for HSMR is currently **126.40**, which is above the national average of 100.

	HSMR
National Mean	100.00
Trust 1	139.37
North Tees and Hartlepool NHS Foundation Trust	126.40
Trust 3	112.46
Trust 4	109.88
Trust 5	105.94
Trust 6	103.78
Trust 7	101.84
Trust 8	93.84

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

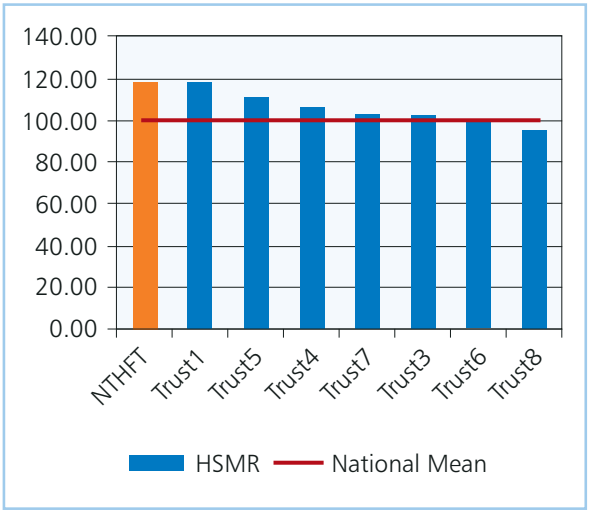
In the 2013-2014 Quality Accounts, the Trust reported the HSMR value being **112.34**, for the time period February 2013 to January 2014.

Summary Hospital-level Mortality Indicator (SHMI) October 2013 to September 2014

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

SHMI includes *deaths up to 30 days after discharge and does not take into consideration palliative care*. The Trust SHMI is reporting as 'higher than expected' with a value of **118.76**.

The following chart and table demonstrate the Trust current SHMI position utilising the latest time period of October 2013 to September 2014, the other *North East Trusts* have been anonymised.



	SHMI
National Mean	100.00
North Tees and Hartlepool NHS Foundation Trust	118.76
Trust 1	118.10
Trust 7	110.85
Trust 4	105.92
Trust 5	103.01
Trust 3	102.40
Trust 6	100.28
Trust 8	95.58

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

In the 2013-2014 Quality Accounts, the Trust reported the SHMI value being **113.08**; for the time period October 2012 to September 2013.

Additional Actions undertaken to understand the SHMI value

Peer Review of Pneumonia Cases

North Tees and Hartlepool NHS Foundation Trust has established a link with a Trust in the North West to undertake a clinical review of any case reviews already undertaken by our Trust. This is to give advice and/or guidance as to how they would have approached each case. This will allow for learning and development, as well as the sharing of best practice.

The Trust will review the final report and where necessary put in place actions to improve on the areas recommended.

Mortality Review by NEQOS

North Tees and Hartlepool NHS Foundation Trust commissioned the North East Quality Observatory System (NEQOS) to undertake a in-depth Mortality review; this involved reviewing the Trusts data, interviewing key clinical and non-clinical members of staff and providing thematic analysis.

NEQOS provided a formal paper detailing their findings and recommendations for the Trust to improve the Mortality levels for HSMR and SHMI.

The Trust has taken note of the recommendations and has subsequently commenced improvements in a number of areas.

The Trust continues with the Community Acquired Pneumonia project of which the Trust are involved in along with South Tees and Co Durham and Darlington Trusts.

Keogh Delivery Group

North Tees and Hartlepool NHS Foundation Trust established a Keogh Delivery group to look into its root and branch review of Keogh's eight indicators which in turn may impact on mortality levels across the Trust.

The Trust is not solely focusing on the figures and data around mortality, but is undertaking a review of the whole process so that all aspects are looked at in a collective manner and not in isolation.

The areas that have actions ongoing are:

- Governance going forward, review of policy and templates
- Mortality reviews
- Clinical leads and ownership
- Concentration of key diagnosis groups
- Regional networking
- Peer review
- Continued collaboration with North East Quality Observatory System (NEQOS)
- Continuous improvement and education
- Pathways of care
- Avoidable vs unavoidable

Palliative Care

The Trust instigated a change to the palliative care process in June 2014; this change was due to low numbers being recorded as being seen by a member of the Specialist Palliative Care team since February 2014.

This decline was impacting on the Trusts HSMR value but more importantly on the quality of care being delivered to the patients at their most vulnerable time.

Updated Palliative Care Process

From the introduction of the new process in June 2014, the Trust showed a marked improvement in the number of patients being seen by a member of the 'Specialist Palliative Care' team.

The following table demonstrates the months with the decline and the subsequent improvement moving forward.

The Trust is keen to keep this improvement and to increase the number of patients being seen by a member of the Specialist Palliative Care team.

	Discharge Month	Palliative discharges
	Jan-14	45
Reduction in numbers identified	Feb-14	23
	Mar-14	21
	Apr-14	23
	May-14	19
NEW PROCESS	Jun-14	49
	Jul-14	41
	Aug-14	40
	Sep-14	35
	Oct-14	40
	Nov-14	42
	Dec-14	63
	Jan-15	61
	Feb-15	32
	Mar-15	*Not available

**Data obtained from the Healthcare Evaluation Data (HED), March 2015 data was not available*

Cardiac arrests

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

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

During 2014-15 there continues to be unprecedented numbers of very sick patients being admitted to hospital. Although this inevitably results in more patients having a cardiac arrest, we are pleased that we are sustaining very low numbers of patients who show signs of deterioration prior to their cardiac arrest.

There were **110** Cardiac Arrests during this period. **47** had signs of deteriorating physiology prior to cardiac arrest which equates to **42.70%**.

	Q1	Q2	Q3	Q4	Total
Avoidable	1	1	2	4	8
Unavoidable	5	8	12	14	39
Total	**6**	**9**	**14**	**18**	**47**

Deteriorating Physiology

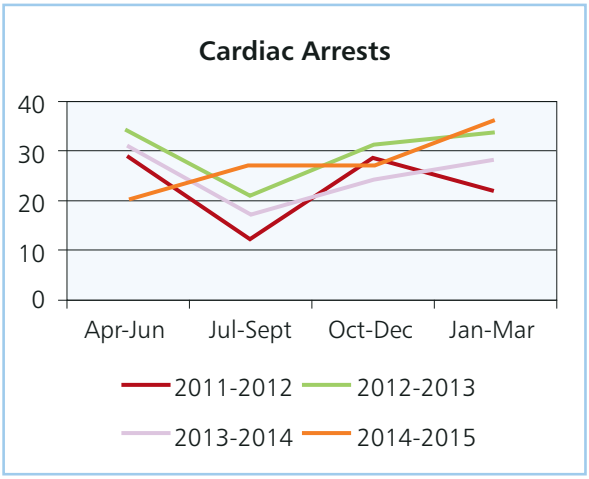
	Q1	Q2	Q3	Q4	Total
Number of cardiac arrests	20	27	27	36	110
Deteriorating Physiology prior to cardiac arrest	1	1	2	4	8
Total	**6**	**9**	**14**	**18**	**47**

**Data obtained via the Trusts Resuscitations Services*

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

All patients sustaining cardiac arrests and peri-arrests are discussed at the Serious Incident panel on Monday mornings in the presence of senior doctors and nurses. This multi-professional team approach includes consultants, resuscitation officers, practice development nurses, ward doctors and nurses who review RCAs from all patients who have sustained cardiac arrests and implement changes as appropriate.

The Trust has introduced the new National Early Warning Score (NEWS) observation chart during July 2014; this has replaced the Trusts previous observation chart, staff have received appropriate training prior to roll-out.



	2010 – 2011	2011 – 2012	2012 – 2013	2013 – 2014	2014 – 2015
Apr – Jun	22	29	34	31	20
Jul – Sept	28	12	21	17	27
Oct – Dec	38	28	31	24	27
Jan – Mar	41	22	34	28	36
Total	**129**	**91**	**120**	**100**	**110**

**Data obtained via the Trusts Resuscitations Services*

Theatre nurse specialist Jill Kirkbride.

Student Nurse Sami Bain.

Priority 1: Patient safety

Dementia

2. Improving care for people with dementia

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

Currently, the Trusts is 77.70% (actual vs estimated) diagnosis rate, this places the Trust 2nd Nationally.

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

Overview of how we said we would do it

- We will use the Stirling Environmental Tool to adapt and audit the impact on our hospital environment.
- We will ensure that all patients over 65 receive an Abbreviated Mental Test (AMT) and are, where appropriate referred for further assessment.
- Patients with Dementia will be appropriately assessed and referred on to specialist services.

Overview of how we said we would measure it

The Stirling Environmental audit assessment tool will be used to monitor the difference pre and post environmental adaptation.

- The percentage of patients who receive the AMT and, where appropriate, further assessment will be reported monthly via UNIFY.
- We will audit the number of patients over 65 admitted as an emergency that are reported as having a known diagnosis of dementia, or have been asked the dementia case finding questions.
- National Audit for dementia round 3 to commence in 2015.

Overview of how we said we would report it

- Dementia Strategy Group quarterly
- Integrated Professional Nursing and Midwifery Board (IPNMB)
- Monthly UNIFY

Completed and reported?

- Reported to the Dementia and Strategy Group ✔
- Reported to IPNMB ✔
- Reported through Commissioning for quality and innovation (CQUIN) measures ✔

How has the organisation focused on patient safety?

1 PATIENT SAFETY FIRST

+75 Screening

How?

We complete a prevalence audit every month for all patients aged +75, and screen for cognitive impairment.

Why?

Every identification of memory issues and relevant sign posting, supports Prime Minister's pledge on dementia and reduces patient anxiety.

Carers Support

- Carers information packs are reviewed and updated annually
- This aims to reduce risk of carer breakdown, and information on how they can access individual carer's assessment
- Informs carers what they have access to
- Increases information on how they can access individual carer's assessment
- If carers feel more supported, there is less risk of admission of the people they care for
- Supports financial and social benefit

Supporting carers of people with Dementia

The organisation is mandated to demonstrate that we have undertaken a monthly audit of carers of people with dementia, to test whether they feel supported and report the results to the Trust Board, this measure forms part of the Trusts CQUINs.

		Carers Surveyed	Supported
Q1	Apr-14	21	100%
	May-14	22	100%
	Jun-14	14	100%
Q2	Jul-14	15	100%
	Aug-14	18	100%
	Sep-14	19	100%
Q3	Oct-14	55	100%
	Nov-14	58	100%
	Dec-14	31	100%
Q4	Jan-15	32	100%
	Feb-15	21	100%
	Mar-15	30	100%

**Data taken from Dementia CQUIN audits*

Training

How?

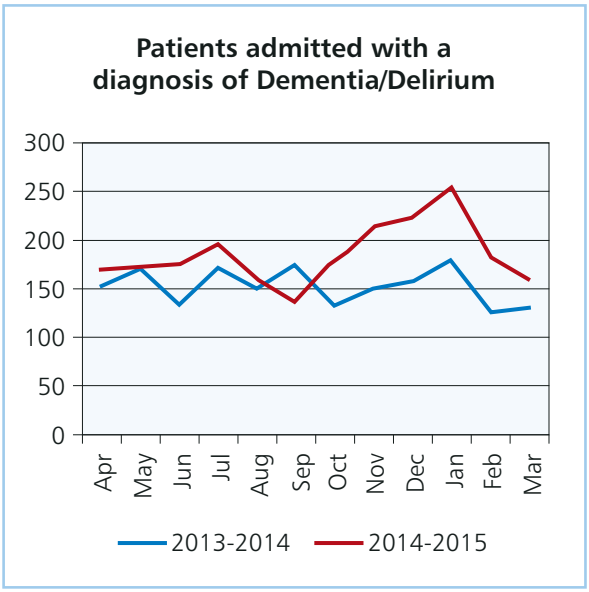
- Review of dementia training, and brought it in line with Health Education North East (HENE) funding.
- More interaction with the trainees
- More practical learning experience.
- Cover all employees within the Trust not just frontline clinical staff
- Utilisation of experiential learning

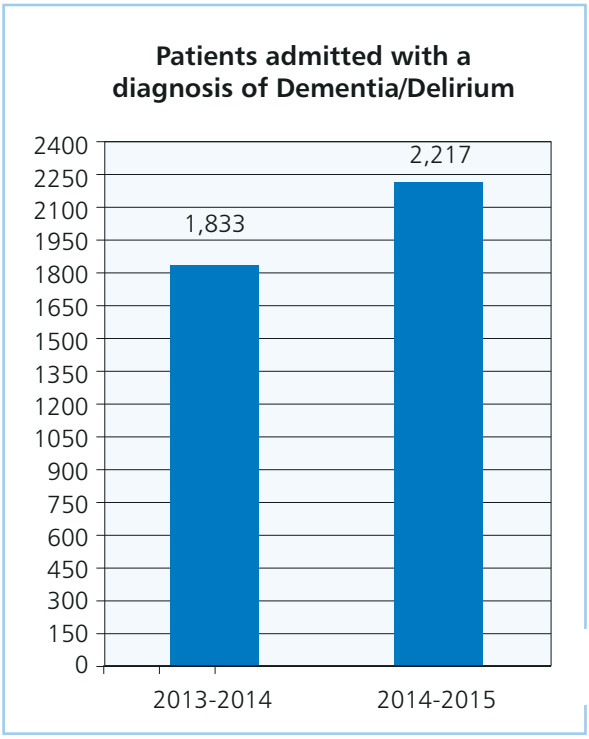
Why?

- To highlight the importance of good quality, trained staff to improve patient experience and patient safety.
- 6Cs.
- Dementia friends.

Patients admitted with a diagnosis of Dementia/Delirium

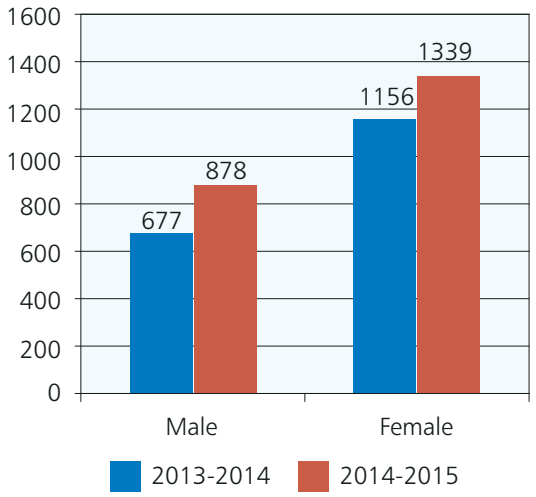
To demonstrate the challenges Dementia/ Delirium are posing on the general healthcare economy, the following tables trend the number of patient's admitted to the Trust since April 2013.





Since April 2013 the Trust has admitted **4,016 patients** with a diagnosis of Dementia/Delirium of which 62% (2,495) are females and 38% (1,555) are males.

Patients (by gender) admitted with a diagnosis of Dementia/Delirium



Community Dementia Liaison Service (CDLS)

- 2.0 Whole time equivalents Hartlepool Locality
- Reablement and admission avoidance
- Educational function across all agencies
- Nil complaints since commencement
- Crisis intervention
- Support whole pathway journey
- Close working relationships with Tees, Esk and Wear Valleys (TEWV) Trust
- Supported discharge process
- Close liaison with GPs

Better Care Fund (BCF)

- South Tees will have similar service during 2015-16
- Support reduction in Length of Stay (LOS) admission and readmission avoidance
- Improve the pathway across all aspects of the dementia pathway.

1 to 1 support workers

- Criteria developed
- Roles and responsibilities
- Standard Operating Procedure
- Detailed training programme
- 1 year funded pilot with evaluation re-outcomes

"I am writing this on behalf of my Nan who is 80 years old and in the later stages of dementia. All staff who supported my Nana were extremely patient and polite with her giving her extra care and time and attention when needed. All involved supported with a very safe discharge including therapists, discharge nurse, palliative nurse, thank you!!" [sic]

Dementia Screening – Monthly Data Collection – April 2014 – March 2015

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

Question a: Number of patients 75 and above admitted as emergency inpatients, reported as having been asked the dementia case finding question within 72 hours of admission to hospital or who have a clinical diagnosis of delirium on initial assessment or known diagnosis of dementia.

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
424	413	379	367	433	345	384	427	478	536	387	424

Question b: Number of patients aged 75 and above, admitted as emergency inpatients, minus exclusions.

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
424	413	379	367	433	359	392	445	510	558	398	451

Question c: % of all patients aged 75 and above admitted as emergency inpatients who are asked the dementia case finding question within 72 hours of admission or who have a clinical diagnosis of delirium on initial assessment or known diagnosis of dementia.

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
100%	100%	100%	100%	100%	96.10%	98%	96%	93.70%	96.10%	97.20%	94%

Question d: Number of admissions of patients aged 75 and above admitted as emergency, inpatients who have scored positively on the case finding question or who have a clinical diagnosis of delirium reported as having had a dementia diagnostic assessment including investigations.

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
30	27	43	25	60	39	29	68	57	111	57	44

Question e: Number of patients aged 75 and above admitted as emergency inpatients who have scored positively on the case finding question or who have a clinical diagnosis of delirium.

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
30	27	43	25	60	39	29	68	57	111	57	44

Question f: % of all patients aged 75 and above admitted as emergency inpatients who have scored positively on the case finding question, or who have a clinical diagnosis of delirium and who do not fall into the exemption categories reported as having had a dementia diagnostic assessment including investigations.

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Question g: Number of all patients aged 75 and above admitted as an emergency inpatient who have had a diagnostic assessment (in which the outcome is either positive or inconclusive) who are referred for further diagnostic advice/follow up.

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
10	13	12	6	14	13	7	42	16	29	32	26

Question h: Number of patients aged 75 and above who were admitted as an emergency inpatient who underwent a diagnostic assessment (in which the outcome is either positive or inconclusive).

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
10	13	12	6	14	13	7	42	16	29	34	26

Question i: % of all patients aged 75 and above, admitted as an emergency inpatient who have had a diagnostic assessment (in which the outcome is either positive or inconclusive) who are referred for further diagnostic advice/follow up.

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	94%	100%

Priority 1: Patient safety

Safeguarding

3. Safeguarding Adults with Learning Disabilities (LD)

All patients with a learning disability admitted to hospital will have a named advocate and an individualised plan of care.

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

Overview of how we said we would do it

- All patients with LD will be referred on admission to the LD Specialist nurse.
- The LD Specialist nurse will act as the named advocate and will ensure that an individualised plan of care is in place and reasonable adjustments documented.

Overview of how we said we would measure it

- Audits will be carried out and results reported.

Overview of how we said we would report it

- Audit results and Action Plans to be reported to Adult Safeguarding Group quarterly.

Completed and reported?

- Audit plans and results presented to Adult Safeguarding Group quarterly ✔
- Learning Disabilities steering group ✔

Adult Safeguarding

Throughout 2014 Adult Safeguarding has continued to make positive strides towards its objectives.

The aim of PREVENT is to stop people from becoming terrorists or supporting terrorism.

Three national objectives have been identified for the PREVENT strategy:

- **Objective 1:** respond to the ideological challenge of terrorism and the threat we face from those who promote it
- **Objective 2:** prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support
- **Objective 3:** work with sectors and institutions where there are risks of radicalisation which we need to address

PREVENT has continued to be addressed within the adult safeguarding portfolio. We currently have **22** PREVENT trainers across the Trust who delivers the nationally agreed Workshop to Raise Awareness of PREVENT (WRAP). Global events in Syria have continued to ensure the principles of counter terrorism outlined below remain in the NHS workforce agenda.

Safeguarding adults

North Tees and Hartlepool NHS Foundation Trust continues to work to enhance and develop standards for safeguarding adults across the hospitals and community services.

During 2014 the Trust saw a change in the post holder of specialist nurse learning disabilities, the outgoing post holder left a visible legacy which has been incorporated into the successful applicant who took up the post in January 2014.

It has long been a national recommendation to ensure that People with a Learning Disability have their healthcare records flagged to ensure that everyone providing care are aware of the lawful requirement to provide reasonable adjustments.

The Trust has worked hard to improve the number flagged from 140 to in excess of 600. This is through effective partnership working with Hartlepool Borough Council.

We are now able to reach more people and raise awareness of the need to consider those essential reasonable adjustments. During 2015 we intend to work with Stockton Borough Council to improve flagging from our Stockton residents.

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

In April 2014 we developed a monitoring group to consider the legal and practice implications of The Cheshire West Ruling following the High Court judgement in March.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300106/DH_Note_re_Supreme_Court_DoLS_Judgment.pdf

The Safeguarding team has processed 166 Deprivation of Liberty Safeguard applications.

During 2013-2014 this number was 10. This is a significant increase in workload in terms of professional advice, administration and training.

The Trust is currently hosting a post via Public Health to respond to Domestic abuse.

The Charity Harbour provides a Domestic abuse Health Link Worker who works alongside the adult safeguarding team.

In April 2015 will see the launch of a Trust Policy addressing the issues of Domestic Abuse.

During 2014 a high profile campaign raising awareness was undertaken in relation to this area of adult safeguarding. This was coupled with innovative planning to coincide with known times in our year plan when the prevalence of domestic abuse is thought to increase. This included the World Cup Football tournament and Christmas / New year festive period.

Training activity 2014-2015

Tees-wide multi-agency training is undertaken at level one via a workbook which is distributed through induction and following completion is marked and discussed with the line manager before being signed off. The target audience for level 1 was widened this year.

Compliance with the **level one training** across the Trust is **95%**.

In April 2014 we rolled out the **level two** workbook and compliance across the Trust is **82%**.

Trust Reporting

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

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

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

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

The report is presented internally and shared with our commissioners.

Location (Local Authority)

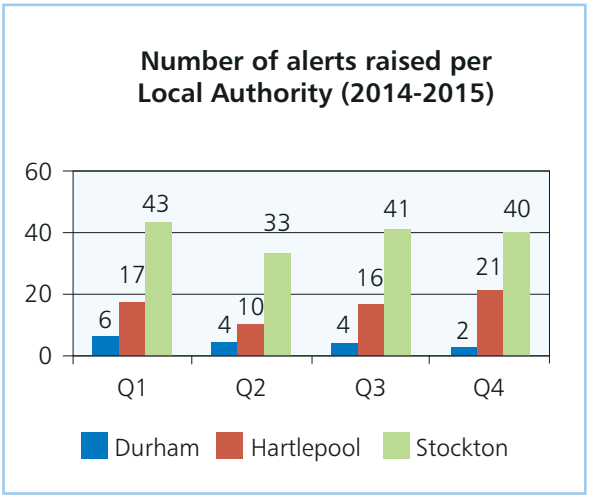
In the **2013-2014 reporting year**, there were **245** adult safeguarding alerts raised across the Local Authorities of Durham, Hartlepool and Stockton.

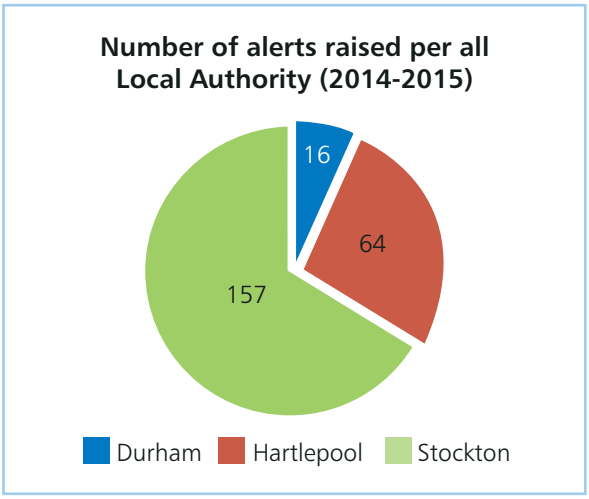
The Trust continues to use and develop further an in-house developed adult safeguarding database. This tool helps to collate, trend and theme the data. The data produced is governed through the quarterly Safeguarding Vulnerable Adults Steering Group to Patient Safety & Quality Standards Committee (PS & QS).

Since **April 2014** there have been **237** Adult Safeguarding incidents across the Local Authorities of Durham, Hartlepool and Stockton. Please see the following breakdown:

		Number of Referrals		
		Durham	Hartle-pool	Stock-ton
Q1	Apr-14	2	4	10
	May-14	1	5	18
	Jun-14	3	8	15
Q2	Jul-14	0	4	18
	Aug-14	2	1	7
	Sep-14	2	5	8
Q3	Oct-14	4	8	13
	Nov-14	0	5	18
	Dec-14	0	3	10
Q4	Jan-15	1	8	9
	Feb-15	0	7	1
	Mar-15	1	6	12
Total		**16**	**64**	**157**

**Data from the Trusts Adult Safeguarding database*





Data obtained from the Trusts Adult Safeguarding database

The following table details the allegation types raised across all Local Authorities. It is important to note, that there can be multiple allegation types per referral.

	Allegation Type		
	Durham	Hartle-pool	Stock-ton
Neglect	7	44	110
Physical	9	16	52
Financial	0	9	12
Emotional	3	4	26
Discriminatory	0	0	1
Institutional	0	2	3
Medication error	0	0	1
Sexual	1	0	1
Total	**20**	**75**	**206**

Data from the Trusts Adult Safeguarding database

Trust Adult Safeguarding Governance Arrangements

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

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

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

Attendance and participation in adult safeguarding activity remains positive.

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

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

Safeguarding Adult Achievements

The Trust has implemented a Single Point of Contact system (SPOC) as well as a reporting system for internal and external safeguarding alerts. Each alert is added to a central database and progress of the vulnerable adult can be tracked and managed towards an acceptable outcome. This has been extended to include a separate equivalent system for people with Learning Disabilities and the main system now includes domestic abuse cases.

These systems enable the Trust to provide a robust basis for developing reports on a regular basis across the Trust. The Adult Safeguarding Steering group now receives the report in respect of activity data each quarter and disseminates the lessons learnt to improve practice.

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

The Trust continues to further develop its National reputation within adult safeguarding and hosted an event for The National Learning Disability network in 2015.

It also contributed to the post House of Lords review of the MCA through the National MCA DoLS Reference group.

To date, the Trust has had no PREVENT referrals.

Looking ahead / key challenges

The key challenges for Adult Safeguarding in 2014-2015 were:

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

Sensory Loss

Following the removal of the portable hearing loops from the wards last year, the systems are now stored in the medical equipment library at UHNT so they are available, when needed.

The medical equipment library is accessible Monday to Friday, 9am – 5pm by contacting (01642 3)83504 and outside of these hours by contacting the portering department and requesting the system be collected from medical equipment library.

They will then collect and decontaminate them on return from the wards, ensuring they are within service date and if not take them to the clinical engineering department before returning them to stock in the library.

When requesting a portable hearing loop, the following information will need to be supplied:

- Ward
- Equipment required
- Date
- Time
- Patient details, such as, name, date of birth or hospital number

A portable hearing loop is also kept in the resilience office at UHNT in case of an emergency.

Children's safeguarding

A child/young person is defined as anyone who has not yet reached their 18th birthday.

North Tees and Hartlepool NHS Foundation Trust has a duty in accordance with the Children Act 1989 and Section 11 of the Children Act 2004 to ensure that its functions are discharged with regard to the need to safeguard and promote the welfare of children and young people. The Trust recognises the importance of partnership working between children/young people, parents/carers and other agencies to prevent child abuse, as outlined in Working Together to Safeguard Children and their Families, 2013. In addition arrangements to safeguard and promote the welfare of children must also achieve recommendations set out by the Care Quality Commission Review of Safeguarding: A review of arrangements in the NHS for safeguarding children, 2009 and give assurance as outlined in the National Service Framework for Children, Young people and Maternity Services, 2004 (Standard 5). The Trust is committed to the implementation of robust arrangements for safeguarding and promoting the welfare of children.

The Trust has continued to deliver on all local performance indicators relating to children's safeguarding and in 2014 underwent a review of Health Services for Children Looked After and Safeguarding in Stockton on Tees by the Care Quality Commission (CQC) and a single agency OFSTED review in Hartlepool. The devised action plan from this is continually monitored and fed back through the safeguarding children steering group.

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

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

There are a number of examples of excellent developments which have been undertaken. An adult risk behaviours assessment tool which considers the impact of risky adult behaviours upon the child has been devised and introduced in A&E and the Minor Injuries Unit. This is now embedded in the Trust via a programme of training and plans are in place for this to be rolled out to the Emergency Assessment Unit. An audit is currently being performed to establish the effectiveness of the tool for improving outcomes for children.

Quality audit record panels are now embedded in children's services. This includes an internal audit process that incorporates a quarterly deep dive audit where the clinical director for community services and deputy director of nursing, patient safety and quality attend. The quality of assessment, planning and outcomes for children who are at risk of significant harm are measured, and areas of good practice and lessons to be learnt are identified and fed back to front-line practitioners. A report is produced bi-annually on the findings and commonly occurring themes. Multi-agency case file audits are also carried out with Hartlepool and Stockton local safeguarding children boards to identify learning across wider agencies.

An audit of the Nice Guideline 89 was undertaken, the purpose of which is to raise awareness and help staff within the Trust who are not specialists in child protection to identify children at risk of harm. Of the selected cohort 92% of the workforce, were satisfied with the response from the safeguarding children team. A further staff questionnaire is to be devised to look at the small proportion of staff who were dissatisfied and the reasons for this. A recent audit undertaken on 'did not attend' pathway identified its limited use. Further work is being undertaken to revise this pathway.

A sharepoint page has been developed and is now live on the intra net which identifies members of the team, their contact details and useful resources.

Within the Trust awareness of E-Safety has been a priority which has resulted in the development of the E-Safety agreement (this is an agreement that parents and children are asked to sign up to when a child becomes an inpatient).

In essence parents and children are asked to follow some basic rules to ensure safe use of electronic/smart equipment within hospital premises. This will be complimented by E-Safety awareness posters in relevant children's areas throughout the Trust.

Child Sexual Exploitation (CSE) is a growing concern and the senior nurses within the team sit on the Vulnerable Exploited Missing and Trafficked (VEMT) multi-agency operation group. This identifies those children and young people at risk, allows for the sharing of information between practitioners and helps to put safety measures in place to attempt to reduce risk.

The Named Nurses are involved with partner agencies in identifying and compiling learning lessons reviews and serious case reviews, the learning of which is disseminated to front-line practitioners and actions implemented to improve practice.

To assist staff within the Trust to raise and take forward child protection concerns, escalation flowcharts have been developed which compliments the local Tees Procedures.

Senior nurses attend Multi Agency Risk Assessment Conferences (MARAC) where high risk victims of domestic abuse are identified and safety plans put in place. Work is on-going within safeguarding adults to complete a Domestic Abuse policy.

Safeguarding Medical Champions have been identified from each Directorate throughout the Trust to support and drive forward the safeguarding children agenda. It is planned to role this out to identify safeguarding nursing champions within each directorate. The Named Doctors for safeguarding children hold a peer review monthly meeting to discuss cases and share practice issues and experiences. An annual evaluation report is produced by one of the Named doctors. The medical team are currently undertaking two separate audits looking at the quality of child protection medical reports and the quality of Neglect medical reports.

Safeguarding Children Training Programme

Throughout 2014-2015 the Trust's in-house Safeguarding Children Training Programme has continued to provide mandatory foundation and update single agency training for all staff employed within the organisation. The training is in-line with the requirements of Safeguarding Children and Young people: roles and competences for healthcare staff; Intercollegiate Document (2014) and the Trust's Safeguarding Children Training Policy. High levels of compliance and standards have been maintained.

- **Level 1** – All non-clinical staff working in healthcare settings. For example, receptionists, administrative, porters.
- **Level 2** – All clinical staff who have any contact with children, young people and/or parents/carers. This includes healthcare students, clinical laboratory staff, pharmacists, adult physicians, surgeons, anaesthetists, radiologists, nurses working in adult acute/community services, allied healthcare practitioners and all other adult orientated secondary care healthcare professionals, including technicians.
- **Level 3** – All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concern. This includes paediatric allied health professionals, all hospital paediatric nurses, hospital based midwives, accident and emergency/minor injuries unit staff, obstetricians, paediatric radiologists, paediatric surgeons, children's/paediatric anaesthetists, and paediatric dentists.

Where appropriate staff are required and supported to attend multi-agency training provided by the LSCB and other external providers.

Bespoke training is developed and provided and mandatory in-house training is continually updated and reviewed in response to learning identified in practice, during supervision, appraisals, Datix themes, Learning Lessons Reviews, Serious Case Reviews, and new and changing national guidance and legislation.

Examples of this include bespoke training sessions provided in 2013-14 to one department in response to a Facilitated Learning Review following a SUI and a presentation to the Trust Board as identified in the Intercollegiate Document 2014.

In addition in early 2014 a series of bespoke training sessions on 'Professional Challenge' have been provided in response to feedback from one of the LSCBs.

Senior nurses within the team are currently delivering Domestic Abuse training to Health Visitors within the Trust and information sharing training is being delivered in partnership with Hartlepool Safeguarding Children Board. The Safeguarding Children Trainer has jointly developed a core foundation multiagency training course with Hartlepool LSCB and co-facilitates the course with the LSCB Business Manager. The Safeguarding Children Trainer and Named Doctors also jointly facilitate Safeguarding Babies training for Stockton LSCB.

A new safeguarding children trainer has been appointed on a part-time basis.

Overall Trust Compliance for Safeguarding Children Training

Month	Level 1	Level 2	Level 3
Apr-14	99%	97%	94%
May-14	100%	97%	92%
Jun-14	100%	98%	91%
Jul-14	100%	97%	91%
Aug-14	100%	98%	91%
Sep-14	100%	98%	93%
Oct-14	100%	98%	93%
Nov-14	100%	98%	93%
Dec-14	99%	98%	94%
Jan-15	100%	98%	91%
Feb-15	100%	97%	91%
Mar-15	100%	97%	92%

Priority 1: Patient safety

Clostridium difficile

4. Infection Prevention and Control

Rationale: Key stakeholders asked us to continue to report on Clostridium difficile in 2014-2015 as this remains high on the infection agenda.

Overview of how we said we would do it

- We will closely monitor testing regimes, antibiotic management and repeat cases and ensure we understand and manage the root cause wherever possible.

Overview of how we said we would measure it

- We will monitor the number of hospital and community acquired cases
- We will undertake a multi-disciplinary Root Cause Analysis (RCA) within 3 working days
- We will define avoidable and unavoidable for internal monitoring
- We will benchmark our progress against previous months and years
- We will benchmark our position against Trusts in the North East in relation to number of cases reported; number of samples sent for testing and age profile of patients

Overview of how we said we would report it

- Public Board meetings
- Council of Governor meetings (CoG)
- Infection Control Committee (ICC)
- Patient Safety and Quality Standards Committee (PS & QS)
- To frontline staff through Chief Executive brief
- Nursing Dashboard
- Clinical Quality Review Group (CQRG)

Completed and reported?

- Reported at every Public Board of Directors meeting ✔
- Reported at every Council of Governors meeting ✔
- Discussed in detail at Audit Committee and Directorate meetings ✔
- Reported in detail to Monitor ✔
- Nursing and Midwifery Dashboard contains infection data ✔
- Unannounced Prevention Protection Control practices undertaken ✔
- Achieved the 2013-14 C difficile target of 40 cases ✔

Clostridium difficile (C diff)

During 2014-2015 we achieved our clostridium difficile target achieving a 50.00% reduction on the previous year. We have continued to work hard to control and reduce opportunity for infections to spread when we treat people in our clinical premises or in their own homes. There is no one way in which clostridium difficile can be eliminated but a consistent approach to cleanliness across all important areas of our environment; appropriate antibiotic prescribing and strict hygiene at the point of care are vigorously pursued. We continue to invest in new equipment which is easier to clean and which is less likely to harbour infections, use of technology to improve our decontamination methods, review and improve our antibiotic stewardship and strive for high standards of hand hygiene.

An action plan was developed following an independent review in 2012 and this has continued to be reviewed and updated throughout 2014-15. It is presented regularly to the Infection Control Committee, Board of Directors, Council of Governors and our commissioners.

The comprehensive review of governance, performance and practices in relation to C difficile, first produced in January 2013 has been enhanced further in 2014-15 and is utilised to update the Board of Directors on a quarterly basis.

How did we do?

In 2014-2015, we had a challenging C diff target set by our commissioners of no more than **40** cases, which we achieved with **20** cases; this was **10** cases under trajectory.

The following table identifies the numbers of hospital acquired cases of C diff cases reported by the Trust against the target for that period. The table also identifies the number of community acquired cases of clostridium difficile reported by our laboratory.

