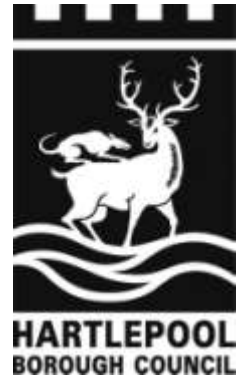


AUDIT AND GOVERNANCE COMMITTEE

AGENDA



Wednesday 14 February 2018

at 10.00 am

**in Committee Room B
Civic Centre, Hartlepool**

MEMBERS: AUDIT AND GOVERNANCE COMMITTEE

Councillors Belcher, Cook, Hall, Hamilton, Harrison, Martin-Wells and Tennant.

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

Parish Council Representatives: Parish Councillor Roderick Thompson (Elwick) and Parish Councillor Darab Rezai, Dalton Piercy.

Local Police Representative: Chief Superintendent Alastair Simpson.

- 1. APOLOGIES FOR ABSENCE**
- 2. TO RECEIVE ANY DECLARATIONS OF INTEREST BY MEMBERS**

3. MINUTES

- 3.1 To confirm the minutes of the meeting held on 24 January, 2018. *(to follow)*

4. AUDIT ITEMS

No items.

5. STANDARDS ITEMS

No items.



6. STATUTORY SCRUTINY ITEMS

- 6.1 Investigation into Elective Surgery at the University Hospital of Hartlepool Site and High Quality Maternity Services:-
- (a) Covering Report – *Statutory Scrutiny Officer*
 - (b) Update on the Sustainability and Transformation Plan (STP) – *STP Representatives*
 - (c) Hartlepool Patient Feedback – Representatives from *North Tees and Hartlepool NHS Foundation Trust*
- 6.2 Hospital Shuttle Bus – Verbal Update – *Representatives from North Tees and Hartlepool NHS Foundation Trust*
- 6.3 Care Quality Commission - Update – *Statutory Scrutiny Officer*
- 6.4 North Tees and Hartlepool NHS Foundation Trust – Quality Accounts 2017/18 – *Scrutiny Manager*
- 6.5 North East Ambulance Service NHS Foundation Trust – Quality Account 2017/18 – Covering Report – *Scrutiny Manager*
- 6.6 Tees, Esk and Wear Valleys NHS Foundation Trust – Quality Account 2017/18 – Covering Report - *Scrutiny Manager*
- 6.7 Six Monthly Monitoring of Agreed Scrutiny Recommendations – *Scrutiny Manager*
- Crime and Disorder Scrutiny*
- 6.8 Safer Hartlepool Partnership Performance – *Director of Regeneration and Neighbourhoods*

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

No items.

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

No items.

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

- 9.1 The minutes of the meeting held on 11 October 2017.

10. MINUTES FROM RECENT MEETING OF SAFER HARTLEPOOL PARTNERSHIP

No items.

11. REGIONAL HEALTH SCRUTINY UPDATE



12. ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS URGENT

For information: -

Date and time of forthcoming meetings –

Wednesday 14 March, 2018 at 10.00 am

Wednesday 25 April, 2018 at 10.00 am



AUDIT AND GOVERNANCE COMMITTEE

MINUTES AND DECISION RECORD

24 JANUARY 2018

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

Present:

Councillor: Ray Martin-Wells (In the Chair).

Councillors: Ged Hall, Lesley Hamilton, Brenda Harrison and John Tennant.

Co-opted Members: Mr Stan Cronin.

Also Present: In accordance with Council Procedure Rule 5.2 (ii), Councillor Carl Richardson was in attendance as substitute for Councillor Sandra Belcher.

Councillor Alan Clark

Professor Dr Denis Walsh, University of Nottingham
Professor Jane Metcalf and Dr Cath Monaghan – North Tees and Hartlepool NHS Foundation Trust

Officers: Chris Little, Director of Finance and Policy
Jill Harrison, Director of Adults and Community Based Services
Esther Mireku, Acting Consultant in Public Health
Joan Stevens, Statutory Scrutiny Officer
Jo Stubbs, Democratic Services Team

84. Apologies for Absence

Apologies were submitted by Councillors Sandra Belcher and Rob Cook and Co-opted Members Norman Rollo and Clare Wilson.

85. Declarations of Interest

None.

86. Minutes of the meeting held on 6 December 2017

Confirmed.

87. Treasury Management Strategy *(Director of Finance and Policy)*

The Director of Finance and Policy reported on the proposed 2018/19 Treasury Management Strategy, a review of Treasury Management activity for 2016/17 including the 2016/17 outturn Prudential Indicators and a mid-year update of the 2017/18 Treasury Management activity. There were no proposed changes to the borrowing strategy and a proposal to increase the investment limit for Svenska Handelsbanken to bring them in line with other category A counterparties.

Recommended

- a) That the 2016/17 Treasury Management Outturn be noted
- b) That the 2017/18 Treasury Management Mid-year Position be noted
- c) That the prudential indicators be approved
- d) That the remainder of the under borrowing is netted down against investments following the securing of exceptionally low interest rates
- e) That the Director of Finance and Policy may take out additional borrowing in the event of a change in economic circumstances if this secures the lowest long term interest cost
- f) That the strategy of internally borrowing for business cases to mitigate counterparty risk, reduce borrowing costs and generate an internal investment return be approved. The Director of Finance and Policy may externally borrow for these schemes if an interest rates rise is expected
- g) That Svenska Handelsbanken be brought into line with other category A counterparties and no longer identified separately
- h) That the Counterparty limits be approved
- i) That the Minimum Revenue Provision Statement be approved.

88. Consultation on External Auditor Scale of Fees for 2018/19 *(Director of Finance and Policy)*

The Director of Finance and Policy informed members that formal communication had been received from the Public Sector Auditor Appointments to consult on the proposed scale of fees for the work to be undertaken by appointed auditors in respect of the 2018/19 financial statement. It was proposed that scale fees for 2018/19 should be reduced by 23%, meaning HBC's fees would reduce from £108 thousand in 2017/18

to £83 thousand in 2018/19. As the response deadline for the consultation was 15th January a favourable response had been sent out following consultation with the Committee Chair. He congratulated the Council's finance officers for negotiating such a positive deal, particularly in light of the fact that fees in 2010 were around £300 thousand.

Recommended

That the response to the PSAA consultation on the scale of fees for 2018/19, following consultation with the Chair, be noted.

89. Delayed Transfers of Care (*Director of Adult and Community Based Services*)

The Director of Adults and Community Based Services gave a brief update on the current position in relation to Delayed Transfer of Care. Key targets had not been achieved for 2016/17, due in a large part to the lack of availability of nursing home beds. This had improved significantly in 2017/18 with a new nursing home opened in May 2017 and another due to open in the next few weeks however delayed transfers for the first 6 months of the year were still 10% under target. The main reasons for this were lack of nursing home placement or availability, patient or family choice and people awaiting packages of care. Delays were also expected to have increased during the Winter months as usual. Performance would be closely monitored through the Better Care Fund and reported quarterly to Health and Wellbeing Board.

The Director highlighted that the Integrated Discharge Team had won the Best Innovation Project award at the 2017 North East, Cumbria, Yorkshire and Humber Commissioning Awards.

Recommended

That the current positive position in relation to Delayed Transfers of Care be noted.

90. Investigation into Elective Surgery at the University Hospital of Hartlepool Site and High Quality Maternity Services – Expert Evidence (*Statutory Scrutiny Officer*)

Dr Denis Walsh, Associate Professor in Midwifery at the University of Nottingham, gave a presentation on factors influencing the utilisation of free-standing and alongside midwifery units in England. Pregnant women could currently choose to give birth in a traditional labour ward within a hospital, in an alongside midwifery unit within a hospital, in a freestanding midwifery unit or at home, depending on their health and advice from their

GP or midwife. Of these options and for women expecting to have a straightforward labour and birth midwifery units were considered the preferred option as they were safer for mum and baby and led to a reduction in labour complications and caesarean sections. Around 25% of births were currently by caesarean section despite the World Health Organisation recommending 15% meaning large numbers of women were having them that shouldn't. Post-birth recovery for mothers took longer and the process was more costly for the NHS than natural childbirth.

Figures showed that since 2010 the number of births in traditional labour wards had decreased while births in alongside midwifery units had increased. Births in freestanding midwifery units remained the same. The Chair noted that the number of births at the freestanding midwifery unit at Hartlepool had decreased from 1800 to 9 the previous year. Dr Walsh was shocked at these figures which he felt were due to the facility not being promoted as a preferable alternative. The Chair agreed this was a problem saying the risks tended to be highlighted to expectant mothers rather than the positive aspects such as the reduction of intervention and other complications when compared with a traditional labour ward. Dr Walsh commented that expectant mothers would clearly have concerns about their baby's safety and needed to be reassured. Many healthcare professionals would also recommend close access to medical facilities due to concerns over potential litigation.

A member commented on the lack of maternity facilities compared to 23 years ago. People wanted their children to be born in Hartlepool but there was not the capacity. Doctor Walsh felt that given the extremely low number of births at Hartlepool the facility would need to be used for clinics and other groups in order to make it financially viable. The Chair confirmed that it was currently used for daytime clinics.

A member referred to a national shortage of midwives and asked what could be done to address this. Dr Walsh advised that recruitment and retention rates for midwives were higher in midwifery units as they were given more autonomy and the facilities were less frenetic and stressful than traditional labour units.

The Chair referred to concerns around safe transfer times between freestanding units and hospitals. Dr Walsh indicated that 98% of complications were not urgent and could safely be transferred in 30-45 minutes. He noted that North Tees Hospital did not have an alongside midwifery unit and was instead located within the labour ward. This meant it was hard to protect low risk mothers from interventions as the mindset within the ward was already in favour of intervention. 30% of expectant mothers should be giving birth in alongside or freestanding midwifery units and more needed to be done to increase current uptake.

The Chair noted that there was a potential proposal as part of the STP process to close North Tees Maternity Unit and move those services to. This would result in an increase in the number of births at James Cook

Hospital to 10 thousand, a figure that concerned Dr Walsh. Dr Walsh commented that mega units of this kind were unique to England and tended to be counterproductive, resulting in an assembly line attitude to birth. The Chair was pleased to hear Dr Walsh's comments which he would feed back to the Durham, Darlington and Teesside, Hambleton, Richmondshire and Whitby STP Joint Overview and Scrutiny Committee.

Members queried whether the trend for elective caesareans among celebrities had an impact. Dr Walsh confirmed that it did but large numbers of celebrities were also having water births which were not being as publicised. It was all about giving midwifery units a higher public profile.

The Statutory Scrutiny Officer asked what could be done to in terms of promoting Hartlepool's midwifery unit. Dr Walsh suggested engaging with local community groups and holding open evenings at the unit. He referred to Blackburn where the existing labour ward had been closed, merged with Burnley and a freestanding midwifery unit opened. A massive publicity campaign had been undertaken which had ultimately been successful.

The Chair thanked Dr Walsh for attending the meeting. The Statutory Scrutiny Officer indicated that based on today's presentation officers would give consideration to the use of obstetric champions. They would also seek advice on best practice in terms of publicity from contacts in Burnley. Professor Metcalf from North Tees and Hartlepool NHS Foundation Trust expressed an interest in being involved in this.

Recommended

- a) That the comments of Dr Walsh be noted.
- b) That the use of Obstetrics Champions be considered.
- c) That best practice be investigated and the potential of a site visit to observe the the Burnley model be explored.

91. The Refugee Project *(Deputy Medical Director, North Tees and Hartlepool NHS Foundation Trust)*

Professor Jane Metcalf and Cath Monaghan from North Tees and Hartlepool NHS Foundation Trust were in attendance to advise members on the Resettlement Programme for Overseas Doctors and Healthcare Professionals (REPOD). A partnership between Health Education North East, Investing in People and Culture and the North Tees and Hartlepool NHS Foundation Trust the aim of REPOD was to support refugee and asylum seeker healthcare professionals back into practice in the UK thereby helping with medical recruitment and providing them with gainful employment in their chosen field. It was a 3 stage project encompassing language exams, clinical exams and help securing employment. Since the programme started in December 2016 22 Doctors and 2 pharmacists had

taken part with 1 doctor already in place within North Tees and Hartlepool NHS Trust. The cost of the project as a whole was £60 thousand per year compared to £290 thousand to train one doctor in the UK. It would help reduce locum costs, improve recruitment and retention of medical personnel on Teesside and give overseas trained doctors a chance to work in their chosen field and provide for their families.

The Chair queried how DBS checks were carried out in these circumstances. Professor Metcalf advised that all people accepted onto the programme had been given leave to remain in the UK by the border authority and as such standard checks will have already been conducted. Most participants had been in the UK for at least 9 months and had been doing charitable work long enough for standard DBS checks.

The Chair expressed his support for the programme, particularly in terms of there being no charge for participation, but queried whether there was scope to include a clause requiring them to work within the Teesside area for a specified period of time. Professor Metcalf felt that this could be a risk as they might not necessarily wish to offer them a job. However some sort of first refusal system could be considered for the future.