	Target for Trust attributed cases	Number of Trust attributed cases	Number of non-Trust attributed cases (acquired in people's own homes)
Q1	10	2	24
Q2	10	6	26
Q3	10	7	7
Q4	10	5	14

**Data obtained from Healthcare Associated Infections (HCAI) data capture system – data as of 31 Mar 2015*

Trust	2014-15		
	Total	Monitor Target	% towards Monitor target
Trust 6	76	49	155.10%
Trust 7	13	10	130.00%
Trust 8	89	80	111.25%
Trust 3	26	24	108.33%
Trust 5	30	30	100.00%
Trust 1	42	51	82.35%
NTHFT	20	40	50.00%
Trust 2	18	37	48.64%

**Data obtained from Healthcare Associated Infections (HCAI) data capture system*

HCAI – Cdiff rate per 100,000 Bed Days

Trust	Cdiff rate per 100,000 Bed Days
Trust 6	17.23
Trust 1	15.99
Trust 8	15.68
Trust 3	12.67
NTHFT	9.62
Trust 5	8.37
Trust 7	7.22
Trust 2	4.95

**Data obtained from the Healthcare Evaluation Data (HED) – data as April 14 to Jan 15*

C diff trend year on year for the Trust

Trust	Trust attributed	Non-Trust attributed
2011-2012	68	107
2012-2013	61	95
2013-2014	30	95
2014-2015	20	71

"Recent family admission through A&E, Emergency Assessment and finally onto Ward 40. All areas excellent with staff keeping us informed at all stages and involving us in care decisions. Ward 40 staff very compassionate at a difficult time and provided us with privacy to be together as a family." [sic]

Priority 2: Effectiveness of Care

Discharge Processes

1. Discharge processes – Information/Communication

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

Overview of how we said we would do it

- All patients discharged back to a named GP based on the Electronic Discharge Summaries (EDS)
- All patients will have a Predicted Date of Discharge (PDD) within 24 hours of admission

Overview of how we said we would measure it

- Audit a number of patients with a Predicted Date of Discharge
- Audit a number of Patients discharged to their named GP

Overview of how we said we would report it

- To the Discharge Liaison Group
- To the CQUIN Board

Completed and reported?

- Reported to Discharge Liaison Group ✔
- Reported to the CQUIN Board ✔

"Very smooth process of admission and discharge with sensitive situation handled well." [sic]

Predicted Date of Discharge (PDD) within 24 Hours of admission

The following information demonstrates the number of patients who had a PDD prior to discharge and a PDD within 24 hours of admission.

	Q1	Q2	Q3	Q4
Total number of patients who stayed in the Trust for more than 24 hours.	5,865	5,860	5,981	6,032
Total number of patients who had a PDD entered prior to discharge.	3,616	4,857	5,207	5,416
Percentage of Patients who had a PDD entered prior to discharge.	61.60%	82.80%	87.00%	89.80%
Total number of patients who had a PDD entered within 24 hours of admission.	356	1,209	3,561	4,071
Percentage of patients who had a PDD entered within 24 hours of admission.	6.10%	20.60%	59.50%	67.50%

**Data obtained from the Discharge Processes CQUIN Audits*

Patient discharged back to a named GP based on the Electronic Discharge Summaries (EDS)

The following information demonstrates the number of patients discharged with an EDS back to their GP practice.

	Q1	Q2	Q3	Q4
Total number of patients whom stayed in the Trust for more than 24 hours.	12,088	11,974	12,750	12,168
Total number of patients discharged with an EDS back to their GP practice.	11,931	11,746	12,352	11,907
Percentage of patients discharged with an EDS back to their GP practice.	98.70%	98.10%	96.88%	97.90%
Total number of patients discharged with an EDS sent within 24 hours of discharge.	10,115	10,668	11,727	10,554
Percentage of patients discharged with an EDS sent within 24 hours of discharge.	83.67%	89.09%	91.97%	86.74%

**Data obtained from the Discharge Processes CQUIN Audits*

Priority 2: Effectiveness of Care

Discharge Processes - Medication

2. Discharge processes – Medication

Rationale: The latest national patient experience survey identified that the Trust still has work to do with regards to medication discharge processes.

Overview of how we said we would do it

- All patients will receive information about medication side-effects to watch out for at home.

Overview of how we said we would measure it

- Via national and local patient surveys

Overview of how we said we would report it

- Local audit reports reported to Drug and Therapeutic committee
- National inpatient survey report to PS & QS

Completed and reported?

- Reported to PS & QS ✔
- Reported to the Drug and Therapeutic committee ✔

> "All nurses were helpful and friendly. They were as quick as possible with the medication and the ward was lovely and clean." [sic]

The National In-patient and Out-patients Surveys are undertaken and include questions about medicines, including one for patients receiving information regarding which medication side-effects to watch out for at home.

Medicines are dispensed mainly as Original Packs to ensure patients will receive information leaflets to inform them of any possible side effects that the medication may cause. Medicines are also dispensed with green sheets to show what medication has been dispensed and a web link to get more information.

The Trust has shown an increase in the number of medication errors being reported. **477** incidents were reported in 2013-14 as originating with the Trust. In the first half of 2014-15 the figure was 276 which is almost 57% of the previous year's total figure. This shows an improvement in awareness of the importance of reporting incidents which allow incidents to be investigated and actions taken to improve safe practice.

Medicines Safety

In **2013-2014** there were **537** medicines related incidents reported via our internal reporting database (Datix), of which **477** originated within the Trust.

In **2014-2015** there were **624** medicines related incidents reported via our internal reporting database (Datix), of which **554** originated within the Trust.

Type of incidents	2013-2014	2014-2015
Prescribing	124	147
Administration	256	314
Dispensing	41	43
Other	56	50
Total	**477**	**554**

Optimising

Safe Medication Practices Group

- Medications Safety Officer appointed
- Analyse and theme incidents
- Introduce system changes to reduce errors
- Engage with users

As a Trust we are using technology to improve safety and reduce delays in medication administration. One example is electronic medicine cupboards with biometric access which have been introduced in a number of areas. This has improved services through:

- Keys no longer necessary
- Increased access to pre-labelled medicines outside of pharmacy hours
- Guiding lights improves safety and reduces time searching for items
- Stock controlled by pharmacy allowing nurses to spend more time with patients and reduces waste through appropriate stock levels

Automated Cupboards

Omnicell Cupboards reduce administration through:

- Fingerprint access means staff no longer having to search for keys
- Cupboards reduce delayed discharges by allowing increased access to pre-labelled medicine outside of pharmacy hours
- Organisation and Guiding Lights improves safety and reduces time searching cupboards

Other associated technology

- Pharmacy Intranet Resource
- Updated Ascribe programme for:
- Decision Support System
    - Drug Interactions
    - Dose/Age
    - Dose/Weight
- Patient Leaflets
- Planned improvements to electronic prescribing
- Planned Computer Tablets

The Pharmacy department has increased the level of support available to staff by taking pharmacy to the wards. Pharmacy intranet resource and pharmacy discharge teams mean that:

- More pharmacist prescribers support with writing of discharge prescriptions
- Amendments to prescriptions and supply of medicines can be made at ward level
- Counselling can be provided by pharmacy staff to the patient at the point of discharge identifying any potential issues

Support

- Increasing outreach of pharmacy support reducing delays
- Amendments can be made to prescription at point of supply reducing time spent contacting the Doctor
- Discharge prescriptions can be written by a pharmacist
- Pharmacy discharge teams
- Supply can be made at ward level reducing need to send to hospital dispensary
- Discharge team can provide counselling on discharge medications, identifying any potential issues
- Medicines discharge check list developed to reduce errors/omissions at point for discharge
- Documents/Forms

Post Graduate Training

The pharmacy is involved in postgraduate and undergraduate training for staff. Links with the education department and analysis of medication errors means that we can provide the training that a safer workforce needs. This training can be delivered through classroom, workbook and e-learning packages. We also work with our local universities influencing curricula and are involved with inter-professional learning.

Priority 2: Effectiveness of Care

Discharge Processes – Safe and Warm

3. Discharge processes – Safe and Warm

Rationale: Following receipt of complaints in December 2012, the Trust has included Safe and Warm discharge and transfer as an additional measure for 2013-2014 to 2014-2015.

Overview of how we said we would do it

- We will continue to deliver a 'Safe and Warm' campaign in collaboration with Cleveland Fire and Rescue service.
- We will review our protocols for transferring and discharging patients to ensure that blankets are always provided and are adequate to maintain warmth throughout the patient journey.
- We will liaise with the ambulance services and staff to ensure patients are kept warm until they arrive at their destination.

Overview of how we said we would measure it

- Referrals to the 'Stay Safe and Warm campaign scheme' will be monitored
- Revised patient admission documentation will reflect need for onward referral on discharge

Overview of how we said we would report it

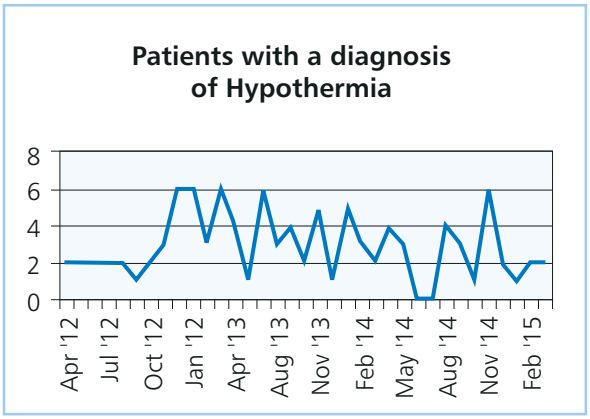
- Annual report to the Tees-wide Vulnerable Adults Patient Experience Group

Completed and reported?

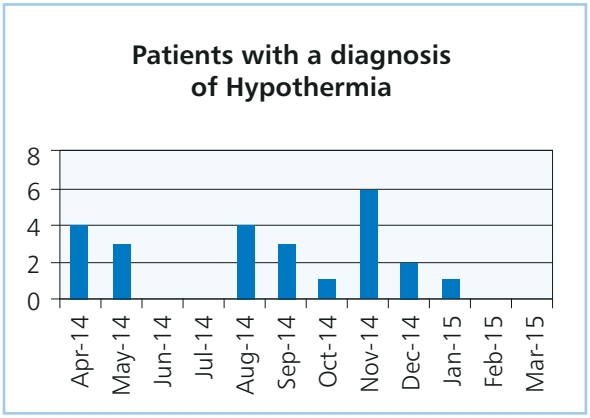
- The Trust monitors the number of patients admitted with a diagnosis of hypothermia; the following table demonstrates the year-on-year trend. ✔

Trust	PATIENTS WITH DIAGNOSIS OF HYPOTHERMIA
2011-2012	37
2012-2013	36
2013-2014	28

Since April 2012, the Trust has seen admitted **101** patients with a diagnosis of hypothermia; the following chart demonstrates the monthly trend.



For the latest reporting period of 2014-2015, the Trust has had 28 patients admitted, with November 2014 having the highest number with 6.



**Data obtained from the Trusts Activity Data*

The Trust aims to discharge home safely and into a warm safe environment.

Priority 2: Effectiveness of Care

Nursing Dashboard

4. Nursing Dashboard

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

Overview of how we said we would do it

- Training will be completed and each department will evidence that their results have been disseminated and acted upon.
- Ward matrons will present their analysis on a public area of the ward for patients and staff to see. The results will be discussed and minutes taken.

Overview of how we said we would measure it

- Senior Clinical Matrons (SCMs) will monitor ward areas to ensure that data is up to date, accurate and displayed in a public area.

Overview of how we said we would report it

- Monthly dashboard analysis to the Director of Nursing, Patient Safety and Quality.
- Monthly to Senior Matron and to IPNMB.

Completed and reported?

- Dashboard analysis report presented to Director of Nursing, Patient Safety and Quality on a monthly basis. ✔
- Reported to IPNMB and SCM quarterly. ✔

Nursing and Midwifery Dashboard

From April 2014 the Trust rolled out a modified Nursing and Midwifery Dashboard to all in-patient ward areas. This was also made available to all ward matrons, managers and Directors of the Trust.

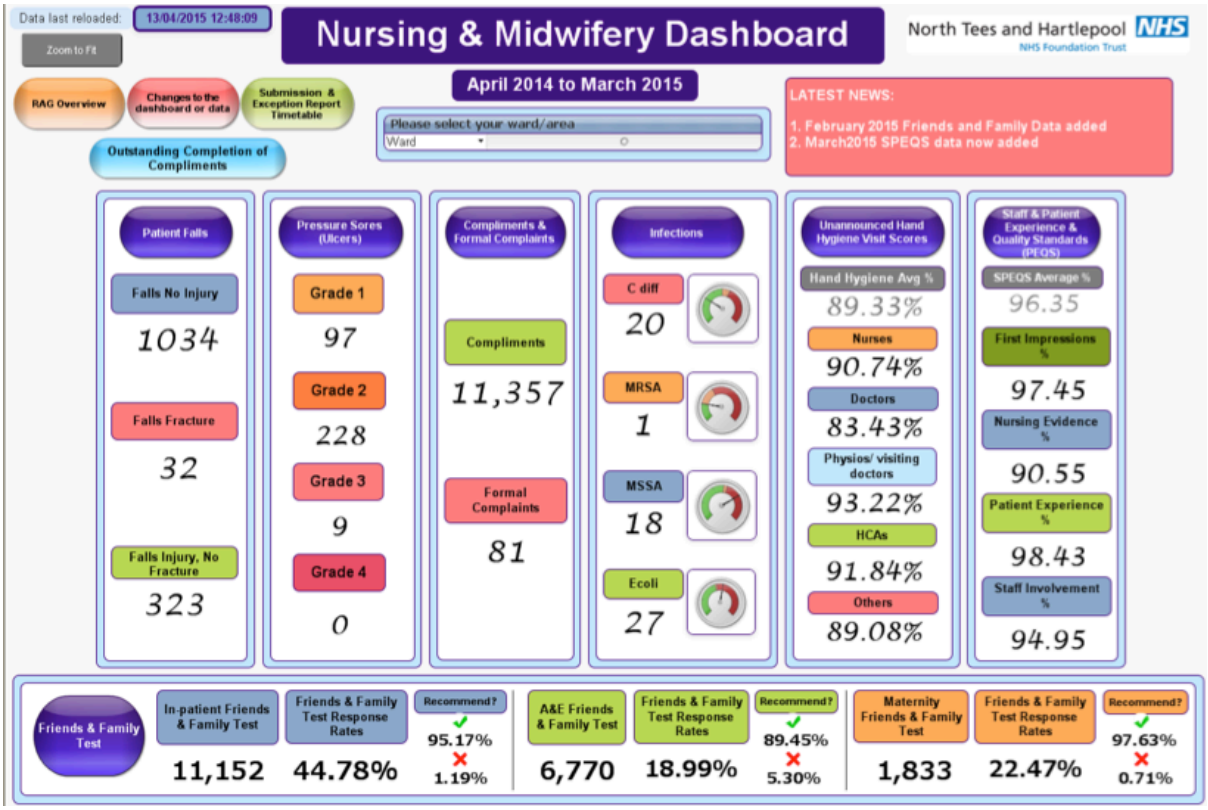
The dashboard consists of the following indicators:

- Patient Falls
- Pressure Ulcers
- Compliments and Formal Complaints
- Infections
- Staff & Patient Experience and Quality Standards (SPEQS)
- Unannounced Hand Hygiene
- Friends and Family Test

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

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

The dashboard is printed off monthly and displayed on all inpatient 'Productive Ward' boards for public display.



Healthcare assistant Linda Guttridge, sister Melissa McKie and nurse Gayle Kier.

Priority 3: Patient Experience

Care For the Dying Patient (formerly End of Life Pathway) and Family's Voice

Care For the Dying Patient and Family's Voice

Rationale: The Trust uses the Care For the Dying Patient (CFDP) and Family's Voice. Stakeholders and the Trust believe that this needs to remain a priority in 2014-2015 both in hospital and in the community.

The review of the Liverpool Care Pathway (LCP) was commissioned by Care and Support Minister Norman Lamb in January 2013, because of serious concerns arising from reports that patients were wrongly being denied nutrition and hydration whilst being placed on the Pathway.

The Care of the Dying Patient document has been established within the Trust to consider the contents of the Independent Review of the Liverpool Care Pathway led by Professor Julia Neuberger.

Overview of how we said we would do it

- We will continue to use of the Family's Voice in hospital and continue to roll its use out in the community

Overview of how we said we would measure it

- We will evaluate feedback in relation to pain, nausea, breathlessness restlessness, care for the patient and care for the family

Overview of how we said we would report it

- Quarterly to IPNMB
- Annually to PS & QS

Completed and reported?

- Reported to IPNMB and quarterly ✔
- Reported to PS & QS annually ✔

> "Shocked and stunned, loved ones of a dying lady were treated with respect and care. The patient, my mam was given dignity and her family spent crucial time with her when it mattered. They informed our family of her condition and kept her comfortable with appropriate drugs. For these nurses it's everyday work, for us it was once in a lifetime but they managed to find the right words and actions and as a family we are forever grateful that a stretched underfunded, overworked group of people can night after night do such an important job. Forever thankful and please continue to do what you do." [sic]

The Family's Voice

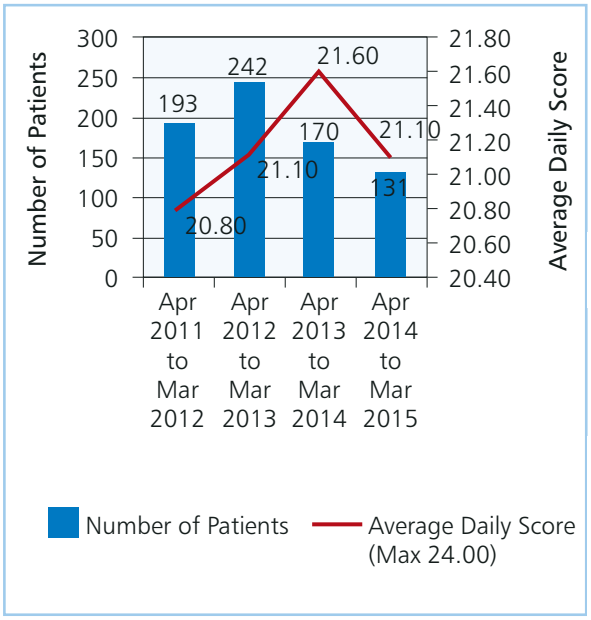
The Family's Voice continues to be given out to relatives within the Trust and the community.

Between April 2014 and March 2015, we have given out **131** diaries; this is a drop of 39 from the previous reporting year, the average score is 21.10.

It has been a very busy year with unprecedented pressure, more deaths and with increased work load on wards.

From an internal audit of the diary, there have been implications from the demise of the Liverpool Care Pathway as there remains a lot of uncertainty about when End of Life (EOL) occurs; therefore this is creating an issue for when to engage with relatives

Even though the number of diaries decreased, these results have demonstrated that a **high standard of care continues** to be provided.



Reporting Period	Number of Patients	Average Daily Score (Max 24.00)
April 2011 to March 2012	193	20.80
April 2012 to March 2013	242	21.10
April 2013 to March 2014	170	21.60
April 2014 to March 2015	**131**	**21.10**

**Data obtained from the Trusts Family's Voice database*

Care For the Dying Group

The Care For the Dying Patient (CFDP) was created and implemented during this reporting period. The group embodies the recommendations suggested in Independent Review of the Liverpool Care Pathway (LCP) ('More Care, Less Pathway)'.

Two audits have been undertaken that show both negative and positive feedback.

These audits have taken place during an extremely busy time in the Trust when the number of deaths had increased and the Trust had been under NEEP (North East Escalation Plan) 3 and 4.

A significant number of patients were not started on the document until a very late stage, sometimes only in the last 12 hours.

It was acknowledged that many doctors are reluctant to use the document due to previous problems with the Liverpool Care Pathway and the way it was covered in the media.

A new document Caring For the Dying has been created by the Regional Care of the Dying Group that contains much of the work from the Trust's original document. The Trust will move over to the new document in the summer of 2015.

The documentation is being developed by a sub-group of the Regional End of Life Network, which has a Consultant in Palliative Medicine representation from North Tees and Hartlepool NHS Foundation Trust.

Educational Strategy for Palliative Care

The Specialist Palliative Care Team within the Trust has developed an educational strategy for palliative care.

With the launch of the new regional document and the new medicine Kardex, staff will undergo education and awareness sessions.

New palliative care role

The Trust is developing a new palliative care post, one of the main roles for this position will be to focus on all dying patients within this Trust.

Monitoring palliative care patients in the last year of life

The Trust has developed a process of monitoring those palliative patients we suspect are in the last year of life; we inform the patients GP via the discharge letter and request that they place them on their palliative care register, the Trust also adds the patient onto our own palliative care register.

When these patients are subsequently admitted they populate two 'virtual wards'. The first is called a 'Palliative Care Ward'. The second is called 'Amber Ward'.

What is a Virtual Ward?

The Trust's internally developed Bed Management system has the concept of a virtual ward, which is simply a view of currently admitted patients sharing one or more characteristics. Automated rules move patients into one or more virtual wards at admission time, or at different points along their pathway e.g. on placing the patient on an EOL Pathway. This then allows specialist teams to view specific cohorts of patients irrespective of the ward on which the patient is admitted.

The *Amber Ward* is a particular group of palliative care patients who should become a high priority of monitoring because it is at least their second admission since the discharge letter.

From a monitoring position, the Trust knows who sent them to hospital. Why they were admitted and on what day and time. We know if they came in via A&E or GP admission, we know their length of stay and how many times they were admitted before dying.

What we know so far:

- **1,300** patients have been placed on our palliative care register since July 2013
- **857** have died
- **231** have died in the Trust
- **92** on the virtual end of life ward

Of those on our register, **73%** have died outside of the hospital and **27%** within the Trust.

In addition, the analysis of historic admission information, the list of patients in their final year of life and the patients known to be on the palliative care team's caseload, allows the Specialist Palliative Care team to identify improvements to pathways and communication, such that the right care can be provided in the right setting in accordance with clinical need and patient preferences.

For those patients who do die in the hospital, an alert system is in place to help ensure that the Specialist Palliative Care team are informed, and the Carers Diary given to relatives.

We are starting to build up this valuable database so we can provide quality of care to this group and aim that their last year is about living out their last year rather than many hospital admissions.

Quotes from family members/carers for the dying patient

"The doctors, nurses and staff are doing everything in their power to keep her comfortable and at peace and feel no one could do any more. My grateful thanks at this time."[sic]

"Nothing of all! The staff of ward 3 at Hartlepool Hospital have given my dad the very best of care. Not just today but for the last four months." [sic]

"No The service has been excellent. We have been dealt with in a sympathetic, caring and very friendly way. Much appreciated. Thank You No the staff are a great team and deserve the highest praise. Thanks." [sic]

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

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

Actions taken by the Trust:

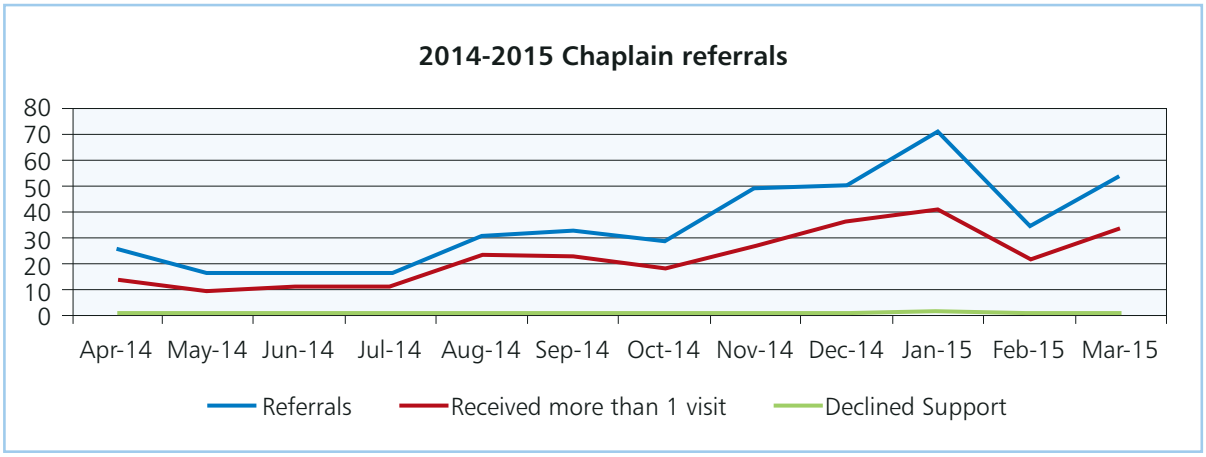
Since July 2009, this Trust has routinely referred patients on the end of life care pathway to the chaplaincy team. During 2014-2015, **424** patients were referred by our staff to this pioneering service provided by the Trust chaplains. They provide **spiritual, pastoral and emotional support** to patients, families and staff. Only one patient declined support during the reporting year. **272** patients welcomed and received multiple visits. This service offers added value to the quality of overall care provided to patients and their loved ones and has highlighted the importance of this aspect of support to the dying patient.

The Trust continues to address the spiritual and pastoral needs of patients in the community. Initially, this was for patients on or near the end of life, but practice has indicated that the service needs to be offered to patients earlier in the palliative care stage, in order to build up a relationship with the patient and offer a meaningful service. Perhaps because of management restructuring in the community, referrals have been less frequent than in the acute Trust, but they are now beginning to gather momentum.

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

Please see the following chart and table for additional detail:

Chaplain Referrals, Received more than 1 visit and Declined Support



The following table provides a year-on-year comparison on the services provided by the Trust's chaplains:

	2013-2014	2014-2015
Referrals	397	424
Received more than 1 visit	233	272
Declined Support	3	1

**Data obtained from the Trusts Chaplain service*

Priority 2: Effectiveness of Care

Is our care good?

Is our care good? (Patient Experience)

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

Overview of how we said we would do it

- We will ask the question to every patient interviewed in the Staff & Patient Experience and Quality Standards (SPEQS) reviews.
- We will ask the question in all Trust patient experience surveys.
- We will monitor patient feedback from national surveys.

Overview of how we said we would measure it

- We will analyse feedback from SPEQS and patient experience/national surveys.

Overview of how we said we would report it

- Reports to Trust Board

Completed and reported?

- Reported to Trust Board ✔

Patient Experience Surveys

Below are a list of the surveys that the Trust carried out between April 2014 and March 2015. The 'Number of patients surveyed' column shows out of how many patients were eligible to take part.

Survey	Month Survey published	Number of Patients Surveyed		
National Cancer Patient Experience Survey 2013-14	August 2014	410 patients		
CQC National Inpatient Survey 2013	April 2014	373 patients		
CQC National Accident and Emergency Survey 2014	December 2014	295 patients		
CQC Children's and Young People's Survey 2014	Spring 2015	101 patients		
CQC National Inpatient Survey 2014	April 2015	387 patients		
Friends and Family Test – Inpatients, Accident and Emergency and Maternity (commenced Oct)	April 14 – Dec 14	**IP 11,152**	**A&E 6,770**	**MAT 1,895**
	TOTAL	**19,817 patients**		
Assisted Reproduction Unit – Client Survey	Jan – Dec 2014	111 patients (still on-going)		
Endoscopy Patient Survey	June 2014	211 patients		
Local Food and Cleanliness Survey	Jan – Dec 2014	298 patients (still on-going)		
Acute Oncology Survey	April 2015	37 patients (still on-going)		
Cardiac Rehabilitation Programme Survey	April 2015	65 patients (still on-going)		
Bariatric Surgery Survey	April – November 2014	30 patients		
Upper GI Cancer Survey	April 2015	43 patients		
Pulmonary Rehabilitation Programme Survey (CQUIN)	Dec 2014 – April 2015	17 patients		
Family and care givers survey – Early Health Visitor Sessions Survey (CQUIN)	April 2015	45 patients		
Dexa Scan Patient Survey	March 2015	103 patients		
Rapid Access Area – Patient Survey	January 2015	49 patients		
Assessment of Frail Elderly – Patient Survey	March 2015	30 patients		

"The staff work very hard in trying conditions, felt safe and well cared for nothing was too much trouble. Auxiliary staff so helpful as well." [sic]

National Surveys

CQC National Inpatient Survey data for 2014

This survey is a Care Quality Commission (CQC) requirement for all Acute NHS Trusts. Each Trust randomly selected adult inpatient admissions during **August 2014** (age over 16 years).

There were **387** returns from the **818** patients that received a survey, this equates to a response rate of **47.31%**.

Survey Period	Number of patients Surveyed	Number of patients Surveyed	Response Rate
2010	369	823	44.84%
2011	438	832	52.64%
2012	381	794	47.98%
2013	373	803	46.45%
2014	**387**	**818**	**47.31%**

National Cancer Patient Experience Programme 2014 National Survey

The following is a sample of questions that were asked in the latest **National Cancer Patient Experience Survey 2014 – Questions**, benchmarked against previous year's results; there were 623 patients surveyed with a response rate of 70% against a National response rate of 64%.

The survey was conducted with cancer patients that were discharged between 1 September and 30 November 2013.

	Survey Year	
	2012	2013
Patient definitely involved in decisions about care and treatment	80%	79%
Patient was able to discuss worries or fears with staff during visit	69%	72%
Always given enough privacy when being examined or treated	95%	97%
Possible side effects explained in an understandable way	82%	81%
Patient given written information about side effects	87%	87%
Staff told patient who to contact if worried post discharge	94%	95%

A sample of the type of comments the Trust received in regards to cancer treatment taken from the National Cancer Patient Experience Programme 2014

"The chemotherapy unit at North Tees is excellent. All the staff are great, friendly, supportive and actually make it a 'jolly' place, which in turn helps when you're getting chemicals injected into you!" [sic]

"I have had excellent treatment from all of the cancer care team. I cannot praise them highly enough. My cancer care is excellent and I can't thank the whole team enough. Any problems have been dealt with quickly and efficiently." [sic]

National Accident & Emergency Survey 2014

The survey was conducted in the spring of 2014 sampling March 2014 Accident and Emergency attendees.

The following is a sample of questions that were asked in the survey, score out of 10.

	Survey Year
Questions	2014
Did you have enough time to discuss your health or medical problem with the doctor or nurse?	8.5
Did a doctor or nurse explain your condition and treatment in a way you could understand?	8.1
Did the doctor and nurses listen to what you had to say?	8.7
If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?	6.7
If you needed attention, were you able to get a member of medical or nursing staff to help you?	7.8
Were you involved as much as you wanted to be in decisions about your care and treatment?	7.8

"I would like to say everyone from doctors to receptionists were fantastic. All made me feel at ease with myself. I really could not praise them enough. Thank you to all of them." [sic]

"The haematology unit at North Tees Hospital was first class and I can't speak highly enough of them to specialist to nurse." [sic]

"To the Staff of the A & E, All, I would like to make it known that the standard of care my wife [name removed] received at the North Tees A&E department on [date and time removed] was exemplary. From the team on the ambulance to the team at the hospital we could not have asked for more.

I believe it is important to shout to all those who decry our Heath Service that we are blessed with dedicated professional's who do an outstanding job in demanding circumstances. Thank you all." [sic]

Priority 3: Patient Experience

Friends and Family recommendation

5. Friends and Family recommendation

Rationale: The Department of Health require Trusts to ask the Friends and Family recommendation questions from April 2013. Stakeholders agreed that this remains being reported in the 2014-2015 Quality Account.

Overview of how we said we would do it

- We have incorporated the Friends and Family test wording into SPEQS and patient surveys
- We ask patients to complete a questionnaire on discharge from hospital

Overview of how we said we would measure it

- We analyse feedback from SPEQS and patient surveys and discharge questionnaires

Overview of how we said we would report it

- Report to Improving Patient Safety and Experience (IPSE) group
- Report to Board

Completed and reported?

- Reported to Improving Patient Safety and Experience (IPSE) meeting ✔

The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.

It is initially for providers of NHS funded acute services for inpatients (including independent sector organisations that provide acute NHS services) and patients discharged from A&E (type 1 & 2) from April 2013.

The Friends and family data can be found at:

http://www.england.nhs.uk/statistics/statistical-work-areas/friends-and-family-test/friends-and-family-test-data/

North Tees and Hartlepool NHS Foundation Trust – Returns for April 2014 to March 2015

How likely... recommend?	In-patients	A&E
1 Extremely likely	8,264	4,296
2 Likely	2,360	1,760
3 Neither	254	290
4 Unlikely	70	160
5 Extremely unlikely	57	199
6 Don't know	143	65
Blank	0	0

**Data from April 2014 to March 2015*

Would recommend and wouldn't recommend percentages

	In-patients	A&E
Would recommend	95.30%	89.45%
Wouldn't recommend	1.14%	5.30%

Data from April 2014 to March 2015

How 'would recommend' and 'wouldn't recommend' % is calculated

Would recommend

Extremely likely + likely x 100

Extremely likely + likely+neither+extremely unlikely+don't know

Wouldn't recommend

Extremely unlikely + unlikely x 100

Extremely likely + likely+neither+extremely unlikely+don't know

It is important for the Trust to monitor the type and number of comments made on the Friends and Family Test returns. To date the Trust has had **19,817** returns (A&E, In-patient & Maternity) of which there have **13,757** positive comments and **715** negative comments made.

The Trust is pleased to show that by far the most common positive comment is in regards to our staff followed by Care then service.

From the **13,757** positive comments, **8,144 (59.20%)** were made in regards to staff, **2,651 (19.27%)** in regards to our Care, **789 (5.73%)** in regards to our service.

The Trust continuously monitors the positive and negative comments on a weekly basis to ensure that any similar issues or concerns can be acted upon by the ward matrons.

This helps in reducing the reoccurrence of similar issues in the future.

Comment type
Positive comment
Negative comment
Neither positive or negative

Accident & Emergency Themes

Theme	Total Comments
Staff +	40
Service +	13
Waiting time -	11
Communication +	7
Service -	5
Care +	4
Staff -	3
Miscellaneous	2
Cleanliness +	1
Waiting time +	1

Inpatient Themes:

Theme	Total Comments
Staff +	7,075
Care +	2,285
Service +	619
Miscellaneous	480
Treatment+	359
Cleanliness +	335
Communication +	294
Food +	258
Understaffed	120
Staff -	99
Food -	88
Respect +	82
Environment +	93
Communication -	65
Medication -	59
Environment -	52
Support +	46
Dignity +	40
Discharge -	38
Service -	33
Medication +	30
Wait time -	29
Unreadable	24
Care -	29
Comfort +	36
Noise -	21
Atmosphere +	25
Cleanliness -	17
Treatment -	19
Facilities -	18
Facilities +	15
Privacy +	8
Discharge +	8
Moving wards -	6
Comfort -	7
Hygiene -	5
Information +	22
Response rate -	5
Response rate +	7
Hygiene +	5
Privacy -	3
Respect -	3
Dignity -	2
Equipment -	3
Noise +	6
Support -	2

To note: It is possible to have more than one comment on a returned questionnaire.

"I was required to visit the A&E children's department with my 7 year son. We were seen promptly & efficiently. The staff introduced themselves & informed my son & myself what they were planning to do. I was very impressed." [sic]

"Would just like to feed back that I was very impressed with the level of care I received during a recent hospital admission. I was in 3 wards altogether, A&E, Intensive Care ward 20 and Diabetic Ward 29. All the staff were extremely caring and competent." [sic]

North Tees and Hartlepool NHS Foundation Friends and Family word bubble

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

The Trust also produces a Trust version incorporating the negative and positive comments, please see the following word bubble for the Trust during April 2014 to March 2015.

You Said	We did
"No toilets on the floors for visitors. Have to go back to the bottom floor"	One of the two staff toilets on each landing of the Tower Block are now being made into public toilets.

What our patients have said about their hospital experience (taken from the Trust's Friends and Family Test Comments April 14 – March 15)

Friends and Family – Maternity Services

The Friends and Family Test (FFT) aims to provide a simple, headline metric which, when combined with follow-up questions, can be used across the maternity pathway to drive a culture change of continuous recognition of good practice and potential improvements in the quality of the care received by NHS patients and service users. The implementation of the FFT across all NHS services is an integral part of NHS England's Business Plan, and is designed to help service users, commissioners and practitioners.

The data collection for Maternity Friends and Family commenced in October 2013.

The questions each woman will be asked up to four FFT questions:

1. How likely are you to recommend our antenatal service to friends and family if they needed similar care or treatment?
2. How likely are you to recommend our labour ward/birthing unit/homebirth service to friends and family if they needed similar care or treatment?
3. How likely are you to recommend our postnatal ward to friends and family if they needed similar care or treatment?
4. How likely are you to recommend our postnatal community service to friends and family if they needed similar care or treatment?

The official guidance for Friends and Family – Maternity Services can be located at:

http://www.england.nhs.uk/wp-content/uploads/2013/09/fft-mat-guide.pdf

The following data refers to North Tees and Hartlepool NHS Foundation Trust from April 2014 to March 2015.

	Question			
How likely... recommend?	**1**	**2**	**3**	**4**
1 Extremely likely	257	519	464	176
2 Likely	79	155	150	37
3 Neither	5	10	10	5
4 Unlikely	1	4	2	0
5 Extremely unlikely	1	2	2	1
6 Don't know	1	4	8	1
Blank	0	0	0	0

Data from April 2014 to March 2015

Would recommend and wouldn't recommend percentages

	Question			
	1	**2**	**3**	**4**
Would recommend	97.57%	97.05%	96.31%	96.30%
Wouldn't recommend	0.69%	0.78%	0.67%	0.53%

Data from April 2014 to March 2015

"After a scan and concern I was admitted and the decision for me to have a C-section was made. All staff during the procedure were excellent. They kept me informed of what was happening. The whole procedure was very quick and I felt my worries and stresses were taken away due to the staff and care I received." [sic]

"Throughout my pregnancy and delivery, I have received excellent care and support from all staff involved in my journey." [sic]

Friends and Family – Staff

From April 2014 the Staff Friends and Family Test was introduced to allow staff feedback on NHS Services based on recent experience. Trust Staff are asked to respond to two questions.

Staff Friends and Family Test is conducted on a quarterly basis ***(*excluding Quarter 3 when the existing NHS Staff Survey takes place)***.

Care: ***'How likely staff are to recommend the NHS services they work in to friends and family who need similar treatment or care'***.

Breakdown of Responses – **Care**

How likely... recommend?	**Q1**	**Q2**	**Q3***	**Q4**
1 Extremely likely	112	173	280	116
2 Likely	206	302	881	152
3 Neither	92	109	645	38
4 Unlikely	21	44	237	23
5 Extremely unlikely	17	34	108	25
6 Don't know	8	6	0	10
Blank	0	0	0	0

Would recommend and wouldn't recommend percentages for **care**

	Q1	**Q2**	**Q3***	**Q4**
Percentage Recommended - Care	70%	71%	54%	74%
Percentage Not Recommended - Care	8%	12%	16%	13%

Work: ***'How likely staff would be to recommend the NHS service they work in to friends and family as a place to work'***.

Breakdown of Responses – **Work**

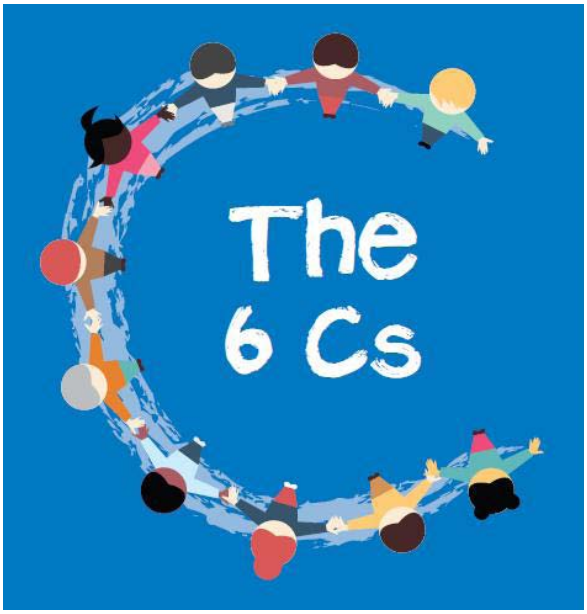
How likely... recommend?	**Q1**	**Q2**	**Q3***	**Q4**
1 Extremely likely	101	149	280	87
2 Likely	186	261	817	133
3 Neither	79	10	667	61
4 Unlikely	60	82	280	36
5 Extremely unlikely	28	67	129	32
6 Don't know	2	3	0	15
Blank	0	0	0	0

Would recommend and wouldn't recommend percentages for **work**

	Q1	**Q2**	**Q3***	**Q4**
Percentage Recommended - Care	63%	61%	50%	60%
Percentage Not Recommended - Care	19%	22%	19%	19%

Priority 3: Patient Experience

The 6Cs: Our culture of compassionate Care



"I found the ward very friendly and the staff couldn't do enough to make your stay on the ward as comfortable as possible. They explained everything they were going to do before they did it; I even found the consultants were friendly and approachable." [sic]

Background

The 6Cs supports the delivery of the six areas of action defined by the Compassion in Practice strategy and vision based on the 6Cs – care, compassion, competence, communication, courage and commitment - which was launched by the Chief Nursing Officer of England in December 2012

Summary

Delivering care with compassion dignity and respect is fundamental within the NHS and those values are echoed throughout North Tees and Hartlepool NHS Foundation Trust.

Our entry articulates a strong vision for change which is driven from the top of the organisation. It describes the innovative approach our organisation has taken to ensure that Compassion in Practice is at the heart of everything that we do.

As a result of the launch of *Compassion in Practice* our team which consists of three senior nurses was introduced in March 2014. The team focus is to deliver and embed the 6Cs into practice which has a multidisciplinary emphasis across acute, community and midwifery settings.

Our team recognises the value of a positive culture and environment and believe that it is important to value and engage our staff, as this will ultimately result in high quality care being delivered.

The team developed a bespoke training programme to achieve this which works in parallel with other initiatives such as *Insights Discovery* staff profiling, Open and Honest Care, the Sainsbury's Model ***#hellomynameis*** and identifying multidisciplinary *care makers* throughout the Trust.

Our programme

Our team believe that working clinically with staff and being 'visible' is invaluable and spend two weeks working a range of shifts in each clinical area.

Prior to this we deliver training away from the clinical areas where emphasis is placed upon the impact the 6Cs can have on patient care when practised by everyone.

Combined with this we have utilised Insights Discovery profiling to allow staff to gain a better understanding of themselves and others allowing them to communicate more effectively. This training inspires and prepares staff to engage and embrace our *Compassion in Practice 6Cs programme*. Due to our successful programme other disciplines e.g. medical Physics and wheelchair services have requested our team to support them in delivery of the 6Cs. This highlights the importance of patient and staff engagement and how this can influence organisational culture and enables staff to acknowledge the strengths and values associated with the NHS Constitution.

Our team approach

Our overriding aim is to ensure everyone works towards a common purpose, where 'patients are at the heart of everything we do' and believe that 'happy staff equal happy patients'.

Our programme places emphasis on improving team work, staff engagement and empowerment to improve patient experience, quality of care and service improvement. Our team has a clinical focus and spend time working closely alongside colleagues to supporting those staff to deliver the 6Cs values and drive home the importance of compassion in practice.

Our model follows a standardised approach reflecting a number of initiatives to ensure that the patients are at the heart of everything we do:-

1. Educational (6Cs/Insights Discovery) – prior to working with clinical teams we have a bespoke 3 hour interactive training programme which is delivered to all grades of staff. We have currently trained over 1000 multidisciplinary staff members including nursing, allied healthcare professionals, estates and facilities and medical staff. Insights Discovery training allows staff to connect better with patients and their teams. Some staff have been given the opportunity to complete a personal profile. The programme equips staff with the skills and capabilities to drive the concept of the 6Cs forward every day as part of NHS England Investors in Behaviours, work is currently underway comparing the benefits of staff having a profile or not. By introducing Insights Discovery staff have commented that they feel valued, that they are able to communicate and understand their colleagues and patients' needs better.
2. Care makers – we have now over 100 multidisciplinary care makers within the organisation. Our care makers are important to us as they are the ambassadors to sustain and drive the 6Cs. The team holds quarterly care makers events within the Trust. As part of this event our care makers are encouraged to share stories demonstrating the 6Cs in practice. Stories shared demonstrate that our staff are really going that extra mile to improve patient experience. Consequently our story was chosen as 6Cs Live story of the month August 2014 and published within the Nursing Times.

6Cs team - Claire Wong, Debbie Blackwood & Louise Samuel

3. Staff & visitor survey pre /post programme – We use this area specific data (based on the national survey) as a basis to measure organisational culture, encouraging staff to have courage to be open and honest. Visitor surveys provide timely information around their experience.
4. "#hellomynameis" campaign – this is being introduced by the team throughout the organisation. It has been recognised that always introducing yourself is vital and first impressions really do make a difference.
5. Sainsbury model – We have introduced this model which encourages all staff not to just 'sign post' but to take any member of the public within the organisation to their required destination if needed. Our team believe that this really does create a caring and compassionate environment.

6Cs nurses with staff on ward 25.

Benefits of our programme

Although the programme commenced six months ago qualitative and quantitative benefits are being recognised around this new way of working:

- Improved patient satisfaction
- True multidisciplinary approach
- Staff feel more valued
- Reduction in complaints (Nursing focus)
- Improved communication
- Recognition of the value a positive culture can have upon patient care
- Provided a platform to showcase the Trust e.g. Finalist 2014 (CNO Summit Compassion in Practice awards)

Our team is truly inspirational and has adopted an innovative approach to delivering care with compassion. Although the NHS evolves the fundamentals of care will always be at the heart of everything we do.

> "Staff were friendly and co-operative, nothing was too much trouble. I felt fully involved in my care and I was kept up to date with all decisions." [sic]

Part 2b: 2015-2016 priorities for improvement

Introduction to 2015-2016 Priorities

Key priorities for improvement for 2015-2016 have been agreed through numerous consultation events with our patients, our staff, our governors, our Healthwatch colleagues, our commissioners, our local health scrutiny committees, our healthcare user group and our Trust Board.

We started the consultation period in August 2014 which allowed us to consult widely and provide stakeholders with a significant opportunity to consider and suggest the priorities that they would like to see us address.

Quality Accounts Marketplace

The Trust held is first annual Quality Accounts Marketplace in December 2014. The aim of this event was to engage on a 1 to 1 level with our stakeholders, staff and patients.

Leads from key areas were at the event to describe the work that has been undertaken during the 2014-2015 reporting year.

This event allowed the participants to discuss and actively engage with the leads for areas such as, dementia, adult safeguarding, complaints, compliments, Friends and Family Test and mortality.

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

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

We would like to thank all of those involved in setting priorities for 2015-16 which are linked to patient safety, effectiveness of care and patient experience. We all agree that our priorities for improvement should continue to reflect three key principles, they are as follows.

Stakeholder priorities for 2015-2016

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

Patient Safety

1. Mortality
2. Dementia
3. Safeguarding

Effectiveness of Care

4. Discharge Processes
5. Discharge Medication
6. Nursing Dashboard

Patient Experience

7. Palliative Care & Care For the Dying Patient
8. Patient Surveys
9. Friends & Family Test

Rationale for the selection of priorities for 2015-2016

Through the Quality Accounts Marketplace and other engagement events we provided an opportunity for stakeholders, staff and patients to provide what they would like to see in the 2015-2016 Quality accounts as the priorities.

We then choose three from each of the key themes of Patient Safety, Effectiveness of Care and Patient Experience.

The Trust will continuously monitor and report progress on each of the above indicators throughout the year by reporting to the Board.

The following details for each selected priority, how we will achieve it, measure it and report it.

Patient Safety

Priority 1 – Mortality

To reduce avoidable deaths within the Trust, by reviewing all available mortality indicators.

Overview of how we will do it

We will use Healthcare Evaluation Data (HED) benchmarking tool to monitor and interrogate the data to determine areas that require improvement. We will also review/improve existing processes involving palliative care, documentation and coding process.

And finally, we will continue to work closely with the North East Quality Observatory System (NEQOS) for third party assurance.

Overview of how will measure it

We will monitor mortality within the Trust using the two national measures of Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) as well as the Care Quality Commission – Intelligent Monitoring Report (IMR).

Overview of how we will report it

- Report to Board
- Report quarterly to the commissioners
- Report to Keogh Delivery Group

Priority 2 – Improving care for people with dementia

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

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

Overview of how we will do it

We will use the Stirling Environmental Tool to adapt and audit the impact on our hospital environment.

We will ensure that all patients over 65 receive an Abbreviated Mental Test (AMT) and are, where appropriate referred for further assessment.

Patients with Dementia will be appropriately assessed and referred on to specialist services.

Overview of how will measure it

The Stirling Environmental audit assessment tool will be used to monitor the difference pre and post environmental adaptation.

The percentage of patients who receive the AMT and, where appropriate, further assessment will be reported monthly via UNIFY (national reporting system).

We will audit the number of patients over 65 admitted as an emergency that are reported as having a known diagnosis of dementia, or have been asked the (Prime Ministers) dementia case finding question.

We will continue to be involved in the National Audits and to review the outcomes.

Overview of how we will report it

- Dementia Strategy Group quarterly
- Integrated Professional Nursing and Midwifery Board (IPNMB)
- Monthly UNIFY

Priority 3 – Safeguarding Adults with Learning Disabilities (LD)

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

Overview of how we will do it

All patients with LD will be referred on admission to the LD specialist nurse. The LD specialist nurse will act as the named advocate and will ensure that an individualised plan of care is in place and reasonable adjustments documented.

Overview of how we will measure it

Audits will be carried out and results reported and areas highlighted will be acted upon.

Overview of how we will report it

- Audit results and action plans to be reported to Adult Safeguarding Group quarterly.

Effectiveness of Care

Priority 4 – Discharge processes – Information/Communication

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

Overview of how we will do it

All patients discharged to a nursing or care home requiring district nurse review, will receive a written summary of care provided and of ongoing care required.

A copy will be provided to the home, district nurse and GP.

Overview of how we will measure it

Audit a number of patients discharged with a letter.

Overview of how we will report it

- To the Discharge Liaison Group

Priority 5 – Discharge processes – Medication

The latest national patient experience survey identified that the Trusts still have improvements to make with regards to medication discharge processes.

Overview of how we will do it

All patients will receive information about medication side-effects to watch out for at home.

Overview of how we will measure it

We will measure it via improvements in national and local patient surveys.

Overview of how we will report it

- Local audit reports reported to Drug and Therapeutic committee
- National inpatient survey report to Patient Safety and Quality (PS & QS) Committee

Priority 6 – Nursing & Midwifery Dashboard

The Nursing & Midwifery Dashboard will support close monitoring of nurse sensitive patient indicators on a day-to-day basis. It will support sharing of best practice and speedy review of any potential areas of concern.

Overview of how we will do it

Training will be undertaken and each department will evidence that their results have been disseminated and acted upon.

Ward matrons will present their analysis on a public area of the ward for patients and staff to see. The results will be discussed at ward meetings.

Overview of how we will measure it

The dashboard will be a standing agenda item on the Senior Clinical Matrons (SCMs) meeting. SCMs will monitor ward areas to ensure that data is up to date, accurate and displayed in a public areas.

Overview of how we will report it

- Monthly dashboard analysis to the Director of Nursing, Patient Safety and Quality.
- Monthly to Senior Clinical Matron meeting and to IPNMB.

Patient Experience

Priority 7 – Care For the Dying Patient (formerly End of Life Pathway) and Family's Voice

The Trust has continued in the use of Care For the Dying Patient (CFDP) and Family's Voice, although this has been challenging this year due to a lower than in previous years.

Stakeholders and the Trust believe that this still needs to remain a priority in 2014-2015 both in hospital and in the community.

Overview of how we will do it

We will continue to embed use of the Family's Voice in hospital and continue to roll its use out in the community.

Overview of how we will measure it

We will evaluate feedback in relation to pain, nausea, breathlessness restlessness, care for the patient and care for the family.

Overview of how we will report it

- Quarterly to IPNMB
- Annually to PS & QS

Priority 8 – Patient Surveys

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

Overview of how we will do it

We will ask the question(s) to every patient interviewed in the Staff & Patient Experience and Quality Standards (SPEQS) reviews. We will also ask the question in all Trust patient experience surveys, along with monitoring patient feedback from national surveys.

Overview of how we will measure it

We will analyse feedback from SPEQS and patient experience/national surveys.

Overview of how we will report it

- Reports to Trust Board

Priority 9 – Friends and Family recommendation

The Department of Health require Trusts to ask the Friends and Family recommendation questions from April 2013. Stakeholders agreed that this remains being reported in the 2015-2016 Quality Account.

Overview of how we will do it

We have incorporated the Friends and Family test wording into SPEQS and patient surveys.

We currently ask patients to complete a questionnaire on discharge from hospital for in-patients, Accident & Emergency and Maternity

Overview of how we will measure it

We analyse feedback from SPEQS and patient surveys and discharge questionnaires.

Overview of how we will report it

- Report to Eliminating Mixed Sex Accommodation (EMSA) group
- Report to Board

"Excellent, could not fault anything, staff were friendly and so efficient and caring. From desk clerk to surgeons. Thank-you so much." [sic]

"All the staff on every level have treated me with kindness, consideration and respect. They have been wholly attentive and informative and are extremely friendly and likeable. I have felt in safe hands. Thank you all." [sic]

"All the staff at North Tees have been very helpful and chatty. Its my first visit to this hospital and found myself surprised by the level of conscientiousness in each department. I have had a smooth running course of treatment." [sic]

Part 2c: Statements of Assurance from the Board

Review of Services

During 2014-2015 the North Tees and Hartlepool NHS Foundation Trust provided and/or subcontracted 64 relevant health services. The majority of our services were provided on a direct basis, with a small number under sub-contracting or joint arrangements with others.

The North Tees and Hartlepool NHS Foundation Trust has reviewed all the data available to them on the quality of care in 64 of these relevant health services.

The income generated by the relevant health services reviewed in 2014-2015 represents 100% of the total income generated from the provision relevant health services by North Tees and Hartlepool NHS Foundation Trust for 2014-2015.

Participation in clinical audits

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

The Healthcare Quality Improvement Partnership (HQIP) provides a comprehensive list of national audits which collected audit data during 2014-2015 and this can be found on the following link:

http://www.hqip.org.uk/assets/National-Team-Uploads/Quality-Accounts/Quality-Accounts-Resource-2010-15-updated-09.02.2015.xls

During 2014-2015, 35 national clinical audits and 6 national confidential enquiries covered the relevant health services that North Tees and Hartlepool NHS Foundation Trust provides.

During 2014-2015 North Tees and Hartlepool NHS Foundation Trust participated in 100% of national clinical audits and 100% 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 North Tees and Hartlepool NHS Foundation Trust was eligible to participate in during 2014-2015 are as follows:

Audit title
Adult community acquired pneumonia (British Thoracic Society)
Adult critical care (Case Mix Programme – ICNARC CMP)
National Emergency Laparotomy Audit (NELA) (Royal College of Anaesthetists / Royal College of Surgeons)
National Joint Registry (NJR)
Severe trauma (TARN) (Trauma Audit & Research Network)
National Comparative Audit of Blood Transfusion programme (3 audits): i. Patient information and consent ii. Blood transfusion in Sickle Cell disease iii. Patient blood management in scheduled surgery
Bowel cancer (NBOCAP)
Lung cancer (NLCA)
Oesophago-gastric cancer (NAOGC)
Acute coronary syndrome or Acute myocardial infarction (MINAP)
National Heart Failure Audit
National Cardiac Arrest Audit (NCAA)
National COPD Audit Programme (Royal College of Physicians/British Thoracic Society) (2 audits): i. Pilot COPD Audit ii. Pulmonary Rehabilitation Audit Diabetes (Paediatric) (NPDA)
UK Inflammatory bowel disease (3 audits): i. Audit of adult patients ii. Audit of paediatric patients iii. Audit of biologics
Sentinel Stroke National Audit Programme (SSNAP)
Elective surgery (National PROMs Programme) (4 audits): i. Hip replacement ii. Knee replacement iii. Varicose Vein surgery iv. Groin Hernia surgery
Epilepsy 12 audit (Childhood Epilepsy)
Maternal infant and perinatal (MBRRACE-UK)
Neonatal intensive and special care (NNAP)
Paediatric intensive care (PICANet)
Rheumatoid and early inflammatory arthritis (British Society for Rheumatology)

National Confidential Enquiry into Patient Outcome and Death (NCEPOD) (5 audits): i. Lower Limb Amputation Study ii. Tracheostomy Study iii. Gastrointestinal Haemorrhage Study iv. Sepsis Study v. Acute Pancreatitis Study National Diabetes Footcare Audit
Falls and Fragility Fractures Audit Programme (FFFAP) (including the national hip fracture database)
Fitting Child Audit (College of Emergency Medicine)
Cognitive Assessment in Older People (College of Emergency Medicine)
Mental Health in Acute Trusts (College of Emergency Medicine)

The national clinical audits and national confidential enquiries that North Tees and Hartlepool NHS Foundation Trust participated in during 2014-2015 are as follows:

Audit title
Adult community acquired pneumonia (British Thoracic Society)
Adult critical care (Case Mix Programme – ICNARC CMP)
National Emergency Laparotomy Audit (NELA) (Royal College of Anaesthetists / Royal College of Surgeons)
National Joint Registry (NJR)
Severe trauma (TARN) (Trauma Audit & Research Network)
National Comparative Audit of Blood Transfusion programme (3 audits): i. Patient information and consent ii. Blood transfusion in Sickle Cell disease iii. Patient blood management in scheduled surgery
Bowel cancer (NBOCAP)
Lung cancer (NLCA)
Oesophago-gastric cancer (NAOGC)
Acute coronary syndrome or Acute myocardial infarction (MINAP)
National Heart Failure Audit
National Cardiac Arrest Audit (NCAA)
National COPD Audit Programme (Royal College of Physicians/British Thoracic Society) (2 audits): i. Pilot COPD Audit ii. Pulmonary Rehabilitation Audit Diabetes (Paediatric) (NPDA)
UK Inflammatory bowel disease (3 audits): i. Audit of adult patients ii. Audit of paediatric patients iii. Audit of biologics
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Rheumatoid and early inflammatory arthritis (British Society for Rheumatology)
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) (5 audits): i. Lower Limb Amputation Study ii. Tracheostomy Study iii. Gastrointestinal Haemorrhage Study iv. Sepsis Study v. Acute Pancreatitis Study National Diabetes Footcare Audit
Falls and Fragility Fractures Audit Programme (FFFAP) (including the national hip fracture database)
Fitting Child Audit (College of Emergency Medicine)
Cognitive Assessment in Older People (College of Emergency Medicine)
Mental Health in Acute Trusts (College of Emergency Medicine)

The national clinical audits and national confidential enquires that North Tees and Hartlepool NHS Foundation Trust participated in, and for which data collection was completed during 2014-2015, 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.

Audit title	Participation M= Mandatory N= Non-Mandatory	% cases submitted
Adult community acquired pneumonia (British Thoracic Society)	Yes (N)	100%
Adult critical care (Case Mix Programme – ICNARC CMP)	Yes (N)	Data collection ongoing
National Emergency Laparotomy Audit (NELA) (Royal College of Anaesthetists / Royal College of Surgeons)	Yes (M)	Year 1 data collection: 24% Year 2 data collection: ongoing
National Joint Registry (NJR)	Yes (M)	Data collection ongoing
Severe trauma (TARN) (Trauma Audit & Research Network)	Yes (N)	Data collection ongoing
National Comparative Audit of Blood Transfusion programme (3 audits): i. Patient information and consent ii. Blood transfusion in Sickle Cell disease iii. Patient blood management in scheduled surgery	 Yes (N) Yes (N) Yes (N)	 100% 100% Data collection ongoing
Bowel cancer (NBOCAP)	Yes (M)	100%
Lung cancer (NLCA)	Yes (M)	100%
Oesophago-gastric cancer (NAOGC)	Yes (M)	100%
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes (M)	Data collection ongoing
National Heart Failure Audit	Yes (M)	Data collection ongoing
National Cardiac Arrest Audit (NCAA)	Yes (N)	Data collection ongoing
National COPD Audit Programme (Royal College of Physicians/British Thoracic Society) (2 audits): i. Pilot COPD Audit ii. Pulmonary Rehabilitation Audit	 Yes (M) Yes (M)	 100% Data collection ongoing
Diabetes (Paediatric) (NPDA)	Yes (M)	100%
UK Inflammatory bowel disease (3 audits): i. Audit of adult patients ii. Audit of paediatric patients iii. Audit of biologics	 Yes (M) Yes (M) Yes (M)	 100% 100% 100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes (M)	Data collection ongoing
Elective surgery (National PROMs Programme) (4 audits): i. Hip replacement ii. Knee replacement iii. Varicose Vein surgery iv. Groin Hernia surgery	 Yes (N) Yes (N) Yes (N) Yes (N)	Based on return rate of the pre-operative questionnaire: i. 95% ii. 91% iii. 66% iv. 57%
Epilepsy 12 audit (Childhood Epilepsy)	Yes (M)	100%
Maternal infant and perinatal (MBRRACE-UK)	Yes (M)	100%
Neonatal intensive and special care (NNAP)	Yes (M)	100%
Paediatric intensive care (PICANet)	Yes (M)	100%

Audit title	Participation M= Mandatory N= Non-Mandatory	% cases submitted
Rheumatoid and early inflammatory arthritis (British Society for Rheumatology)	Yes (M)	Data collection ongoing
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) (5 audits): i. Lower Limb Amputation Study ii. Tracheostomy Study iii. Gastrointestinal Haemorrhage Study iv. Sepsis Study v. Acute Pancreatitis Study	 Yes (M) Yes (M) Yes (M) Yes (M) Yes (M)	 100% 100% 25% 60% Data collection ongoing
National Diabetes Footcare Audit	Yes (M)	Data collection ongoing
Falls and Fragility Fractures Audit Programme (FFFAP) (including the national hip fracture database)	Yes (M)	Data collection ongoing
Fitting Child Audit (College of Emergency Medicine)	Yes (N)	100%
Cognitive Assessment in Older People (College of Emergency Medicine)	Yes (N)	100%
Mental Health in Acute Trusts (College of Emergency Medicine)	Yes (N)	100%
National Pleural Procedures Audit (British Thoracic Society)	Yes (N)	100%

National Clinical Audits

The reports of 6 national clinical audits were reviewed by the provider in 2014-2015 and North Tees and Hartlepool NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Audit title	Actions taken/in progress
National Care of the Dying Audit	It was noted that many relatives had raised concerns about hydration and nutrition and that many needed reassurance in this area. The action plan focussed on the ongoing challenge of establishing a patient's preferred place of death, this will be audited by the electronic discharge summary. All new doctors to have a palliative care induction within the first month of service with the Trust. A new palliative section had been introduced to the electronic discharge summaries letter.
National Cardiac Arrest Audit	Of 258 cases audited, results showed that there were 46% cardiac arrests, 27% Peri-arrest, 11% cancelled calls and 16% false calls in which a 1/3 of patients who had a false call went on to have a cardiac arrest.
National Re-audit of Seizure Management in Hospitals (NASH2)	This audit sampled 30 consecutive patients who were 16 years and over. Results showed improvement on documenting vital signs, alcohol intake and giving advice to patients about driving, but results were disappointing around the documentation of discussions about the management of future seizures. There had been an increase in senior reviews of seizures following the merger of the sites and a lower rate of admissions.
CEM National Sepsis audit	The audit was a sample of 50 cases. Results showed problems with documentation, loss of fluid balance charts and EWS charts as well as difficulty in identifying patients due to coding errors. Recommendations from the audit were to revert back to the use of 'sepsis 6 stickers' in notes and to promote knowledge of sepsis 6 to all medical staff.
National Comparative Audit of Blood Transfusion: Red Cell Survey	It was noted that transfusions are prescribed by junior doctors and that this should be prescribed by middle grade doctors only.
National Early Warning Score (NEWS) Audit	A total of 514 cases were audited and overall results were good. Actions included a new workbook to go to all nursing staff. A total monthly submission figure will be sent to each ward matron and copied to the Senior Clinical Matron for each area.

Local Clinical Audits

The reports of 103 local clinical audits were reviewed by the provider in 2014-2015 and North Tees and Hartlepool NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Audit title	Actions taken/in progress
Management of Subarachnoid Haemorrhage in Emergency Medicine	Education to medical and nursing staff to be undertaken around importance of urgent investigation and management of patients with suspected subarachnoid haemorrhage. Additional education to be undertaken around the importance of full documentation of neurological examination in patients with neurological conditions.
Management of Atopic Eczema in Children (NICE CG 57)	Requirement for an Eczema leaflet to be developed for patients, carers and parents. More information required from clinical staff regarding eczema flare up, how to recognize and treat it. There is a need for Eczema to be graded appropriately – a poster and flow chart about Eczema will be developed for junior doctors at the ward and doctors room.
Per Vaginam (PV) Bleeding in Pregnancy	Guidelines for management of PV bleeding in early pregnancy will be developed for use in Emergency Department out of hours.
Fluid Balance Management in Theatres	Theatre sisters to reiterate message regarding importance and methods of fluid balance recording. Spot checks in recovery will be developed.
Peri-operative hypothermia audit (NICE CG 65)	Risk assessments pre operatively are getting better - this will be monitored via a re-audit in 2015.
Adult Community MUST Tool (NICE CG 32)	The transition plan for implementation of paper-light records is part-competed and the success of this will be reported on in the next year.
Word Catheter for Bartholyn's cyst or abscess (inc. NICE IP 323)	There is a need for a patient leaflet to support this new procedure which will be addressed in the coming year.
Arthroscopic Rotator Cuff Repair	All cases with both pre op and post op Oxford shoulder scores showed dramatic improvement of shoulder function, there are some issues with documentation to be addressed in 2014-15.
Interspinous Distraction Procedures for Lumbar Spine Stenosis	Data gathering system needs improvement but there is good compliance with NICE guidelines.

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

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

National Confidential Enquiries (NCEPOD):

i. Lower Limb Amputation Study

ii. Tracheostomy Study

iii. Gastrointestinal Haemorrhage Study

iv. Sepsis Study

v. Acute Pancreatitis Study

MBRRACE-UK:

i. Maternal infant and perinatal mortality confidential enquiry

Patients recruited into research

The Government wishes to see a dramatic and sustained improvement in the performance of providers of NHS services in initiating and delivering clinical research. The aim is to increase the number of patients who have the opportunity to participate in research and to enhance the nation's attractiveness as a host for research by faster approvals and delivering to time and target.

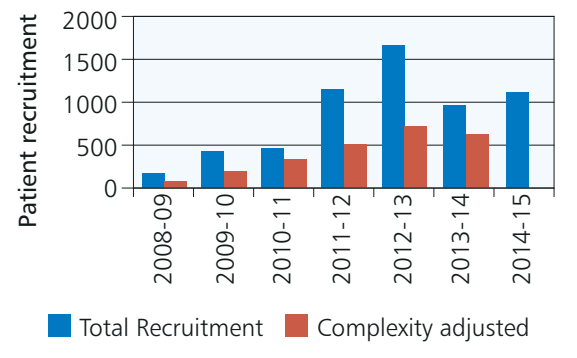
Performance Data

Total year on year recruitment into National Institute for Health Research (NIHR) portfolio research is shown below:

Complexity adjusted figs explanation:

Interventional studies are more intensive in terms of workload and input required than some of the observational studies which may recruit high numbers but are less resource intensive. To more accurately describe activity therefore, complexity adjustment of the figures applies a weighting to studies depending on their level of complexity. Patients recruited to interventional studies carry a greater weighting than observational studies.

	Total Recruitment	Complexity adjusted
2008-09	159	73
2009-10	412	200
2010-11	458	338
2011-12	1,147	510
2012-13	1,666	708
2013-14	956	621
2014-15	1,113	*N/A



**Complexity adjusted figures no longer available in comparative format.*

2014-15 Study participation – number of studies

The National Institute of Health Research Clinical Research Network (NIHR CRN) portfolio is a database of clinical research studies that are supported by the NIHR CRN in England.

Adoption on to the portfolio is dependent on a study meeting eligibility criteria. The Clinical Research Network provides infrastructure support including NHS Service Support costs (SSCs) and access to R&D support. Research studies are reviewed for inclusion in the NIHR CRN Portfolio in parallel with the NHS Ethics review and R&D governance process.

A non-portfolio study is a research study without the above support that has not been adopted onto the portfolio.

Study Type		No of Studies	Actively recruiting patients	In follow-up
NIHR portfolio studies	Observational	63	100	58
	Interventional	95		
Non-portfolio studies	Observational	36	46	1
	Interventional	11		
Total	Observational	99		
	Interventional	106		

The number of studies currently active within the Trust has increased dramatically in the last year. Last year we had just **91** studies open with the biggest increases seen in the number of portfolio studies open within this year. Part of this is due to the requirement to follow-up patients on studies previous studies where patients are now in follow-up will be counted as "active" and open although not actively recruiting patients.

The number of patients receiving relevant health services provided or subcontracted by North Tees and Hartlepool NHS Foundation Trust in 2014-15 that were recruited during that period to participate in research approved by a research ethics committee was **1,113** (portfolio and non-portfolio studies).

National position / ranking

Year	Overall national position	Ranking in "medium sized acute Trusts" category
2012-13	101st out of 394 organisations *	7th out of 48 Trusts
2013-14	157th out of 454 organisations	25th out of 47 Trusts
2014-15	141st out of 445 organisations	26th out of 47 Trusts

**In 2012-13 we had two exceptionally large recruiting observational studies which led to our much higher ranking in the league tables and the recruitment spike you seen in the first two graphs on the previous page. Also the number of "organisations" was less (394 vs 454 in the following year)*

Performance in Initiation and Delivery of research (PID data)

From 2013, government funding for research to our Trust has become conditional on meeting national benchmarks. We report quarterly to the Department of Health on the following performance measures. Latest figures relate to our quarter 3 submission.

We report quarterly to the Department of Health on the following performance measures.

For non-commercial studies: meeting a 70-day benchmark to recruit first patients for trials

70 day benchmark met	No of Studies	Reason
Yes	8	
No	13	1 NHS delay & Sponsor delay 9 NHS delay 3 Sponsor delay

- For commercial studies: Recruitment to time and target stated in clinical trial agreement

Time and target met	No of Studies	Reason
Yes	2	
No	4	**2 studies** – closed early due to national recruitment difficulties **1 study** – our site closed early due to target not being met **1 study** – v tight inclusion criteria and recruitment window
Still ongoing	9	

Failure to provide acceptable explanation for poor performance over two consecutive quarters may result in financial penalties. We have provided extensive narrative to support why sometimes these metrics haven't been met; the R&D team meet monthly to review the data and work with teams to highlight when benchmarks are in danger of not being met and develop an action plan. Once submitted to the DH, we have to post this information in a publically accessible area of the Trust's website. A response to our submission is given to the Chief Executive so we ensure he receives a copy of our submission prior to upload so that any queries can be resolved prior to the receipt of the official response from DH.

Achievements

The research and development (R&D) team have worked with departments across the Trust to promote the importance of healthcare professionals being involved in research.

Through the Trust's provision of an R&D Incentive fund of £50,000, we have been able to help to develop staff knowledge and skills to enable them to lead and/or be involved in research studies.

Five members of staff have had either MD fees or MSC fees supported this year and three individuals have had sessional support provided to enable them to complete a research grant application. Colleagues from Respiratory Rehabilitation, General Surgery, and Paediatrics are supported through the fund and another three colleagues in Gastroenterology, Podiatry and Assisted Reproduction are in discussions to develop Trust – sponsored research studies.

We currently have 128 members of staff with valid Good Clinical Practice (GCP) training.

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

There are 77 members of staff acting as principal investigators/local collaborators in research approved by a research ethics committee within the Trust, some of whom have up to ten studies in their research portfolio. We have 26 clinical research network funded research staff within the Trust (nurses, midwife, data assistants and Pharmacy technician) and two nurses/research practitioners funded from commercial income.

Our bi-monthly research nurses working group continues to be well attended and provides professional support and mentorship as well as assisting us with national research initiatives such as raising the profile of research with patients, involving patients in meaningful PPI (patient and public involvement), developing training packages for research nurses and training nurses for commercial studies (70 day benchmark).

Commercially sponsored Studies

We continue to increase our participation in commercially sponsored studies. We now have 17 commercially sponsored studies active within the Trust (12 last year) within Respiratory Medicine, Paediatrics, Neonates and Cardiology with more planned within Gastroenterology.

Our respiratory research team continue to develop their reputation as a "preferred site" for commercially sponsored research studies and our Cardiology research team just missed on the first UK recruit to the REPORT-HF study by a matter of hours.

We are in final stages of discussions with an Israeli Company 'Early Sense' to be the first UK site to pilot a contactless patient monitoring system on two wards within the Trust and run a research project collaboratively with Durham University alongside this.

Awards and accolades

We assisted three student nurses from Teesside University with their 'service improvement placements' this year by allowing them to shadow research nurses and midwives across the range of specialisms we cover. Feedback was very positive from this and one of the students nominated the research nurses for a 'Certificate of Excellence'.

Julie Gray, Cardiology Research Nurse was awarded 'Research Practitioner of the Year' by the Clinical Research Network for North East & N Cumbria at their annual regional network Event in February. The Reproductive Health Research team was awarded 'Research Team of the Year' at the same event.

Commissioning for quality and innovation (CQUIN)

A proportion of North Tees and Hartlepool NHS Foundation Trust income in 2014-15 was conditional on achieving quality improvement and innovation goals agreed between North Tees and Hartlepool NHS Foundation Trust 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.

2013-2014 income

The total income received through achievement of CQUIN goals in 2013-2014 was **£3,112,253.00**.

Further details of agreed goals for 2014-2015 and the following 12 month period are available electronically at:

http://www.england.nhs.uk/wp-content/uploads/2014/02/sc-cquin-guid.pdf

2014-2015 income

The total income received through achievement of CQUIN goals in 2014-2015 is **£1,058,612.00** (Q1 to Q3) from £1,652.839 available; This value was conditional upon achieving quality improvement and innovation goals. The following table demonstrates which measures the Trust achieved.