Professor Metcalf also advised that consideration was now being given to direct resettlement of qualified people from refugee camps. The Chair and Committee gave their support to this proposal being put forward to the Better Health Programme.

Members were very supportive of the programme asking what could be done to make the learning of the English language more accessible. Professor Metcalf indicated that room hire charges for classes in Stockton had been waived and volunteering opportunities were available.

A member raised concerns that the NHS should not become reliant on this as a form of recruitment. Professor Metcalf felt this would not happen however a reputation for supporting healthcare professionals from overseas was not a bad thing. The Chair noted that most countries relied on healthcare professionals from overseas.

Members asked if the programme could be widened to include nurses. Professor Metcalf commented that nurses had previously experienced problems with the English language exams and so had not been included in the pilot. However their future inclusion could be considered. Members expressed support for the extension of the programme to include nurses.

It was also suggested that the scope of the programme could be widened to include social workers and teachers, particularly those specialising in science. This suggestion was noted and it was agreed that the benefits of a similar scheme for teachers (particularly those specialising in science) should be brought to the attention of the Chair of the Children's Services Committee.

Professor Metcalf also advised that consideration was now being given to direct resettlement of qualified doctors from refugee camps. The Chair and Committee gave their support to this proposal being reported to the Durham, Darlington and Teesside, Hambleton, Richmondshire and Whitby STP Joint Overview and Scrutiny Committee, to explore how the creation of a direct resettlement programme could be supported.

Recommended

- a) That details of the REPOD programme be noted.
- b) That the potential expansion of the programme to include direct resettlement of qualified doctors from refugee camps be reported to the Durham, Darlington and Teesside, Hambleton, Richmondshire and Whitby STP Joint Overview and Scrutiny Committee, with a view to exploring how the creation of a direct resettlement programme could be supported.
- c) That the potential benefits of a resettlement programme for teachers (particularly those specialising in science) be brought to the attention of the Chair of the Children's Services Committee.

92. Big Conversation (Mortality Rates) *(Deputy Medical Director, North Tees and Hartlepool NHS Foundation Trust)*

Professor Jane Metcalf gave an update on mortality rates for North Tees and Hartlepool NHS Foundation Trust. Statistics showed they were currently in the 'as expected' range for both the HSMR module (the ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups; in a specified patient group) and the SHMI module (the ratio of the observed number of deaths to the expected number of deaths for a trust either in-hospital or within 30 days (inclusive) of discharge from the trust. There were still issues around the documentation of co morbidities and it was noted that as more illnesses were being coded the figures could be impacted upon however they did not feel over coding was taking place and the figures were not the highest in the region. There had also been less stroke-related deaths than expected.

The Chair praised Professor Metcalf's team for their work in this area. He noted in particular that previous statistics had erroneously appeared to better than they were. The current figures, while not as good as had previously been reported, were more in line with what would be expected. A member of the public queried whether minor conditions were coded. Professor Metcalf advised that this varied depending on the condition. Details would be taken on first entry into the Trust and then recoded as appropriate. He also asked whether deaths of patients who had been

transferred to another trust would be included. Professor Metcalf confirmed that these would be included as part of the SMHI provided the death had occurred within 30 days of transfer.

Professor Metcalf also highlighted concerns around elderly patients being admitted from their home on the point of death and the potential trauma for them and their loved ones. There was a need to have discussions with family members around the end of life and what people would prefer in terms of hospital admittance at that time. The Chair referred back to work the Committee had previously undertaken on end of life pathways when most people had expressed a wish to die at home in familiar surroundings. However without those discussions there could be a tendency for relatives to panic.

Professor Metcalf referred to the number of deaths caused by alcoholism particularly among young drinkers. She expressed her support for the introduction of a minimum unit price on alcohol saying this would not impact upon occasional drinkers or those visiting pubs. The Chair expressed concern that this would affect the poorest in society and asked if a report could be brought back to the committee on this issue. Other members expressed their support in principle but felt it needed to be introduced nationally otherwise those affected would go elsewhere for cheap alcohol. The Chair also noted the increase in black market tobacco and cigarettes which had resulted from a rise in the cost of products bought over the counter. He felt that when speaking to children in schools around the dangers of tobacco and alcohol there needed to be more emphasis on the impact it would have on their appearance rather than the long term health risks. There also needed to be more investigation into the root causes of people drinking excessively as this could be linked to undiagnosed mental health problems.

The Acting Consultant in Public Health advised that Safer Hartlepool Partnership were due to consider these issues. She suggested that Professor Metcalf and her colleagues would be welcome to be involved with this

Recommended

- a) That details of the current mortality rates be noted
- b) That a report on minimum unit pricing for alcohol be brought back to the Committee

93. Mental Health - Council Referral *(Statutory Scrutiny Officer)*

The Statutory Scrutiny Officer advised members that a formal referral had been made to the committee by full Council on 14th December 2017 as follows:

‘That Council makes a formal referral to the Audit and Governance Committee requesting that a review of mental health provision in Hartlepool

be undertaken with a view to finding ways of improving access to the availability of mental health services within the Borough for all residents. The referral to be undertaken as part of the 2018/19 work programme'

The Chair was pleased to note the request for inclusion within the 2018/19 work programme as otherwise the review would have had a 12 work completion period. He also noted that a similar review was due to be undertaken by Adult Services Committee and in order to avoid duplication of work Audit and Governance Committee would carry out the review (with input from Adult Services Committee) and report back to them. He also urged members to give due consideration to officer and committee workloads when considering any future referrals, particularly in terms of completion deadlines.

Recommended

That the referral be noted

94. Minutes of the meeting of Health and Wellbeing Board held on 16 October, 2017

The minutes were received.

95. Minutes of the meeting of Tees Valley Health Joint Scrutiny Committee held on 20 July, 2017

A member referred to the update on respite care which had been given within this meeting saying that Hartlepool members had made it clear that they would not be in favour of facilities being reduced or closed and she had been shocked that members from other authorities had not been as vocal. The Statutory Scrutiny Officer confirmed that a response on this issue had been sent to the Joint Scrutiny Committee and would be sent on to the Joint Governing Body Committee. A final decision would then be reported back to the Joint Scrutiny Committee who would decide what action was required. A further update would then be reported to Audit and Governance Committee with the option for a referral to Council if deemed appropriate.

The minutes were received

96. Minutes of the meeting of Safer Hartlepool Partnership held on 20 October, 2017

The minutes were received

97. Any Other Items which the Chairman Considers are Urgent

The Chair advised that the last meeting of the Regional Health Scrutiny Committee had been cancelled due to unavailability of members. The next meeting was scheduled for the following month.

The meeting concluded at 12.20 pm.

CHAIR

AUDIT AND GOVERNANCE COMMITTEE

14 February 2018



Report of: Statutory Scrutiny Officer

Subject: INVESTIGATION INTO ELECTIVE SURGERY AT THE UNIVERSITY HOSPITAL OF HARTLEPOOL SITE AND HIGH QUALITY MATERNITY SERVICES

1. PURPOSE OF REPORT

- 1.1 To inform Members that as part of the Committee's investigation into Elective Surgery at the University Hospital of Hartlepool (UHH) Site and High Quality Maternity Services, information will be provided at today's meeting regarding the progress of the Sustainability and Transformation Plan, with specific focus on the maternity aspect.
- 1.2 Representatives from North Tees and Hartlepool NHS Foundation Trust (NTHFT) will also be present at today's meeting to provide feedback from Hartlepool patient's regarding their maternity experiences.

2. BACKGROUND INFORMATION

- 2.1 STP representatives will be in attendance at today's meeting to provide the Committee with the following information:-
 - (a) Progress of the Sustainability and Transformation Plan, with specific focus on the maternity aspect.
- 2.2 Hartlepool patient feedback about their maternity experiences is attached as **Item 6.1(c)** for Member's consideration.
- 2.3 Regarding, elective activity provided at the UHH, a briefing report is attached as **Appendix A** for Member's consideration.
- 2.4 In light of the information that will be provided at today's meeting, Member's are asked to consider if they require any further evidence before the draft final report is produced. To date, Members have received information covering:-
 - (a) The maternity services that are provided at the UHH to understand local need and demand;
 - (b) The variability of access to maternity services, focusing on the quality of care, outcomes and differences between a mid-wife led unit and a consultant led unit, including the factors that determine where a baby will be born;

- (c) The elective surgery services that are provided at the UHH to understand local need and demand;
- (d) The variability of access to elective surgery services, focusing on the quality of care and outcomes at the UHH;
- (e) Additional information regarding day cases at UHH; and
- (f) Expert evidence from Dr Dennis Walsh

2.5 The Committee may wish to consider:-

- (a) If a site visit to Blackburn Maternity Unit providers, to gather best practice evidence is required; and
- (b) Whether, in addition to the survey carried out by NTHFT, the Committee wish to conduct its own survey.

2.6 The draft final report for the investigation is due to be presented to the Committee at the March meeting, however, if the Committee wish to gather additional evidence, Members may wish to consider delaying the draft report until the first meeting in the new municipal year.

3. RECOMMENDATIONS

3.1 The Audit and Governance Committee consider:-

- (a) The information presented at today's meeting and seek clarification on any issues, where required;
- (b) If a site visit to gather best practice evidence is required; and
- (c) If an additional maternity survey is required to gather further evidence and if so, whether the draft final report should be presented to the first Committee meeting in the new municipal year.

BACKGROUND PAPERS

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

No background Papers were used in preparation of this report.

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

North Tees and Hartlepool NHS Foundation Trust

Overview of elective activity provided at University Hospital of Hartlepool

Introduction

North Tees and Hartlepool NHS Foundation Trust continues to provide an extensive number of services from the University of Hartlepool hospital site to provide care closer to home, alongside the community services designed to reduce avoidable hospital visits and admissions.

These include Outpatient, Diagnostic, Daycase and Inpatient elective services. The following brief provides an overview of the key elective services provided during the January to December 2017 period, in comparison to the same period in 2016, recognising there has been a shift of more routine Orthopaedic Inpatient surgery during 2017.

Outpatient Services

The Trust currently provides outpatient appointments across the following specialties from University Hospital of Hartlepool (UHH);

- Accident and Emergency (follow up clinics)
- Anaesthetics/Pain Management
- Cardiology
- Chemical Pathology
- Diabetic Medicine
- Elderly Care
- Gastroenterology
- General Medicine
- General Surgery
- Gynaecology
- Clinical Haematology
- Clinical Psychology
- Obstetrics
- Trauma and Orthopaedics
- Paediatrics
- Rheumatology
- Respiratory Medicine
- Urology

The Trust also accommodates outreach outpatient services from South Tees NHS Foundation Trust at the UHH site covering;

- Dermatology
- Ear Nose and Throat
- Vascular
- Nephrology
- Neurology

- Paediatrics
- Plastic Surgery
- Radiology

These appointments include consultant, nurse and therapy led services, covering suspected cancer, urgent and routine appointments.

In the January to December 2017 period, 95,316 (new and follow up) appointments were booked at the UHH site, this was a 2.81% (n=2605) increase on the same period in 2016.

Elective Daycase

The Trust currently provides elective Daycase activity, including Endoscopy tests, across the following specialties from University Hospital of Hartlepool (UHH);

- Breast Surgery
- Clinical Haematology
- Clinical Oncology (Chemotherapy)
- Colorectal Surgery
- Gastroenterology (Endoscopy)
- General Surgery
- Gynaecology (including oncology)
- Pain Management
- Rheumatology
- Trauma and Orthopaedics
- Urology

In the January to December 2017 period, 13,192 Daycases were carried out at the University Hospital of Hartlepool (UHH), approximately 38.5% of all the overall Trust's Daycase activity.

This was a reduction on the same period in 2016, which reported 14,234 Daycases at the UHH site, a decrease of 7.3% (n=1042), however this was due to a shift in additional Orthopaedic elective Inpatient procedures to the UHH site, converting Daycase lists to Inpatient lists.

The Trust continues to review the Daycase activity provided at the Hartlepool site, with the potential to move additional Gynaecology lists to the UHH site in the future.

Elective Inpatients

The Trust currently provides elective inpatient activity across the following sub specialties from University Hospital of Hartlepool (UHH);

- Breast Surgery
- General Surgery
- Major Hip and Knee replacements
- Complex Hand Surgery
- Complex Hip surgery

In the January to December 2017 period, 1929 Inpatient procedures were carried out at the UHH site, approximately 39.5% of all the overall Trust's Inpatient elective activity.

Although the overall Inpatients procedures show a slight reduction in comparison to 2016, which reported at 2003, 3.7% (n=74) decrease, the proportion of the Trust's overall Inpatient activity carried out at UHH increased from 30.6% to 39.5%, demonstrating the movement of more routine electives to the UHH site.

As the table below demonstrates, in 2017 52.13% of the patients receiving elective care at UHH where Hartlepool residents, a slight increase on the 51.38% in 2016.