Trust	Q1	Q2	Q3	*Q4
1a - Friends and Family Test - Implementation of Staff FFT	Achieved	N/A	N/A	
1b - Friends and Family Test - Early Implementation of FFT in Outpatient and day case departments	Achieved	Achieved	Achieved	
1c - Friends and Family Test - Increased response rate in A&E and Inpatients	Achieved	N/A	N/A	
1d - Friends and Family Test - Further increased response rate within Inpatients	N/A	N/A	N/A	
2a - NHS Safety Thermometer	Achieved	Partial	Queried	
3a - Dementia - Find, Assess, Investigate and Refer (FAIR)	Achieved	Achieved	Achieved	
3b - Dementia - Clinical Leadership	N/A	N/A	N/A	
3c - Dementia - Supporting of Carers of People with Dementia	Achieved	Achieved	Achieved	
4 - Making every health contact count (Phase 2) - Alcohol & Smoking	Not Achieved	Achieved	Achieved	
5 - Pulmonary Rehabilitation	Achieved	Achieved	Achieved	
6 - Assessment of Frail Elderly	Not Achieved	Not Achieved	Queried	
7a - 7 days a week standard 2	Achieved	Achieved	Queried	
7b - 7 days a week: ICU Consultant to Consultant Referrals	Achieved	Achieved	Queried	
7c - Discharge Planning	Achieved	Achieved	Achieved	
7d - National Early Warning Score (NEWS)	Not Achieved	Achieved	Achieved	

Trust	Q1	Q2	Q3	*Q4
8 - Ambulance Handover	Achieved	Achieved	Not Achieved	
9 - AQP Adult Hearing: Local Patient Experience	Queried	Achieved	Achieved	
10 - AQP Adult Hearing: Record Keeping	Queried	Achieved	Achieved	
11 - AQP Adult Hearing: Discharge Summaries	Queried	Achieved	Achieved	
12 - Quality Dashboards	Achieved	Achieved	Unconfirmed	
13 - Chemotherapy Drug Wastage	Not Achieved	Achieved	Unconfirmed	
14 - Neonatal Intensive Care: Retinopathy of prematurity	Not Achieved	Achieved	Achieved	
15 - Access to breast milk	Not Achieved	Achieved	Achieved	
16 - Health Inequalities Screening	Achieved	Not Achieved	Unconfirmed	
17 - Health Visiting	Not Achieved	Not Achieved	Unconfirmed	

**Q4 data was not available at the time of print.*

Care Quality Commission (CQC)

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

The Care Quality Commission (CQC) has not taken enforcement action against North Tees and Hartlepool NHS Foundation Trust during 2014-15.

North Tees and Hartlepool NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

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

Inspection Regime

Following an extensive consultation exercise the CQC have published details of the various inspection regimes across all areas of Healthcare provision. Currently the Essential Standards for Health set in 2010 remain in place; however these will be replaced on 1 April 2015 by Fundamental Standards that were highlighted in the Health and Social Care Act 2010 (Regulated activities) Regulations 2014. The CQC guidance in relation to the Fundamental Standards is yet to be published; however, the Trust is currently reviewing the new regulations to assess compliance.

It is anticipated that the Trust will undergo an inspection against these standards before December 2015 as the CQC pledged to inspect all Trusts before this date

The Trust has not received any CQC Inspections during 2014-15. However, the Trust has provided support to partner organisation Tees, Esk and Wear Valleys Mental Health Trust during their recent inspection in January 2015; with an on-site visit being undertaken. Initial feedback has not revealed any issues; the final report is not available at the time of writing this summary.

The CQC has continued to publish quarterly Intelligent Monitoring Reports (IMR); these reports provide a risk rating on between 82-96 indicators made up of a variety of clinical and safety statistics (quantitative) and also patient experience measures (qualitative). The patient experience information comes from direct contacts with the CQC through their website, complaints or whistleblowing direct to the CQC, NHS Choices and also from numbers of complaints reported by the Trust. Specific areas of the staff survey and human resources data are also included.

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

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

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

- No Evidence of Risk
- Risk
- Elevated Risk

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

North Tees and Hartlepool NHS Foundation Trust 'Priority banding for inspection' currently is at **3** (Dec 2014)

	Report Month	
	Jul-14	Dec-14
Indicators	96	87
No Evidence of Risk	92	82
Risk	1	1
Elevated Risk	3	4
Trust	4	3

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

The table below provides a summary of the 5 areas of risk identified in the latest IMR; the remaining 90 have not shown any areas of risk. There is further information relating to the Trusts Mortality rates in Part 3.

Elevated risk	**Dr Foster Intelligence:** Mortality rates for conditions normally associated with a very low rate of mortality (01-Apr-13 to 31-Mar-14) Higher than expected
Elevated risk	Summary Hospital-level Mortality Indicator (01-Apr-13 to 31-Mar-14) Higher than expected
Elevated risk	**Dr Foster Intelligence:** Composite of Hospital Standardised Mortality Ratio indicators (01-Apr-13 to 31-Mar-14) Higher than expected
Elevated risk	**Composite indicator:** In-hospital mortality - Respiratory condition (01-May-13 to 30-April-14) Elevated risk for overall In-hospital mortality - Respiratory condition
Risk	**PROMs EQ-5D score:** Groin Hernia Surgery (01-Apr-13 to 31-Mar-14) 0.05 observed was lower than the expected 0.09

CQC Inspection

We have recently being notified of our planned Care Quality Commission (CQC) inspection visit, dates for these are 7 to 9 July 2015.

Commissioners Assurance

The Trust had one scheduled and one unscheduled Commissioner Assurance visit during 2014.

The unscheduled visit took place in June 2014 and covered the following areas, Ward24, Paediatrics, Emergency Assessment Unit (EAU) and Ward 28.

The Scheduled visit took place in October 2014 and covered Ward 32 and Ward 40. An action plan has been developed and delivered on any suggestions and/or comments received during the visit; this has been shared with the commissioners.

Quality of Data

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

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

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

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

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

In order to test and improve quality of data the Trust will continue to commission independent audits of its key business.

NHS number and general medical practice validity

North Tees and Hartlepool NHS Foundation Trust submitted records during 2014-15 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episodes Statistics (HES) which are included in the latest published data.

The percentage of records in the published data is shown in the following table:

Which included the patient's valid NHS number was:	%	Which included the patient's valid general medical practice code was:	%
Percentage for admitted patient care	98.90	Percentage for admitted patient care	100
Percentage for outpatient care	99.99	Percentage for outpatient care	100
Percentage for accident and emergency care	99.10	Percentage for accident and emergency care	100

**Data for April 2014 to February 2015*

Information governance (IG)

Information governance means keeping information safe. This relies on good systems, processes and monitoring. Every year we audit the quality of specific aspects of information governance through the national information governance toolkit report. Staff training and awareness of Information Governance is a key indicator, in 2015-2016 we again had to ensure that **95%** of all of our staff had received information governance training. This target was challenging, however we have continued to make significant progress and for the fourth year running we have met the target with a total of **95.16%** of all staff trained during the year.

North Tees and Hartlepool NHS Foundation Trust Information Governance Assessment Report overall score for 2015-2016 has increased from **84%** to **86%** and was graded as GREEN. A green rating is achieved where Trusts achieve level 2 or above on all requirements (see following table). We continue to provide assurance to the Trust Board that we are constantly assessing and improving our systems and processes to ensure that information is safe.

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

Requirement	2012-2013	2013-2014	2014-2015
Information governance management	Green	Green	Green
	93%	100%	100%
Corporate Information Assurance	Green	Green	Green
	66%	77%	77%
Confidentiality and Data Protection assurance	Green	Green	Green
	79%	87%	91%
Clinical information assurance	Green	Green	Green
	93%	93%	86%
Secondary use assurance	Green	Green	Green
	83%	83%	79%
Information security assurance	Green	Green	Green
	75%	75%	84%
Overall Assessment	Green	Green	Green
	81%	84%	86%

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

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

Clinical coding error rate

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

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

- Primary diagnoses correct (98.00%)
- Secondary diagnoses correct (95.40%)
- Primary procedures correct (93.90%)
- Secondary procedures correct (80.00%)

The services reviewed within the sample were 200 finished consultant episodes (FCEs) in consultant episodes. The secondary procedure had 60 procedure codes to be audited and 12 were incorrect. The results should not be extrapolated further than the actual sample audited.

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

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

Our coders organise their work so that they are closer to the clinical teams. This results in sustained improvements to clinical documentation. This supports accurate clinical coding and a reduction in the number of Healthcare Resource Group changes made.

This is the methodology which establishes how much we should get paid for the care we deliver. We will continue to work hard to improve quality of information because it will ensure that NHS resources are spent effectively.

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

Coders currently code from discharge summaries within medicine which does not always give them the depth of coding required. The Trust is in the process of recruiting additional coders to enable the coding of medical discharges from notes. Specialist coders will work closely with the clinicians on the wards to ensure all relevant information is recorded.

Community dental team Wendy McGee and Lyndsey Neville support National Smile Month.

Part 2d: Core set of Quality Indicators

Measure	Measure Description	Data Source
1a	The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust	Health and Social Care Information Centre Portal (HSCIC)

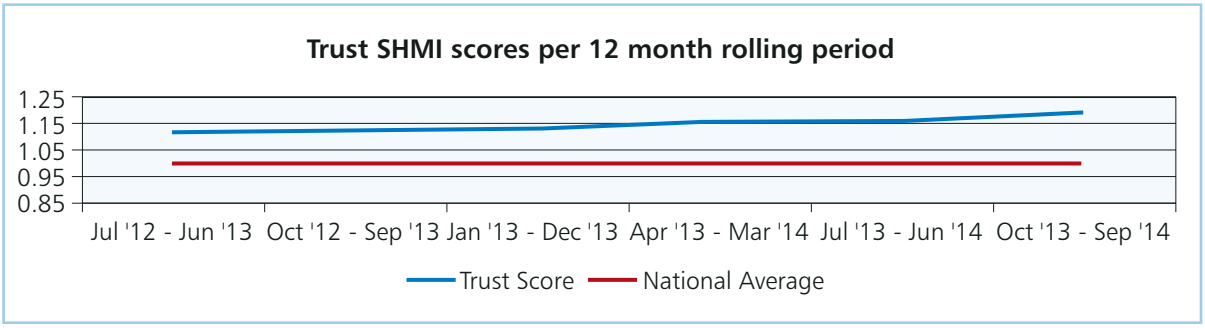
Summary Hospital-level Mortality Indicator (SHMI) – Deaths associated with hospitalisation, England, October 2013 – September 2014

Time period	OD banding	Trust Score	National Average	Highest – SHMI Trust Value in the country	Lowest – SHMI Trust Value in the country
Jul 2012 – Jun 2013	Band 1	1.123	1.00	1.156	0.625
Oct 2012 – Sept 2013	Band 1	1.130	1.00	1.185	0.630
Jan 2013 – Dec 2013	Band 1	1.128	1.00	1.176	0.624
Apr 2013 – Mar 2014	Band 1	1.160	1.00	1.197	0.539
Jul 2013 – Jun 2014	Band 1	1.162	1.00	1.198	0.541
Oct 2013 – Sept 2014	Band 1	1.189	1.00	1.198	0.597

OD banding 1 – higher than expected

OD banding 2 – as expected

OD banding 3 – lower than expected



Trust	OD banding	Trust Score	National Average
North Tees and Hartlepool NHS Foundation Trust	Band 1	1.189	1.00
South Tyneside NHS Foundation Trust	Band 1	1.183	1.00
City Hospitals Sunderland NHS Foundation Trust	Band 2	1.110	1.00
Northumbria Healthcare NHS Foundation Trust	Band 2	1.061	1.00
County Durham and Darlington NHS Foundation Trust	Band 2	1.031	1.00
South Tees Hospitals NHS Foundation Trust	Band 2	1.025	1.00
Gateshead Health NHS Foundation Trust	Band 2	1.005	1.00
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	Band 2	0.956	1.00

North East	1.070
England	1.000
National High	1.198
National Low	0.597

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

The **North Tees and Hartlepool NHS Foundation Trust** has taken the following actions to improve this measure. The Trust has introduced a policy in relation to undertaking reviews of mortality cases across the organisation. This is linked closely with the work being undertaken regionally and has provided the opportunity for peer reviews to give assurance of the quality of the reviews but also the opportunity to benchmark regionally and also to share best practice. The clinical reviews undertaken provide the organisation with the opportunity to assess the quality of care being provided as this will continue to be the priority over and above the statistical data.

The Trust has established a Keogh Delivery Group that is responsible for application of the eight ambitions identified within the Keogh Report. This group is led from Director level and the on-going work is aimed at impacting positively on the mortality levels across the Trust. This work is aimed mainly at promoting good, safe clinical care but also considers the issues relating to the actual data collection that impacts on the statistical calculations.

The Medical Director is continuing to work closely with the partner General Practitioners of the organisation in order to identify where pathways of care can be improved across the whole health economy for patients who are reaching the end of their lives.

Over the last year the Trust has reviewed the process for recording patients who are receiving Specialist Palliative Care or End of Life Care, to ensure that this activity is included in the data collection from clinical coding. Education of clinical staff in relation to the importance of clinical coding from records has formed part of this work; with clinical coding policies being reviewed to ensure consistently accurate data collection.

The Trust continues to take a key role in regional Community Acquired Pneumonia Project which is running in conjunction with two other North East Trusts and will be managed by the North East Quality Observatory (NEQOS) with informatics performed by Clarity. The study will be continuing into 2015-16 and may be expanding into other regional Trusts which will give a more robust picture of the management of Community Acquired Pneumonia.

Podiatrist Sheree Lyons checks a man's foot during a member event.

Measure	Measure Description	Data Source
1b	The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust	Health and Social Care Information Centre Portal (HSCIC)

Percentage of deaths with palliative care coding, October 2013 – September 2014

Time period	Diagnosis Rate	Diagnosis Rate National Avg	Highest - Diagnosis Rate	Lowest - Diagnosis Rate	Combined Rate	Combined Rate National Avg	Highest - Combined Rate	Lowest - Combined Rate
Oct11 – Sep12	21.60	19.00	43.30	0.20	21.60	19.20	43.30	0.20
Jan12 – Dec12	19.30	19.30	42.70	0.10	19.30	19.47	42.70	0.10
Apr12 – Mar13	17.80	20.25	43.90	0.10	17.80	20.38	44.00	0.10
Jul12 – Jun13	16.50	20.50	44.10	0.00	16.50	20.65	44.10	0.00
Oct12 – Sept13	17.90	21.17	44.80	0.00	17.90	21.29	44.90	0.00
Jan13 – Dec13	19.00	22.22	46.90	1.30	19.00	22.35	46.90	1.30
Apr13 – Mar14	18.40	22.81	48.50	0.00	18.40	23.94	48.50	0.00
Jul13 – Jun14	16.80	24.64	49.00	0.00	16.80	24.76	49.00	0.00
Oct13 – Sept14	16.70	25.32	49.40	0.00	16.70	25.44	49.40	0.00

Latest Time Period benchmarking position – October 2013 – September 2014

Trust	Trust Score	National Average
Northumbria Healthcare NHS Foundation Trust	32.80	33.60
City Hospitals Sunderland NHS Foundation Trust	26.30	26.30
South Tyneside NHS Foundation Trust	24.40	24.40
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	24.20	24.20
South Tees Hospitals NHS Foundation Trust	19.40	19.40
County Durham and Darlington NHS Foundation Trust	19.00	19.00
North Tees and Hartlepool NHS Foundation Trust	16.70	16.70
Gateshead Health NHS Foundation Trust	14.40	14.90
National Average	**25.32**	**25.44**

The **North Tees and Hartlepool NHS Foundation Trust** considers that this data is as described for the following reason. The use of palliative care codes in the Trust has remained static over recent years, and processes and procedures required reviewing and adjusting where necessary.

The **North Tees and Hartlepool NHS Foundation Trust** has taken the following actions to improve this number, and so the quality of its service. The review of case notes continues to demonstrate that there are a high number of patients who have been discharged home to die in accordance with their wishes and this has affected the hospital HSMR and SHMI value.

The Trust continues to work with commissioners to review pathways of care and support patient choice of residence at end of life wherever possible, further work is ongoing with GPs to try and reduce inappropriate admissions to the Trust.

Specialist palliative care processes have been reviewed, with amendments made to both practice and procedures. With an improvement in specialist palliative care being documented, this allows for the information to be coded more accurately, thus in turn help reduce the HSMR value.

Measure	Measure Description	Data Source	Value
2	The Trust's patient reported outcome measure scores (PROMS) for- 1. Groin hernia surgery 2. Varicose vein surgery 3. Hip replacement surgery 4. Knee replacement surgery	Health and Social Care Information Centre Portal (HSCIC)	Adjusted average health gain EQ-5D Index

The data for hips and knee replacements is now split between primary and revisions.

April 12 to March 13	Groin hernia	Varicose vein	Hip replacement - Primary	Hip replacement - Revisions	Knee replacement - Primary	Knee replacement - Revisions
Trust Score	0.038	**No data**	0.407	0.258	0.292	**No data**
National Average	0.085	0.093	0.438	0.270	0.318	0.251
Highest National	0.153	0.176	0.539	0.355	0.416	0.368
Lowest National	0.014	0.015	0.319	0.168	0.209	0.195

April 13 to March 14	Groin hernia	Varicose vein	Hip replacement - Primary	Hip replacement - Revisions	Knee replacement - Primary	Knee replacement - Revisions
Trust Score	0.059	0.046	0.433	0.273	0.361	**No data**
National Average	0.085	0.093	0.436	0.255	0.323	0.245
Highest National	0.139	0.150	0.342	0.365	0.416	0.290
Lowest National	0.008	0.023	0.545	0.154	0.215	0.100

April 14 to March 15	Groin hernia	Varicose vein	Hip replacement - Primary	Hip replacement - Revisions	Knee replacement - Primary	Knee replacement - Revisions
Trust Score	0.037	0.124	0.440	**No data**	0.333	**No data**
National Average	0.084	0.102	0.449	0.289	0.319	0.253
Highest National	0.155	0.158	0.548	0.219	0.414	**No data**
Lowest National	0.009	0.009	0.335	0.219	0.226	**No data**

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

The **North Tees and Hartlepool NHS Foundation Trust** has taken the following actions to improve this score. The Trust has agreed internally that we will carry out 3 reviews in the 1st year and we are in the process of putting that in place.

The reviews will occur at 6 weeks, then 6 months with the final review being at 12 months. The reviews will be carried out by the joint replacement practitioners unless otherwise identified. This is in line with other healthcare providers within our area.

The Trust has also reinstated the telephone review clinics, thus ensuring that communication remains open with the patient listening and acting upon any issues/concerns that they may have.

Measure	Measure Description	Data Source
3	The percentage of patients readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period; aged: (i) 0 to 15; and (ii) 16 or over.	Health and Social Care Information Centre Portal (HSCIC)

Age Group	Value	Data for 2012-13 standardised to persons 20xx-xx	Data for 2011-12 standardised to persons 2007-08	Data for 2010-11 standardised to persons 2006-07	Data for 2009-10 standardised to persons 2006-07	Data for 2008-09 standardised to persons 2006-07
0 to 15	Trust Score	Not Available	11.45	11.45	12.23	11.87
	National Average	Not Available	10.15	10.15	10.18	10.09
	Band	Not Available	A1	A1	A1	A1
	Highest National	Not Available	25.80	25.80	22.53	22.73
	Lowest National	Not Available	0.00	0.00	0.00	0.00
16 or over	Trust Score	Not Available	11.48	11.48	11.23	11.32
	National Average	Not Available	11.42	11.42	11.16	10.90
	Band	Not Available	W	W	W	A5
	Highest National	Not Available	23.99	23.99	16.82	24.43
	Lowest National	Not Available	0.00	0.00	0.00	0.00

5 Band Comparison against national average

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

B1 = Significantly better than the national average at the 99.8% level;

B5 = Significantly better than the national average at the 95% level but not at the 99.8% level;

W = National average lies within expected variation (95% confidence interval);

A5 = Significantly poorer than the national average at the 95% level but not at the 99.8% level;

A1 = Significantly poorer than the national average at the 99.8% level.

To Note: the publication of the 2012-2013 data has been delayed, therefore is not available at the time of print

The **North Tees and Hartlepool Foundation Trust** considers that this data is as described for the following reasons.

The Trust monitors and reports readmission rates to the Board and directorates on a monthly basis. Current performance (April 2014 to January 2015 internal position) indicates the Trust has an overall readmission rate of 7.99% against the internal stretch target of 8.30%. Directorates have access to the relevant patient level data, to enable regular audits of readmissions to be carried out, with the aim to identify areas for improvement. An annual audit of readmissions is carried out in conjunction with commissioners and clinical stakeholders to identify the level of avoidable and un-avoidable readmissions to feed into the annual contract agreements.

Survey lead Charlotte Pett and Associate Director of Nursing, Patient Safety and Quality Barbara Carr speak to a patient about the Trust's friends and family test which is used to gather feedback from patients and visitors.

The **North Tees and Hartlepool Foundation Trust** has taken the following actions to improve performance in preventing avoidable readmissions within 30 days of discharge. This still presents a considerable challenge for the Trust and is being addressed by several means including the reinvestment of readmission penalty money and other non-recurrent funding sources. With the required focused clinical leadership and strategic approach there has been an improvement to the elective and emergency readmission position.

Cardiology research nurse Julie Gray and research midwife Anne-Marie Jones.

Patient pathways continue to be redesigned to incorporate an integrated approach in collaboration with primary and social care services, providing care closer to home and reducing hospital admissions and readmissions. There have been a number of initiatives introduced within 2014-15 including: increased investment into the discharge liaison team of therapy staff to actively support timely discharge; the undertaking of an audit in collaboration with primary and social care colleagues to identify themes to direct efforts in improvements in pathways; increasing the profile of integrated care pathways for long term conditions by direction and delivery through an executive director led programme.

Directorates continue to undertake regular audits to identify pathways to redesign. Other initiatives are being developed, tested and implemented; resulting in a better patient experience whilst maintaining a safe, quality and efficient service.

Measure	Measure Description	Data Source
4	The Trusts responsiveness to the personal needs of its patients	Health and Social Care Information Centre Portal (HSCIC)

Period of Coverage	National Average	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST (out of 100)
*2014-15	Not Available	Not Available
2013-14	76.90	77.90
2012-13	76.50	76.10
2011-12	75.60	76.20

**2014-2015 data not available at the time of print*

Benchmarked against over North East Trusts for 2014-2015;

Trust	Overall score (out of 100)
Northumbria Healthcare NHS Foundation Trust	Not Available
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	Not Available
Gateshead Health NHS Foundation Trust	Not Available
County Durham and Darlington NHS Foundation Trust	Not Available
South Tyneside NHS Foundation Trust	Not Available
South Tees Hospitals NHS Trust	Not Available
North Tees and Hartlepool NHS Foundation Trust	Not Available
City Hospitals Sunderland NHS Foundation Trust	Not Available

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

The scores are out of 100. A higher score indicates better performance: if patients reported all aspects of their care as "very good" we would expect a score of about 80, a score around 60 indicates "good" patient experience. The domain score is the average of the question scores within that domain; the overall score is the average of the domain scores.

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

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

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

"The staff were very helpful even when I got distressed. Explained everything to me and made me feel at ease." [sic]

"If I had not been in pain, I would have thought I have been in a 4* hotel. The care and help was exceptional and if I did have to have another operation, I would choose your hospital without question. Thank you." [sic]

Measure	Measure Description	Data Source
5	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.	Health and Social Care Information Centre Portal (HSCIC)

All NHS organisations providing acute, community, ambulance and mental health services are *now required to conduct the Staff Friends and Family Test each quarter.*

The aim of the test is to:

- Encouraging improvements in service delivery - by "driving hospitals to raise their game"

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

National NHS Staff Survey

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

	Survey Year					
Trust Name	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Trust 1	52	**57**	59	63	59	**65**
Trust 2	63	56	49	50	57	54
Trust 3	76	70	73	69	70	75
North Tees and Hartlepool	67	66	63	61	57	54
Trust 4	67	71	70	69	77	81
Trust 5	68	75	69	74	76	70
Trust 6	65	60	63	68	64	63
Trust 7	78	82	79	86	87	85
North East	67	68	66	67	68	65
England	65	63	62	65	67	67
National High	-	-	-	**86**	**89**	**89**
National Low	-	-	-	**35**	**40**	**38**

Friends and Family Test - Staff

Care: 'How likely staff are to recommend the NHS services they work in to friends and family who need similar treatment or care'.

	Q1*	Q2*	Q3**	Q4*
Percentage Recommended - Care	70%	71%	54%	74%
Percentage Not Recommended - Care	8%	12%	16%	13%

*Q1, Q2 and Q4 data obtained from the Friends and Family Test for Staff

**Q3 information taken from the NHS National Staff Survey

Work: 'How likely staff would be to recommend the NHS service they work in to friends and family as a place to work'.

	Q1*	Q2*	Q3**	Q4*
Percentage Recommended - Work	63%	61%	50%	60%
Percentage Not Recommended - Work	19%	22%	19%	19%

*Q1, Q2 and Q4 data obtained from the Friends and Family Test for Staff

**Q3 information taken from the NHS National Staff Survey

More detail can be found for the Friends and Family Test in Part 3: Review of Quality Performance 2014-2015, under Priority 3: Patient Experience – Friends and Family recommendation, point 3.

The **North Tees and Hartlepool NHS Foundation Trust** considers that this data is as described for the following reasons. Trust Staff have been actively engaged and encouraged to complete and returning the 2014 Staff Survey along with the quarterly Staff Friends and Family Test, so that areas of improvement(s) can be identified and acted upon in future.

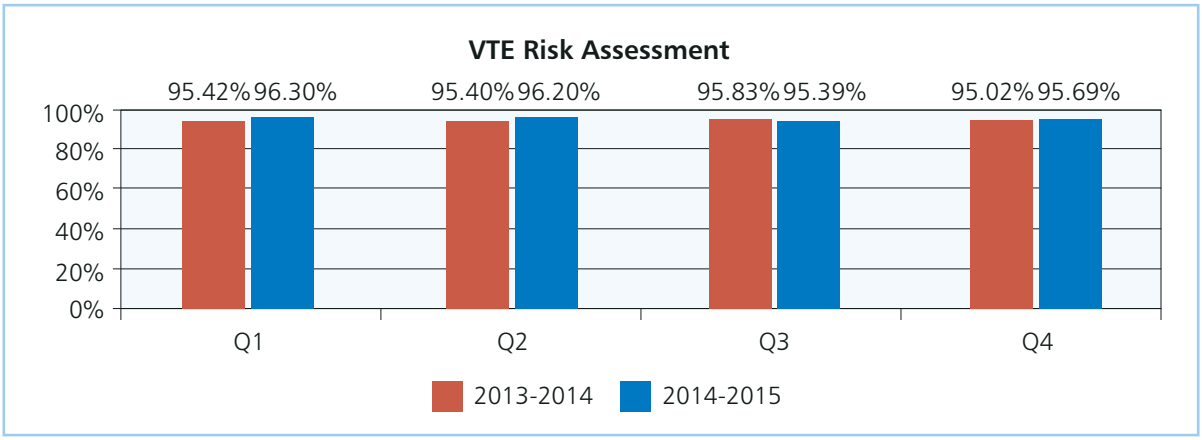
The **North Tees and Hartlepool Foundation Trust** has taken the following actions to further improve this percentage, and so the quality of its services, by involving the views of the staff in developing a strategy for care.

Understanding the views of staff is an important indicator of the culture of care within the organisation, and as such all departments are monitored in relation to the Staff Friends and Family test, ensuring that all anonymous negative comments made on the returns are reviewed and plans put in place to improve the level of care provided by the Trust.

Measure	Measure Description	Data Source
6	Friends and Family Test – Patient All Acute providers of adult NHS funded care, covering services for inpatients and patients discharged from Accident and Emergency.	Health and Social Care Information Centre Portal (HSCIC)

Please refer to Part 2a, Priority 3 – Patient Experience point 5 – Friends and Family Recommendations

Measure	Measure Description	Data Source
7	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE)	Health and Social Care Information Centre Portal (HSCIC)



Two year reporting trend

Measure	Reporting Year	2013-2014				2014-2015			
Venous Thrombo-embolism	Quarter	Q1	Q2	Q3	Q4	Q1	Q2	Q3	*Q4
	Value	95.42%	95.40%	95.83%	95.02%	96.30%	96.20%	95.39%	95.69%
	National Average	95.45%	95.74%	95.84%	96.13%	96.00%	96.00%	95.95%	95.90%
	Highest National	100%	100%	100%	100%	100%	100%	100%	100%
	Lowest National	78.78%	81.70%	77.70%	75.00%	87.20%	86.40%	81.19%	75.65%

**Q4 data only includes February 2015*

North East Trust benchmarking 2014-2015

Trust	Q1	Q2	Q3	Q4*
North Tees and Hartlepool NHS Foundation Trust	96.30%	96.20%	95.39%	95.69%
City Hospitals Sunderland NHS Foundation Trust	97.30%	97.60%	97.61%	97.46%
South Tees Hospitals NHS Trust	95.70%	95.90%	95.16%	95.75%
South Tyneside NHS Foundation Trust	97.60%	96.80%	95.91%	96.88%
County Durham and Darlington NHS Foundation Trust	96.00%	95.60%	96.22%	96.14%
Gateshead Health NHS Foundation Trust	95.30%	95.30%	95.09%	95.33%
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	96.40%	95.80%	95.46%	95.55%
Northumbria Healthcare NHS Foundation Trust	93.50%	95.00%	94.75%	94.33%

**Q4 data only includes February 2015*

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

The **North Tees and Hartlepool Foundation Trust** considers that this data is as described for the following reasons. Understanding percentage of patients who were admitted to hospital who were risk assessed for VTE helps the Trust to understand and reduce cases of avoidable harm. The Trust also has a robust reporting system in place and adopts a systematic approach to data quality improvement.

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

Each directorate clinical leads are responsible for monitoring and audit of compliance of NICE VTE guidelines and this will be presented yearly to the Audit and Clinical Effectiveness (ACE) committee.

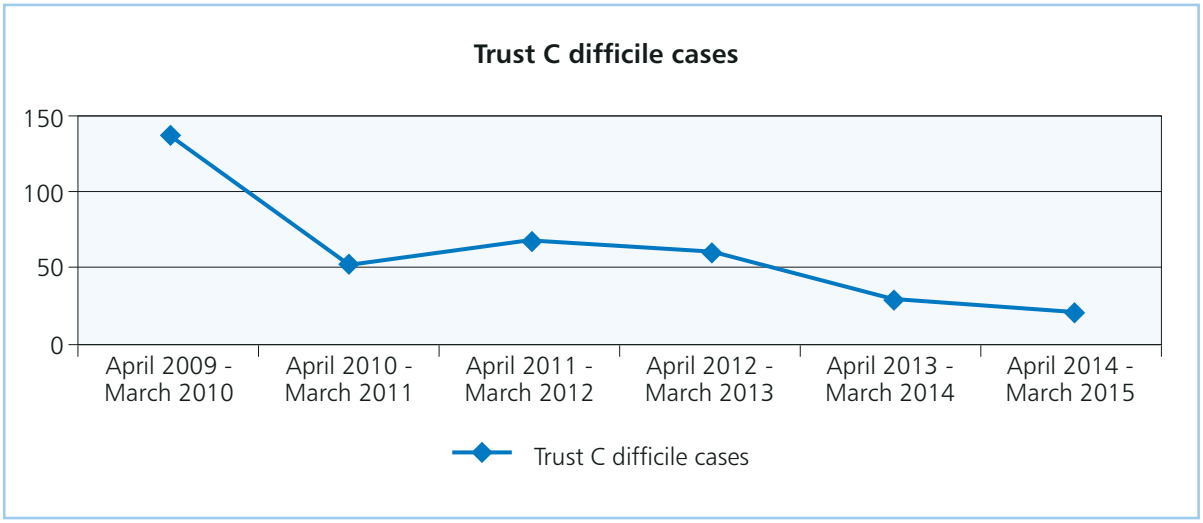
The following table demonstrates the venous thromboembolism (VTE) mandatory training for the whole Trust as recorded at the end of March 2015.

Requiring Training	Trained	% Compliance
1,292	1,233	95.43%

Measure	Measure Description	Data Source
8	The rate per 100,000 bed days of cases of C.difficile infection that have occurred within the Trust amongst patients aged 2 or over during the reporting period.	Health and Social Care Information Centre Portal (HSCIC)

	Rate per 100,000 bed-days for specimens taken from patients aged 2 years and over				
Reporting Period	Trust C difficile cases	Trust Rate	National Average	Highest National rate	Lowest National rate
April 2014 – March 2015	20	Not Available	Not Available	Not Available	Not Available
April 2013 – March 2014	30	15.70	13.60	37.10	0.00
April 2012 – March 2013	61	30.80	17.40	31.20	0.00
April 2011 – March 2012	68	35.80	22.20	58.20	0.00
April 2010 – March 2011	53	27.10	29.70	71.20	0.00
April 2009 – March 2010	136	63.90	35.30	128.90	0.00

** 2014-2015 data not available at the time of print*



The **North Tees and Hartlepool Foundation Trust** considers that this data is as described for the following reasons. The Trust has robust reporting system in place and adopts a systematic approach to data quality checks and improvement.

The **North Tees and Hartlepool Foundation Trust** has taken the following actions to improve this, and so the quality of its services; high standards of ward cleaning and decontamination of patient equipment with the introduction of a mattress decontamination service to enhance the existing domestic and decontamination services, raised awareness and audit of antimicrobial prescribing and stewardship including the identification of antibiotic champions for each directorate, emphasis on high standards of hand hygiene for staff and patients and daily monitoring of affected patients to ensure good clinical management and the reduction in risk of cross infection. The Trust intends to continue with these measures and will explore every opportunity for further improvement in 2015-2016.

Measure	Measure Description	Data Source
9	The number and, where available, rate of patient safety incidents that occurred within the Trust during the reporting period, and the percentage of such patient safety incidents that resulted in severe harm or death.	Health and Social Care Information Centre Portal (HSCIC)

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

Medium Acute organisations – Organisational incident data by organisation in 6-month period, **1 April 2014 – 30 September 2014**

	Based on occurring dataset		National			Our Trust		National			Our Trust	
			Degree of harm - Severe			Degree of harm - Severe		Degree of harm - Death			Degree of harm - Death	
Report period	No of incidents occurring	Rate per 100 admissions	Avg %	Highest %	Lowest %	No of incidents	%	Avg %	Highest %	Lowest %	No of incidents	%
Apr14 – Sep14	3,068	3.23	0.40	74.30	0.00	5	0.20	0.10	8.60	0.00	3	0.10
Oct13 – Mar14	2,986	7.13	0.50	1.80	0.00	12	0.40	0.20	1.00	0.00	6	0.20
Apr13 – Sep13	2,903	6.93	0.50	2.00	0.00	6	0.20	0.20	1.11	0.00	5	0.20
Oct12 – Mar13	2,576	6.18	0.50	1.70	0.00	25	0.97	0.20	3.00	0.00	3	0.12
Apr12 – Sep12	2,615	6.27	0.60	3.10	0.00	17	0.70	0.20	1.30	0.00	1	0.00
Oct11 – Mar12	2,309	5.23	0.60	3.00	0.00	30	1.30	0.20	0.60	0.00	3	0.10
Apr11 – Sep11	2,272	5.15	5.50	24.80	0.50	16	0.70	0.50	0.90	0.00	2	0.10
Oct10 – Mar11	2,011	4.66	0.60	2.80	0.00	8	0.40	0.20	1.00	0.00	2	0.10

The **North Tees and Hartlepool Foundation Trust** considers that this data is as described for the following reasons. The safety culture of the Trust can be assessed by considering the understanding of staff, within the organisation, in relation to reporting of all incidents but in particular those where the outcome in relation to the level of harm caused by an incident was serious or death. Over or under reporting of incidents at this level of harm can suggest a lack of knowledge within the reporting culture in relation to the root cause of an incident.

The **North Tees and Hartlepool Foundation Trust** has taken the following actions to improve the proportion of this rate and so the quality of its services.

The Trust ensures that all reported incidents are reviewed both internally within the local departments for accuracy of harm assessment; but also externally from the reporting team, to provide assurance that the appropriate level of harm has been allocated in higher level harm incidents.

Where discrepancies are noted the reporting team are asked to provide further details in order to allow for a decision to be made regarding the level of investigation. Where there are uncertainties around the level of harm the Medical Director and/or the Director of Nursing, Patient Safety and Quality are asked to arbitrate and agree upon the level of investigation.

Weekly meetings, held to review all serious incidents within the Trust, provide a forum for any cases to be discussed within a multidisciplinary team and agree a way forward. The incidents are then managed within the national framework for serious incidents and the current requirements for the Clinical Commissioning Groups (CCGs).

The weekly panel not only considers newly reported incidents where there has been serious harm or death reported as an outcome; the panel also considers the final Executive Review reports developed from the internal investigations into these incidents. Once an investigation into any serious incident, which has been reported to the CCG, has been agreed as complete by this panel; and there are assurances that actions have been initiated to reduce the risks of recurrence; the summary report are forwarded to the CCG for external review and approval prior to closure.