Table 1: Daycase and Inpatient Elective activity by Resident locality

	2016	2017
Hartlepool residents	8342	7882
Other residents	7895	7239
% Hartlepool residents	51.38%	52.13%

Radiology Tests

The Trust continues to provide Radiology tests at UHH, with a 13% increase evident in 2017 compared to 2016, totalling over 70,900 tests. This includes;

- Plain film 19054
- Ultrasound 13928
- CT 11792
- Obstetrics 9794
- MRI 8905
- Nuclear Medicine 3410
- Breast Screens 2974
- Fluoroscopy 1004
- Medical Photography 66

Summary

North Tees and Hartlepool NHS Foundation Trust is committed to providing care closer to home for all its resident population.

Elective services continue to be delivered at the University Hospital of Hartlepool, including Outpatients, Diagnostics, Daycase and Elective procedures, however recognising more complex surgery is provided at University Hospital of North Tees, where additional intensive support is available for patients with multiple comorbidities etc.

Community services continue to be reviewed and developed to further support care in the home, with the aim to reduce avoidable admissions.

Maternity Services in Hartlepool- Patient Feedback

January 2018

Background information

Since 1 April 2017 to date there have been 89 deliveries to women cared for by the Birthing Team in Hartlepool of these 87 babies were born at the University Hospital of North Tees. (UHNT) (with the Birthing Team midwives present at 36 of those births due to long term sickness and two vacancies within the team that we are having difficulty recruiting into). The remainder of the Women received care from the Midwives and Obstetricians based on the Delivery Suite at UHNT. There have been two births since April 2017 in the Birthing Centre at the University Hospital of Hartlepool.

Details of the type of delivery for the 87 births at University Hospital of North Tees:

Type of delivery	Second or subsequent pregnancy	First pregnancy
Normal	33	34
Caesarean Section	3	8
Assisted- forceps etc.	4	5

It is important to note that the maternity service provided for women is more than just the delivery of the baby, throughout pregnancy a large number of contacts are made with the service and the minimum requirements are detailed below, however the midwives also provide drop in sessions for women who may be concerned about an aspect of their pregnancy or post natal health or in some cases the health of their baby, these sessions are in addition to those listed below and attendance is determined by the woman and her partner according to need.

Hartlepool Planned contacts:

Weeks of pregnancy (approximately)	Type of contact	Location
10-12 weeks	Early Bird visit	Childrens Centre Hartlepool
	Booking	Hartlepool Birthing Centre
	Dating scan/combined screening	University Hospital Hartlepool (UHH)
16 weeks	Home visit by midwife to help the parents start to plan environment for the new baby.	Home
	Anomaly scan and check	UHH
24 weeks	Ante Natal check	Childrens Centre Hartlepool
28 weeks	Ante Natal check for women with Rhesus negative blood group	Childrens Centre Hartlepool
31 weeks	Ante Natal check (1st pregnancy only)	Childrens Centre Hartlepool

34 weeks	Ante Natal check	Childrens Centre Hartlepool
36 weeks	Birth plan completion	Home
38 weeks	Ante Natal check	Childrens Centre Hartlepool
40 weeks	Ante Natal check	Childrens Centre Hartlepool
41 weeks	Ante Natal check	Home
Ante Natal Parent craft	4 sessions are offered to all parents.	Childrens Centre Hartlepool
Post natal contacts (after the baby's birth)	3 -4 home visits depending on the need of the family with further visits scheduled to support breastfeeding if necessary.	Home

Feedback from Mother's in Hartlepool

The NHS Friends and Family test for Maternity Services was introduced in 2013 to help service providers and commissioners understand whether Mothers are happy with the service provided, or to identify where improvements are needed. It is an anonymous way for Mothers and Mothers to be to give feedback to service providers.

Friends and Family responses are collected for all North Tees and Hartlepool Maternity services and are closely scrutinised, the enclosed comments have been made by women from Hartlepool who have used the Maternity Service and have anonymously given their views on the service they have received.

Please see enclosed:

Appendix 1 *Hartlepool Antenatal Friends and Family Responses March to November 2017*

Appendix 2 *Hartlepool Postnatal Friends and Family Responses March to November 2017*

Ante natal no.	MidwifeTeam	FFT_qCommAntenatal	ReasonsCommAntenatal	What_age_are_you?	MTType
1	Hartlepool	1 Extremely likely		16to18	Community Antenatal
2	Hartlepool	1 Extremely likely	Great service, loads of advice and help.	30to34	Community Antenatal
3	Hartlepool	1 Extremely likely	I felt very looked after by your wonderful midwives - we had lots of scans to check the well-being of our baby and can't fault the care we received!	30to34	Community Antenatal
4	Hartlepool	1 Extremely likely	Lovely midwife.	19to24	Community Antenatal
5	Hartlepool	1 Extremely likely	No problems and very friendly/professional.	25to29	Community Antenatal
6	Hartlepool	2 Likely		25to29	Community Antenatal
7	Hartlepool	1 Extremely likely	Supportive, caring, always calls back when leave message.	30to34	Community Antenatal
8	Hartlepool	1 Extremely likely	Very happy with the care I receive.	30to34	Community Antenatal
9	Hartlepool	1 Extremely likely		35to44	Community Antenatal
10	Hartlepool	1 Extremely likely	Great friendly staff, very welcoming.	25to29	Community Antenatal
11	Hartlepool	1 Extremely likely	Reliable service.	35to44	Community Antenatal
12	Hartlepool	1 Extremely likely	Very helpful and friendly staff.	30to34	Community Antenatal
13	Hartlepool	1 Extremely likely		30to34	Community Antenatal
14	Hartlepool	1 Extremely likely	You provide your patients with very good service.	35to44	Community Antenatal

Hartlepool Antenatal Friends and Family Responses March to November 2017 6.1 (c) Appendix 1

15	Hartlepool	2 Likely	Good service but long waiting times.	19to24	Community Antenatal
16	Hartlepool	2 Likely	Happy with the service, happy with everything. Thank you.	19to24	Community Antenatal
17	Hartlepool	1 Extremely likely	Very helpful.	19to24	Community Antenatal
18	Hartlepool	1 Extremely likely	Everybody has been friendly and helpful.	25to29	Community Antenatal
19	Hartlepool	2 Likely	You feel welcome and I get explained everything if I'm not sure about something.	35to44	Community Antenatal
20	Hartlepool	1 Extremely likely	My CMW is lovely. Never feel rushed when I see her. Always gives opportunity to ask questions. Staff in scanning and clinic departments are welcoming.	25to29	Community Antenatal
21	Hartlepool	3 Neither		19to24	Community Antenatal
22	Hartlepool	1 Extremely likely	Happy with everything.	35to44	Community Antenatal
23	Hartlepool	1 Extremely likely	Midwife is lovely, she is helpful and friendly.	30to34	Community Antenatal
24	Hartlepool	1 Extremely likely	Appointment with midwife.	19to24	Community Antenatal
25	Hartlepool	1 Extremely likely	Good professional care.	25to29	Community Antenatal
26	Hartlepool	1 Extremely likely	Extremely helpful no matter what questions are given.	19to24	Community Antenatal
27	Hartlepool	1 Extremely likely	It's important to monitor the child's development. Friendly and make you feel at ease.	25to29	Community Antenatal

28	Hartlepool	1 Extremely likely	Friendly, informative.	25to29	Community Antenatal
29	Hartlepool	1 Extremely likely	The midwife has been excellent through my pregnancy, nothing is too much trouble and I feel confident going forward to the birth.	30to34	Community Antenatal
30	Hartlepool	1 Extremely likely		19to24	Community Antenatal
31	Hartlepool	1 Extremely likely	All staff have been so helpful, understanding and caring and taken time to ease any worries I've had throughout pregnancy.	30to34	Community Antenatal
32	Hartlepool	2 Likely	Most the care is thorough, but some feels need more attention.	30to34	Community Antenatal
33	Hartlepool	2 Likely	Friendly and helpful, always welcoming and happy to help.	19to24	Community Antenatal
34	Hartlepool	1 Extremely likely	I have heard that it's been really good.	30to34	Community Antenatal
35	Hartlepool	1 Extremely likely	Love my midwife.	25to29	Community Antenatal
36	Hartlepool	1 Extremely likely	It's a really good service.	19to24	Community Antenatal
37	Hartlepool	2 Likely	Always helpful, very friendly.	30to34	Community Antenatal
38	Hartlepool	1 Extremely likely	Great service. Nice staff.	30to34	Community Antenatal
39	Hartlepool	1 Extremely likely	The service is very friendly and helpful.	30to34	Community Antenatal
40	Hartlepool	1 Extremely likely	Always helpful and knowledgeable.	30to34	Community Antenatal

Hartlepool Antenatal Friends and Family Responses March to November 2017 6.1 (c) Appendix 1

41	Hartlepool	1 Extremely likely		35to44	Community Antenatal
42	Hartlepool	1 Extremely likely	Very informative.	19to24	Community Antenatal
43	Hartlepool	2 Likely	Happy.	30to34	Community Antenatal
44	Hartlepool	1 Extremely likely	They are very helpful and friendly.	19to24	Community Antenatal
45	Hartlepool	1 Extremely likely	Excellent service from Rossmere Sure Start Centre.	30to34	Community Antenatal
46	Hartlepool	1 Extremely likely	Extremely lovely and caring midwife.	25to29	Community Antenatal
47	Hartlepool	1 Extremely likely	Very friendly, very helpful, would definitely recommend.	30to34	Community Antenatal
48	Hartlepool	1 Extremely likely	Midwives and staff are lovely, very kind and helpful.	19to24	Community Antenatal
49	Hartlepool	2 Likely		25to29	Community Antenatal
50	Hartlepool	1 Extremely likely		25to29	Community Antenatal
51	Hartlepool	1 Extremely likely	Very helpful.	19to24	Community Antenatal
52	Hartlepool	1 Extremely likely	Friendly, supportive, always there when needed.	30to34	Community Antenatal
53	Hartlepool	1 Extremely likely		25to29	Community Antenatal
54	Hartlepool	1 Extremely likely	Really helpful all the way through pregnancy.	19to24	Community Antenatal
55	Hartlepool	1 Extremely likely	I am always very well informed and treat and spoken to lovely.	19to24	Community Antenatal
56	Hartlepool	1 Extremely likely	Friendly happy pleasure to see.	30to34	Community Antenatal

57	Hartlepool	1 Extremely likely	The service is always very smooth and the staff are welcoming. Never had any problems.	30to34	Community Antenatal
58	Hartlepool	1 Extremely likely	Fantastic midwife. Very knowledgeable and good at explaining everything.	35to44	Community Antenatal
59	Hartlepool	2 Likely		30to34	Community Antenatal
60	Hartlepool	2 Likely		25to29	Community Antenatal
61	Hartlepool	1 Extremely likely	Midwife is a lovely and makes you really welcome. Rossmere is a friendly centre.	25to29	Community Antenatal
62	Hartlepool	1 Extremely likely		16to18	Community Antenatal
63	Hartlepool	1 Extremely likely		16to18	Community Antenatal
64	Hartlepool	1 Extremely likely		25to29	Community Antenatal
65	Hartlepool	1 Extremely likely	Always feel reassured when seen.	30to34	Community Antenatal
66	Hartlepool	2 Likely	Midwife is lovely.	19to24	Community Antenatal

NHS Friends and Family Test

North Tees and Hartlepool 

NHS Foundation Trust

We would like you to think about your experience of our antenatal service.

COMMANTE v1.2

Which midwife team have you been with?

- ☐ Hartlepool ☐ Stockton (North)
☐ Stockton (South) ☐ Peterlee
☐ Hospital team

Please enter the last date you were seen.

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How likely are you to recommend our antenatal service to friends and family if they needed similar care or treatment?

- ☐ Extremely likely
☐ Likely
☐ Neither likely nor unlikely
☐ Unlikely
☐ Extremely unlikely
☐ Don't know

Please can you tell us the main reason for the answer you have given?

What age are you?

- ☐ Under 16 ☐ 16-18 ☐ 19-24 ☐ 25-29 ☐ 30-34 ☐ 35-44 ☐ 45+

When you have completed the form, please return it using the pre-paid envelope provided. Thank you.



Hartlepool Postnatal Friends and Family responses March to November 2017

Appendix 2 - 6.1 (c)

postnatal no.	MidwifeTeam	FFT_qCommPostnatal	Reasons Comm Postnatal	What_age_are_you?	MTType
1	Hartlepool	2 Likely		19to24	Postnatal
2	Hartlepool	1 Extremely likely	The help, support and advice we have received, particularly in regards to breast feeding has been outstanding.	30to34	Postnatal
3	Hartlepool	1 Extremely likely	Very friendly. Able to answer any questions I had.	25to29	Postnatal
4	Hartlepool	1 Extremely likely	Under the Delivery Service care Hartlepool - was unable to deliver at Hartlepool which was really disappointing, such a lovely birthing centre not getting used. Delivered at North Tees with * as my midwife who was by far outstanding in every aspect.	30to34	Postnatal
5	Hartlepool	1 Extremely likely	Everyone was really friendly and good at their job. Always there to listen if you need to talk.	25to29	Postnatal
6	Hartlepool	1 Extremely likely		35to44	Postnatal
7	Hartlepool	1 Extremely likely	Midwife's were very informative when answering any questions I had, they made me feel at ease with any concerns I had regarding pregnancy pre and post natal.	30to34	Postnatal

Hartlepool Postnatal Friends and Family responses March to November 2017

8	Hartlepool	1 Extremely likely	Very helpful and supportive, no question was not answered.	30to34	Postnatal
9	Hartlepool	1 Extremely likely	All midwives I have seen have been lovely, offered great support and advice throughout pregnancy, during labour and after.	25to29	Postnatal
10	Hartlepool	1 Extremely likely		19to24	Postnatal
11	Hartlepool	2 Likely	Because she was very helpful and a lovely lady.	30to34	Postnatal
12	Hartlepool	1 Extremely likely		25to29	Postnatal
13	Hartlepool	1 Extremely likely	Very friendly and helpful on each visit, thank you.	35to44	Postnatal
14	Hartlepool	3 Neither	The service I got was good however there was a lack of information to do with antenatal classes (parent craft etc). I felt that because I didn't see the midwife much due to being under a consultant I missed out on the practical aspects of antenatal care.	35to44	Postnatal
15	Hartlepool	1 Extremely likely	I was very unsure about feeds/breastfeeding and routines and they were very supportive and helpful. They were always there to help, on the phone or in person.	25to29	Postnatal

Hartlepool Postnatal Friends and Family responses March to November 2017

16	Hartlepool	1 Extremely likely	I really enjoyed having my visits at home. It worked really well with also having a toddler.	19to24	Postnatal
17	Hartlepool	1 Extremely likely	Extremely helpful and so easy to approach. Really friendly and very professional.	35to44	Postnatal
18	Hartlepool	1 Extremely likely		30to34	Postnatal
19	Hartlepool	1 Extremely likely		30to34	Postnatal
20	Hartlepool	2 Likely	Give all the information that's needed.	19to24	Postnatal
21	Hartlepool	1 Extremely likely	Great ladies, friendly and so helpful. Would recommend to anyone.	25to29	Postnatal
22	Hartlepool	1 Extremely likely	Friendly staff, helpful and make you feel like you're doing a great job as a new mam.	25to29	Postnatal
23	Hartlepool	3 Neither	Generally care was good, but still waiting for my medication five days after baby was born. Have to go all the way back to North Tees to collect it. Community midwives have been great in organising it for me.	16to18	Postnatal
24	Hartlepool	1 Extremely likely	Excellent care.	25to29	Postnatal

Hartlepool Postnatal Friends and Family responses March to November 2017

25	Hartlepool	1 Extremely likely	I have been thoroughly impressed with the care that both myself and my daughter have received. I would particularly like to praise my midwife * for the care she has given to my family. I would also like to praise the care we were given at North Tees.	35to44	Postnatal
26	Hartlepool	1 Extremely likely	Delivery suite - excellent, community care - excellent, ward staff (22) - excellent however do not agree to have to listen for 30 minutes on how to care for baby at home having just had a section sitting in an uncomfortable position - this should be choice.	25to29	Postnatal
27	Hartlepool	1 Extremely likely	Team were excellent and attentive.	30to34	Postnatal
28	Hartlepool North	2 Likely		30to34	Postnatal
29	Hartlepool	1 Extremely likely	The reason that I would is due to the help from all supportive staff, well done ladies and gentlemen.	25to29	Postnatal
30	Hartlepool	1 Extremely likely		19to24	Postnatal

NHS Friends and Family Test

www.nhs.uk/friendsandfamily/

North Tees and Hartlepool 

NHS Foundation Trust

We would like you to think about your experience of our postnatal service.

COMMPOST v1.2

Which midwife team have you been with?

- ☐ Hartlepool ☐ Stockton (North)
☐ Stockton (South) ☐ Peterlee
☐ Hospital team

Please enter the last date you were seen.

--	--	--	--	--	--	--	--	--	--

How likely are you to recommend our postnatal service to friends and family if they needed similar care or treatment?

- ☐ Extremely likely
☐ Likely
☐ Neither likely nor unlikely
☐ Unlikely
☐ Extremely unlikely
☐ Don't know

Please can you tell us the main reason for the answer you have given?

What age are you?

- ☐ Under 16 ☐ 16-18 ☐ 19-24 ☐ 25-29 ☐ 30-34 ☐ 35-44 ☐ 45+

When you have completed the form, please return it using the pre-paid envelope provided. Thank you.



AUDIT AND GOVERNANCE COMMITTEE

14 February 2018



Report of: Statutory Scrutiny Officer

Subject: CARE QUALITY COMMISSION - UPDATE

1. PURPOSE OF REPORT

- 1.1 To introduce representatives from North Tees and Hartlepool NHS Foundation Trust (NTHFT) and the Care Quality Commission (CQC) who will be in attendance at today's meeting to provide the Committee with an update on the Action Plan for NTHFT following the CQC's inspection of the Trust in July 2015.

2. BACKGROUND INFORMATION

- 2.1 The Trust was inspected by the CQC during July 2015. The outcome of the inspection was published on 3 February 2016. The Audit and Governance Committee at their meeting held on 17 March 2016 received an update regarding the inspections and its outcomes. The CQC rated the Trust as 'requiring improvement'.
- 2.2 Following the inspection, an action plan was developed and a CQC Board was established to monitor the implementation of the action plan. Subsequently, representatives from NTHFT and the CQC will be in attendance at today's meeting to provide the Committee with an update on the progress made against the action plan.

3. RECOMMENDATIONS

- 3.1 The Audit and Governance Committee note the update and seek clarification on any issues, where required.

BACKGROUND PAPERS

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

- (a) Inspection of the North Tees and Hartlepool NHS Foundation Trust – Update – 17 March 2016
https://www.hartlepool.gov.uk/meetings/meeting/3336/audit_and_governance_committee
- (b) Minutes from the Audit and Governance Committee held 17 March 2016

https://www.hartlepool.gov.uk/meetings/meeting/3336/audit_and_governance_committee

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

AUDIT AND GOVERNANCE COMMITTEE

14 February 2018



Report of: Scrutiny Manager

Subject: NORTH TEES AND HARTLEPOOL NHS
FOUNDATION TRUST – QUALITY ACCOUNTS
2017/18

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 2017/18; 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 2017/18.

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). Details of the comments made by the Audit and Governance Committee in relation to the Quality Account for 2016/17 are attached at **Appendix A** for Members information.
- 2.3 Responsibility for the formulation of the Councils third party Declaration falls within 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 will:-

- i) Reflect on NTHFT's Quality Account for 2016/17 leading into 2017/18; and
 - ii) Engage with Members of the Committee in terms of the Trust's Quality Account for 2017/18, 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 (2017/18), timetabled for March 2017, 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, a copy of the current Quality Account (2016/17) 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, Statutory Scrutiny Officer
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 meeting of the Audit and Governance Committee held on 16 February 2017
- (b) The Health Act 2009 (Part 1, Chapter 2, Section 8)

Appendix A**Hartlepool Borough Council – Audit and Governance Committee’s Third Party Declaration**

Hartlepool Borough Council’s Audit and Governance Committee on the 16th February 2017 received an update on the North Tees and Hartlepool NHS Foundation Trust’s Quality Account for 2016/17. The Committee focussed on two areas within the Quality Account and made the following comments for inclusion in the Committee’s Third Party Declaration:-

- (a) Data was provided to the Committee on the Friends and Family Tests undertaken which showed that 93.94% of those who had undertaken the test would recommend the Trust to others with 1.49% who would not. Members were informed that the Friends and Family survey was given to all patients on wards and those attending Accident and Emergency. If a patient was unable to complete the survey, a friend or relative would be asked to complete it on their behalf. A number of people in attendance at the meeting commented that they had not received a questionnaire to complete; despite a number of attendances at hospital, and that questionnaires were not readily available in locations around the hospital. The Committee was informed that a Trust representative would investigate these concerns.
- (b) Members were informed that, overall, over 30,000 responses had been received in response to the Friends and Family surveys. The Committee questioned how this figure equated to the total number of patients that attended the hospitals. Members were informed that the percentage of completed surveys was low in comparison to the overall numbers; this was because some people did not complete the surveys, particularly, regarding maternity services, as people were asked the same questions several times throughout their pregnancy. Therefore, the Trust was looking at alternative ways of gathering the information.

The Committee welcome the information that is shared with them regarding the Quality Account and hope that this continues throughout the 2017/18 Municipal Year.



Quality Account

ANNUAL QUALITY REPORT (Quality Accounts) 2016-17

Contents

Part 1		
Statement on quality from the Chief Executive		
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Annex D	Quality Accounts Feedback Form	
Glossary		
Glossary	Definition of some of the terms used within this document	



Executives on the ward

Part 1: Statement on quality from the Chief Executive

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

I am pleased to introduce the North Tees and Hartlepool NHS Foundation Trust Quality Report for 2016-17 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 2017-18.

The 2016-17 financial year has again proven to be a very busy year where we continued to achieve high performance overall and good outcomes for patients across the Trust despite a very challenging financial budget.

As always we continue to appreciate the excellence of our staff, and in this reporting period our staff have been particularly recognised for their achievements throughout the year, having been nominated for a number of awards. 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.

A big improvement for 2016-17 related to our Hospital Standardised Mortality Ratio (HSMR) and Summary hospital-level mortality indicator (SHMI) mortality values, ensuring that these values reduced closer to the national mean. The Trust instigated numerous actions in relation to this, all overseen by the Deputy Medical Director. The Trusts recent HSMR and SHMI values are now within the 'as expected' range and I would like to thank all staff members aiding in this reduction, whilst maintaining high standards of care. The Trust continually works with external bodies to ensure as an organisation we have third party assurance on the work we are undertaking.

This reporting year the Trust was set a very low Clostridium difficile target by our commissioners of no more than 13 hospital acquired cases. Even though the Trust failed to meet this target, the report will outline the actions taken during this financial year with the aim to improve future infection rates.

Following the Care Quality Commission (CQC) inspection in July 2015, the Trust was rated overall as 'requiring improvement' but achieved a good rating for safe, caring and responsive care. Of the 85 individual ratings, 65 were rated as good. The report will outline the actions taken by the Trust to meet the CQC requirements for improvement and to detail the improvements so far.

The Trust held its third annual Quality Accounts Marketplace on 14 December 2016 at the North Tees site; this event was well received and attended by our stakeholders. This event produced our quality strategy and Quality Accounts priorities for 2017-18. The priorities 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 (HUG).

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

- University Hospital of North Tees is rated at **4.5** out of 5
- University Hospital of Hartlepool is rated at **4.5** out of 5

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

Date: 31 May 2017

What is a Quality Report/Accounts?

Quality Accounts are annual reports to the public from us 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

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 PS & QS 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 at every opportunity.

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 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 45,000 patients in a variety of settings including, in their own homes, community clinics, and our inpatient and outpatient hospital wards as well as departments. We always ask patients how we are doing and what we could do better.

Unconditional CQC Registration

During 2016-17 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.

CQC Rating

The Trust was inspected during 2015-16 by the CQC and was rated as '**requiring improvement**', the CQC section within this report provides greater detail of the work undertaken to improve this rating.

Achievements 2016-17

Congratulations to all of our staff who picked up awards or who were shortlisted at the Hartlepool Mail Best of Health awards. They were:

Employee of the month – The winners of the Trusts employee of the month scheme which was started last year:

April 16 – Claire Woodhouse (Health Visitor)

May 16 – Lorraine Miller (Chaplain)

June 16 – Gail Fincken (Site clinical co-ordinator)

July 16 – Lyndsey Brownless (District nursing sister)

August 16 – Emma Brown (Associate practitioner)

September 16 – Andy Howard (Deputy Head porter)

October 16 – Jane Hird (EPAC specialist nurse)

November 16 – Mohammed El-Bashir (Trust registrar)

December 16 – Melanie Wenn (Family nurse)

January 17 – Lisa Tomlinson (Healthcare assistant)

February 17 – Maria Samuels (SHO Surgery)

March 17 – James Dundas – (Registrar)

Congratulations Amanda – Successfully passed a diploma to become a qualified plaster technician

Congratulations to the two sets of winners of the Trust's clinical audit prize. First prize for use of the paediatric early warning score for unwell children went to medical trainees in A&E Gemma Foran and Sobia Hussain. Second prize for community acquired pneumonia: high frequency simulation project went to A&E consultant Kate Williamson.

Two cohorts of staff have become dementia champions.

Richard Kirton and Ian Cannon helped the Trust take silver best in class at Salon Culinaire Hotelympia HCA Hot Cookery Competition.

Occupational health were recognised at the North East Better Health at Work Awards at Hartlepool Borough Hall. The department was handed their third year *Continuing Excellence Award*.

Congratulations to the Trust's podiatry team who won *Community Research Engagement* award at the North East and North Cumbria (NENC) Research Network Quality Improvement awards.

Respiratory nurse specialist Barbara Thompson has been recognised with the prestigious title of Queen's Nurse.