The Trust also uses a similar process for incidents where any actual harm is identified as being at a lower level, but when the incident is reviewed the Trust feels that lessons can be learned from further analysis outside of the reporting team. It is felt that this proactive approach to safety and quality allows the Trust to internally consider areas of service provision before they escalate in more serious concerns.

In November 2014 the Department of Health published the updated Health and Social Care Act 2008 (Regulated Activities) Regulations (2014), this brought the statutory Duty of Candour in to practice. These new regulations have updated the approach previously known as 'Being Open' and requires the Trust to review all incidents graded as moderate harm or higher in relation to the new regulations. The application of the regulations is undertaken within the appropriate clinical directorate, however, the Trust review all such incidents at the weekly meeting to provide further assurance in relation to application.

District nurses outside Billingham Health Centre.

Part 3a: Additional Quality Performance measures during 2014-2015

This section is an overview of the quality of care based on performance in 2014-2015 against indicators

In addition to the three local priorities outlined in Section 2, the indicators below further demonstrate that the quality of the services provided by the Trust over 2014-2015 has been positive overall.

The following data is a representation of the data presented to the Trust Board on a monthly basis in consultation with relevant stakeholders for the year 2014-15. The indicators were selected because of the adverse implications for patient safety and quality of care should there be any reduction in compliance with the individual elements.

Removed indicators from 2013-2014:

Patient Safety: Reducing mortality and SHMI elements have been moved to Section 2, as this was deemed by the Board and Stakeholders a more prominent position and to ensure that all mortality data is together to give a full picture.

Medication Errors has been moved to Discharge Process Medication as this data helps to finalise that section giving a rounded conclusion.

The Safety Thermometer data has been replaced with the Trusts own Falls data, giving a full detailed analysis and detail of all the falls that have occurred within the Trust.

Effectiveness of care: People with learning disabilities has been incorporated into the Adult Safeguarding section.

Early Warning System (EWS) has been removed, this was due to a change in the service which resulted in very low numbers being returned and therefore the data could not be used.

Patient Safety

E coli

Why / How we chose this measure.

Following consultation with key stakeholders it was evident that all infections should be reported and not just C difficile, the Trust continues to monitor and improve on.

The numbers of E coli bacteraemia (blood stream infection) reported across community and hospital during the year are shown in the table below. When compared against the previous year(s) it is clear that there needs to be a healthcare economy approach to reducing infection although improvements have been made in the last 2 years.

Root cause analysis is completed for all cases deemed to have been Trust attributable and action plans are developed where actions are identified. In many cases these infections are related to urine infections and are thought to be not preventable.

	Trust attributed	Non-Trust attributed
2011-2012	41	149
2012-2013	31	194
2013-2014	22	169
2014-2015	27	176

**Data obtained from Healthcare Associated Infections (HCAI) data capture system – data as of 31 Mar 2015*

HCAI – Ecoli rate per 100,000 Bed Days

	Ecoli rate per 100,000 Bed Days
Trust 5	138.68
Trust 1	110.99
Trust 6	106.12
NTHFT	99.23
Trust 2	94.46
Trust 3	90.08
Trust 8	76.60
Trust 7	76.26

**Data obtained from the Healthcare Evaluation Data (HED) – data as April 14 to Jan 15*

Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia

The importance of hand hygiene is fully understood by all staff and is visible through the use of the **bare below the elbow** policy, as well as the presence of alcohol gel dispensers, hand-washing facilities and awareness posters throughout the Trust. Environmental cleanliness is equally important and improvements to our environment and the practices used are constantly being implemented and evaluated. These include making sure that cleaning products are effective and appropriate as well as reviewing the equipment we buy to make sure it is easy to clean and maintain. We have invested in a bespoke on site mattress decontamination facility this year which will not only improve assurance around cleaning of this equipment but also make it more readily available for our patients.

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

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

We routinely have around 150 colonised patients in our hospitals each month. The majority of these patients are known to have had MRSA colonisation prior to admission to hospital, sometimes for several years. It is important that we know when these patients are admitted so that the correct precautions are taken to reduce the risk of any spread of bacteria. To assist with this a daily report on known patients is provided to the infection prevention and control team, who then follow each up reported incident with the wards to ensure all required measures have been considered.

How did we do?

In 2014-15, our organisation performed well against regional and national standards in relation to almost all aspects of infection prevention and control and this reflects the hard work of all staff, both clinical and non-clinical, in ensuring that high standards are maintained all of the time. We reported **1 (one)** hospital MRSA bacteraemia during 2014-15, having had over 730 days without a case prior to December 2014.

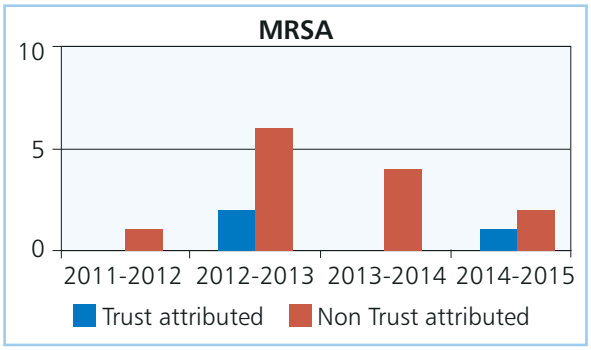
HCAI – MRSA bacteraemia rate per 100,000 Bed Days

	MRSA bacteraemia rate per 100,000 Bed Days
Trust 2	1.42
Trust 1	1.41
Trust 6	1.23
Trust 7	1.03
Trust 8	0.90
Trust 5	0.73
Trust 3	0.70
NTHFT	0.60

**Data obtained from the Healthcare Evaluation Data (HED) – data as April 14 to Jan 15*

	Trust attributed	Non-Trust attributed
2011-2012	41	149
2012-2013	31	194
2013-2014	22	169
2014-2015	27	176

**Data obtained from Healthcare Associated Infections (HCAI) data capture system – data as of 31 Mar 2015*



**Data obtained from Healthcare Associated Infections (HCAI) data capture system*

Methicillin-sensitive Staphylococcus aureus (MSSA)

How did we do?

In 2014-15 we reported **18** cases of Trust attributed MSSA bacteraemia which was an increase on the previous year total of 13. Each case is subject to a root cause analysis and the analysis of these investigations has shown that there are no apparent trends in terms of linked cases or frequently seen sources of infection. In many cases the source has been a chest or skin infection which would have been difficult to prevent.

However, the Trust recognises that improvement is needed in this infection and increased emphasis on clinical practices such as the insertion and care of intravenous lines will be a focus of activity in 2015-16 in an attempt to reduce the number of MSSA bacteraemia. An increase in non-Trust attributed cases was also seen this year.

HCAI – MSSA bacteraemia rate per 100,000 Bed Days

	MRSA bacteraemia rate per 100,000 Bed Days
Trust 8	12.99
NTHFT	10.22
Trust 6	7.07
Trust 1	5.64
Trust 2	5.31
Trust 5	4.73
Trust 3	4.22
Trust 7	3.09

**Data obtained from the Healthcare Evaluation Data (HED) – data as April 14 to Jan 15*

	Trust attributed	Non-Trust attributed
2011-2012	41	149
2012-2013	31	194
2013-2014	22	169
2014-2015	27	176

**Data obtained from Healthcare Associated Infections (HCAI) data capture system – data as of 31 Mar 2015*

You Said

"Gentleman's washroom, insufficient space to put razor and wash bag while washing, shelf needed"

We did

Matron requested shelving and coat hooks to be situated in the wash rooms for patients use. Estates have agreed and this is now complete in both male and female wash areas with the toilets.

Falls

Why / How we chose this measure.

Following consultation with key stakeholders it was evident that falls continue to be one of the Trusts key harm measures to monitor and improve on.

Patients aged 65 years and over are at highest risk of falling and patients aged 85 and over are at highest risk of injury from a fall.

Falls with Fracture

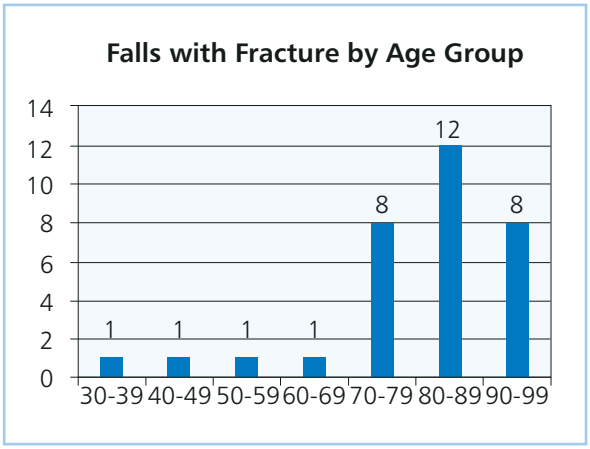
During 2014-2015 the Trust has experienced **33** falls resulting in fracture, this has increased from **21** in the 2013-2014 reporting period.

The following table demonstrates the year on year increase from 2013 to 2015.

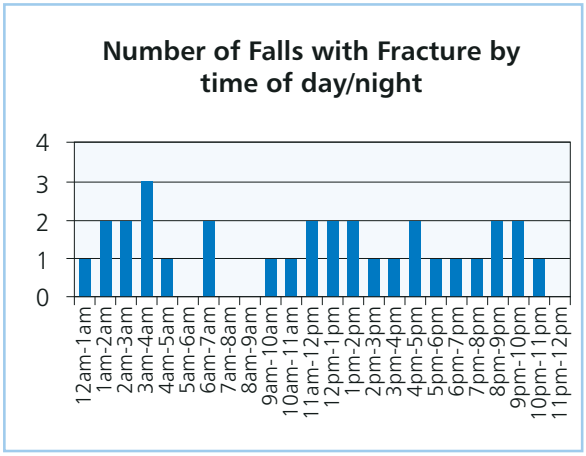
	2013-2014	2014-2015
Apr	1	1
May	2	4
Jun	1	2
Jul	1	7
Aug	4	1
Sep	4	4
Oct	4	3
Nov	1	5
Dec	1	0
Jan	0	3
Feb	1	2
Mar	1	1
Total	**21**	**33**

**Data obtained via the Trusts Incident Reporting database (Datix).*

The following chart details the 2014-2015 falls by age group



The following chart details the 2014-2015 falls by age group



The Trust works on the basis that Out of Hours working is 8pm to 8am and In Hours working is 8am to 8pm.

The following table demonstrates the number of 'Falls with Fracture' suffered both In and Out of Hours:

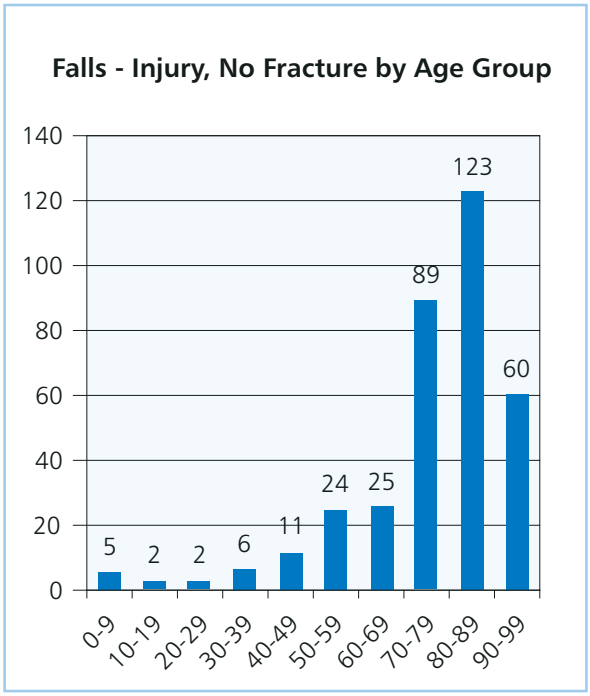
	Number of Falls with Fracture
Out of Hours (8pm to 8am)	16
In Hours (8am to 8pm)	15

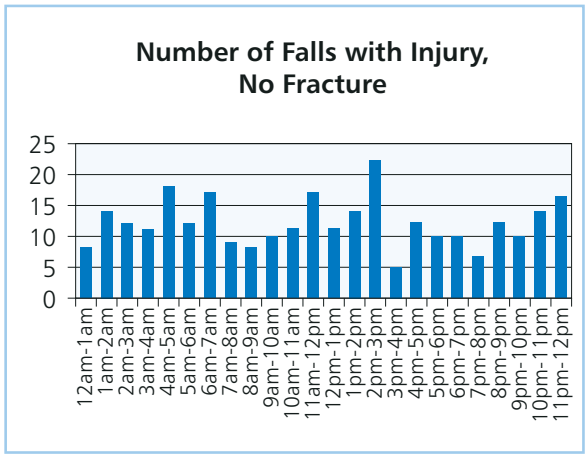
Falls Injury, No Fracture

During 2014-2015 the Trust has experienced **355** falls resulting in an injury but no fracture, this has increased from 330 in the 2013-2014 reporting period.

	2013-2014	2014-2015
Apr	28	25
May	21	27
Jun	27	19
Jul	35	29
Aug	22	33
Sep	37	29
Oct	23	27
Nov	26	31
Dec	31	33
Jan	30	37
Feb	24	40
Mar	26	25
Total	**330**	**355**

**Data obtained via the Trusts Incident Reporting database (Datix).*





The following table demonstrates the number of 'Falls with Injury, No Fracture' suffered both In and Out of Hours:

	Number of Falls with Injury, No Fracture
Out of Hours (8pm to 8am)	153
In Hours (8am to 8pm)	137

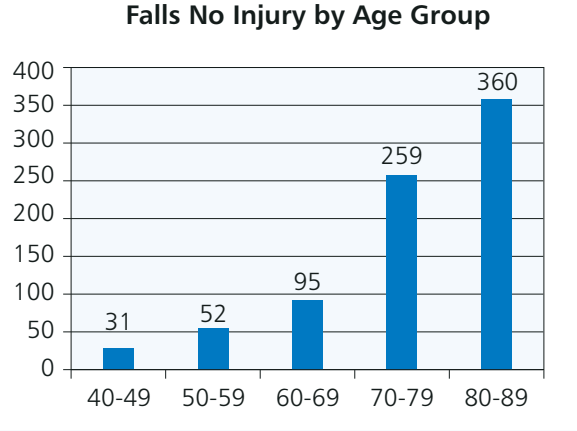
**The discrepancy of 65 is due to those records not having a timeframe attributed.*

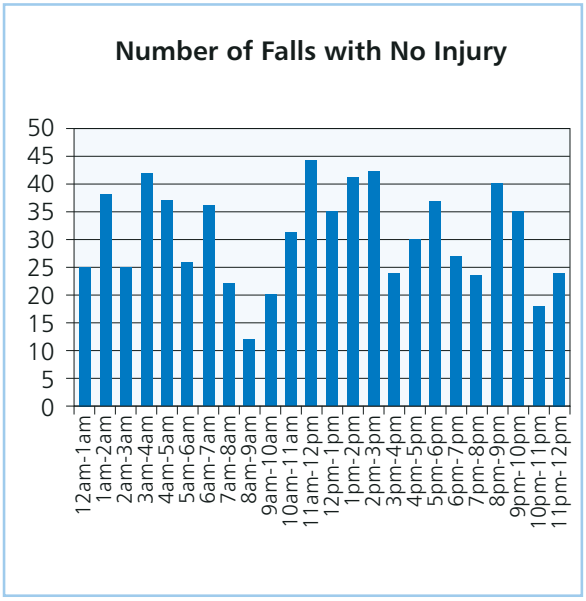
Falls with No Injury

During 2014-2015 the Trust has experienced **1,094** falls resulting in no injury, this has increased from 1,043 in the 2013-2014 reporting period.

	2013-2014	2014-2015
Apr	100	120
May	110	87
Jun	67	66
Jul	98	84
Aug	71	108
Sep	80	93
Oct	84	97
Nov	96	84
Dec	88	88
Jan	101	85
Feb	78	100
Mar	70	82
Total	**1,043**	**1,094**

**Data obtained via the Trusts Incident Reporting database (Datix).*





The following table demonstrates the number of 'Falls with No Injury' suffered both In and Out of Hours:

	Number of Falls with No Injury
Out of Hours (8pm to 8am)	418
In Hours (8am to 8pm)	444

**The discrepancy of 232 is due to those records not having a Time Frame attributed.*

Actions taken by the Trust

To ensure that the risk of suffering a fall within the Trust resulting in injury has drawn together a Falls Management action plan.

Key elements with the plan are as follows:

- Review the template for the development of Root Cause Analysis (RCA) to ensure directorates cover all areas of possible causes of the fall
  - At present Directorate RCA's do not address all areas to be considered when completing local RCAs for a fall incident.
- Falls policy to be reviewed
  - To make clear the assessment tool is to support management decisions and ensure a person - centred care approach from staff is delivered
- Further develop the DATIX reporting of falls categories to allow more comprehensive analysis of the falls incidents that do not result in Fracture
  - Not all reported incidents are comprehensive to allow trend identified
- Identification of the Impact on patient medications of the risk of falls
  - Recognising the impact of medications increasing the risk of falls
- Environmental impact
  - Recognising how the environment has an impact on the risk of falls
- Falls Training
  - Ability to release staff from wards for training
  - Sensor Training to be reviewed

All of the above actions will be monitored though the Trusts Falls Group.

Never Events

Why / How we chose this as a priority.

The Trust continues to work hard to improve patient safety therefore stakeholders and the Board wanted to reflect the low numbers of Never Events in the organisation.

Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event.

Since 2008 the Trust has had 7 Never Events and they are broken down as follows:

Reporting Year	Number of Never Events
2008-09	1
2009-10	0
2010-11	2
2011-12	1
2012-13	1
2013-14	1
2014-15	1
Totals:	**7**

The one Never Event in this reporting period of 2014-2015, was reported in March 2015. The Never Event was a wrong side procedure – insertion of a chest drain

The NHS England report can be accessed via:

http://www.england.nhs.uk/ourwork/patientsafety/never-events/ne-data/

Effectiveness of Care

Staff & Patient Experience and Quality Standards (SPEQS)

Patient experience is what drives the Trust in ensuring that the standard of care being provided is of a high standard.

The following data for Staff & Patient Experience and Quality Standards (SPEQS) is an internal reporting tool used when visits have taken place.

The SPEQS led by the *Director of Nursing, Patient Safety and Quality* or by the *Associate Director of Nursing, Quality and Patient Experience* are undertaken by Senior Clinical Matrons, members of the Board, Assistant Directors and our governors.

SPEQS is an additional avenue to provide valuable feedback on patient's standard of care.

In May 2014, the Trust developed the SPEQS database further, to include Staff Involvement questions and to also incorporate integrated services.

The Database records all reviews allowing for detailed analysis, the trends are available for each area and ward allowing them to monitor and share good practice as well as providing support where needed.

To reward good practice, each area that achieves 100% across all areas are rewarded with a certificate to display on the ward.

Over the reporting year, during our scheduled SPEQS reviews, our senior nurses, governors and directors have visited **289** wards/areas which are achieving an average SPEQS score of **96.35%**.

The following table provides data relating to the 2014-2015 visits:

	SPEQS Visit Month	First Impressions % 2014-2015		Nursing Evidence % 2014-2015		Patient Experience % 2014-2015		Staff Involvement % 2014-2015	
Q1	June	99.05		83.33		98.52		90.69	
Q2	July	96.00	↓ (R)	85.78	↑ (G)	95.56	↓ (R)	95.33	↑ (G)
	August	94.87	↓ (R)	87.61	↑ (G)	98.29	↑ (G)	95.51	↑ (G)
	September	98.04	↑ (G)	90.85	↑ (G)	97.60	↓ (R)	94.61	↓ (R)
Q3	October	98.64	↑ (G)	95.69	↑ (G)	99.02	↑ (G)	96.26	↑ (G)
	November	97.22	↓ (R)	91.67	↓ (R)	99.79	↑ (G)	93.98	↓ (R)
	December	No Visit due to Pressures							
Q4	January	97.56	↑ (G)	91.87	↑ (G)	98.83	↓ (R)	97.15	↑ (G)
	February	No Visit due to Pressures							
	March	96.83	↓ (R)	92.59	↑ (G)	98.59	↓ (R)	95.24	↓ (R)

**Data obtained from the Trusts internal PEQS visits database*

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

The following table is a combined Hospital and Integrated Services results, the table provides an opportunity to see year-on-year scores for the reported four areas; to note, the 2014-2015 year now consists of the new Staff Involvement element.

	2011-2012	2012-2013	2013-2014	2014-2015
First Impressions	91%	85%	92%	97%
Nursing Evidence	90%	87%	90%	91%
Patient Experience	98%	96%	97%	98%
Staff Involvement	N/A	N/A	N/A	95%

The following two tables provide a breakdown between Hospital and Integrated Services scores for 2014-2015.

Hospital	2014-2015
First Impressions	97%
Nursing Evidence	90%
Patient Experience	98%
Staff Involvement	94%

Hospital	2014-2015
First Impressions	100%
Nursing Evidence	96%
Patient Experience	100%
Staff Involvement	100%

**Data obtained from the Trusts internal SPEQS visits database*

In total, the Trust has inspected **761** toilets of which **754 (99.08%)** were clean, also **453** commodes of which **442 (97.57%)** were clean and taped.

Assistant Director of Nursing and Professional Standards Debbie Blackwood chats to members and governors at a member event.

Clinical Effectiveness Indicators

Why / How we chose this as a priority.

The Trust has decided to include more detail around a couple of Clinical Effectiveness indicators, this will be built on year and year, including more detailed data around the Monitor Compliance Framework.

For this report the Trust has chosen, High Risk TIAs and Stroke indicators.

The following table demonstrates the quarter on quarter performance with a benchmark position against 2013-2014 data and against the 2014-2015 performance target.

	2013-14 Performance	2014-15 Target	Q1	Q2	Q3	Q4	2014-15 Performance
Stroke - 80% of people with stroke to spend at least 90% of their time on a stroke unit	86.70%	80%	93%	98%	94%	83%	91.91%
Percentage high risk TIA cases treated within 24 hours	89.60%	60%	100%	91%	100%	75%	88.24%

Patient Experience

Formal complaints and compliments

Why / How we chose this as a priority.

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

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

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

Complaints

Complaints process

The Trust continues to use three complaints streams:

Stage 1 – concern; to be dealt with by the Patient Experience Team (PET) or at the time of complaint at ward level

Stage 2 – Informal; for a meeting to be arranged with the complainant to discuss the complaint with the Senior Clinical Matron, consultant and relevant personnel involved in the complaint with hopefully a resolution at this stage

Stage 3 – Formal; if Stage 1 or stage 2 did not resolve the issue or the complainant did not want to go through those routes, a formal stage 3 is then raised

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

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

Stage	Number of Complaints
Stage 1	699
Stage 2	75
Stage 3 (Formal)	324

There are additional sections within the dashboard that show monthly trends on the complaints for Directorates, method of complaint, method of receipt, average time taken to close complaint types and the complaints subject.

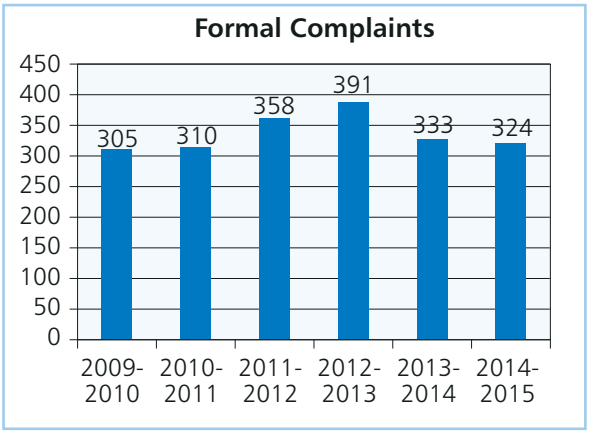
Since the 1 April 2014, the Trust has received **1,202** complaints of which **324** have gone onto the formal complaint process, this only equates to **27.54%** of the complaints. This is an **improvement** over the previous reporting period of April 2013 to March 2014 which was 28.67%.

Stage 3 – Formal Complaints

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

	Formal Complaints
2009-2010	305
2010-2011	310
2011-2012	358
2012-2013	391
2013-2014	333
2014-2015	324

**Data obtained via the Trusts Incident Reporting (Datix)*

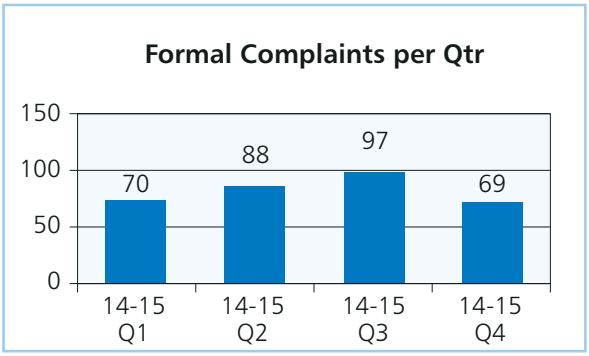


The following table trends the 2014-2015 formal complaints by quarter.

	2014-2015				
	Q1	Q2	Q3	Q4	Total
Totals	70	88	97	69	324

**Data obtained via the Trusts Incident Reporting database (Datix)*

2014-2015 Formal Complaints by complaint type:



From the **324** formal complaints received in 2014-2015 there are **797** complaint types.

Please see the following breakdown of the top 20 complaint types.

Category of Complaint	Number of Complaint types
Communication - Insufficient	119
Failure to monitor	80
Competence of staff member	60
Delay to diagnosis	60
Treatment and procedure delays	51
Care and compassion	37
Pain Management	33
Attitude - unprofessional	29
Incorrect diagnosis	21
Communication - Unhelpful	21
Communication - Inappropriate	20
Attitude - unhelpful	19
Nutrition	16
Discharge arrangements	16
Personal Hygiene	15
Communication - Unprofessional	14
Outpatient delay	13
Failure to follow guidelines/policy	12
Dignity & respect	12
Attitude - rude	11

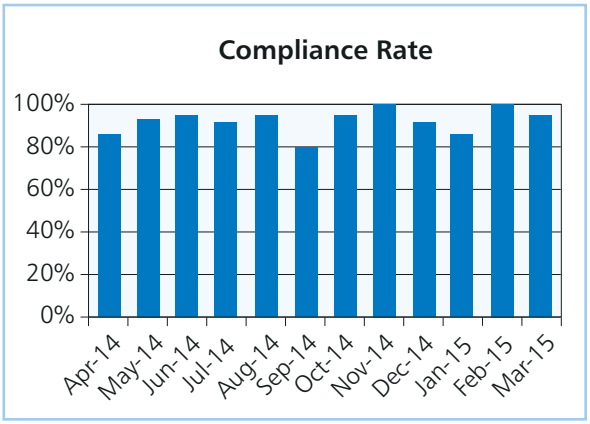
**Data for 2014-2015 obtained via the Trusts Nursing and Midwifery Dashboard – via Datix*

All lessons learned from complaints are taken back into the clinical teams and managed proactively.

Formal Complaints Compliance with 25 day target

We continually monitor the percentage of formal complaints that the Trust responds to in the required 25 day turn-around period.

We are proud to show that we have responded to over 90% of formal complaints 9 out of the 11 months, with November 2014 and February 2015 recording 100% of all formal complaints responded to within 25 days.



	Compliance Rate
Apr-14	86.00%
May-14	95.00%
Jun-14	96.00%
Jul-14	94.00%
Aug-14	96.00%
Sep-14	80.00%
Oct-14	97.00%
Nov-14	100.00%
Dec-14	94.00%
Jan-15	88.00%
Feb-15	100.00%
Mar-15	96.60%

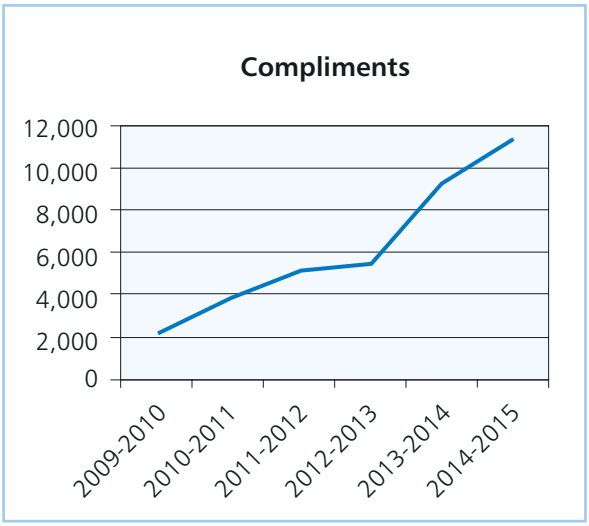
The Trust has developed a Directorate Complaints dashboard; this dashboard details the areas within the Directorate where the highest complaints are originating as well as to the themes.

The dashboard was rolled out in December 2014. The dashboard will encourage complaint ownership within the Directorates and therefore should improve learning within each area to reduce similar complaints in the future.

Compliments

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

Year	Compliments
2009-10	2,212
2010-11	3,786
2011-12	5,097
2012-13	5,414
2013-14	9,296
2014-15	11,357



**Data for 2014-2015 obtained via the Trusts Nursing and Midwifery Dashboard, all previous years are from each individual department*

The reason behind the increase from the 2012-2013 reporting period, is due to wards being able to capture and report the number of compliments received more effectively via the use of Friends and Family Test and report the information on the Nursing and Midwifery Dashboard.

Patient experience manager Jen Olver.

Pressure ulcers (also known as decubitus ulcer or pressure sores)

Why / How we chose this as a priority.

Following consultation with key stakeholders it was evident that pressure ulcers continue to be one of the Trusts key measures for improvement, therefore it was agreed to retain this indicator as rolling priority for our patients.

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

Year on Year Comparison – Hospital Acquired

Reporting Period	Grade 1	Grade 2	Grade 3	Grade 4
2012-2013	0	317	25	0
2013-2014	0	343	25	0
2014-2015	113	327	20	2

**Data obtained via the Trusts Incident Reporting database (Datix)*

Year on Year Comparison – Community Acquired

Reporting Period	Grade 1	Grade 2	Grade 3	Grade 4
2012-2013	0	458	124	0
2013-2014	3	759	187	0
2014-2015	126	684	78	26

**Data obtained via the Trusts Incident Reporting database (Datix)*

To note: prior to 2014-2015 reporting year, Pressure ulcers were classified as **Grade 2 and below** and **Grade 3 and above**, this explains the zero values in the above table for 2012 to 2014.

Actions taken by the Trust:

Over the course of the year we have further enhanced training in the prevention and management of pressure ulcers. The Trust has instigated the 'Shining the Light on Skin Integrity' study day, delivered by the Tissue Viability Nurses. It is held on a quarterly basis and is open to all staff in both the hospital and community. This study day covers all aspects of pressure ulcer avoidance and management and focuses on some of the difficulties of pressure ulcer assessment. The Trust specialist nurses also support bespoke training and support clinical teams to maximise treatment options. The outcome of one such bespoke programme in the Elective Care directorate has led to a significant reduction in pressure ulcer incidents in the latter part of the year, and this process will now be rolled out further across the Trust with the support of additional tissue viability nurse resources.

Communication between services continues to be promoted in order that seamless holistic care can be achieved when patients move between hospital and community. A key element of this is ensuring wound care information is passed onto the next care provider.

The SSKIN (surface inspection, skin inspection, keep moving, incontinence and nutrition) bundle has been rolled out across hospital and community settings. This care bundle is a pro-active tool to assist staff in the prevention of pressure ulcers in patients and is nationally regarded as the best evidence based tool for the promotion of skin integrity. Following feedback from staff the SSKIN part of the care plan on SystmOne has been made more visible to prompt staff to utilise it and this is considered as part of each incident investigation. Compliance with use of SSKIN is now improving.

Within the Trust all **Grade 3** *(full thickness skin loss involving damage necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia)* and **Grade 4** *(Extensive destruction, tissue necrosis, or damage to muscle, bone or supporting structure with or without full thickness skin loss)*, pressure ulcers continue to be subject to a full investigation which is reviewed internally and by the CCG. Incidents are categorised into avoidable and unavoidable, and the root cause analysis identifies where any lessons can be learned. All such incidents are presented to the Pressure Ulcer Assurance Panel for agreement. This panel consists of senior Trust staff and representatives from the commissioners to ensure independent scrutiny of cases and assurance around sharing of learning.

The Integrated Professional Nursing and Midwifery Board continue to oversee the Pressure Ulcer Operational Group which has the remit of reviewing the Trust action plan and Trust policies and guidelines to pursue continuous improvement in performance.

Monthly pressure ulcer prevalence reports are compiled via the NHS Safety Thermometer, along with larger scale pressure ulcer prevalence audits which are conducted across all areas, as a minimum, on an annual basis.

Section 3b: Performance from key national priorities from the Department of Health Operating Framework, Appendix B of the Compliance Framework

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

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

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

Monitor Compliance Framework Indicators	2014-15 Target	2014-15 Perfor-mance	2013-14 Perfor-mance	Achieved (cumula-tive)
Clostridium difficile -meeting the C.diff objective	40	20	30	✔
Cancer 31 day wait for second or subsequent treatment - surgery	94%	97.73%	96.65%	✔
Cancer 31 day wait for second or subsequent treatment - anti cancer drug treatments	98%	99.85%	99.85%	✔
Cancer 31 day wait for second or subsequent treatment - radiotherapy	n/a	n/a	n/a	
Cancer 62 Day Waits for first treatment (urgent GP referral for suspected cancer)	85%	84.34%	87.35%	✘
Cancer 62 Day Waits for first treatment (from NHS cancer screening service referral)	90%	96.58%	96.65%	✔
Cancer 31 day wait from diagnosis to first treatment	96%	98.89%	99.49%	✔
Cancer 2 week wait from referral to date first seen, all urgent referrals (cancer suspected)	93%	93.91%	94.53%	✔
Cancer 2 week wait from referral to date first seen, symptomatic breast patients (cancer not initially suspected)	93%	94.04%	94.74%	✔
Maximum time of 18 weeks from point of referral to treatment in aggregate, admitted patients	90%	91.83%	92.83%	✔
Maximum time of 18 weeks from point of referral to treatment in aggregate, non-admitted patients	95%	98.21%	98.91%	✔
Maximum time of 18 weeks from point of referral to treatment in aggregate, patients on incomplete pathways	92%	96.77%	97.39%	✔
A&E: maximum waiting time of 4 hours from arrival to admission /transfer/ discharge	95%	95.16%	96.17%	✔
Community care data completeness - referral to treatment information completeness (March 15)	50%	93.90%	94.61%	✔

Monitor Compliance Framework Indicators	2014-15 Target	2014-15 Perfor-mance	2013-14 Perfor-mance	Achieved (cumula-tive)
Community care data completeness - referral information completeness (March 15)	50%	87.52%	89.97%	✔
Community care data completeness - activity information completeness (March 15)	50%	70.92%	70.73%	✔
Compliance with access to healthcare for patients with learning disabilities		Full compliance	Full compliance	
Other National and Contract Indicators	**2014-15 Target**	**2014-15 Perfor-mance**	**2013-14 Perfor-mance**	**Achieved**
Cancelled Procedures for non medical reasons on the day of op	0.80%	0.41%	0.44%	✔
Cancelled Procedures reappointed within 28 days	100%	100%	100%	✔
Eliminating Mixed Sex Accommodation	0	0	0	✔
A&E Trolley waits > 12 hours	0	0	0	✔
Choose and Book slot issues	4%	3.00%	3.18%	✔
Stroke - 90% of time on dedicated Stroke unit	80.00%	91.91%	86.70%	✔
Stroke - TIA assessment within 24 hours	60.00%	88.24%	89.60%	✔
Delayed transfers of care	3.50%	2.65%	1.92%	✔
Breast Feeding at Delivery	45%	51.22%	51.29%	✔
Number of Diagnostic waiters over 6 weeks	99.00%	99.30%	99.93%	✔
Retinal Screening - offered an appointment within 48 hours (can be over 100% in rolling period)	95%	92.86%	103.58%	✘
VTE Risk Assessment	95%	95.97%	95.58%	✔
Health Visitor Numbers (March 15)	73.49	61.39	62.22	✘

** Retinal Screening can have more than 1 offer per patient; therefore can be greater than 100%*

Limited Assurance Report:

The following indicators are the subject of the limited assurance report of the independent auditors PricewaterhouseCoopers:

Further assurance indicators	Data Source	Definition
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period	Medifusion (internal system used to track referrals to treatment), Patient Administration System (PAS) data as well as patient notes	The Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report: • the indicator is expressed as a percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period; • the indicator is calculated as the arithmetic average for the monthly reported performance indicators for April 2014 to March 2015; • the clock start date is defined as the date that the referral is received by the Foundation Trust, meeting the criteria set out by the Department of Health guidance; and • the indicator includes only referrals for consultant-led service, and meeting the definition of the service whereby a consultant retains overall clinical responsibility for the service, team or treatment.
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	Somerset (internal cancer data collection system), Patient Administration System (PAS) data as well as patient notes	The Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report: • the indicator is expressed as a percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer; • an urgent GP referral is one which has a two week wait from date that the referral is received to first being seen by a consultant; • the indicator only includes GP referrals for suspected cancer (i.e. excludes consultant upgrades and screening referrals and where the priority type of the referral is National Code 3 – Two week wait); • the clock start date is defined as the date that the referral is received by the Trust; and • the clock stop date is the date of first definitive cancer treatment as defined in the NHS Dataset Set Change Notice. In summary, this is the date of the first definitive cancer treatment given to a patient who is receiving care for a cancer condition or it is the date that cancer was discounted when the patient was first seen or it is the date that the patient made the decision to decline all treatment.