Stop smoking service lead Pat Marshall has been awarded a Mayors good citizens award for her contribution to health and wellbeing to the Borough of Stockton since 2004

Healthcare assistants in accident and emergency James Sullivan and Ben Bains are among a group of our staff already completing a new apprenticeship.

The University Hospital of North Tees became the first Trust in the northern region to run the national Endoscopic retrograde cholangiopancreatography (ERCP) training, which combines live cases, clinical discussion and hands-on training which attracted professionals from across the country.

Congratulations to claims administrator Liz Bainbridge who has completed the Capsticks Diploma in Clinical Risk and Claims Management.

More health care staff at the Trust have achieved 'The Care Certificate' – an assessment which demonstrates their competency and skill in providing safe, high quality care.

- Healthcare assistants in orthopaedic outpatients UHNT
- Healthcare assistants in orthopaedic UHH
- Radiography assistants in the breast unit
- HCA's Medical rehab day unit
- Hartlepool district nursing team
- Stockton District nursing team
- Rapid response teams at Stockton and Hartlepool

The Trust's specialist palliative care team were shortlisted in the compassionate patient care category at the 2016 Health Service Journal (HSJ) Awards.

The following staff received the Trust Outcome and Performance Team Award by deputy medical director Professor Jane Metcalf and medical director Dr Deepak Dwarakanath. The award is recognition of their valuable contribution towards the improvement of care and the reduction in mortality rates.

- Consultant geriatrician Helen Skinner
- Clinical coding manager Caroline Griffin
- Doctor in acute medicine Stephen Wiltshire

Nurses recruited from the Philippines completed the last part of their training; the group are all qualified nurses in the Philippines but must still pass the OSCE test - a Nursing and Midwifery Council test of competence preparation, as well as English exams.

Becky Taylor, a staff nurse in the Trust's neonatal unit was awarded the Inspirational Mother award at this year's national Butterfly Awards.

Congratulations to the staff in orthopaedic outpatients who have been awarded with a certificate of excellence from Teesside University.

North Tees and Hartlepool NHS Foundation Trust have come top of the rankings for highest overall satisfaction in core general surgery training in the country, from the Messly Training Navigator, based on the General Medical Council survey of trainees.

Five of the Trust's apprentices were recognised for their hard work at an annual NHS estates apprentices awards evening.

- Jamie Boylan
- Jake Hopkins
- Benjamin Larkin
- Thomas Redpath
- Zach Trattles

The first two cohorts of students who have successfully completed The Royal Society of Public Health Level 3 Diploma in Anatomical Pathology Technology are celebrating their success.

A team made up of two physiotherapists, two social workers, an occupational therapist and a nurse has won best health and well-being initiative in this year's Association of Public Service Excellence Awards (APSE).

Congratulations to Health Visitor Catherine Abidi whose work was recognised at the recent Black History Youth Awards. Catherine, who is the health visitor working with newly-arrived asylum seekers and refugees in Stockton and beyond has supported, educated and comforted thousands of families.

Senior nurses Alison Hamilton, Beth Alderton and Rebecca Poyser have all qualified as surgical practitioners. They are all now able to work at a more advanced level in surgical and clinical care, after passing a demanding training programme.

Scan4Safety lead Jane Hawkes who won the GS1 UK healthcare industry champion at an awards event. This is for work the Trust is doing to roll out a new programme (Scan4Safety) which will involve scanning barcodes to trace things such as patient records and products and will lead to improvements in patient care.

Finance Healthcare Financial Management Association awards:

- Contract income accountant Peter Robinson won accountant of the year
- Stuart Burney, Neill Waters, Jonathan Sheldon and Dan Morris won the Northern branch small team of the year award

Congratulations to Amelia Kehoe who was awarded 'best research paper' by the Association for Medical Education in Europe, for a study carried out around the experience overseas doctors have working in the NHS.

Congratulations to our procurement and supplies team who achieved the NHS Standards of Procurement Assessment level 1 accreditation.



Podiatry team who won community research engagement award



Team who won best health and well-being initiative

Part 2a: 2016-17 Quality Improvement Priorities

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 2015-16. We are very pleased 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 for 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 2016-17 priorities.

Stakeholder priorities 2016-17

The quality indicators that our external stakeholders said they would like to see reported in the 2016-17 Quality Accounts were:

Patient Safety	Effectiveness of Care	Patient Experience
1. Mortality	1. Safety Thermometer	1. Palliative Care & Care For the Dying Patient (CFDP)
2. Dementia	2. Discharge Processes Medication	2. Is our care good? (Patient Experience Surveys)
3. Safeguarding	3. Safety, Quality and Infections Dashboard (previously Nursing Dashboard)	3. Friends and Family recommendation
4. Infections		

"Very efficient, Staff excellent and made to feel very calm, thanks to all. Maybe public should hear about the marvellous side to the NHS. We are all very lucky."[sic]



Endometriosis team

Priority 1: Patient Safety

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 use the 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.

The Trust continues to work closely with the North East Quality Observatory System (NEQOS) for third party assurance.

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)
- We will 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 of Directors
- Report quarterly to the Commissioners
- Report to the Trust Outcome Performance Delivery Operational Group

Completed and reported?

- Reported to Board of Directors ✓
- Reported to the Commissioners ✓
- Reported to the Trust Outcome Performance Delivery Operational Group ✓

The Trust Board of Directors has an understanding of the values of both Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI). The Trust has achieved reductions for both metrics, to such an extent they have both gone from being 'higher than expected' to 'as expected'.

The Trust's Deputy Medical Director has overall responsibility to improve processes that will aid in the reduction of mortality within the Trust.

Weekly centralised mortality reviews are now undertaken twice a week, with mortality workshops being held once a month for clinicians to attend to gain an understanding of the Trusts position and how they play a key part in future improvements.

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 the following:

- Ensuring a continued close working relationship with North East Quality Observatory (NEQOS) who provide an independent review of a number of indicators and also provide a quarterly mortality report.
- To aid in collaborative thinking the Trust remains part of the Regional Mortality Group, this group has representation from all eight North East Trusts where all key mortality issues are discussed.
- 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 data is from the two nationally recognised mortality indicators of Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI).

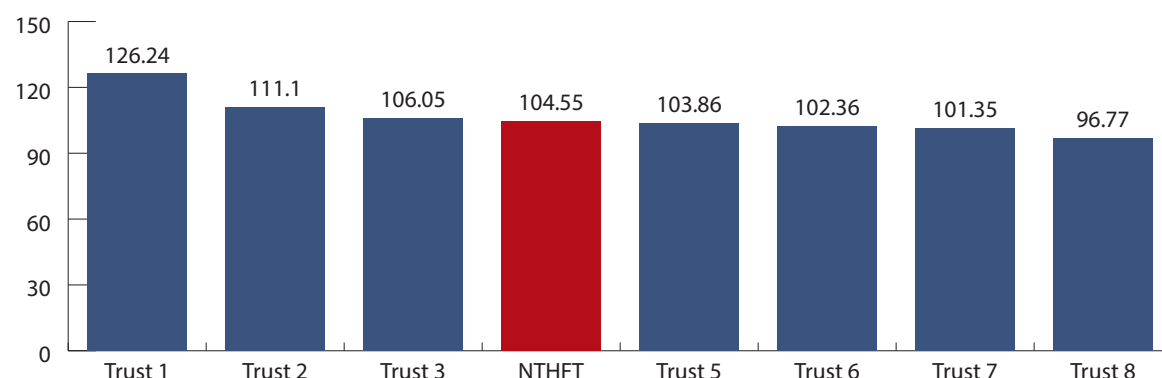
Hospital Standardised Mortality Ratio (HSMR)

March 2016 to February 2017

The Trust's HSMR value was at one point the 2nd highest value in the country at 128.10 for the 12 month rolling period from April 2014 to March 2015. The Trust has now managed to reduce the value to **104.55** for the reporting period from **March 2016 to February 2017**; this value continues to place the Trust in the 'as expected' range. The National Mean is 100, which denotes the same number of people dying as expected by the calculations, any value higher means more people dying than expected.

Regional Trust Name	HSMR
Trust 1	126.24
Trust 2	111.10
Trust 3	106.05
North Tees and Hartlepool NHS Foundation Trust	104.55
Trust 5	103.86
Trust 6	102.36
Trust 7	101.35
Trust 8	96.77

Regional HSMR - Mar 16 to Feb 17



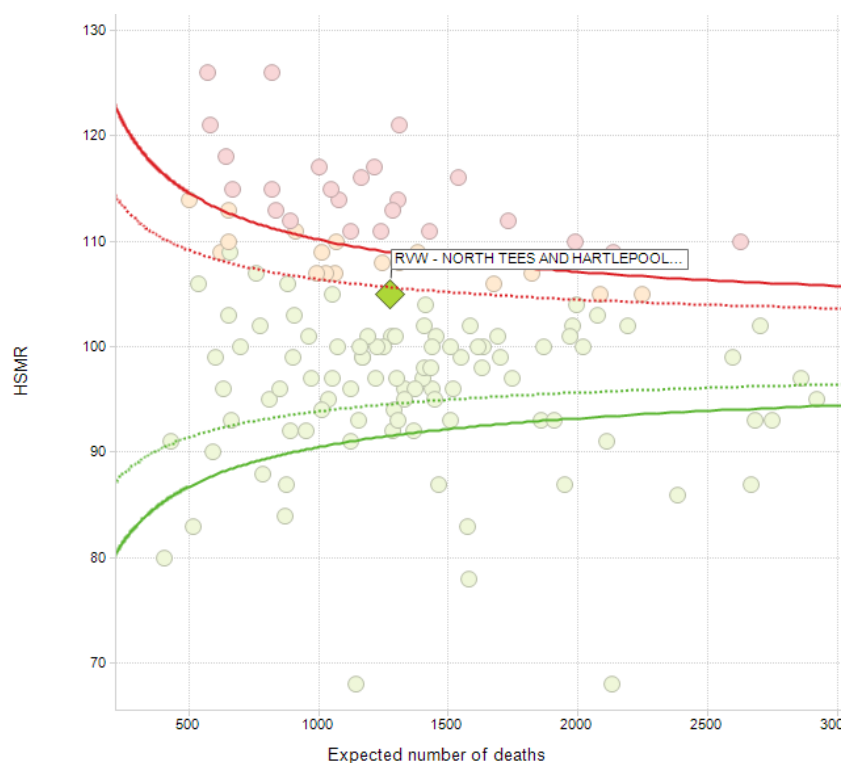
*Data obtained from the Healthcare Evaluation Data (HED)

The above HSMR chart and table demonstrates the Trust's 12 month HSMR value throughout the reporting period from **March 2016 to February 2017**, benchmarked against the other North East Trusts. The Trusts 12-month average for HSMR is currently **104.55** which whilst above the national mean of 100 is within the 'as expected' range.

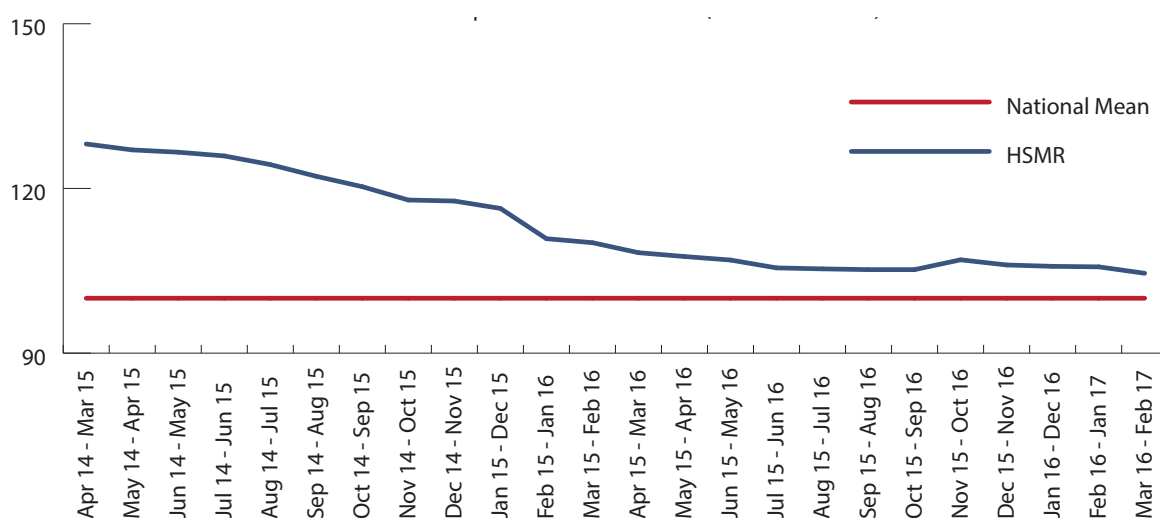
Trust HSMR Improvement

The following table and chart demonstrates, the Trust has made great strides in reducing the HSMR value to 104.55 (Mar 16 to Feb 17) from the peak of 128.10 (Apr 14 to Mar 15), now placing the Trust in the 'as expected' range.

12 Month period	HSMR
Apr 14 - Mar 15	128.10
May 14 - Apr 15	127.02
Jun 14 - May 15	126.60
Jul 14 - Jun 15	125.92
Aug 14 - Jul 15	124.35
Sep 14 - Aug 15	122.21
Oct 14 - Sep 15	120.32
Nov 14 - Oct 15	117.89
Dec 14 - Nov 15	117.71
Jan 15 - Dec 15	116.36
Feb 15 - Jan 16	110.85
Mar 15 - Feb 16	110.12
Apr 15 - Mar 16	108.30
May 15 - Apr 16	107.60
Jun 15 - May 16	106.96
Jul 15 - Jun 16	105.53
Aug 15 - Jul 16	105.35
Sep 15 - Aug 16	105.21
Oct 15 - Sep 16	105.21
Nov 15 - Oct 16	107.00
Dec 15 - Nov 16	106.06
Jan 16 - Dec 16	105.81
Feb 16 - Jan 17	105.72
Mar 16 - Feb 17	104.55



North Tees and Hartlepool HSMR value Trend (12 month values)

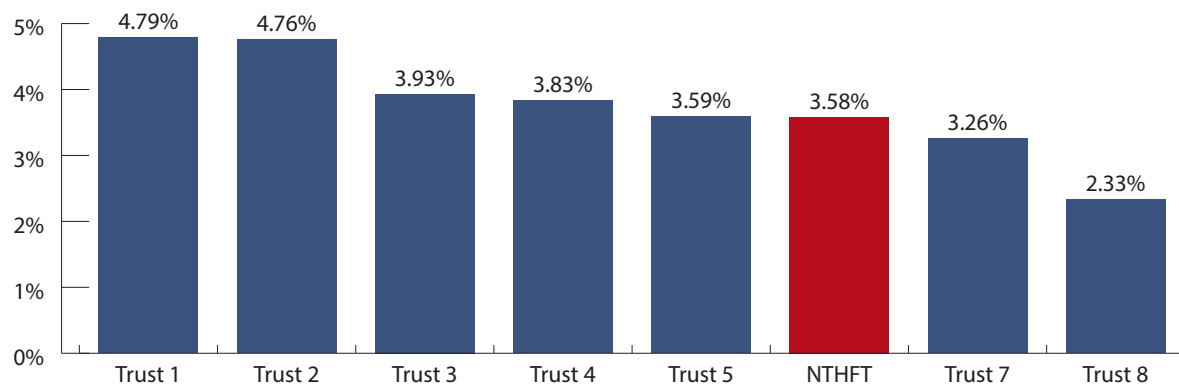


*Data obtained from the Healthcare Evaluation Data (HED)

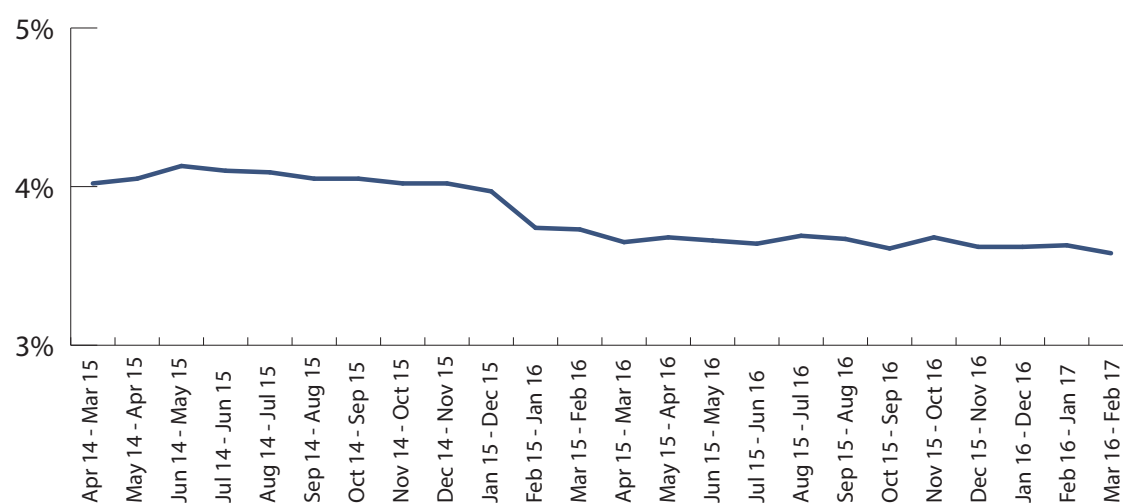
HSMR Crude Mortality Rate – 3.58%

March 2016 to February 2017

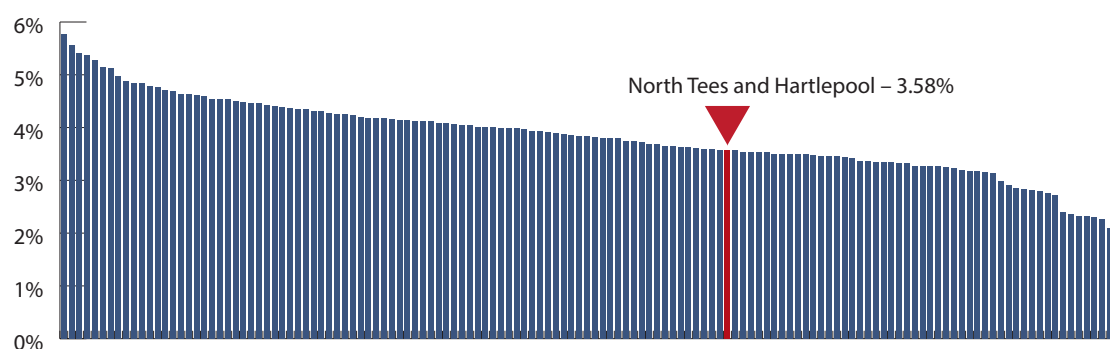
Crude mortality rate - Regional



Trust Crude Mortality Rate Reduction (Rolling 12 month)



Crude mortality rate - National



*Data obtained from the Healthcare Evaluation Data (HED)

Summary Hospital-level Mortality Indicator (SHMI)

October 2015 to September 2016

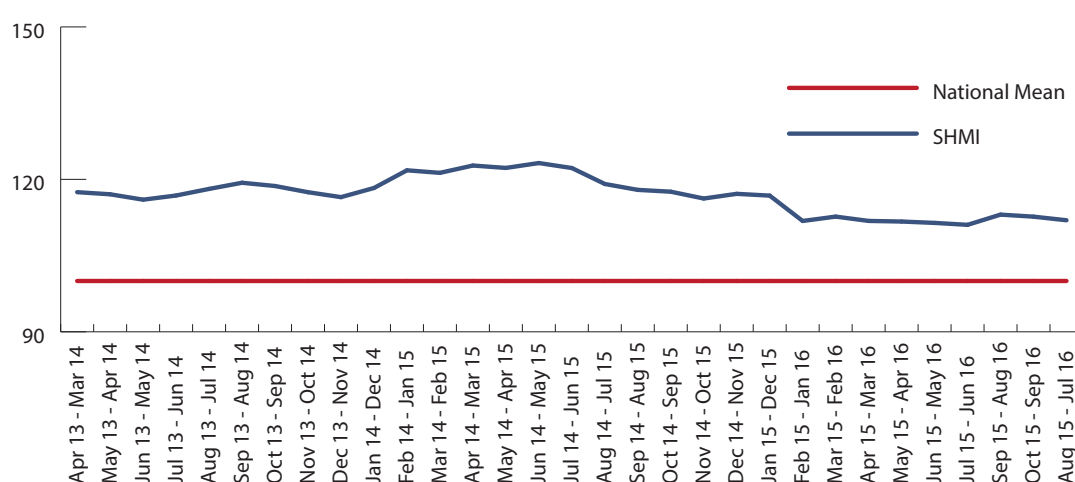
The SHMI indicator provides an indication on whether the mortality ratio of a provider is as expected, higher than expected or lower than expected when compared to the national baseline in England.

SHMI includes *deaths up to 30 days after discharge and does not take into consideration palliative care.*

The Trust's SHMI value was at one point the highest value in the country at 123.21 for the 12 month rolling period of June 2014 to July 2015. The Trust has now managed to drive this value down to **111.95** for the reporting period of **October 2015 to September 2016**, this value now places the Trust within 'as expected' range.

SHMI (12 Month Values)

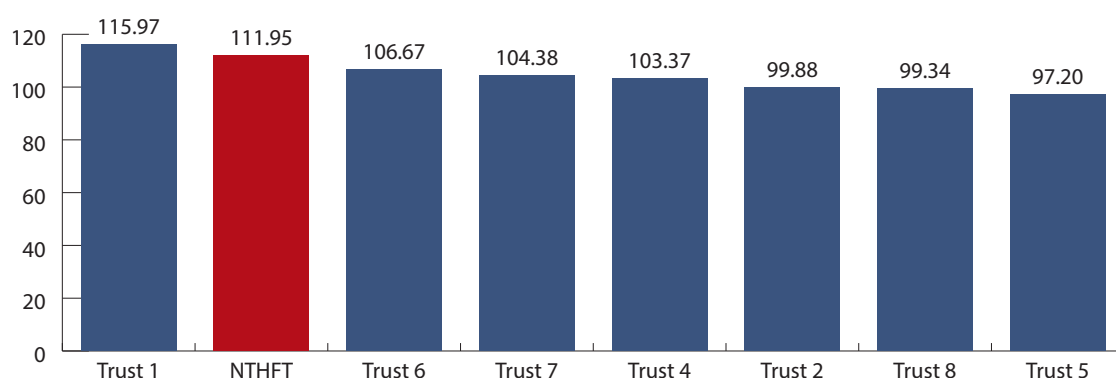
Reporting period	SHMI
Jun 14 - May 15	123.21
Jul 14 - Jun 15	122.23
Aug 14 - Jul 15	119.09
Sep 14 - Aug 15	117.93
Oct 14 - Sep 15	117.57
Nov 14 - Oct 15	116.23
Dec 14 - Nov 15	117.15
Jan 15 - Dec 15	116.80
Feb 15 - Jan 16	111.81
Mar 15 - Feb 16	112.67
Apr 15 - Mar 16	111.82
May 15 - Apr 16	111.70
Jun 15 - May 16	111.43
Jul 15 - Jun 16	111.05
Aug 15 - Jul 16	113.06
Sep 15 - Aug 16	112.66
Oct 15 - Sep 16	111.95



The following chart and table demonstrate the Trust current SHMI position utilising the latest time period of **October 2015 to September 2016**, the other *North East Trusts* have been anonymised.

Regional Trust Name	SHMI
Trust 1	115.97
NTHFT	111.95
Trust 6	106.67
Trust 7	104.38
Trust 4	103.37
Trust 2	99.88
Trust 8	99.34
Trust 5	97.20

Regional SHMI - October 15 to September 16



*Data obtained from the Healthcare Evaluation Data (HED)

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 County 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.

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 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.

Overview of how we said we would report it

- Dementia Strategy Group quarterly
- Monthly UNIFY

Completed and reported?

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

How has the organisation focused on patient safety?



+75 Screening

How?

All patients aged 75+ are captured via the monthly UNIFY data; this has demonstrated compliance with the first 72 hours of screening for those fitting the inclusive criteria within the Trust. This highlights the need to refer to memory services and for delirium management support from the Trust's mental health provider, Tees Esk Wear Valley.

The screening process supports the North of Tees approach to early diagnosis enabling the person to be informed along with the family to enable decision and consideration for life planning whilst capacity is still evident.

Why?

The new draft guidance is available on the NHS England website providing a future direction for supported early diagnosis and intervention to engage the person whilst they are able to engage and retain information. This is part of the dementia collaborative work stream.

Carers' Support

- Carers' information packs are reviewed and updated regularly
- This aims to reduce risk of carer breakdown, and information on how they can access individual carer's assessment.
- Informs carers what services they have access to.
- Increases information on how they can access individual carer's assessment
- Both Local authorities gave detailed directory of services to support the low level interventions required for people in their own homes.
- If carers feel more supported, there is less risk of admission of the people they care for.
- Supports financial and social benefit.
- Promoting the pilot of John's Campaign (www.Johnscampaign.org.uk). This supports carers to outline which elements of care/support they would prefer to do for the patient whilst in hospital, and which elements they would prefer staff to complete. It also outlines allowances for carers and family i.e. if family/carers are spending significant amounts of time visiting, allowing flexible visiting, ability to order from the hospital menu for themselves and the Trust is in discussions with Parking Eye regarding parking allowances.

Letter from Jeremy Hunt - Secretary of State for Health

The Trust received a letter from the Secretary of State for Health praising the Trusts excellent performance during Quarter 3 2016-17. The letter outlined the exceptional Trust performance in identification of patients with Dementia in A&E, during this period the Trust were the best performers in the whole of England.

Dementia Assessment and Referral 2016-17

This data collection reports on the number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours in England who have been identified as potentially having dementia, who are appropriately assessed and who are referred on to specialist services.