Annex A: Third party declarations

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

Statement from NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group (HAST) and Durham, Dales, Easington and Sedgefield (DDES) Clinical Commissioning Group, for North Tees and Hartlepool Hospital NHS Foundation Trust (NTHFT) Quality Account 2015-16.

NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group (HAST CCG) commission healthcare services for the population of Hartlepool and Stockton-on-Tees. NHS Durham, Dales, Easington and Sedgefield Clinical Commissioning Group (DDES CCG) commission services for its respective populations. Both CCGs welcome the opportunity to submit a statement on the Annual Quality Account for North Tees and Hartlepool NHS Foundation Trust (NTHFT).

HAST and DDES CCGs can confirm that to the best of their ability, the information provided within the Annual Quality Account is an accurate and fair reflection of the Trust's performance for 2014-15. The CCGs would like to provide the following statement:

As commissioners we have remained sighted on the Trusts priorities for improving the quality of its services for its patients, and have continued to provide robust challenge and scrutiny at the regular Clinical Quality Review Group (CQRG) meetings with the Trust. These meetings have been refreshed to ensure that 'in depth reviews' of quality issues can be examined, and targeted actions identified and progressed in a timely, transparent and evidence based manner. HAST CCG has also conducted a programme of Commissioner led inspection visits to the Trust to gain further insight and assurance into the quality of care provided for patients. This enhanced approach has been welcomed by the Trust as an opportunity to demonstrate their duty of candour.

The CCGs support the Trusts priorities for 2015-16 which reflect stakeholder's comments and feedback to improve patient safety, patient experience and overall effectiveness of care and the measures identified that emphasise outcomes. The CCGs acknowledge that the Trust will build on work undertaken in 2014-15, which has proved challenging in some areas specifically in relation to mortality and the Friends and Family Test quality indicators. The CCGs are particularly pleased to see the proactive continuation of plans in 2015-16 for implementing and measuring improvements in care for people with dementia, and also in supporting carers of people with dementia.

The CCGs noted that during 2014-15, the Trust remained an outlier in relation to both measures of mortality, the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Indicator (SHMI). This has been closely scrutinised both by the CCGs and NHS England (Cumbria and North East region). We recognise, the work undertaken by the Trust to demonstrate commitment to improving mortality outcomes, through the commissioning of an in depth mortality review by North East Quality Observatory System (NEQOS) and the establishment of an internal Keogh mortality delivery group. The CCGs will continue to provide robust scrutiny and challenge in relation to this during 2015-16 and identify with the Trust opportunities for shared learning across the health economy.

The Trust has also demonstrated improvement against the cancer standards introduced in the Going Further with Cancer Waits guidance (2008), which supports their commitment to 'Putting Patients First', with the exception of the Cancer 62 Day Waits for first treatment (urgent GP referral for suspected cancer). The CCG will continue to monitor the Trusts performance during 2015-16 to understand the impact on patient safety and experience.

We would like to commend the Trust in sustaining a significant reduction in Health Care Associated Infection (HCAI) rates, cases and incidents, in particular clostridium difficile numbers, which has been achieved through strong leadership and systematic embedding of improvement actions Trust wide.

The CCGs are pleased with the Trust's approach to implementing,' the 6Cs: 'Our compassionate care', across the Trust. The Trust's vision, values and cultural ambition is clearly evident in their nursing and midwifery strategy and the CCG look forward to this strategy impacting positively on patient experiences.

We recognise that the Trust has made progress in delivering improvements in adult and children safeguarding arrangements in their training, systems and processes, and governance and welcome the Trusts ambition to secure continuous improvements in 2015-16.

The CCGs recognise the Trust commitment to reducing harm from specific types of patient safety incidents, including pressure ulcers and falls, and also the Trust's plans for implementing 'duty of candour' requirements in their patient safety incidents.

Finally, the CCGs would like to congratulate the Trust and its staff in being shortlisted for its maternity services, by CHKs as part of its top hospitals programme awards and on being a finalist in the 'Compassion in Practice Awards'. We would like to acknowledge staffs' continued commitment, enthusiasm and professionalism to delivering good quality care and improving patient experiences during significant service transformation.

NHS Hartlepool and Stockton-on-Tees CCG and NHS Durham Dales, Easington and Sedgefield CCG look forward to continuing to work in partnership with North Tees and Hartlepool NHS Foundation Trust during 2015-16 to ensure the quality of services the Trust provides for the local population continues to improve.'

Yours sincerely

Ali Wilson
Chief Officer (HAST CCG)

Gillian Findley
Director of Nursing, Patient Safety and Quality (DDES CCG)

Hartlepool Healthwatch

Following receipt of the draft quality account, HealthWatch Hartlepool wish to make a formal response to the approach taken by the Trust with regards to quality. This response encompasses the views of HealthWatch members, which have been relayed to both the Trust via our recent meeting (3 March 2015). Please note this opinion is based on factual data presented to HealthWatch Hartlepool, referrals received into HealthWatch Hartlepool and actual patient experience of Healthwatch Hartlepool members.

Our view of future priorities would be of agreement in particular the detail surrounding Patient Safety, Effectiveness of Care and Patient Experience. We firmly believe that key recommendations borne out of our collaborative working with the Trust, fit within the priorities and focus of the quality account.

We have worked collaboratively with the Trust over the last year and we have been impressed by what has been achieved, observed and what we have been told in particular our work with regards to Hospital Transport. All joint work has been underpinned by what we believe to be openness and honesty with information freely given, which in turn has allowed Healthwatch Hartlepool to produce meaningful and robust reports. We therefore would encourage implementation of our recommendations in respect of our 'Discharge' report.

At the moment we would welcome a greater focus on reducing mortality rates as this has been of great concern to Healthwatch Hartlepool over the last year. Whilst it is an emotive subject we would recommend a greater emphasis on 'End of Life' Pathways & Palliative Care as this has been of increased concern to HealthWatch Hartlepool. This is a critical if mortality rates are to be reduced.

One area Healthwatch Hartlepool is keen for the Trust to focus upon is within the key priority of Patient Experience. As a move towards improving meaningful communication we have noted from our members that the initiative 'Friend's & Family recommendation' is still not widely advertised or consistently applied. We would also like to see a more transparent pathway for patients who submit complaints and the publishing of complaint resolutions.

Overall, HealthWatch Hartlepool welcomes the opportunity to respond to the Draft Quality Account and would hope it will continue to reflect the views we present as the sole statutory consultation body for the people of Hartlepool in what has been our first year as Local HealthWatch.

Yours Faithfully,
Margaret Wrenn

Chair HealthWatch Hartlepool

Stockton Healthwatch

Please see below comments from Healthwatch Stockton-on-Tees in response to the recent Quality Account.

Healthwatch Stockton-on-Tees welcomes our involvement in the North Tees and Hartlepool Foundation Trust Quality Account. The Healthwatch Board would like to note the progress made in relation to quality in general over the last year and anticipates significant changes to outcomes for 2015-16.

Yours sincerely
Joanne Shaw-Dunn
Community Development Worker

Healthwatch Stockton-on-Tees

Statement from Adult Services and Health Select Committee, Stockton-on-Tees

The Committee once again welcomes the opportunity to consider and comment on the quality of services at the Trust. Councillors are grateful for the ongoing engagement throughout the year, including in-depth discussion with clinicians at Committee. The Stakeholder Event was a welcome development and opportunity to speak directly with the staff undertaking the work to improve services.

The Committee recognises that 2014-15 has seen an extremely challenging period for the regional NHS. There has been a negative impact on A and E waiting times, including on this Trust although not to the extent as other Trusts in the North East. There is no doubt that there is increasing pressure on the health and care system as a whole and it is critical that the focus on quality must be maintained.

The Quality Priorities for 2013-14 were rolled over into 2014-15. It is proposed to continue to focus on these during 2015-16, minus infection control and with the addition of mortality as noted below. This will enable continuity and to track progress over time, however the Trust should not lose sight of emerging issues which may require additional attention in future years.

The Trust added mortality as a priority during 2014-15. This was a key issue for the Committee during 2014-15, following on from the concerns noted in the previous year. Further focus on this during 2015-16 is strongly supported.

The Trust scores for SHMI (which takes account of deaths within 30 days of discharge), and HSMR have now showed a higher than expected value for an extended period of time, and is higher than other Trusts in the region.

The Committee has therefore reviewed the perceived reasons for this and actions taken. It is clear that detailed work is ongoing within the Trust to understand and improve the scores.

Some reassurance was provided to the Committee by the external review of the Trust's approach through the North East Quality Observatory System (NEQOS); this review endorsed the actions taken by the Trust to date and made further recommendations for change.

The mortality scores used are based on risk factors and the amount of deaths that may be expected for particular patient groups. Part of the issue appears to relate to different methods of coding patient episodes within Trusts, and different methods of caring for patients, for instance the configuration of ambulatory care at North Tees.

One of the benefits of using standardised metrics across organisations is that it should enable comparisons between Trusts. It would be a concern if different practices had a significant impact on comparability between Trusts.

The amount of end of life care provided is key; and if there is a high percentage of end of life provided, and if cases are incorrectly coded, this will affect the scores. It is also important, not least for the family and patient experience, that end of life care takes place outside of hospital in accordance with wishes of the patient wherever appropriate and so the Committee would support any work to achieve this aim. This includes the role of primary care and care homes to help avoid admissions that may not be clinically necessary.

The Council has provided details of any unexpected deaths that have occurred in Council rehabilitation care following discharge from hospital for consideration as part of the Trust's mortality reviews, and will review whether patients were referred appropriately.

This reinforces the need for community based-care, and the Trust itself, to ensure that referrals to and from hospital are correctly managed, by all staff including agency workers. The Committee support the continuing focus on discharge as a quality priority during 15-16.

The Committee recognise that mortality and how it is recorded is a complex issue, and it is good to see this recognised as a priority by the Trust itself. However there is a need for further work to fully understand the continuing high mortality scores, and the Committee will want to be updated on this during 2015-16.

In November, the Committee examined the issue of cancer referral to treatment performance following a dip in performance in the period April-August 2014. The Committee is pleased to note that in quarter 3, all targets had been exceeded following the remedial actions taken.

Members have monitored the NHS Staff survey results over the last two years. In 2014 there was no major change in the 2013 score for 'number of staff recommending the Trust as a place to work or receive Treatment', which was below average, so this will need further monitoring.

There had been one case of MRSA during 14-15 which was the first since 2012, and overall the infection control performance has been very good. By early March, C. diff. rates were lower than the previous year, and this is very welcome. The complementary role of good prescribing and hygiene in the community should be promoted at every opportunity.

Child sexual exploitation is a key area of focus for the Council. The Trust has confirmed that it places a high priority on the issue and described its contribution to the local safeguarding arrangements. Compliance with Level 3 Children's Safeguarding Training (for staff in contact with children and young people) was not at 100% during 14-15 and so it is pleasing to see that the Trust has employed an additional trainer to help with this, and that Level 3 training was not cancelled during the operation of the winter pressures escalation plan.

Patient Friends and Family Test returns have increased and show positive results, although Members agree with the Trust that the NHS must be aware of consultation fatigue amongst patients.

The Care Act 2014 is starting to become operational from April 2015. The Trust may in future wish to demonstrate more fully the impact of the Care Act and co-operation with social care within its Account. For example, the statutory entitlement to carer assessments, and the role of social care in relation to the priority on discharge.

The Trusts Council of Governors – 11 March 2015

The Governors of North Tees and Hartlepool NHS Foundation Trust (the Trust) confirm that once again they have been involved in the formulation of the Trust's Annual Quality Account. All aspects of the Account's content were disseminated via performance update reports and individual presentations throughout 2014-15.

Market place events were held in December 2014 to obtain the views and feedback from Governors and stakeholders, as well as a wider public perspective of the Quality Account.

A Governor Quality Accounts Working Group, assisted by the Associate Director of Nursing, Patient Safety and Quality and Public Involvement reviewed the draft Annual Quality Account in detail on behalf of the Council of Governors, not only providing challenge and seeking assurance regarding the data and content of the report, but also constructive comments in respect of design, layout and language. Feedback obtained from both the market place events and the Working Group helped shape the key priorities and final content within the Quality Account for 2014-15.

At the Council of Governor development sessions during the year, workshops took place to provide Governors and the Board of Directors with an in depth insight of priority areas, including corporate strategy; annual plan; understanding mortality; pathways to discharge planning; open and honest care; the 6Cs; new hospital 'pause', and fundamental standards. These sessions allowed Governors to provide valuable feedback and suggestions regarding work being undertaken in these areas, and also ensured that they were fully aware of both the challenges being faced by the Trust, and the valuable improvements being made to patient care, including service transformation plans.

The Council of Governors are updated in detail on such issues as service transformation at each Council of Governors meeting, where it was reported that following the 'pause' decision on the new hospital project (October 2014), strategic scoping of clinical services delivery was necessary, as part of the Clinical Services Strategy, to provide care closer to home, and develop integrated care pathways with primary and social care, with a requirement for continuous assurance around patient safety and quality. These and other initiatives form the basis of the Trust's plans in respect of the Better Care Fund.

The range of regular reports that are presented to the Council of Governors highlight the performance and compliance of the Trust against its many performance indicators and particular areas of focus, which this year have included the work around hospital acquired infections; the Care Quality Commission intelligent monitoring, and mortality rates. A Quality Report is also provided at every Council of Governors and Board of Directors meeting by the Director of Nursing, Patient Safety and Quality. The content of the report includes information relating to mortality; patient falls and safety thermometer; compliments and complaints, and the friends and family test; a national initiative introduced in April 2013. The meetings are an opportunity for the Governors to openly provide challenge and share their opinions.

In addition to the Council of Governor meetings there are a number of Governor Sub-committees, particularly the Strategy Committee and Service Development and Quality Committee, whose remit is to keep Governors updated regarding service developments and future vision, and allows their contribution in respect of the refresh of the Trust's Corporate Strategy. Presentations regarding the annual plan; cancer services; orthopaedic services and management of the fractured neck of femur; emergency assessment unit and ambulatory care, and compliance and service improvement were given at the Service, Development & Quality Committee.

As well as receiving strategic, performance and compliance information, Governors are invited to take part in the Staff, Patient Experience, Quality and Standards (SPEQS) panel and the Patient Led Assessment of the Care Environment (PLACE) panel, which provide the opportunity for panel members, including Governors and board members to visit operational areas and speak directly with patients, visitors and staff about their experiences at the Trust.

The SPEQS panel is a monthly review of the standards of care given to our patients both in hospital and community services. The visits which are led by clinicians and senior nursing staff are to witness first-hand the levels of care and service being provided in specific clinical areas. The standards are reviewed in relation to the environment, evidence of standards of clinical care and most importantly, patient experience. During 2014 staff involvement was included as an additional section in the assessment with questions covering staffing levels and duty rotas and whether the levels are adequate to meet patient need.

PLACE assessments are carried out on a monthly basis, with one additional regulatory inspection, and are undertaken by a team of NHS and private/independent healthcare providers, 50% of which are members of the public (patient assessors). Governors play a vital role in these assessments, which focus entirely on the care environment and assessing the quality of the hospital environment. Reports and feedback from both panels are shared with the Council of Governors at every meeting.

Governors have also been assisting with the recruitment of new members for the Trust by supporting recruitment events in local colleges and member events. Some of the Governors are involved in a number of other groups; the Menu Review Group, Patient Information Evaluation Group and the Healthcare User Group, which focus on specific service areas.

As reported at the Council of Governors meeting in January, the Trust has continued to experience unprecedented levels of activity, which has resulted in increasing the North East Escalation Policy (NEEP) to level 3 and level 4 on a sustained basis.

It was explained that this is the agreed protocol between Trusts to manage resilience. It means that the Trust is experiencing service pressures and requires support from staff in all areas, both clinical and non-clinical. Governors were informed that the response by staff has been excellent throughout this period, and where possible activity such as the SPEQS panels has continued. The Board had formally thanked staff for their hard work and ensured that provisions were made for staff unable to leave clinical areas for a break.

Hartlepool Borough Council

As part of the Quality Accounts process, Members of Council were invited to attend a Market place event which was held in December 2014. The event was held to gain the views and feedback from stakeholders, as well as a wider public perspective of the Quality Accounts.

The event gave stakeholders the opportunity to speak directly with the responsible leads for each area. In addition to this, Full Council on the 16 February 2015 considered the North Tees and Hartlepool NHS Foundation Trust's Quality Account for 2014-15, with the following comments made for inclusion in the Council's Third Party Declaration:-

In relation to the survey results, Council were of the view that there is a need to be able to drill down survey results on a locality basis to show the financial cost to family and friends of a hospital stay. Whilst it is noted that this cannot be done as part of the 'friends and family' survey element of the Quality Account, it is suggested that the collection of this information be undertaken through the Travel and Transport Group.

In relation to patient experiences, Members noted the Trust's activities in seeking out patient experiences, via the Internal Staff and Patient Experience and Quality Standards (SPEQS) process, patient experience surveys and the Friends and Family Test.

Members noted that the complaints compliance rate was averaging, with over 90% responded to all formal complaints within 25 days.

Council was informed that the Trust had added mortality as a priority during 2014-15 and this had been included due to the Trust position nationally for the two benchmarking indicators HSMR and SHMI. Council expressed concerns at the higher than average mortality rates, with the Trust experiencing more deaths than the standardised calculation expects. Council was of the view that the mortality rates are a sad reflection of the Trust's performance.

Additional information in relation to the mortality figures, provided at the request of Full Council, highlighted that an external review of the Trust's approach had been carried out through the North East Quality Observatory System (NEQOS).

Council notes that the review endorsed actions taken by the Trust to date and made further recommendations for change.

Council raised concerns about in-patient discharge procedures at the University Hospital of North Tees and, in particular, instances that resulted in elderly patients being discharged out of hours / in the early hours of the morning, with no way of getting home other than expensive taxi fares. Council questioned public awareness of financial assistance available to pay for transport in these instances and identified the need to better publicise the availability of this funding.

Regarding the midwife led unit at the University Hospital of Hartlepool, Members expressed concern regarding the number of births taking place in the Hartlepool Unit.

The quality of the care offered by the staff at the Trust was not in question, as Members recognised the skill and commitment of staff. However, the provision of quality care is reliant on the goodwill of staff and it is clear that this is being stretched to breaking point. Members were of the view that the Trust has a duty of care to its staff and the pressure that is being placed upon them will inevitably have a knock on effect to patients. It was noted by Council that the infection control results, in particular those relating to clostridium difficile are reflective of the efforts made by staff throughout the Trust.

In relation to Hartlepool becoming a Dementia Friendly Town, Council were made aware that the Trust had taken specific steps within both the University Hospital of Hartlepool and the University Hospital of North Tees to make them dementia friendly. Examples of this were the use of bright colours in corridors, and on doorways, and emphasis on the provision of robust discharge procedures for people with dementia.

Councillor Stephen Akers-Belcher
Chair of Council

Healthcare User Group (HUG)

The main role of the Healthcare User Group (HUG) is to assist the Trust with the Patient and Public Involvement (PPI) agenda. This is achieved through independent visits to inpatient wards and outpatient clinics, talking to staff and patients. HUG is also represented on other Trust committees including the Audit & Clinical Effectiveness Group (ACE), Quality Standards Steering Group (QSSG), Discharge Liaison Group, Infection Control Committee (ICC) and Patient Quality & Safety Standards Group (PS & QS). A HUG representative also attends the Trust Board.

During our visits over the past year, we have been very aware of the emphasis on Patient Safety especially relating to dementia and safeguarding adults and children.

The infection control results, in particular those relating to clostridium difficile, reflect the excellent efforts made by staff throughout the Trust. It is right that Patient Safety remains a stakeholder priority for 2015-16.

We have seen improvements to the discharge process and it is evident that the Trust is striving to improve the process and discharge patients in a timely and safe manner. This is an ongoing priority and we have seen from our visits that most patients have a predicted date of discharge within 24 hours of admission. This has to remain a major priority and we are aware of the efforts the Trust is making to achieve a more efficient discharge procedure.

The Trust has, in our view, rightly continued to focus on care for the dying patient and support the work done by staff with respect to palliative care. The positive comments from the Friends and Family recommendation concur with the findings from our inpatient and outpatient visits.

The HUG team has been impressed with the approach and work undertaken by the 6Cs team in embedding the Compassion in Practice strategy, the training delivered and the resultant positive culture. The national recognition for good practice reflects the innovative approach taken by the team and the Trust.

We feel the Trust has provided the right level of support to allow HUG to perform its independent visits to various wards and clinics. Our reports have been acknowledged and concerns or recommendations have been acted upon in a prompt manner.

We view the Quality Accounts as a true and fair reflection of what we have seen on our visits to the Trust's inpatient wards and outpatient clinics. HUG supports the priorities selected for 2015-16 and as a stakeholder, has had the opportunity to influence these priorities.

HUG will continue to be an impartial and encouraging party, assisting in developing and monitoring patient services within the Trust.

Bill Johnson
Healthcare User Group

Annex B: Quality Report Statement

Statement of Directors' Responsibilities in Respect of the Quality Account

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 2014-15* and supporting guidance
- 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 2014 to April 2015
  - papers relating to Quality reported to the Board over the period April 2014 to April 2015
  - feedback from commissioners dated 20 April 2015
  - feedback from governors dated 11 March 2015
  - feedback from Hartlepool Healthwatch dated 19 March 2015 and Healthwatch Stockton-on-Tees dated 17 April 2015
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated Q3 2014-2015
  - feedback from Hartlepool Borough Council dated 24 April 2015
  - feedback from the Adult Services and Health Select Committee at Stockton-on-Tees Council dated 01 April 2015
  - feedback from the Healthcare User Group dated 29 March 2015
  - the latest national inpatient survey 2014
  - the latest national staff survey 2014
  - the Head of Internal Audit's annual opinion over the Trust's control environment dated May 2015
  - CQC Intelligent Monitoring Report July 2014 and December 2014
- 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) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the quality report (available at www.monitor.gov.uk/annualreportingmanual).

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 28 May 2015
Chairman

Date 28 May 2015
Chief Executive

Annex C:

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

We have been engaged by the Council of Governors of North Tees and Hartlepool NHS Foundation Trust to perform an independent assurance engagement in respect of North Tees and Hartlepool NHS Foundation Trust's Quality Report for the year ended 31 March 2015 (the "Quality Report") and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance (the "specified indicators"), marked with the symbol Ⓐ in the Quality Report, consist of the following national priority indicators as mandated by the Independent Regulator of NHS Foundation Trusts ('Monitor'):

Specified indicators	Specified indicators criteria
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period	Page 84
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	Page 84

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the specified indicators criteria referred to on pages of the Quality Report as listed above (the "Criteria"). The Directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "Detailed requirements for quality reports 2014-15" issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the "Detailed requirements for quality reports 2014-15";
- the Quality Report is not consistent in all material respects with the sources specified below; and
- the specified indicators have not been prepared in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the "2014-15 Detailed guidance for external assurance on quality reports".

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM and the "Detailed requirements for quality reports 2014-15; and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the following documents:

- Board minutes for the period April 2014 to April 2015;
- papers relating to the quality report reported to the Board over the period April 2014 to April 2015;
- feedback from the Commissioners (NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group and Durham Dales, Easington and Sedgefield Clinical Commissioning Group) dated 20 April 2015;
- feedback from Governors dated 11 March 2015;
- feedback from Healthwatch Hartlepool dated 19 March 2015 and Healthwatch Stockton-on-Tees dated 17 April 2015;

- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 as contained within the North Tees and Hartlepool NHS Foundation Trust CLIP Report 2014-15 Q3;
- feedback from Hartlepool Borough Council dated 24 April 2015;
- feedback from the Adult Services and Health Select Committee at Stockton-on-Tees Council dated 1 April 2015;
- feedback from the Healthcare User Group dated 29 March 2015;
- the most recent National Inpatient Survey 2014;
- the most recent 2014 National NHS Staff Survey;
- Care Quality Commission Intelligent Monitoring Reports for July 2014 and December 2014; and
- the Head of Internal Audit's annual opinion for 2014-15 over the Trust's control environment.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales ("ICAEW") Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of North Tees and Hartlepool NHS Foundation Trust as a body, to assist the Council of Governors in reporting North Tees and Hartlepool NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2015, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and North Tees and Hartlepool NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ("ISAE 3000"). Our limited assurance procedures included:

- reviewing the content of the Quality Report against the requirements of the FT ARM and "Detailed requirements for quality reports 2014-15";
- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM, the "Detailed requirements for quality reports 2014-15 and the Criteria referred to above.

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS entities.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by North Tees and Hartlepool NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2015:

- the Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the "Detailed requirements for quality reports 2014-15";
- the Quality Report is not consistent in all material respects with the documents specified above; and
- the specified indicators have not been prepared in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the "Detailed guidance for external assurance on quality reports 2014-15".

PricewaterhouseCoopers LLP
Newcastle upon Tyne
29 May 2015

The maintenance and integrity of the North Tees and Hartlepool NHS Foundation Trust website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

Annex D:

We would like to hear your views on our Quality Accounts.

North Tees and Hartlepool NHS Foundation Trust value your feedback on the content of this year's Quality Account.

Please fill in the feedback form below, tear it off and return to us at the following address:

Patient Experience Team
North Tees and Hartlepool NHS Foundation Trust
Hardwick Road
Stockton-on-Tees
Cleveland
TS19 8PE

Thank you for your time.

Feedback Form (please circle all answers that are applicable to you)

What best describes you: Patient	Carer	Member of public	Staff	Other
Did you find the Quality Account easy to read?		Yes	No	
Did you find the content easy to understand?		Yes all of it	Most of it	None of it
Did the content make sense to you?		Yes all of it	Most of it	None of it
Did you feel the content was relevant to you?		Yes all of it	Most of it	None of it
Would the content encourage you to use our hospital?		Yes all of it	Most of it	None of it
Did the content increase your confidence in the services we provide?		Yes all of it	Most of it	None of it

Are there any subjects/topics that you would like to see included in next year's Quality Account?

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In your Opinion, how could we improve Our Quality Account?

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Alternatively you can email us at: **Patientexperience@nth.nhs.uk** with the subject Quality Accounts.

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

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

NCEPOD	The National Confidential Enquiry into Patient Outcome and Death
NCRN	National Cancer Research Network
NEPHO	North East Public Health Observatory
NEQOS	North East Quality Observatory System
NEWS	National Early Warning Score
NICE	The National Institute of Health and Clinical Excellence
NICOR	The National Institute for Cardiovascular Outcomes Research
NIHR	National Institute for Health Research
NNAP	National Neonatal Audit Programme
OFSTED	The Office for Standards in Education
PALS	Patient Advice and Liaison Service
PAS	Patient Administration System
Patient Safety and Quality Standards (Ps&Qs) Committee	The committee responsible for ensuring provision of high quality care and identifying areas of risk requiring corrective action
PICANet	Paediatric Intensive Care Audit Network
PREVENT	The government's counter-terrorism strategy
PROMs	Patient Reported Outcome Measures
Pseudonymisation	A process where patient identifiable information is removed from data held by the Trust
R&D	Research and Development
RCA	Root Cause Analysis
RCOG	The Royal College of Obstetricians and Gynaecologists
RCPCH	The Royal College of Paediatric and Child Health
REPORT-HF	International Registry to assess Medical Practice with longitudinal observation for Treatment of Heart Failure
RESPECT	"Responsive, Equipped, Safe and secure, Person centered, Evidence based, Care and compassion and Timely" - a nursing and midwifery strategy developed with patients and governors aimed at promoting the importance of involving patients and carers in all aspects of healthcare
RMSO	Regional Maternity Survey Office
SBAR	Situation, Background, Assessment and Recommendation - a tool for promoting consistent and effective communication in relation to patient care
SCM	Senior Clinical Matron
SHA	Strategic Health Authority
SHMI	Summary Hospital Mortality-level Indicator - a hospital-level indicator which reports inpatient deaths and deaths within 30-days of discharge at Trust level across the NHS
sic	The Latin adverb sic ("thus"; in full: sic erat scriptum, "thus was it written"), inserted immediately after a quoted word or passage, indicates that the quoted matter has been transcribed exactly as found in the source text, complete with any erroneous or archaic spelling, surprising assertion, faulty reasoning, or other matter that might otherwise be taken as an error of transcription.

SINAP	Stroke Improvement National Audit Programme
SPOC	Single point of contact
SSKIN	Surface inspection, skin inspection, keep moving, incontinence and nutrition
SSU	Short Stay Unit
STAMP	Screening Tool for the Assessment of Malnutrition in Paediatrics
STERLING	Environmental Audit Assessment Tool
Tough-books	Piloted in 2010, these mobile computers aim to ensure that community staff has access to up-to-date clinical information, enabling them to make speedy and appropriate clinical decisions
UHH	University Hospital of Hartlepool
UHNT	University Hospital of North Tees
VSGBI	The Vascular Society of Great Britain and Ireland
VTE	Venous Thromboembolism
WRAP	Workshop to Raise Awareness of PREVENT

Signature: 

Paul Garvin

Signature: 

Alan Foster

AUDIT AND GOVERNANCE COMMITTEE

11th February 2016

Report of: Director of Regeneration and Neighbourhoods

Subject: COMMUNITY SAFETY PLAN 2014-17 (YEAR 3)

1. PURPOSE OF REPORT

1.1 To consider and comment on the Community Safety Plan 2014-17 (Year 3).

2. BACKGROUND

2.1 The Crime and Disorder Act 1998 established a statutory duty for the Local Authorities, Police, Fire Brigades, Clinical Commissioning Groups, Community Rehabilitation Companies and National Probation Service to work together to address local crime and disorder, substance misuse and re-offending issues. Collectively these six bodies are known as Responsible Authorities and make up the Safer Hartlepool Partnership.

2.2 In accordance with the Crime and Disorder Act 1998 and the Crime and Disorder Regulations 2007, the Safer Hartlepool Partnership is required to produce a three year Community Safety Plan setting out how it intends to tackle crime and disorder, substance misuse and re-offending in Hartlepool.

2.3 The current Community Safety Plan published in 2014 outlines the Safer Hartlepool Partnership's strategic objectives for a three year period, with a requirement to refresh the plan on an annual basis following completion of the annual strategic assessment.

2.4 The Community Safety Plan (Year 3) which is attached at **Appendix A** was considered and approved by the Safer Hartlepool Partnership at their meeting on 22nd January 2016.

3 2016-17 COMMUNITY SAFETY PLAN /PROPOSED ANNUAL PRIORITIES

3.1 The Community Safety Plan (Year 3) provides an overview of progress made by the Safer Hartlepool Partnership during 2015-16 with an update on end of year performance**.** It describes some of the Partnership activity undertaken to reduce crime and improve safety during the last 12 months,

and incorporates the 2016-17 annual priorities as follows:

Strategic Objectives 2014 - 17	Annual Priorities 2016 - 2017
Reduce crime and repeat victimisation	**Acquisitive Crime** - reduce acquisitive crime through raising awareness and encouraging preventative activity with a particular focus on domestic burglar **Domestic Violence and Abuse –** safeguard individuals and their families from violence and abuse and implement programmes to tackle those identified as 'high risk'
Reduce the harm caused by drug and alcohol misuse	**Substance Misuse** - reduce the harm caused to individuals, their family and the community, by illegal drug and alcohol misuse and alcohol related violence.
Create confident, cohesive and safe communities	**Anti-social behaviour** - reduce anti-social behaviour through a combination of diversionary, educational, and enforcement action and increase restorative interventions. **Vulnerable Victims -** work together to identify and support vulnerable victims and communities experiencing crime and anti-social behavior.
Reduce offending and re-offending	**Re-offending** - reduce re-offending through a combination of prevention, diversion and enforcement activity

4 PERFORMANCE MONITORING

4.1 Progress made against the Community Safety Plan (Year 3) will be managed and monitored by the Safer Hartlepool Partnership, through quarterly performance reports and a review of Partnership Task Group/Sub Group Action Plans. The Community Safety Plan (Year 3) incorporates performance indicators for 2016-17, along with a proposed delivery structure to progress the 2016-17 priorities.

5 FINANCIAL CONSIDERATIONS

5.1 It is estimated that the total cost of crime in Hartlepool during the last 12 months amounts to more than £95 million.

6 STAFF CONSIDERATIONS

6.1 There are no staff considerations associated with this report.

7 SECTION 17 CONSIDERATIONS

7.1 The Community Safety Plan (Year 3) provides an agreed plan of action between statutory partners in relation to how they will discharge their Section 17 considerations within the Borough.

8 LEGAL CONSIDERATIONS

8.1 Under the Crime and Disorder Act 1998, Community Safety Partnerships (CSPs) have a statutory responsibility to develop and implement strategies to reduce crime and disorder, substance misuse and re-offending in their local area. Part of this statutory responsibility is to produce an annual Community Safety Plan.

9 EQUALITY AND DIVERSITY CONSIDERATIONS

9.1 Based on the needs identified in the Partnerships strategic assessment, the Community Safety Plan (Year 3) sets out how the Safer Hartlepool Partnership will aim to protect and improve the safety of vulnerable individuals, groups and localities in Hartlepool.

10 CHILD POVERTY CONSIDERATIONS

10.1 There are no child poverty implications associated with this report.

11 RECOMMENDATIONS

11.1 In accordance with their crime and disorder scrutiny function the Audit and Governance Committee are asked to consider and comment upon the Community Safety Plan (Year 3).

12 REASON FOR RECOMMENDATIONS

12.1 As a Responsible Authority, the Local Authority has a statutory duty to develop and implement strategies aimed at reducing crime and disorder, substance misuse, and re-offending behaviour.

13 BACKGROUND PAPERS

13.1 The following backgrounds papers were used in the preparation of this report:

https://www.hartlepool.gov.uk/meetings/meeting/3414/safer_hartlepool_partnership

14 CONTACT OFFICER

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Director of Regeneration and Neighbourhoods
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Level 3
Email: Denise.Ogden@Hartlepool.gov.uk
Tel: 01429 523300

Clare Clark
Head of Community Safety and Engagement
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Safer Hartlepool Partnership Plan 2014 – 2017 Year 3

Contents

Foreword

I am pleased to introduce the Safer Hartlepool Partnership Annual Plan which is based on the findings of the Partnership's Annual Strategic Assessment and consultation with the public through our on-line survey and our annual "Face the Public" event. The Plan outlines the Partnership's strategic objectives and priorities for 2016-17 and will be refreshed next year to incorporate new objectives and priorities as they emerge.

Since becoming Chair of the Safer Hartlepool Partnership in May 2013, I have been impressed by the strength of partnership working and the dedication and continued support of those organisations that are responsible for the Partnership including; the Council, Police, Fire Authority, Clinical Commissioning Group, Probation and the Cleveland Police and Crime Commissioner.

By working together, over the last year recorded anti-social behaviour has reduced by 5.2%, equating to 392 less incidents than in the previous assessment period. .

During 2015-16 the Safer Hartlepool Partnership has also successfully supported and delivered numerous partnership initiatives that have contributed to improved safety in Hartlepool and some of these successes are outlined in this plan.

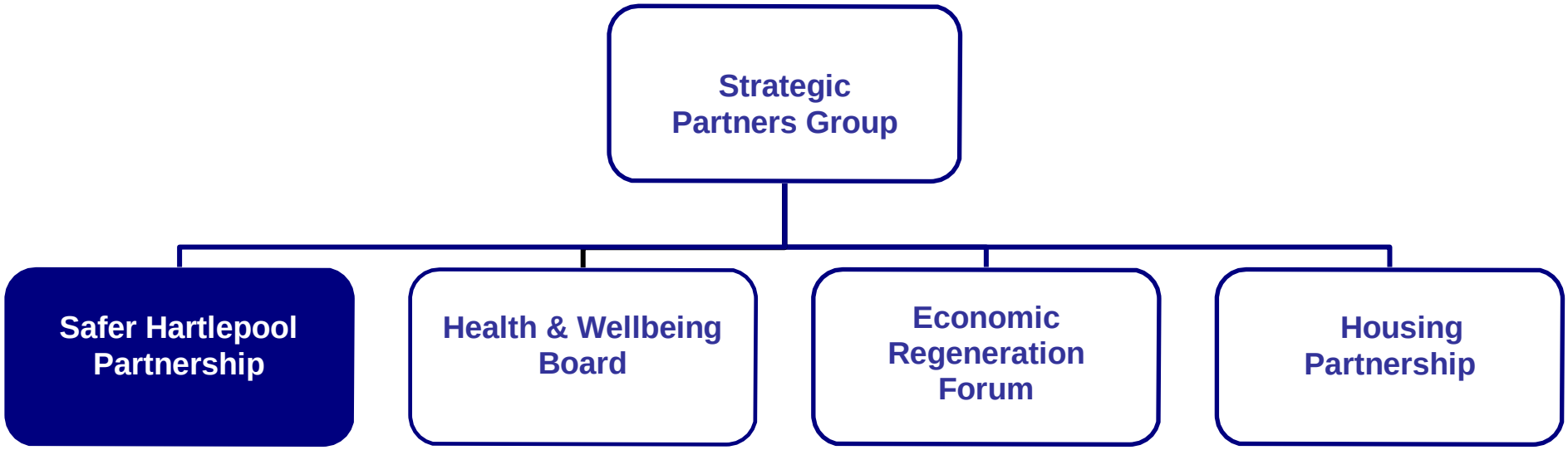
However crime has increased during this reporting period, and over the coming year there are a number of factors that will present the Safer Hartlepool Partnership with challenges including; an enduring poor economic climate; Welfare Reform; the emergence of new types of serious and organised crimes; and further significant cuts to public expenditure following the Governments Comprehensive Spending Review in November 2015. Ministry of Justice plans to close Hartlepool Magistrates Court and County Court if they go ahead will also inevitably impact on the ability to access justice in the town.

Whilst the year ahead will be full of challenges I am confident that this Partnership Plan will help us to make Hartlepool a safer place to live, work, and socialise.

Councillor Christopher Akers-Belcher
Chair of the Safer Hartlepool Partnership

The Safer Hartlepool Partnership

The Safer Hartlepool Partnership is Hartlepool's statutory Community Safety Partnership and is one of the four[1] themed partnerships of the Hartlepool Strategic Partners Board. The aim of the Safer Hartlepool Partnership is to make Hartlepool a safer place to live, work and socialise by addressing crime and anti-social behaviour, substance misuse and to reduce re-offending.



The Partnership is responsible for delivering the following: *Community Safety Plan; annual Youth Justice Plan; Substance Misuse Plan (Drugs and Alcohol); CCTV Strategy; Domestic Violence Strategy; Social Behaviour Plan; Prevent Action Plan; Cohesion Strategy; Troubled Families Programme. The Partnership is also responsible for the delivery of the community safety outcomes within the Sustainable Communities Strategy and the Hartlepool Plan*. These local strategies and plans will have regard to the Cleveland Police and Crime Plan and appropriate national strategies and plans, to ensure that national policy is followed.

[1] The themed Partnerships are: The Safer Hartlepool Partnership, The Health and Well Being Board, the Housing Partnership and the Economic Regeneration Forum

Local Context

Hartlepool is the smallest unitary authority in the North East region and the third smallest in the country comprising of some of the most disadvantaged areas in England. Issues around community safety can be understood by a number of contextual factors:

Population

- Hartlepool has a stable population rate, maintained by low levels of migration.
- Hartlepool has become more diverse in recent years, although a very small proportion of the population are from the Black Minority Ethnic (BME) community.
- 56% of the population in Hartlepool live in six of the most deprived wards in the country, where crime and anti-social behaviour rates are high.

Health & Wellbeing

- There is a higher prevalence of long term health problems, including mental health.
- Alcohol related hospital admissions in Hartlepool are significantly worse than the regional and national.
- Hartlepool has 40% greater need in relation of mental illness compared to England.
- The number of Class A drug users in Hartlepool is more than double the national average.

Deprivation

- Hartlepool has pockets of high deprivation where communities experience multiple issues: higher unemployment, lower incomes, child poverty, ill health, low qualification, poorer housing conditions and higher crime rates.
- Hartlepool is the 18th most deprived local authority area out of 326 local authorities.
- Residents living in more deprived and in densely populated areas have high perceptions of crime

Housing

- The percentage of long term empty properties in Hartlepool is higher than the Tees Valley average.

Geography

- Community safety problems are not evenly spread and tend to be concentrated in geographic hotspots, particularly in the most deprived wards in Hartlepool.

Unemployment

- Unemployment rates in Hartlepool are above the regional average and double the national average.
- The unemployment rate of young people aged 18-24 years remains above the national average.

Partnership Activity 2015– 2016

Over the last year, the Partnership has delivered a number of projects and initiatives against the strategic priorities in the Partnership Plan 2015 - 2016, and d eveloped new services which have been designed to reduce crime, disorder, anti-social behaviour, substance misuse and re-offending. Examples are listed below:

Strategic Objective: Reduce Crime & Repeat Victimisation

- **Crime Prevention & Target Hardening -** We have continued to offer crime prevention advice and promote safety measures throughout the year, with seasonal campaigns addressing specific crime types and issues.

- **Serious and Organised Crime - We** have set up a local 'Organised Crime Disruption Panel to disrupt the activities of known organised crime groups in Hartlepool. Front line staff across organisations working in Hartlepool have also be trained to recognise the signs of crimes such as modern day slavery and human trafficking and how to report it.

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- **Dedicated Victims Service** - Over the last year we have provided support to 593 victims including 315 victims of crime, and 105 victims of anti-social behavior with the remainder being indirect victims such as those living in high crime and disorder areas and living in the fear of crime. 354 homes have also benefited from improved security across Hartlepool, providing reassurance to victims and reducing their risk of repeat victimisation. Over 88% of victims who have received this service also report increased feelings of safety.

- **Domestic Violence and abuse** – In March this year we launched Operation Encompass to ensure timely information sharing between schools, police, and social care, to improve early intervention and support for children who have witnessed domestic abuse. We have also improved refuge provision for those made homeless by domestic abuse through a dispersed properties scheme.

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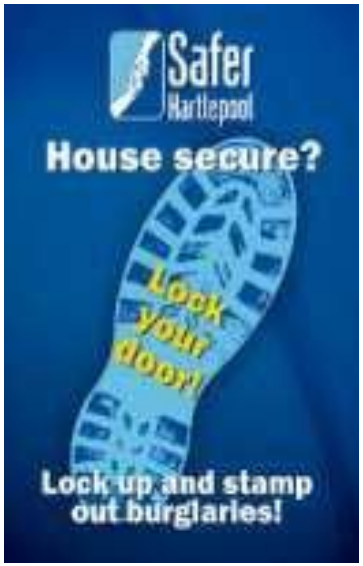

victim support
find the strength

Strategic Objective: Reduce the harm caused by drug & alcohol misuse

- **Drug and Alcohol Treatment and Support –** The Partnership has commissioned a range of community based specialist services to support those who misuse substances. To improve access and increase engagement this service now includes an outreach element. Overall these services have helped more than 900 people on their journey to recovery**.**
- **Awareness Campaigns –** The Partnership is driving forward campaigns to promote responsible drinking and highlight the dangers of drug misuse - campaigns include Dry January, Substance Misuse Week, and Foetal Spectrum Disorder.
- **Education and awareness-** The Partnership has provided education and awareness in relation to the dangers of alcohol to young people through healthy life style work in schools.
- **Enforcement -** The Partnership has continued to monitor sales of underage drinking, undertaking test purchasing where required, and delivered mandatory training to licensees around irresponsible drink promotions.

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Strategic Objective: Create confident, cohesive and safe communities:

- **Respect Your Neighbourhood Campaign** - Throughout the year we have delivered eleven multi-agency Neighbourhood Action Days to tackle environmental crime.
- **Targeted Youth Outreach Activities -** Have been delivered in anti-social behaviour hotspot areas to ensure young people remain safe and are diverted into positive activities.
- **Selective Licensing of landlords** – Following consultation we have identified further streets to extend selective licensing of landlords to more areas of the town.
- **Supported a number of Voluntary Sector Groups -** such as the Asylum Seeker Group, and Crime Prevention Panel to promote crime prevention messages and cultural diversity, and raise awareness of services available for victims of hate crime and domestic abuse.
- **Anti-social Behaviour Awareness Day (ASBAD) –** More than 1,500 secondary school pupils have taken part in the annual ASBAD event with interactive sessions on topics such as alcohol awareness, making hoax calls, and bullying.
- **Hate Crime** – We undertook an investigation into the levels and impact of hate crime through the Councils Overview and Scrutiny Committee, and a hate crime action plan will be delivered this year.
- **Operation Impact** - Introduced intensive police patrols in anti-social behaviour hotspot areas, and made extensive use of new powers under new anti-social behaviour legislation including dispersal orders.

Strategic Objective: Reduce offending and re-offending

Reducing offending and re-offending has been one of the main focuses of the Partnership during 2015/16. In response to high rates of reoffending in Hartlepool the Partnership has introduced a new strategy which aims to break the cycle of re-offending behaviour and improve public safety. The strategy aims to strengthen the ability of the Partnership to work together to provide local solutions to reoffending set against the broader context of the national Transforming Rehabilitation Strategy. Current activities aimed at reducing offending and reoffending include:

- **Triage Programme -** This scheme diverts young offenders into positive activities and support, instead of charging them and taking them to court. The initiative continues to reduce the numbers of young Hartlepool people entering the criminal justice system in Hartlepool and the success of the scheme is now being replicated across the Cleveland area.

- **Integrated Offender Management (IOM) –** This multi-agency approach to reducing re-offending has benefited from further development work this year with a multi-agency hub comprising of a Police Sergeant, HMP Prison Officers, a Community Rehabilitation Company Officer, Restorative Justice Co-ordinator, and Performance Officer co-located at Holme House Prison. The hub aims to improve 'through the gate services' ensuring a smooth transition for offenders into the community to reduce the risk of further offending behaviour.

- **Troubled Families Programme – Think Family / Think Community –** This government funded initiative entered its second phase during 2015. The programme aims to reduce youth offending, reduce anti-social behaviour, increase education attendance and get people into work. Due to the local success of the programme the government has committed funding to enable work to be undertaken with a further 143 families over the forthcoming year.

Strategic Assessment 2015

The ninth Safer Hartlepool Strategic Assessment was completed in December 2015 and contains information to aid the Partnership's understanding of the priority community safety issues in Hartlepool. The Assessment forms part of an intelligence-led approach to community safety, which enables a more focused, resource-effective and partnership-orientated delivery of options to help:

- Better understand the patterns and trends relating to crime, disorder and substance misuse issues affecting the Borough;
- Set clear and robust strategic priorities for the Partnership;
- Develop interventions and activities that are driven by reliable intelligence-led evidence.

The Strategic Assessment covers the twelve month period October 2014 to September 2015 and contains analysis of data obtained from both statutory and non-statutory partner agencies including: the Hartlepool Borough Council, Cleveland Police, Cleveland Fire Brigade, North Tees & Hartlepool NHS Foundation Trust, Housing Hartlepool, and Harbour Support Services. Additional information has also been obtained from community consultations and meetings.

Key findings from the Strategic Assessment period include:

Strategic Objective: Reduce Crime & Repeat Victimisation

- Recorded crime in Hartlepool has increased by 36% and remains above the national average.
- Acquisitive crimes, particularly domestic burglary offences, have increased.
- Repeat victimisation is evident in most crime categories; however it is even higher in violence offences, particularly domestic related violence.
- In the current economic climate there is potential that the numbers of repeat and vulnerable victims will increase.

Strategic Objective: Reduce the harm caused by drug & alcohol misuse

- Alcohol specific hospital admissions for adults and under 18's in Hartlepool are significantly higher than the national average.
- The number of people dependant on drugs in Hartlepool is twice the national average.
- There is a clear link between Class A drug misuse and the occurrence of acquisitive crime.
- The number of individuals accessing drug treatment has remained stable since the previous assessment period.

Strategic Objective: Create confident, cohesive and safe communities

- The number of anti-social behaviour incidents recorded in Hartlepool have reduced by 5%.
- Our most disadvantaged communities and neighbourhoods suffer from disproportionate levels of anti-social behaviour.
- Anti-social behaviour in all its forms act as visible signs of disorder in the community and is closely linked to perceptions of safety and satisfaction with their local area.

Strategic Objective: Reduce offending and re-offending

- Adult re-offending continues to be a significant factor, with more than 90% of repeat offenders being aged 18 years or over.
- Re-offenders have greater needs in respect of housing, education, training, employment and substance misuse.
- The number of young people entering the criminal justice system for the first time has reduced by 29% in comparison to the previous assessment period.

Public Consultation

To ensure that the Partnership is focusing on the issues that residents consider to be a priority, findings from local community consultations have been taken into consideration when setting the strategic objectives and priorities.

Face the Public

Consultation in the lead up to and at the Safer Hartlepool Partnership 'Face the Public' event held in October 2015 raised the following issues:

- How to sustain Neighbourhood Policing; the vital links with the community; and strong multi-agency partnership working.
- The importance of tackling anti-social behaviour and looking after the local environmental to improve quality of life.
- Improving safety on the streets and safety 'on-line'.
- Working with offenders and the importance of drug and alcohol treatment services.
- The need to ensure continued support for victims of crime and anti-social behaviour.

Safer Hartlepool Partnership On-line Survey

During September and October 2015 the Partnership undertook an on-line survey. Accessed via the Safer Hartlepool Partnership website, more than 200 people responded. As part of the survey participants were asked:

"Which of the Safer Hartlepool Partnership priorities is the most important to you?"

From the four choices available, the majority of respondents identified creating confident, strong and safe communities as the most important priority, as below:

- Create confident, strong and safe communities (41%)
- Reduce crime and repeat victimisation (25%)
- Reduce offending and re-offending (18%)
- Reduce the harm caused by drug and alcohol misuse (16%)

When participants were presented with a list of anti-social behaviour issues, and asked to tell us which they felt were a very or fairly big problem in their local area the following five issues were identified:

Rubbish or litter lying around **Speed and volume of road traffic** **Groups hanging around the streets**

People being drunk or rowdy in public places **People using or dealing drugs**

Partnership Strategic Objectives 2014-2017

Based on the findings in the annual Strategic Assessment and consultation with the local community, the Partnership will retain the following four strategic objectives during the lifetime of the three year plan:

Strategic Objectives 2014 - 2017	
Reduce crime and repeat victimisation	Reduce the harm caused by drug and alcohol misuse
Create confident, cohesive and safe communities	Reduce offending and re-offending

Partnership Priorities 2016-2017

To reflect community priorities evidenced in the community consultation process, during 2016/17 our key focus will be to: **"Create confident, cohesive and safe communities"** by concentrating on the following areas of concern:

Annual Priorities 2016 - 2017	
Re-offending - reduce re-offending through a combination of prevention, diversion and enforcement activity.	**Acquisitive Crime –** reduce acquisitive crime through raising awareness and encouraging preventative activity with a particular focus on domestic burglary.
Domestic Violence and Abuse – safeguard individuals and their families from violence and abuse and implement programmes to tackle those identified as 'high risk'.	**Anti-social behaviour –**. reduce anti-social behaviour through a combination of diversionary, educational, and enforcement action and increase restorative interventions.
Substance misuse – reduce the harm caused to individuals, their family and the community, by drug and alcohol misuse and alcohol related violence.	**Vulnerable Victims -** work together to identify and support vulnerable victims and communities experiencing crime and anti-social behavior.

Key activities over the next 12 months include:

Partnerships - we will review and implement new ways of partnership working investigating the use of new technology to manage anti-social behaviour cases and share information. We will continue to develop multi-agency partnership working in neighbourhoods, particularly those neighbourhoods experiencing high levels of crime, anti-social behaviour and environmental issues.

Crime Prevention – to reduce the opportunity for acquisitive crime to occur we will increase the use of technology to promote crime prevention advice and key safety messages, and continue to deliver our home and personal security service.

Substance Misuse - we will address the impact of drug and alcohol misuse on the broader community working in partnership with the police to target hotspot locations, and ensure appropriate treatment and recovery support services are in place for individuals and their families.

Anti-social behaviour – we will identify persistent offenders; making effective use of enforcement tools to protect the community and environment. We will ensure the effective resolution of anti-social behaviour, and increase the use of our restorative justice and mediation service to prevent escalation of behaviours negatively impacting on quality of life.

Vulnerable Victims – we will improve the identification of vulnerable victims; strengthen support pathways and links with safeguarding, protecting those at risk of exploitation.

Domestic Violence & Abuse – we will undertake an in depth needs analysis, and develop and implement a new strategy for tackling domestic abuse, exploring ways of supporting victims and their families, and making use of programmes to promotes healthy relationships and reduce abusive behaviours.

Offenders – we will continue to work with offenders and those at risk of offending, investing in families through early help services to prevent offending behaviour, and working with “Through the Gate” services to ensure offenders are fully reintegrated back into the community by providing support and improving access to stable accommodation.

Community Engagement – we will maintain vital links with the community ensuring pathways are in place for local residents to raise issues of concern, work with diverse communities, and maximize the work of the voluntary sector.

Measuring Performance

Partnership performance monitoring will be undertaken on a quarterly basis to assess progress against key priorities drawn from the strategic assessment and identify any emerging issues. Performance management reports will be provided to the Safer Hartlepool Partnership.

The following performance indicators will be monitored over the next 12 months:

Strategic Objective	Performance Indicator
Reduce crime & repeat victimisation	Total recorded crime rate per 1,000 population
	Domestic burglary rate per 1,000 household
	Vehicle crime rate per 1,000 population
	Robbery rate per 1,000 population
	Shoplifting rate per 1,000 population
	Violent crime (including sexual violence) rate per 1,000 population*
	% of violent crime (including sexual violence) that is domestic related
	% of repeat cases of domestic violence (MARAC)
	Violent crime (including sexual violence) hospital admissions for violence per 100,000 population*
Reduce the harm caused by drug and alcohol misuse	Drug offences per 1,000 population
	% of people who think drug use or dealing is a problem
	% of opiate drug users that have successfully completed drug treatment*
	% of non-opiate drug users that have successfully completed drug treatment*
	% of alcohol users that have successfully completed alcohol treatment
	Alcohol related hospital admissions rate per 100,000 population*
	Number of young people known to substance misuse services

*Indicators link to the Public Health Outcome Framework

Strategic Objective	Performance Indicator
Create confident, cohesive & safe communities	Anti-social behaviour incidents per 1,000 population
	Public order offences per 1,000 population
	Criminal damage rate per 1,000 population
	Deliberate fires rate per 1,000 population
	Number of reported hate crimes & incidents
	% of the population affected by noise - number of complaints about noise
	% of people who feel safe during the day
	% of people who feel safe after dark
	% of people who think rubbish or litter lying around is a problem
	% of people who think groups hanging around the streets is a problem
	% of people who think people being drunk or rowdy in a public place is a problem
	% of people who think vandalism, graffiti and other deliberate damage to property is a problem
	% of people who think noisy neighbours or loud parties is a problem
	% of people who think abandoned or burnt out cars are a problem
	% of people who think that they belong to their local area
	% of people who feel that they can influence decisions that affect their local area
	% of people who believe that people from different back grounds get on well together
	% of people who think that people in the area pull together to improve the local area
Reduce offending & re-offending	Rate of first-time entrants to the Youth Justice System per 100,000 population*
	Re-offending levels - percentage of offenders who re-offend*
	Re-offending levels - average number of re-offences per offender*
	Re-offending rate of Prolific & Priority Offenders
	Re-offending rate of High Crime Causers
	% of Troubled Families who have reduced their offending behaviour

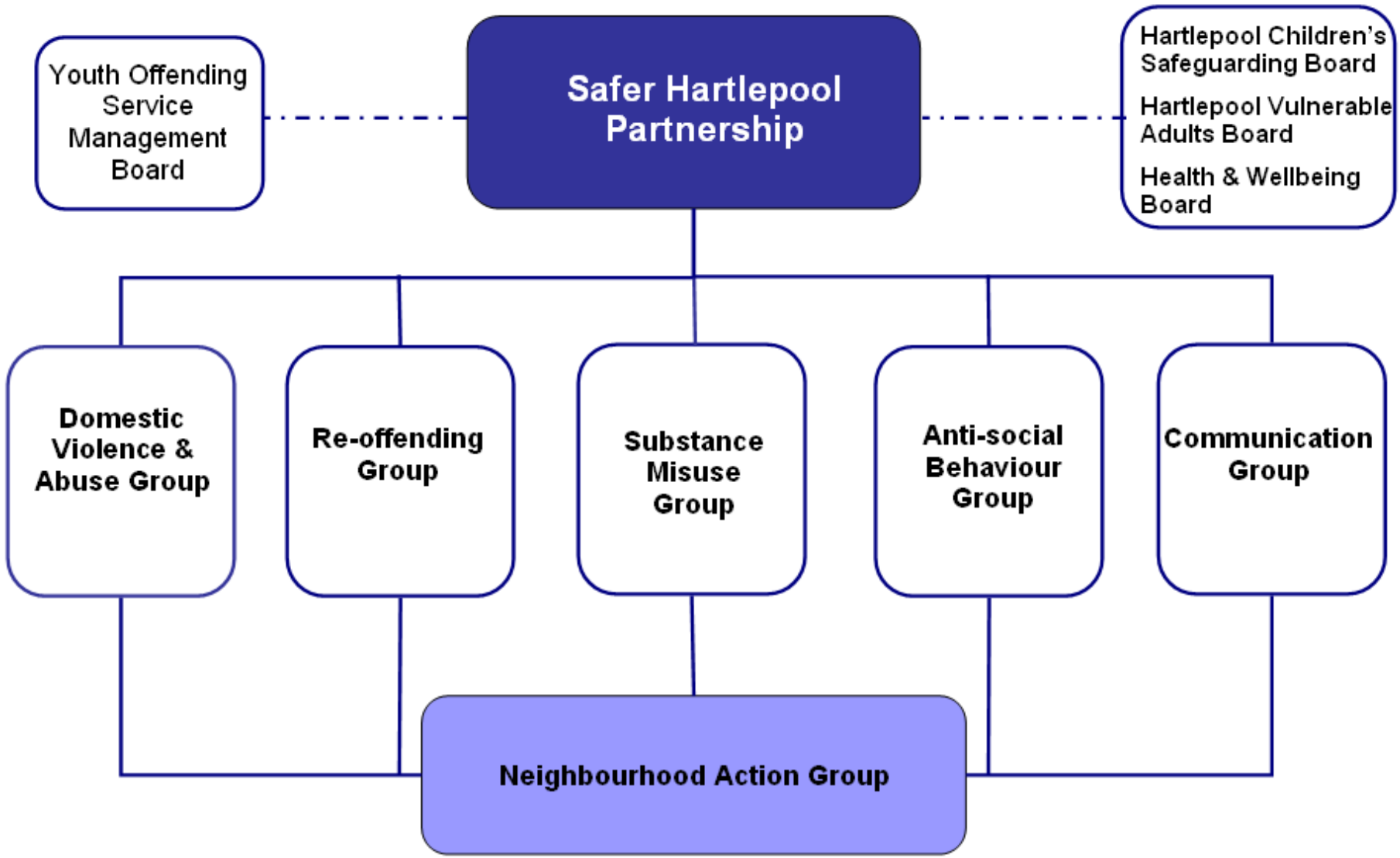
*Indicators link to the Public Health Outcome Framework

To be published in April 2016

Delivering the 2016/17 Priorities – Delivery Structure

Appendix 2

The responsibility for delivery of each of the priorities has been allocated to a dedicated theme group of the Safer Hartlepool Executive Group.




CLEVELAND
POLICE
Putting People First


HARTLEPOOL
BOROUGH COUNCIL


CLEVELAND
FIRE BRIGADE
Protecting local
communities


Durham Tees Valley
Community Rehabilitation Company


NHS
Hartlepool and Stockton-on-Tees
Clinical Commissioning Group


Safe
in Tees Valley


thirteen
Erimus Housing
Housing Hartlepool
Tees Valley Housing
Tristar Homes


National
Probation
Service

AUDIT AND GOVERNANCE COMMITTEE

11 February 2016

HARTLEPOOL BOROUGH COUNCIL

Report of: Scrutiny Manager

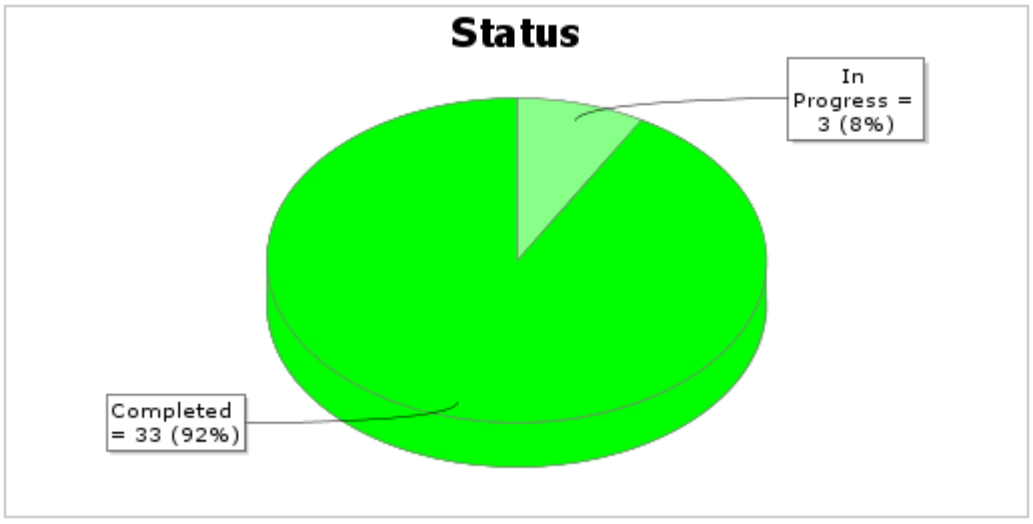
Subject: SIX MONTHLY MONITORING OF AGREED SCRUTINY RECOMMENDATIONS

1. PURPOSE OF REPORT

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

2. BACKGROUND INFORMATION

2.1 This report provides details of progress made against the investigations undertaken by this Committee in the 2013/14 and 2014/15 Municipal Year. **Chart 1** (overleaf) provides a detailed explanation of progress made against each scrutiny recommendation since the last six monthly monitoring report was presented to this Committee in August 2015.



Audit and Governance Committee - Health and Crime and Disorder

Generated on: 29 January 2016

Year 2013/14
Investigation COPD

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
SCR-HS/1a/i That the Health and Wellbeing Board develop a strategic approach to COPD to ensure that inequality is not worsened by:- (i) monitoring the review of the single point of access	SCR-HS/1a/i	Changes have been made to improve access to a respiratory clinician within the Hartlepool CRAMS service. These changes are still in a pilot phase with an evaluation of the impact to commence at the end of September 2014.	Scrutiny	31-Mar-2015	31-Mar-2015	23-Jun-2015 Satisfaction surveys are routinely given to Respiratory patients attending the CRAMS service. On analysis patients who have used the service for several years before the implementation of the Single Point of Access express less satisfaction with the response to a request for calls back or a home visit, while new patients demonstrate an extremely positive opinion of the service with only one or two comments about the length of time it can take to get a response to a query. Referrals from GP practices for pulmonary rehabilitation are as follows: April 13 - March 14: 30 April 14- March 15: 34 March 15-June 12: 27 10-Feb-2015 Changes have been made to improve access to a respiratory clinician within the Hartlepool CRAMS service. These changes are still in a pilot phase	100% Completed

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
						with an evaluation of the impact to commence at the end of September 2014.	
SCR-HS/1a/i That the Health and Wellbeing Board develop a strategic approach to COPD to ensure that inequality is not worsened by:- (i) monitoring the review of the single point of access	SCR-HS/1a/i/1	Data is collected on the use of the single point of access and we regularly review services in order to ensure that there is responsive service for patients. Assessment of the service impact on COPD patients and their families is not currently undertaken on a regular basis.	Scrutiny	30-Sep-2015	30-Sep-2015	07-Apr-2015 Data is collected on the use of the single point of access and we regularly review services in order to ensure that there is responsive service for patients. Assessment of the service impact on COPD patients and their families is not currently undertaken on a regular basis. 11-Feb-2015 Data is collected on the use of the single point of access and we regularly review services in order to ensure that there is responsive service for patients. Assessment of the service impact on COPD patients and their families is not currently undertaken on a regular basis.	100% Completed
SCR-HS/1a/ii That the Health and Wellbeing Board develop a strategic approach to COPD to ensure that inequality is not worsened by:- (ii) ensuring that any changes to service provision are appropriately evaluated	SCR-HS/1a/ii	Changes have been made to improve access to a respiratory clinician within the Hartlepool CRAMS service. These changes are still in a pilot phase with an evaluation of the impact to commence at the end of September 2014.	Scrutiny	31-Mar-2015	31-Mar-2015	06-Jul-2015 Satisfaction surveys are routinely given to Respiratory patients attending the CRAMS service. On analysis patients who have used the service for several years before the implementation of the Single Point of Access express less satisfaction with the response to a request for calls back or a home visit, while new patients demonstrate an extremely positive opinion of the service with only one or two comments about the length of time it can take to get a response to a query. Referrals from GP practices for pulmonary rehabilitation are as	100% Completed

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
						follows: April 13 - March 14: 30 April 14- March 15: 34 March 15-June 12: 27	
						10-Feb-2015 Changes have been made to improve access to a respiratory clinician within the Hartlepool CRAMS service. These changes are still in a pilot phase with an evaluation of the impact to commence at the end of September 2014.	
SCR-HS/1a/ii That the Health and Wellbeing Board develop a strategic approach to COPD to ensure that inequality is not worsened by:- (ii) ensuring that any changes to service provision are appropriately evaluated	SCR-HS/1a/ii/1	The CCG undertake regular review of our commissioned services in order to ensure that they are both effective pathways and complying with our objective to provide the best value for money in care services. Whilst we strive to be innovative in the services that we design and commission we also seek t learn from other areas. We continually monitor and assess the services that are delivered and listen to the feedback and experiences of our patients. We are currently undertaking a review of COPD and Pulmonary Rehab (PR) services which aspires towards a more cost effective service, integrated with primary	Scrutiny	31-Mar-2016	31-Mar-2016	09-Oct-2015 The CCG have completed a review of COPD and Pulmonary Rehab (PR) services which aspires towards a more cost effective service, integrated with primary care and enhancing access to PR for lower levels of COPD severity. The outcome of which has resulted in a new service being piloted that will deliver services closer to the patient with access to specialist support when required. The pilot is being evaluated in a staged process so as to better understand the impact of the changes made. Evaluation should be completed by early 2016.	60% In Progress
						06-Jul-2015 The CCG have completed a review of COPD and Pulmonary Rehab (PR) services which aspires towards a more cost effective service, integrated with primary care and enhancing access to PR for lower levels of COPD severity. The outcome of	

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
		care and enhancing access to PR for lower levels of COPD severity.				which has resulted in a new service being piloted that will deliver services closer to the patient with access to specialist support when required. The pilot is being evaluated in a staged process so as to better understand the impact of the changes made. Evaluation should be completed by early 2016.	
SCR-HS/1b That the Health and Wellbeing Board explores ways to promote COPD support programmes, such as the pulmonary rehabilitation programme, to encourage people to attend	SCR-HS/1b	The services delivering care to COPD patients have actively promoted support programmes through one to one discussions, advertisements in key locations within the community and within the Trust. Staff are also arranging meetings with practices and developing a leaflet to promote and encourage attendance.	Scrutiny	28-Feb-2015	28-Feb-2015	23-Jun-2015 Over the past 12 months the Respiratory team have contacted practices across Hartlepool and Stockton to promote the pulmonary rehabilitation programmes as well as an education programme for newly diagnosed COPD patients. A number of meetings were held to promote services available to COPD patients. Staff delivered road shows at a variety of community settings including the public library and supermarkets. Leaflets were sent out to GP practices on a number of occasions and were erected within secondary care to raise awareness among visitors. The Trust twitter account has been used to promote support services and the Hartlepool Mail and Evening gazette have also printed an article for respiratory services.	100% Completed
						23-Jun-2015 Promotion of the programme will be on-going however meetings with practices to promote uptake and referral is	

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
						due to be complete February 2015	
SCR-HS/1b That the Health and Wellbeing Board explores ways to promote COPD support programmes, such as the pulmonary rehabilitation programme, to encourage people to attend	SCR-HS/1b/i	The CCG are currently undertaking a review of our commissioned PR services to ensure that we commission services which will meet the needs of our patients. We continue to work with our GP members and the acute trust to encourage patients to access the programme and promote self-management. We have also implemented a scheme within practices to identity patients with COPD and which highlights PR use by practice with benchmarking between practices as well as prevalence and uptake of the COPD screening figures which are fed back to practices to help to increase performance.	Scrutiny	31-Mar-2016	31-Mar-2016	09-Oct-2015 The CCG has access to data on levels of activity related to the avoidable attendances and admissions associated with respiratory conditions and therefore this is a contributing factor to our efforts to encourage patient self – management. 03-Jul-2015 The CCG has access to data on levels of activity related to the avoidable attendances and admissions associated with respiratory conditions and therefore this is a contributing factor to our efforts to encourage patient self – management.	80% In Progress
SCR-HS/1c 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	SCR-HS/1c	The CCG continually seek to work in partnership with other commissioners and providers to ensure that we are aware of patient needs and expectations and to develop ways to learn and progress together.	Scrutiny	31-Mar-2016	31-Mar-2016	12-Jan-2016 The CCG continually seek to work in partnership with other commissioners and providers to ensure that we are aware of patient needs and expectations and to develop ways to learn and progress together. Health and Wellbeing Board received the Action Plan in relation to the implementation of the Investigations recommendations	80% In Progress

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
message on COPD through the use of a single questionnaire						at its meeting on the 2 March 2015. The Board noted progress of the COPD recommendations and action plan was noted - to be progressed. 09-Oct-2015 The CCG continually seek to work in partnership with other commissioners and providers to ensure that we are aware of patient needs and expectations and to develop ways to learn and progress together. Health and Wellbeing Board received the Action Plan in relation to the implementation of the Investigations recommendations at its meeting on the 2 March 2015. The Board noted progress of the COPD recommendations and action plan was noted - to be progressed.	
SCR-HS/1d 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	SCR-HS/1d	Public Health has already taken the lead on behalf of the Board over the past year to promote the questionnaire. Public Health will build on this previous activity during 2014/15 to ensure the questionnaire is circulated across a range of settings to find those people with undiagnosed COPD	Carole Johnson; Louise Wallace	31-Mar-2015	31-Mar-2015	18-Aug-2015 In addition to circulating more generally, including a range of businesses and workplaces, the Specialist Stop Smoking Service commissioned by the LA uses the questionnaire to assess the risk of COPD in smokers over the age of 35. Those at risk being signposted to GP practice for further investigation. This work is ongoing. 10-Feb-2015 This work is ongoing. In addition to circulating more generally, the Specialist Stop Smoking Service commissioned by the LA uses the questionnaire to assess the risk of COPD in smokers over the	100% Completed

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
						age of 35. Those at risk being signposted to GP practice for further investigation.	
SCR-HS/1e 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;	SCR-HS/1e	Public Health has led this activity on behalf of the Board and will continue to do so through activities such as theatre in education and schools. This approach has proven successful in raising awareness amongst young people of the short and long term healthy implications of smoking.	Carole Johnson; Louise Wallace	31-Mar-2015	31-Mar-2015	18-Aug-2015 All performances and workshops for year 7 pupils completed by the end of April. Planning for 15/16 already underway. School nurses and some youth workers now trained to deliver smoking cessation support to young people. Performances for Year 10 planned for later in the year. 10-Feb-2015 This work is now progressing well with theatre in education performances/workshops for year 7 pupils being timetabled for the summer term. Additional performance planned for Year 10s to coincide with launch of smoking intervention for young people. School nurses, other school staff and youth workers are being trained to deliver this intervention with support from the Specialist Service.	100% Completed
SCR-HS/1f 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	SCR-HS/1f	Public health are responsible for commissioning the COPD screening programme in primary care. This requires practices to ensure that patients most at risk of developing COPD i.e those that smoke, are made aware of this service. Public Health will provide a report on uptake, impact and	Carole Johnson; Louise Wallace	31-Mar-2015	31-Mar-2015	18-Aug-2015 Work is ongoing although there has been a decline in patients receiving a lung health check in the last quarter. This is being looked at by the Shared Service. 10-Feb-2015 The work is ongoing and a report has been prepared by the Tees Valley Public Health Shared Service for the March Board meeting.	100% Completed

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
variations in practices		variation of this service provided by GP's to the Health and Wellbeing Board by March 2015.					