2016-17	Number to whom case finding is applied	Percentage to whom case finding is applied	Number who had a diagnostic assessment	Percentage with a diagnostic assessment	Number of cases referred	Number with a positive or inconclusive diagnostic assessment	Percentage of cases referred
Quarter 1	1,350	100%	226	100%	60	60	100%
Quarter 2	1,327	100%	245	100%	132	132	100%
Quarter 3	1,358	100%	199	100%	99	100	99%
Quarter 4	921	100%	97%	100%	33	33	100%

*Data obtained from NHS Digital

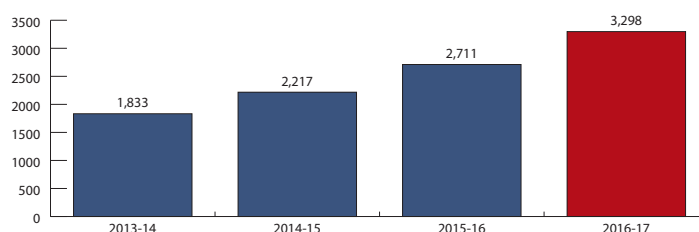
**Quarter 4 information is for January and February 2017 only

Patients admitted to the Trust with a diagnosis of Dementia/Delirium

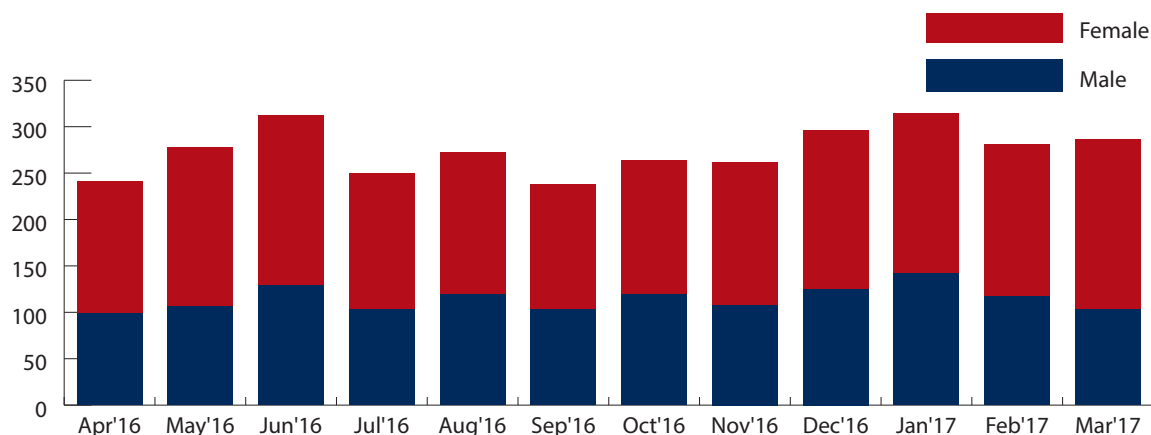
In 2014-15 The Trust appointed a dementia nurse specialist; this post continues to reap benefits, enhancing the patient experience and support to carers.

The challenges the Trust faces regarding patients admitted with a diagnosis of Dementia/Delirium is an unfortunate continued growing trend. The following tables trend the number of patient's admitted to the Trust since April 2013.

	Patients admitted with a diagnosis of Dementia/Delirium
2013-14	1,833
2014-15	2,217
2015-16	2,711
2016-17	3,298
Total	10,059



2016-17 Dementia Patients



*Data from Information Management Department

National Audit of Dementia

The National Audit of Dementia is working with hospitals providing general acute inpatient services to measure criteria relating to care delivery which are known to impact on people with dementia admitted to hospital.

The Royal College of Psychiatrists has been awarded a three year contract to manage a further round of the audit, commissioned by Healthcare Quality Improvement Partnership (HQIP) and funded by NHS England and the Welsh Government. The audit will examine the care provided to people with dementia in acute hospital settings in England and Wales. The audit will include:

- A **survey of carer experience** of quality of care
- A **case note audit** of people with dementia, focusing on key elements of assessment, monitoring, referral and discharge
- An **organisational checklist** and analysis of routine data collected on delayed discharge, complaints and staff training
- A **staff questionnaire** examining support available to staff and the effectiveness of training and learning opportunities

The National Audit of Dementia has been carried out three times from 2009 to present, the Trust results are compared for all 3 cycles, with the National and Regional being available in summer 2017.

Aims and guidelines:

- Defined by the National Audit Team, based on NICE Guidance (CG 42)
- Participation will help hospitals:
 - Identify good practice and areas for improvement in hospital wards
 - Look at the experience of people with dementia and their carers
 - Define the quality of the care experience from the point of view of the patient

	Cycle 1	Cycle 2	Cycle 3
Cases audited	40	40	59
Timeframe	2009-10	2011-12	2016

The following are a selection of questions and results from sections Assessment and Discharge from all three Cycles for the Trust:

Assessment

Multidisciplinary Assessment

Question	Cycle 1	Cycle 2	Cycle 3
An assessment of mobility was performed by a healthcare professional	90%	83%	98%
An assessment of nutritional status was performed by a healthcare professional	83%	80%	95%
The assessment of nutritional status includes recording of BMI or weight	39%	94%	96%
Has a formal pressure ulcer risk assessment been carried out and score recorded?	100%	100%	100%
As part of the multidisciplinary assessment has the patient been asked about any continence needs?	85%	98%	97%
Has an assessment of functioning been carried out?	2%	18%	97%

Mental State Assessment

Question	Cycle 1	Cycle 2	Cycle 3
Has a standardised mental status test been carried out?	38%	43%	76%
Has an assessment been carried out for recent changes or fluctuation in behaviour that may indicate the presence of delirium?	Question not asked	70%	59%
Has the patient been clinically assessed for delirium by a healthcare professional?	Question not asked	85%	91%

Discharge

Assessment before Discharge

Question	Cycle 1	Cycle 2	Cycle 3
At the point of discharge the patient's level of cognitive impairment, using a standardised assessment, was summarised and recorded	5%	21%	46%
At the point of discharge the cause of cognitive impairment was summarised and recorded	85%	94%	94%
Have there been any symptoms of delirium?	Question not asked	55%	38%
Have the symptoms of delirium been summarised for discharge?	N/A	44%	74%

Discharge co-ordination and MDT input

Question	Cycle 1	Cycle 2	Cycle 3
Are any support needs that have been identified documented in the discharge plan/summary?	30%	36%	96%
Has the patient and/or carer received a copy of the plan/summary?	67%	82%	62%
Was a copy of the discharge plan/summary sent to the GP/primary care team on the day of discharge?	Question not asked	Question not asked	100%
Was discharge planning initiated within 24 hours of admission?	63%	67%	27%

Where the values are lower than expected, the Trust has set up an action plan to address the identified issues.

"We are extremely happy with the care of all the hospital staff - we felt our mum couldn't have had better treatment and everyone has been very attentive and given her respect and dignity. We are all very grateful and appreciate your care and attention. " [sic]

"Staff were very considerate of needs and worked well with the family to look at plans of care with a complicated discharge."[sic]

Dementia Training by Staff Group

Training levels:

Tier 1 – Dementia Awareness Raising

This is mandatory to the entire workforce in health and care, involving the completion of 'Essential Dementia Workbooks' at the appropriate level according to job role.

The team also provide a 1.5 hour face to face training session on request. Within this we have an element of 'Barbara's Story' which involves short films focussing on different aspects of Barbara's journey through the healthcare system. Upon completion you have the opportunity to be a Dementia Friend as this training has been accredited by the Alzheimer's Society.

Tier 2 – Knowledge, skills and attitudes for roles that have regular contact with people living with dementia

This is the level 'Dementia Champions' are set.

To support this level of training we have commenced a Dementia Champion programme which runs every month (3 hours) for 11 months. The purpose of the Dementia Champions is to create an individual with a high level of knowledge of dementia. The 6 stages of 'Barbara's Story' is used and discussed. This training involves support from other multi-disciplinary teams as guest speakers.

Tier 3 – Enhancing knowledge, skills and attitudes for key staff in a leadership role

The dementia team do not deliver this but this is relevant to staff working intensively with people affected by dementia; for example, university modules/bespoke study days in relation to dementia care.

Dementia Level Training by Quarter

	Q1	Q2	Q3	Q4
Dementia Tier 1	97%	97%	98%	98%
Dementia Tier 2	97%	93%	91%	93%
Dementia Tier 3	93%	90%	89%	93%

**Data obtained from the Trust dementia training*

The training content for tier 1 and tier 2 dementia training is reported to Health Education North East (HEE) 5 times a year. This meeting involves all NHS trusts in the North East and is used to discuss training content and numbers. This forum is also used for getting HEE approval for training. This ensures a consistency to the training across all trusts in relation to content, it also allows trusts to share information and discuss/advise on new content, both nationally and locally.



Dementia champions

Dementia Screening – Monthly Data Collection – April 2016 – March 2017

The prevalence study identified a number of measures which are 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
471	474	405	434	457	436	419	407	532	520	421	443
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
472	475	405	434	458	436	419	407	532	520	421	443
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
99.80%	99.80%	100%	100%	99.80%	100%	100%	100%	100%	100%	100%	100%
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
92	69	65	76	90	79	83	59	57	40	57	102
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
92	69	65	76	90	79	83	59	57	40	57	102
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%

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
- Learning Disabilities steering group

Completed and reported?

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

Adult Safeguarding - Prevent

Throughout 2016 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 **18** PREVENT trainers across the Trust who deliver 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. An e-learning package has also been developed for staff to complete.

Safeguarding adults

The Trust continues to work to enhance and develop standards for safeguarding adults across the hospitals and community services.

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 2016-17 there has been a significant increase in DoLS to **833** from 683 in 2015-16.

During 2016-17 a high profile campaign raising awareness was undertaken in relation to this area of adult safeguarding. Safeguarding awareness week was carried out in June, to raise awareness on the wards; these sessions were carried out in the tower block, west wing and at the University Hospital Hartlepool site.

The safeguarding team trained 82 safeguarding champions to give key staff more intensive training.

Training activity 2016-17

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

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

Compliance with the **level two training** across the Trust is **97%**.

The adult safeguarding team also deliver safeguarding champions full day (level 2) training and to date over 80 staff have been trained. This training is delivered three times a year.

Trust Reporting

For each quarter the Trust produces an Adult Safeguarding report. The purpose of this report is to provide the Trust Safeguarding Vulnerable Adults Steering Group members with an overview of safeguarding activity, with the objective that information relevant to their areas of representation may be disseminated.

Additionally, the importance of two way communications are recognised as vital to ensure safeguarding adult activity is embedded within practice across adult health and social care.

Therefore this report highlights 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 reports includes:

- Number of referrals
- Number of alerts raised by location
- Number of alerts raised by theme
- Incidents raised by type of abuse, Trust role and outcome

The report is shared with our Commissioners.

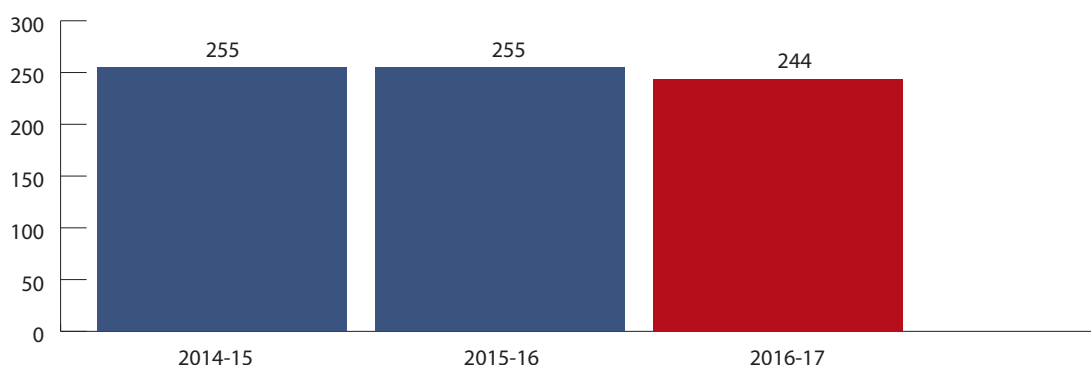
Numbers of Alerts

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)

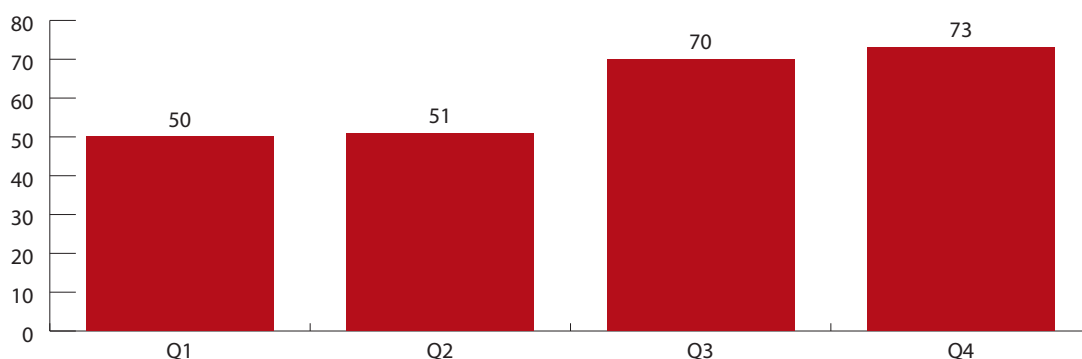
From **April 2016 – March 2017** there have been **244** Adult Safeguarding incidents across the Local Authorities of Durham, Hartlepool and Stockton.