Year 2013/14
Investigation Re-offending

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
SCR-CD/1g/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.	scr-CD/1g/vii	The draft reducing re-offending strategy and associated action plan includes all of the suggestions outlined.	Clare Clark	31-Jul-2014	31-Jul-2014	13-Apr-2015 All actions have been incorporated into the Reducing Reoffending Action Plan approved by the Safer Hartlepool Partnership in November 2014 24-Oct-2014 All actions identified as a result of the review by Scrutiny, will be incorporated into the reducing reoffending strategy action plan and reported back through this mechanism. The reducing reoffending strategy action plan is due to be consider for approval by the Safer Hartlepool Partnership in November.	100% Completed
SCR-CD/1a The extension of the triage service to include adults be explored	SCR-CD/1a	The further development of the triage service will also be explored as part of the Police and Crime Commissioner's - Restorative Justice Hub and the local implementation of the RESTORE project.	Clare Clark	28-Feb-2015	28-Feb-2015	13-Apr-2015 All actions have been incorporated into the Reducing Reoffending Action Plan approved by the Safer Hartlepool Partnership in November 2014 24-Oct-2014 All actions identified as a result of the review by Scrutiny, will be incorporated into the reducing reoffending strategy action plan and reported back through this mechanism. The reducing	100% Completed

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
						reoffending strategy action plan is due to be consider for approval by the Safer Hartlepool Partnership in November.	
SCR-CD/1b 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.	SCR-CD/1b/i	Following the transfer of rehabilitation services to the new Community Rehabilitation Company (CRC) and National Probation Service (NPS) a new service level agreement to ensure the continuance of the Community Payback Scheme in Hartlepool through effective links with HBCs Community Safety and Environmental Teams will be established.	Jon Wright	31-Mar-2015	31-Mar-2015	14-Jul-2015 I have worked with the Service Development team and The Durham Tees Valley Probation Service, therefore have been able to come up with the appropriate risk assessments and working procedures to be able to integrate these service seamlessly. 13-Apr-2015 unfortunately due to HBC restructuring and all the changes within the CRC this has not been accomplished and finalised yet. However contacts have now been made and officers are working towards completion by the end of May 2015.	100% Completed
SCR-CD/1b 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.	SCR-CD/1b/ii	A toolbox talk will be developed to ensure the local workforce is trained to equip them with the skills to effectively interact with the ex-offenders in a work place environment .	Jon Wright	31-Jan-2015	31-Jan-2015	14-Jul-2015 I have worked with the Service Development team and The Durham Tees Valley Probation Service, therefore have been able to come up with the appropriate risk assessments and working procedures to be able to integrate these service seamlessly. 13-Apr-2015 unfortunately due to HBC restructuring and all the changes within the CRC this has not been accomplished and finalised yet. However contacts have now been made and officers are working towards completion by the end of May 2015.	100% Completed

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
SCR-CD/1c 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	SCR-CD/1c	This will be investigated on a Tees-wide basis with the new CRC, exploring links with the GALLANT project.	Clare Clark	31-Dec-2014	31-Dec-2014	13-Apr-2015 All actions have been incorporated into the Reducing Reoffending Action Plan approved by the Safer Hartlepool Partnership in November 2014 24-Oct-2014 All actions identified as a result of the review by Scrutiny, will be incorporated into the reducing reoffending strategy action plan and reported back through this mechanism. The reducing reoffending strategy action plan is due to be consider for approval by the Safer Hartlepool Partnership in November.	100% Completed
SCR-CD/1d 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.	SCR-CD/1d	Funding has been identified and secured to create a Housing Liaison Officer post, based on the Sunderland model, with an anticipated start date of September 2014.	Clare Clark	30-Sep-2014	30-Sep-2014	13-Apr-2015 All actions have been incorporated into the Reducing Reoffending Action Plan approved by the Safer Hartlepool Partnership in November 2014 24-Oct-2014 All actions identified as a result of the review by Scrutiny, will be incorporated into the reducing reoffending strategy action plan and reported back through this mechanism. The reducing reoffending strategy action plan is due to be consider for approval by the Safer Hartlepool Partnership in November.	100% Completed
SCR-CD/1e That the potential for the Council to be involved in schemes similar to the 'Change for	SCR-CD/1e	This will be explored as part of the local strategies attempts to improve the employment pathway with a report on	Patrick Wilson	28-Feb-2015	28-Feb-2015	07-Apr-2015 We have explored the support we can offer to customers through the Reducing Reoffending Task Group with meeting continuing over the next year.	100% Completed

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
Change' scheme operated at Deerbolt Prison		outcome of investigations and potential opportunities for development.				08-Jan-2015 Discussions are continuing between the Reducing Reoffending Task Group and Economic Regeneration to ensure that there are employment and apprenticeship opportunities for ex-offenders using the Change for Change scheme as an example.	
SCR-CD/1f 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.	SCR-CD/1f	This will be developed over the forthcoming year in Hartlepool with police and health partners as part of the roll out Criminal Liaison and Diversion Scheme. A representative will be invited to a future meeting of the SHP to deliver a presentation outlining progress to date and future plans for the service	Clare Clark	31-Oct-2014	31-Oct-2014	13-Apr-2015 All actions have been incorporated into the Reducing Reoffending Action Plan approved by the Safer Hartlepool Partnership in November 2014 24-Oct-2014 All actions identified as a result of the review by Scrutiny, will be incorporated into the reducing reoffending strategy action plan and reported back through this mechanism. The reducing reoffending strategy action plan is due to be consider for approval by the Safer Hartlepool Partnership in November.	100% Completed
SCR-CD/1g/i 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.	SCR-CD/1g/i	The draft reducing re-offending strategy and associated action plan includes all of the suggestions outlined.	Clare Clark	31-Jul-2014	31-Jul-2014	13-Apr-2015 All actions have been incorporated into the Reducing Reoffending Action Plan approved by the Safer Hartlepool Partnership in November 2014 24-Oct-2014 All actions identified as a result of the review by Scrutiny, will be incorporated into the reducing reoffending strategy action plan and reported back through this mechanism. The reducing reoffending strategy action plan is due to be consider for	100% Completed

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
						approval by the Safer Hartlepool Partnership in November.	
SCR-CD/1g/ii The adoption of the Team Around/IOM principles as a template for the provision of holistic / offender centric re-offending prevention services.	SCR-CD/1g/ii	The draft reducing re-offending strategy and associated action plan includes all of the suggestions outlined.	Clare Clark	31-Jul-2014	31-Jul-2014	13-Apr-2015 All actions have been incorporated into the Reducing Reoffending Action Plan approved by the Safer Hartlepool Partnership in November 2014 24-Oct-2014 All actions identified as a result of the review by Scrutiny, will be incorporated into the reducing reoffending strategy action plan and reported back through this mechanism. The reducing reoffending strategy action plan is due to be consider for approval by the Safer Hartlepool Partnership in November.	100% Completed
SCR-CD/1g/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	SCR-CD/1g/iii	The draft reducing re-offending strategy and associated action plan includes all of the suggestions outlined.	Clare Clark	31-Jul-2014	31-Jul-2014	13-Apr-2015 All actions have been incorporated into the Reducing Reoffending Action Plan approved by the Safer Hartlepool Partnership in November 2014 24-Oct-2014 All actions identified as a result of the review by Scrutiny, will be incorporated into the reducing reoffending strategy action plan and reported back through this mechanism. The reducing reoffending strategy action plan is due to be consider for approval by the Safer Hartlepool Partnership in November.	100% Completed
SCR-CD/1g/iv The prevention of duplication in service deliver,	SCR-CD/1g/iv	The draft reducing re-offending strategy and associated action plan includes all of the	Clare Clark	31-Jul-2014	31-Jul-2014	13-Apr-2015 All actions have been incorporated into the Reducing Reoffending Action Plan approved by the Safer	100% Completed

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
and loss of the positive outcomes already achieved, following the implementation of the Reform to improve the delivery of re-offending service are welcomed,		suggestions outlined.				Hartlepool Partnership in November 2014 24-Oct-2014 All actions identified as a result of the review by Scrutiny, will be incorporated into the reducing reoffending strategy action plan and reported back through this mechanism. The reducing reoffending strategy action plan is due to be consider for approval by the Safer Hartlepool Partnership in November.	
SCR-CD/1g/v The development of drug, housing and employment services as a priority for the future to meet the criminogenic needs of offenders in Hartlepool	SCR-CD/1g/v	The draft reducing re-offending strategy and associated action plan includes all of the suggestions outlined.	Clare Clark	31-Jul-2014	31-Jul-2014	13-Apr-2015 All actions have been incorporated into the Reducing Reoffending Action Plan approved by the Safer Hartlepool Partnership in November 2014 27-Oct-2014 All actions identified as a result of the review by Scrutiny, will be incorporated into the reducing reoffending strategy action plan and reported back through this mechanism. The reducing reoffending strategy action plan is due to be consider for approval by the Safer Hartlepool Partnership in November.	100% Completed
SCR-CD/1g/vi The importance of addressing unemployment and poor educational attainment in disadvantaged areas, to raise aspirations and challenge the cycle	SCR-CD/1g/vi	The draft reducing re-offending strategy and associated action plan includes all of the suggestions outlined.	Clare Clark	31-Jul-2014	31-Jul-2014	13-Apr-2015 All actions have been incorporated into the Reducing Reoffending Action Plan approved by the Safer Hartlepool Partnership in November 2014 27-Oct-2014 All actions identified as a result of the review by Scrutiny, will be incorporated into the reducing	100% Completed

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
of offender behaviour across generations.						reoffending strategy action plan and reported back through this mechanism. The reducing reoffending strategy action plan is due to be consider for approval by the Safer Hartlepool Partnership in November.	
SCR-CD/1g/viii Improvement in the provision of services in relation to Housing advice starting earlier than 2 weeks before the release date for prisoner and provision of greater flexibility and ability for housing services to respond more appropriately	SCR-CD/1g/viii	The draft reducing re-offending strategy and associated action plan includes all of the suggestions outlined.	Clare Clark	31-Jul-2014	31-Jul-2014	13-Apr-2015 All actions have been incorporated into the Reducing Reoffending Action Plan approved by the Safer Hartlepool Partnership in November 2014 27-Oct-2014 All actions identified as a result of the review by Scrutiny, will be incorporated into the reducing reoffending strategy action plan and reported back through this mechanism. The reducing reoffending strategy action plan is due to be consider for approval by the Safer Hartlepool Partnership in November.	100% Completed
SCR-CD/1g/vx Pressures placed on the community through the welfare reforms and their potential impact on the issues and factors that influence/ effect re-offending.	SCR-CD/1g/vx	The draft reducing re-offending strategy and associated action plan includes all of the suggestions outlined.	Clare Clark	31-Jul-2014	31-Jul-2014	13-Apr-2015 All actions have been incorporated into the Reducing Reoffending Action Plan approved by the Safer Hartlepool Partnership in November 2014 24-Oct-2014 All actions identified as a result of the review by Scrutiny, will be incorporated into the reducing reoffending strategy action plan and reported back through this mechanism. The reducing reoffending strategy action plan is due to be consider for approval by the Safer Hartlepool Partnership in November.	100% Completed

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
SCR-CD/1g/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.	SCR-CD/1g/x	The draft reducing re-offending strategy and associated action plan includes all of the suggestions outlined.	Clare Clark	31-Jul-2014	31-Jul-2014	13-Apr-2015 All actions have been incorporated into the Reducing Reoffending Action Plan approved by the Safer Hartlepool Partnership in November 2014 24-Oct-2014 All actions identified as a result of the review by Scrutiny, will be incorporated into the reducing reoffending strategy action plan and reported back through this mechanism. The reducing reoffending strategy action plan is due to be consider for approval by the Safer Hartlepool Partnership in November.	100% Completed

Year 2014/15
Investigation Dementia

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
SCR-HS/2a That Council pledge their support towards Hartlepool becoming a Dementia Friendly Town	SCR-HS/2a	Pledges received from key Council Members, pledges being gathered from key council officers. Dementia Friendly Community accreditation obtained, secretary of the DFC steering group to arrange for a launch event – to be raised at next steering group meeting	Jeanette Willis	30-May-2015	30-May-2015		100% Completed
SCR-HS/2b/i That the HWBB raise awareness of dementia in order	SCR-HS/2b/i	Dementia Friends sessions already been rolled out across the council 70 trained so far	Jeanette Willis	30-May-2015	30-May-2015	19-Jun-2015 In place - ongoing awareness raising programme	100% Completed

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
to promote a greater understanding of the condition across:- (i)Council departments by encouraging Council staff to become dementia friends		with a further 50 in partner agencies. Further training to be offered through the Dementia Friendly Communities project & internally via Commissioning team HBC					
SCR-HS/2b/ii That the Health and Wellbeing Board raise awareness of dementia in order to promote a greater understanding of the condition across:- Organisations/businesses in Hartlepool, with the aim of each organisation/business pledging their support	SCR-HS/2b/ii	Already many local organisations signed up to DFC – official launch will be conduit for promotion to wider community and organisations	Jeanette Willis	07-Aug-2015	07-Aug-2015	29-Jan-2016 Hartlepool as a Dementia Friendly Community is well established with initial accreditation and a launch celebrated in September 2015 with a Memory Walk. A steering group comprising local organisations is active in promoting and welcoming new pledges. A dementia hub (The Bridge) is open in a town centre location with a fully integrated Dementia Advisory Service enabling individuals, carers and local organisations to receive information, advice and support.	100% Completed
SCR-HS/2b/iii That the Health and Wellbeing Board raise awareness of dementia in order to promote a greater understanding of the condition across:- (iii) Communities and the general public.	SCR-HS/2b/iii/a	Hartlepool Now – revised information and advice system to be accessed by all professionals and can be accessed by community if internet access available. All providers will link to this site contractually to ensure information is up to date and relevant.	Leigh Keeble	29-May-2015	29-May-2015	19-Jun-2015 In place ongoing promotion across the Council, partner agencies and communities	100% Completed
SCR-HS/2b/iii That	SCR-	The Bridge – community	Leigh Keeble	29-May-2015	29-May-2015		100% Complete

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
the Health and Wellbeing Board raise awareness of dementia in order to promote a greater understanding of the condition across:- (iii) Communities and the general public.	HS/2b/iii/b	central hub for dementia – established by Hospital of God to complement all dementia services.					d
SCR-HS/2c That the HWBB explore how support to people with dementia and their families / carers can be maximised and co-ordinated across all services, including the establishment of identified individuals responsible for maintaining contact	SCR-HS/2c/i	Identified dementia social workers in each of the locality teams in Adult Services.	John Lovatt	29-May-2015	29-May-2015		100% Completed
SCR-HS/2c That the HWBB explore how support to people with dementia and their families / carers can be maximised and co-ordinated across all services, including the establishment of identified individuals responsible for maintaining	SCR-HS/2c/ii	Dementia Advisory service currently out for tender to ensure information and advice available from diagnosis through to end of life.	Jeanette Willis	31-Jul-2015	31-Jul-2015	16-Jul-2015 Hospital of God successfully awarded contract for Dementia Advisory service to be hosted from The Bridge.	100% Completed

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress
contact							
SCR-HS/2c That the HWBB explore how support to people with dementia and their families / carers can be maximised and co-ordinated across all services, including the establishment of identified individuals responsible for maintaining contact	SCR-HS/2c/iii	Dementia contract let October 2014 incorporating, day opportunities and personalised support in the community. Additional services provided by the successful organisation (Hospital of God) include home to hospital support and carer support services.	Jeanette Willis	29-May-2015	29-May-2015		100% Completed
SCR-HS/2c That the HWBB explore how support to people with dementia and their families / carers can be maximised and co-ordinated across all services, including the establishment of identified individuals responsible for maintaining contact	SCR-HS/2c/iiii	ICLES (Intensive Community Liaison Services) working into Care Homes and Community Dementia Liaison Service both provided by TEWV contracted by CCG. Review to be undertaken in coming months to ensure sustainability and effectiveness. Proactive approaches to be taken following review to ensure actions are not retrospective.	John Lovatt; Jeanette Willis	31-Aug-2015	31-Aug-2015	29-Jan-2016 A range of services / organisations work together to ensure support is available for individuals and carers. Hartlepool Now provides advice and information about services and support for people with a range of needs, including dementia. The dementia hub at The Bridge provides a Dementia Advisory Service, health services support early diagnosis and ongoing support, there are a range of community based services in place including day opportunities, individual support and specialist domiciliary care and residential care is supported well throughout the town. Individuals living with dementia and their carers are able to access support at an appropriate level dependent on the point in their journey.	100% Completed

3. RECOMMENDATIONS

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

4. REASONS FOR RECOMMENDATIONS

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

5. BACKGROUND PAPERS

(a) Report of the Scrutiny Support Officer entitled 'Six Monthly Monitoring of Agreed Scrutiny Recommendations' presented to the Audit and Governance Committee on 6 August 2015.

6. CONTACT OFFICER

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Chief Executive's Department – Legal Services
Hartlepool Borough Council
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HEALTH AND WELLBEING BOARD

MINUTES AND DECISION RECORD

30 November 2015

The meeting commenced at 10 am in the Civic Centre, Hartlepool

Present:

Councillor C Akers-Belcher, Leader of Council (In the Chair)

Prescribed Members:
Elected Members, Hartlepool Borough Council – Councillors Carl Richardson, and Chris Simmons
Representatives of Hartlepool and Stockton-on-Tees Clinical Commissioning Group (2) – Dr Schock and Karen Hawkins (as substitute for Ali Wilson)
Director of Public Health, Hartlepool Borough Council - Louise Wallace
Representative of Healthwatch – Ruby Marshall

Other Members:
Chief Executive, Hartlepool Borough Council – Gill Alexander
Representative of Hartlepool Voluntary and Community Sector – Tracy Woodhall
Representative of Tees Esk and Wear Valley NHS Trust – David Brown (as substitute for Martin Barkley)
Representative of North Tees and Hartlepool NHS Foundation Trust – Alan Foster

Also in attendance:-
Ian Hayton, Chief Fire Officer, Cleveland Fire Authority
Phillipa Walters, Pharmaceutical Advisor, Tees Valley Public Health Shared Service
Donna Owens, Joint Commissioning Manager, North of England Commissioning Support

Hartlepool Borough Council Officers:
Jill Harrison, Assistant Director (Adult Services)
N Harrison, Head of Service
Simon Howard, Public Health Registrar
Lesley Huitson, Technical Officer (Health and Safety)
Linda Igoe, Principal Housing Advice Officer
Karen Kelly, Principal Housing Strategy Officer
Sylvia Pinkney, Head of Public Protection
Amanda Whitaker, Democratic Services Team

Also present:-
Healthwatch – L Allison, J Gray, G and S Johnson,

37. Apologies for Absence

Director of Child and Adult Services, Hartlepool Borough Council – Sally Robinson
Representative of Healthwatch – Margaret Wrenn
Director of Regeneration and Neighbourhoods, Hartlepool Borough Council – Denise Ogden
Representative of Cleveland Police – Simon Nickless

38. Declarations of interest by Members

None

39. Minutes

The minutes of the meeting held on 5 October 2015 were confirmed.

40. Transforming Care – North East and Cumbria Fast Track Programme (*Director of Child and Adult Services and Chief Officer of Hartlepool and Stockton-on-Tees Clinical Commissioning Group*)

The Board received a report and presentation on the Regional Plan, with particular reference to the Tees Locality Plan and the North East and Cumbria Fast Track Plan. The Board was advised that North East and Cumbria was one of five fast track sites which had been selected because of high numbers of people with learning disabilities in in-patient settings. An overarching North East & Cumbria plan had been submitted with each of the 13 Local Authority areas also presenting their own plans which outlined local initiatives that reduced the need for admission to hospital. The Board was advised that notification had been received from NHS England on 5 October that the North East and Cumbria had been successful in securing £1,432M from an available pot of £8.2 million. A further £623,000 had been allocated following review of patient level business cases to assist in the double running/ transition where required to ensure safe transition of service from in-patient care to community based provision and to maintain patient safety. The report provided comprehensive background details to the Plan together with details of the areas which had been identified to build upon the progress already achieved locally. It was proposed that through the delivery of the specific areas of the Tees Fast Track Locality Plan, there would be a stronger prevention and intervention response to people who could require high levels of care and support.

The aspirations included in the report were supported by Board Members. Clarification was sought regarding future bed requirements as an important prerequisite to ensuring infrastructure was in place. The Chair requested that

the issue be addressed in next update report to be submitted to the Board.

Decision

(i) The Board supported and approved the National and Regional Plans, in particular the appended Tees Locality Plan
(ii) The Board agreed to receive regular updates on local progress in relation to Fast Track implementation.
(iii) The Board noted the need to reflect the Transforming Care agenda in any wider strategic plans that are developed locally.

41. Pharmaceutical Needs Assessment 2015: Maintenance as Statutory Duty (*Tees Valley Public Health Service*)

The report provided assurance on statutory maintenance of the Hartlepool Pharmaceutical Needs Assessment (PNA) 2015.The Board had published its first Pharmaceutical Needs Assessment on 26 March 2015, in accordance with the statutory duty to do so by 1st April 2015. The report provided an update on required maintenance of the Board's PNA 6 months post-publication.

The Pharmaceutical Advisor, Tees Valley Public Health Shared Service, advised the Board of changes to Pharmaceutical services. NHS England had notified a change to the supplementary opening hours of Victoria Pharmacy located in the H3 PNA locality of Hartlepool such that from 31st March 2015 they would now close at 6 pm (previously 6.30 pm) on the weekdays that they open. This change was used to illustrate the decision-making required to maintain the PNA within the context of the 2013 Regulations. The Health and Wellbeing Board was advised that it did not need to publish a revised assessment and it would be a disproportionate response to do so. Having regard to Part 2 (3), any change to pharmaceutical services could, in some future circumstance be relevant to the granting of applications referred to in section 129(2)(c)(i) or (ii) of the 2006 Act. However, it was not considered that this change alone, at this location in Hartlepool, would be relevant at this time. Nevertheless, a supplementary statement to the PNA could be published to notify this change. The Health and Wellbeing Board would again be satisfied that making a revised assessment would be a disproportionate response.

Decision

(i) The report was received for information and assurance regarding the responsibility of the Board for maintenance of the PNA, including the need to assess on-going changes which might impact on pharmaceutical need and the assessment thereof and respond by initiating early review or publishing a Supplementary Statement to the 2015 PNA as required.

(ii) Member organisations were encouraged to actively contribute intelligence on changes which might impact on the local needs for pharmaceutical services

(iii) It was agreed to continue delegation of authority to the Director of Public Health and Chair to make routine initial assessment with respect to the potential for Supplementary Statement or need for full review.

42. Health and Homelessness (*Director of Public Health*)

The Director of Public Health introduced a presentation regarding health and homelessness. It was highlighted that people who were homeless tended to experience worse health than people who had secure and stable accommodation. The presentation considered the issues relating to health as a result of being homeless and highlighted the following:-

- Importance of housing and health
- Health needs of homeless people.
- Homelessness in Hartlepool
- What actions are being taken to address the solution
- Partnerships

Board Members recognised the complexity of the issue. It was suggested that a copy of the presentation be circulated in order that the issues raised could be considered further. The Chair proposed that the issue of homelessness be considered as part of the refresh of the Health and Wellbeing Strategy. Discussion took place on the number of homeless persons in the town. The Chair referred to national campaigns which had been undertaken and highlighted the need to liaise with the Council's press team to communicate the correct course of action if the public observe any homeless person. It was highlighted that there had been some publicity but a strategy for wider coverage was considered beneficial.

Decision

The content of the presentation was noted.

43. Presentation – Fire as a Health Asset

The Board received a detailed presentation by the Chief Fire Officer, Cleveland Fire Authority, which highlighted that the successful fire prevention approach delivered via 30,000 targeted Home Fire Safety Visits had the potential to be expanded to complement and support the health and social care sector. The Board was advised that Professor Sir Michael Marmot, in the Marmot Review 2010, had recognised "the agenda of preventing ill-health and preventing fires are closely linked. Fires and ill-health occur in the more deprived areas; to people at the bottom of the socio-economic gradient; to

those in poor quality housing and those whose circumstances have led them to take up unhealthy life styles." The presentation highlighted the tangible opportunities for intervention and included the following opportunities to work together:-

- demand for health and social care is increasing as a result of an increase in people with long term conditions alongside an ageing population
- the number of fires has decreased due to preventative work by Fire and Rescue Services alongside regulatory measures
- The NHS Five year forward view highlights calls for an increased focus on service integration and getting serious about prevention to reduce demand increase capacity and save time, money and resources
- There is a significant overlap with risk factors and both the NHS and Fire Service recognise the potential to synergise their preventative needs recognising the importance of making every contact count
- This has resulted in an opportunity for Fire and Rescue Services and the health and social care sector to work together to make the difference needed

Mr Hayton concluded the presentation with an offer from the Fire and Rescue Service to Strategic Health Partners to work together with health partners to use collective capabilities and resources more effectively to enhance intelligence-led early intervention and prevention; ensuring people with complex needs get the personalised, integrated care and support they need to live full lives, sustain their independence for longer and in doing so reduce preventable hospital admissions and avoidable winter pressures/deaths.

Board Members recognised the potential opportunities which had been highlighted by the presentation including the connection to the health and homelessness issues discussed earlier in the meeting. A copy of the presentation was requested by the Chief Executive, North Tees and Hartlepool NHS Foundation Trust.

Decision

(i) The Board agreed that a Task and Finish Group comprising members of the Board would be appropriate to progress the opportunities highlighted in the presentation
(ii) The Board agreed to include reference to the contribution the Fire Service can make to Health and Wellbeing in JSNA.

44. Skin Cancer Prevention – Saving our Skins Initiative

(*Director of Public Health*)

The report provided the Board with information regarding the Public Protection Section's Save Our Skins Initiative. The report emphasised the second phase

of the initiative which was being delivered in pre-school nurseries and after-school clubs. The Board was advised that the aim of the Save our Skins Initiative was to raise awareness of the risk of skin cancer due to overexposure of ultraviolet radiation and promote sun safe behaviour in Hartlepool. In order to effectively deliver the Sun Safe message to a broad cross section of the community, the Sun Safe Initiative had been delivered in phases. The initial phase, which was completed during 2014-15, involved Public Protection staff visiting sun bed salons to assess the level of compliance with the Health and Safety Executive (HSE) Guidance. The second phase was being delivered during 2015-16 in pre-school nurseries and after-school Clubs. The Public Protection Section had enforcement responsibilities in these establishments under the Health & Safety at Work etc. Act 1974 with regard to employees, service users and any others affected by their undertaking. A number of additional visits had been carried out to after-school clubs as the Public Protection Section had established links with these establishments in relation to Food Hygiene visits.

It was proposed that Public Protection officers continue to work with pre-school nurseries and after school clubs in Hartlepool to raise awareness of the risk of skin cancer resulting from overexposure to UVR. Further visits would be carried out to provide support and assistance to nurseries and after school clubs to encourage them to register as Sun Safe Nurseries and encourage children to enjoy the sun safely. All information would be made available to all educational establishments on the Hartlepool Borough Council website and would link to the communications and engagement strategy. The next phase would be to roll out the initiative to other sectors for which the Public Protection Section had enforcement responsibilities under the Health & Safety at Work etc. Act 1974.

Decision

The Board noted the report.

45. Better Care Fund 2015/16 Q2 Return *(Director of Child and Adult Services)*

Further to minute 34 of the meeting of the Board held on 5 October 2015, a report presented by the Director of Child and Adult Services provided the Board with an update on implementation of the Better Care Fund Plan and presented the 2015/16 Quarter 2 return which had been submitted on 27 November. As the documentation had only recently been submitted, the appendix referred to in the report had not been circulated. Copies of the Quarter 2 return were available at the meeting and could be circulated electronically following the meeting. It was highlighted that there continued to be some slippage against the BCF Plan although it was anticipated that all funding would be fully spent in accordance with the Plan by the end of the financial year.

Decision

The report was noted.

Meeting concluded at 11.35 a.m.

CHAIR

SAFER HARTLEPOOL PARTNERSHIP
MINUTES AND DECISION RECORD
20 November 2015

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

Present:

Councillor: Christopher Akers-Belcher (In the Chair)
Councillor Marjorie James, Hartlepool Borough Council
Clare Clark, Head of Community Safety and Engagement
Denise Ogden, Director of Regeneration and Neighbourhoods
Louise Wallace, Director of Public Health
Chief Superintendent Gordon Lang, Cleveland Police
Chief Inspector Lynn Beeston, Chair of Youth Offending Board
Steve Johnson, Cleveland Fire and Rescue Authority
John Bentley, Safe In Tees Valley
Stewart Tagg, Housing Hartlepool
Karen Hawkins, Hartlepool and Stockton on Tees Clinical Commissioning Group

In accordance with Council Procedure Rule 5.2 (ii) Danielle Swainston was in attendance as substitute for Sally Robinson and Neville Cameron was in attendance as substitute for Barry Coppinger

Also present:
Councillors Allan Clark and Jim Lindridge, HBC
Charlotte Jenkinson, National Probation Service
Lauren Howells, Youth Parliament

Officers: Ian Harrison, Trading Standards and Licensing Manager
Denise Wimpenny, Principal Democratic Services Officer

Prior to opening the meeting the Chair welcomed Lauren Howells, a representative from the Youth Parliament, who was shadowing the Chair at today's meeting.

33. Apologies for Absence

Apologies for absence were submitted on behalf of Barry Coppinger, Police and Crime Commissioner, Sally Robinson, Director of Child and Adult Services and Julie Allan and Rosana Roy, National Probation Service.

34. Declarations of Interest

None

35. Minutes of the meeting held on 16 October 2015

Confirmed.

36. Matters Arising from the Minutes

The Chair reported that an update had been provided by the British Transport Police, following their attendance at the last meeting, a copy of which was tabled at the meeting for information purposes. It was noted that a day of action was taking place on Saturday 21 November, to which a Member present, who was planning to travel that day, agreed to provide feedback at the next meeting.

Decision

That the information given be noted.

37. Taxi Marshalling Scheme *(Director of Public Health)*

Purpose of report

To inform the Partnership about proposed changes to funding arrangements that are likely to result in the cessation of the Taxi Marshalling Scheme that has been in operation for a number of years.

Issue(s) for consideration

The Director of Public Health reported on the background to the Taxi Marshalling Scheme and the discussions that had taken place at a meeting of the Finance and Policy Committee on 28 August 2015 in relation to the significant reductions made to the Public Health grant and, as a consequence, a range of options, including the removal of funding for the Taxi Marshalling Scheme, were being considered in order to meet the level of savings required.

In light of the significant in year Public Health national grant cut, it was proposed to withdraw the non-recurring funding of the Taxi Marshalling Scheme as of April 2016. With a view to continuing the service beyond April 2016 a number of options had been considered, details of which were included in the report. Given that it had not been possible to identify any sources of funding it was likely that the service would cease in July 2016. The Partnership was therefore requested to consider jointly funding the scheme.

The Partnership discussed the benefits of the Taxi Marshalling Scheme and various options to enable the service to continue. A number of suggestions were debated including the option to increase taxi fares between midnight and 6.00 am and the option to introduce a levy on licensed premises or taxi companies. In terms of introducing a levy on licensed premises, the Trading Standards and Licensing Manager advised that this had previously been explored and it was determined that a levy of this type would be too costly to administer.

The Trading Standards and Licensing Manager responded to further queries raised by Members. Clarification was provided in relation to the feasibility and legality of the options available to the Council. A number of concerns were raised regarding the potential health and safety impact should this service be lost. Given the Partnership's agreement that this scheme could no longer be funded through the Public Health grant but through partner organisations, the Chair requested that all funding stream options be explored to include partner organisations, licensed premises and food outlets, the outcome of which to be reported to a future meeting of the Partnership. A representative from the Police and Crime Commissioner's Office agreed to explore whether any funding was available in the Police and Crime Commissioner's budget to support this scheme.

Later in the meeting the representative from the Police and Crime Commissioner's Office stated that following discussions with the PCC's Chief Finance Officer, information on how much funding would be available would not be clarified until the New Year. Feedback would therefore be reported to the next meeting of the Partnership.

Decision

(i) That the contents of the report and request for partner funding to sustain the scheme be noted.
(ii) The Partnership supported the continued efforts to secure funding for the continuation of the Taxi Marshalling Scheme.
(iii) That all funding stream options be pursued, the outcome of which to be reported to a future meeting of the Partnership.

38. Think Family, Think Communities (TFTC) Progress Update (*Director of Child and Adult Services)*

Purpose of report

To update Members of the Partnership on the results of Phase 1 of the Think Family, Think Communities (TFTC) Programme and the implementation and progress of Phase 2 of the programme.

Issue(s) for consideration

The Assistant Director, presented the report which provided background information in relation to the Troubled Families Programme. An update on phase 1 of the programme was provided. Hartlepool had been successful in 'turning around' all 290 families by February 2015. A breakdown of what was claimed on a payment by results basis was provided, as detailed in the report. An analysis had been carried out to establish what impact the Think Family Programme had made on families' lives, the findings of which were attached at Appendix A.

The Partnership was provided with information on Phase 2 of the Troubled Families Programme, details of which were set out in the report. Hartlepool had been selected to be one of 51 early adopters of Phase 2 and was expected to identify, engage and turn around 950 families during the expected length of Phase 2 April 2015 – March 2020.

The Chief Superintendent referred to a recent Troubled Families Conference he had attended where emphasis had been placed upon the need to bring together multi-agency teams in terms of data sharing in this regard. The Assistant Director advised that it was the intention to develop multi-agency community hubs which was a key element of this intervention. Discussions had commenced with the police in relation to targeting difficult families. The importance of pursuing partnership working and building upon these initial discussions was emphasised by the Partnership. The mechanisms to support partnership working, and the importance of early intervention was also debated by Members. In considering the statistics, as detailed in the report, whilst the Partnership was pleased to note the positive outcomes that the programme had had on families' lives, it was highlighted that more work was needed in relation to employment statistics. The Chair highlighted the potential opportunity to introduce a referral system between this piece of work and the youth employment initiative.

The Assistant Director provided clarification in response to queries raised in relation to the programme, early intervention arrangements and benchmarking arrangements as well as the challenges associated with worklessness issues.

Decision

(i) That the contents of the report be noted and the suggestions of Partnership Members, as outlined above, be explored with a view to improving outcomes for children, young people and their families.

(ii) That partnership working between the police and the Council in terms of sharing information to target difficult families be pursued and feedback be reported to future meetings of the Partnership.

39. Serious and Organised Crime Update (*Director of Regeneration and Neighbourhoods*)

Purpose of report

To provide the Partnership with an overview of activity being undertaken to tackle Serious and Organised Crime across Cleveland.

Issue(s) for consideration

The Director of Regeneration and Neighbourhoods presented the report which provided background information in relation to the Serious and Organised Crime Strategy together with the aims and key elements of the Strategy. Details of developments to date locally in terms of tackling organised crime in Cleveland were provided. Following discussion at the Partnership in November 2014, a number of staff from a broad range of organisations (including 56 front line Council staff) had participated in training to raise awareness of human trafficking, the signs to look out for, and how to respond where it was suspected that trafficking had occurred in the local area. More recently it had been acknowledged that whilst there was some work being undertaken in partnership to tackle serious and organised crime, there was currently no co-ordinated response to the Prevent strand of the Serious and Organised Crime Strategy across Cleveland.

Members were advised that following discussion with Community Safety Partnership leads across the Cleveland force area and the police it was intended to form a small working group that would take forward the Prevent element of the Serious and Organised Crime Strategy, which would report to the Strategic CONTEST Group of which the Council's Director of Regeneration and Neighbourhoods was the Vice-Chair.

In the discussion that followed presentation of the report, concerns were raised regarding the impact that the loss of PCSO's was having on intelligence gathering and the need to ensure that neighbourhood policing was not lost on estates was emphasised. The importance of maintaining a link between the public and services was highlighted. The Director of Regeneration and Neighbourhoods provided assurances that this issue was currently being considered jointly with the police.

Decision

That developments to date locally in relation to tackling organised crime in Cleveland and comments of Members be noted.

40. Safer Hartlepool Partnership Performance (*Director of Regeneration and Neighbourhoods*)

Purpose of report

To provide an overview of Safer Hartlepool Partnership performance for Quarter 2 – July 2015 to September 2015 (inclusive)

Issue(s) for consideration

The report provided an overview of the Partnership's performance during 2015 comparing the current performance to the previous year. In presenting the report, the Head of Community Safety and Engagement highlighted salient positive and negative data and responded to a number of queries raised in relation to crime figures by type.

Some concerns were raised regarding the ongoing increase in deliberate fires and the impact on the Fire Service as a result.

The Chair thanked the representative from the Youth Parliament for her attendance and was of the view that links should be established with the Youth Parliament with a view to encouraging participation by young people. The benefits of including young people in future Face the Public events was also highlighted.

The Youth Parliament Representative thanked the Chair for the opportunity to attend which had assisted in her understanding of the Council's democratic processes and operations. The Partnership was advised that the Youth Parliament would welcome any guest speakers from the Partnership to assist in their understanding of community safety issues. The Chief Superintendent and Chair of Neighbourhood Services indicated that input from the Youth Parliament would be welcomed. The Chief Superintendent indicated a willingness to attend the Youth Parliament to discuss the most appropriate methods of engagement between the police and young people.

Decision

(i) That Quarter 2 performance and comments of Members be noted.
(ii) That links be established with the Youth Parliament with a view to encouraging participation by young people in future Face the Public events.

41. Date and Time of Next Meeting

It was reported that the next meeting would be held on Friday 22 January 2016 at 10.00 am.

The meeting concluded at 11.20 am.

CHAIR