The Trust works closely with the Local Authorities undertaking internal investigations where concerns are raised.

Year on Year Number of Concerns/Enquiries



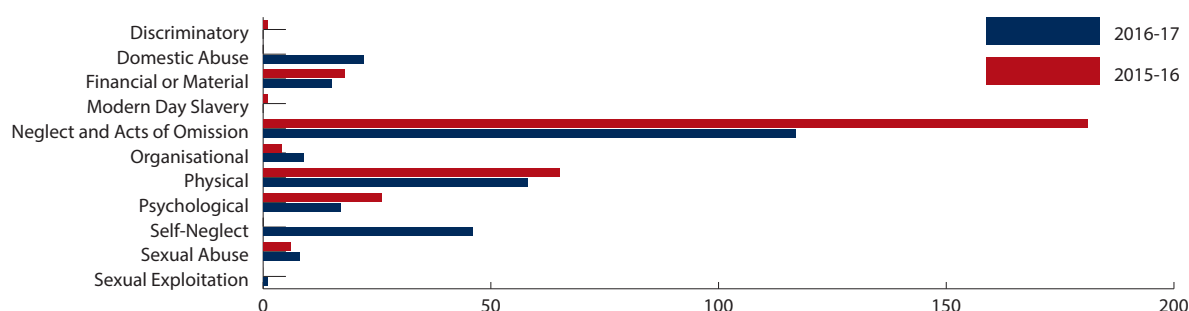
Number of 2016-17 Concerns/Enquiries per Quarter



*Data from the Trusts Adult Safeguarding database

Types of Alerts

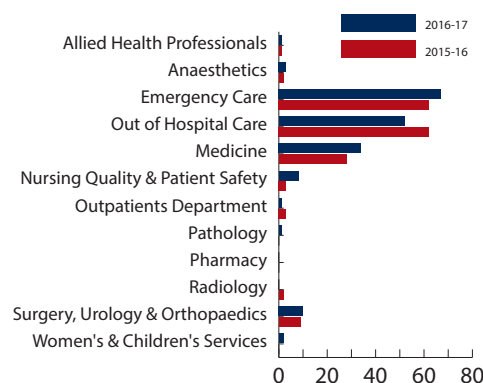
Year on Year Types of Alert



The following tables detail the allegation types raised across all three Local Authorities, it is important to note that there can be multiple allegation types per referral.

Alerting Areas

	2015-16	2016-17	Difference
Allied Health Professionals	1	1	0
Anaesthetics	3	2	-1
Emergency Care	67	62	-5
Out of Hospital Care	52	62	10
Medicine	34	28	-6
Nursing Quality & Patient Safety	8	3	-5
Outpatients Department	1	3	2
Pathology	1	0	-1
Pharmacy	0	0	0
Radiology	0	2	2
Surgery, Urology & Orthopaedics	10	9	-1
Women's & Children's Services	2	0	-2

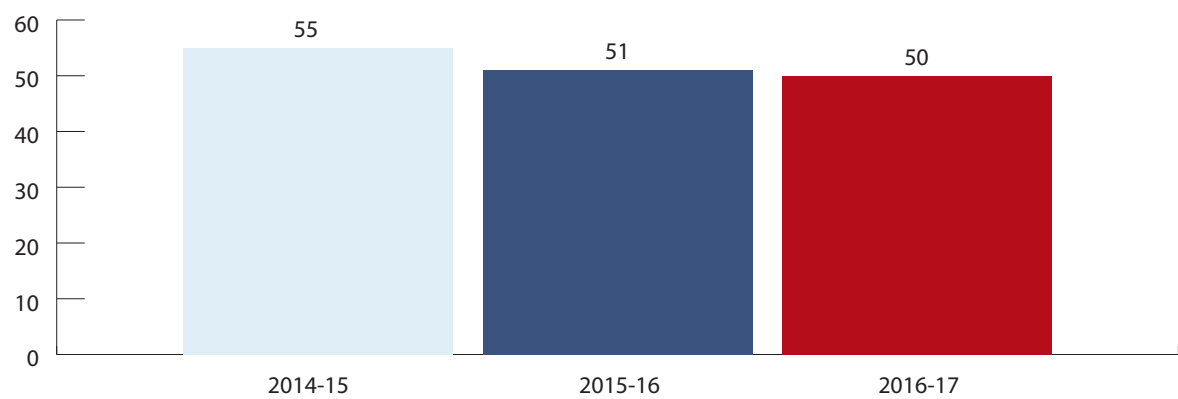


There has been an increase of 23% in the number of alerts raised by Out of Hospital Care in Q2. Face to face safeguarding training sessions have been carried out with Out of Hospital Care staff, new starters and Emergency Care staff. The Mandatory training has also been increased from once only to 3 yearly to increase awareness and provide updates from the Care Act. Medicine has seen a decrease of 21%; this could be due to improved communication and the work of the discharge group. There has been a drop in alerts raised by Emergency Care by 9%, due to A&E sending alerts direct to LA without copying in the safeguarding team, work is being carried out to address this.

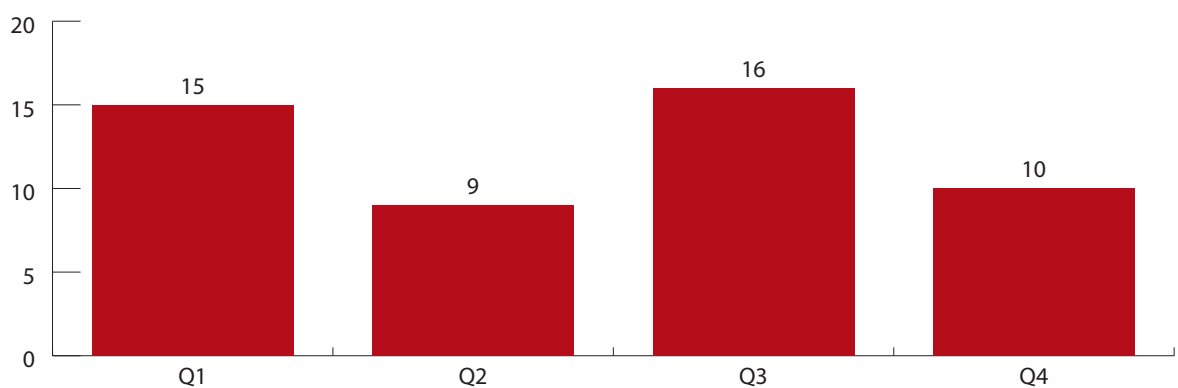
The Named Nurse continues to carry out regular 'walk-about' to encourage staff to express any concerns and provide ad-hoc clinical supervision should it be required. Staff are more aware of Adult Safeguarding within the Trust, and this greater awareness has led to an increased number of referrals.

Alerts against the Trust

Year on Year Number of Concerns/Enquiries against the Trust



Number of 2016-17 Concerns/Enquiries against the Trust per Quarter



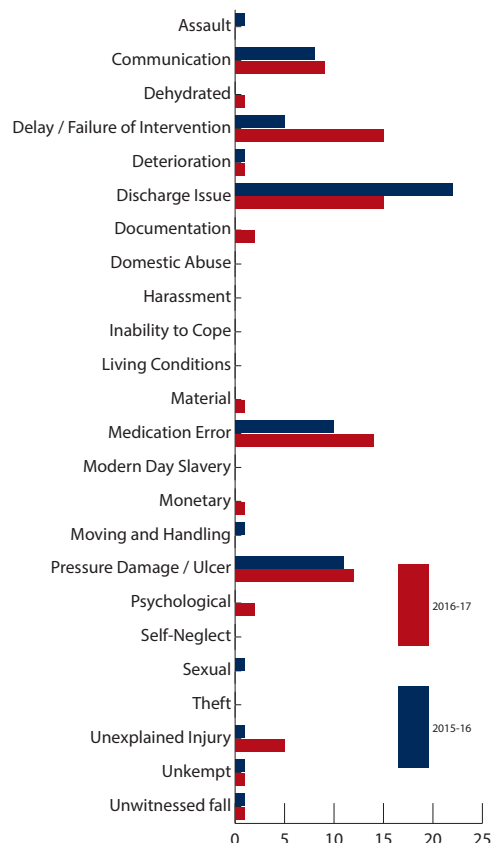
The Trust has seen a slight reduction in 2016-17 of the number of concerns/enquiries raised against the Trust, reducing to 50 from 51 in the previous reporting year.



Hospital at home team

Themes of Alerts against the Trust

	2015-16	2016-17	Difference
Assault	1	0	-1
Communication	8	9	1
Dehydrated	0	1	1
Delay / Failure of Intervention	5	15	10
Deterioration	1	1	0
Discharge Issue	22	15	-7
Documentation	0	2	2
Domestic Abuse	0	0	0
Harassment	0	0	0
Inability to Cope	0	0	0
Living Conditions	0	0	0
Material	0	1	1
Medication Error	10	14	4
Modern Day Slavery	0	0	0
Monetary	0	1	1
Moving and Handling	1	0	-1
Pressure Damage / Ulcer	11	12	1
Psychological	0	2	2
Self-Neglect	0	0	0
Sexual	1	0	-1
Theft	0	0	0
Unexplained Injury	1	5	4
Unkempt	1	1	0
Unwitnessed fall	1	1	0



Please note that one concern can cover multiple themes.

Work is on-going within the Trust on discharge and pressure related incidents. In relation to concerns around Medication Errors Ward Pharmacists are continuing to working closely with Medical and Nursing Staff to provide support and Education.

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.

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).

The Trust is represented at both Hartlepool and Stockton Local Executive Groups 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 a well-established 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 process 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 theme from alerts across Hartlepool and Stockton, this has led to the development of a discharge group and to date the Trust has seen a reduction in the number of discharge related incidents.

Children's safeguarding and Looked After Children (LAC)

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, 2015. 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 continues to demonstrate robust arrangements for safeguarding and promoting the welfare of children.

Children & Young People Governance Arrangements

The Trust has maintained a robust board level focus on Safeguarding and Looked after Children led by the Director of Nursing, Patient Safety and Quality. A bi-monthly steering group, chaired by a Non- Executive Director maintains responsibility for the performance monitoring of the Children's Safeguarding work programme. This group also brings together commissioner and provider with representation from Hartlepool and Stockton on Tees CCG (Designated Doctor and Nurse Safeguarding and Looked after Children) and Designated Nurse Safeguarding and Looked after Children Durham Darlington Easington & Sedgfield.

The Director of Nursing, Patient Safety and Quality has delegated authority to the Deputy Director of Nursing, Patient Safety and Quality who has direct line management of the Safeguarding Children Team.

The Trust has maintained membership and has made active contributions at senior level on the three Local Safeguarding Children Boards (LSCB), Stockton (SLSCB), Hartlepool (HSCB) and County Durham LSCB and on the HSCB Executive group.

The Trust has maintained representation and in some cases chairing of a number of LSCB subgroups including;

- Learning and Improving Practice sub Group (LIPSG) - Hartlepool and Stockton LSCB
- Performance Management - Hartlepool and Stockton LSCB
- The Children's Hub implementation and strategic group for Stockton and Hartlepool
- Hartlepool and Stockton Strategic Vulnerable, Exploited, Missing and trafficked (VEMT) group
- Tees procedures policy group
- Stockton and Hartlepool LSCB Training sub group with Trust nominated chair of the group
- County Durham LSCB Missing Exploited group (MEG)
- County Durham Multi Agency Safeguarding Hub (MASH)
- County Durham Early Help Sub Group
- Graded care profile task and finish group with Trust nominated chair and project lead of the group

Representatives from across all directorates take a lead role or act as a champion for children safeguarding for example in Accident and Emergency (A&E) and Women and Children's services. Meetings take place on a monthly basis bringing together safeguarding professionals to ensure momentum of the Safeguarding and Looked after Children's agenda.

In response to the Savile enquiry and subsequent recommendations for the NHS from the Lampard report in 2015 a task and finish group was established to carry out a gap analysis and actions to meet the recommendations, the Named Nurse represents Children's Safeguarding on this group and updates are presented to the Trust Patient Safety Committee. All actions are now complete.

In February 2016 an unannounced CQC review inspection on safeguarding and Looked After Children services was undertaken in Hartlepool; the report was published in March 2016 and an action plan has been developed to address recommendations. Progress is demonstrated in the Safeguarding and Looked after Children Work Program and monitored via the Safeguarding Children Steering Group. Key areas highlighted in the inspection included ensuring there is identified succession plan for the Senior Nurse Looked After Children; improving quality of Looked After Children health assessments and ensuring that where children are admitted to hospital as a result of self-harm, there are appropriate risk assessments in place (environmental) and that staff delivering care are appropriately trained in mental health issues. Those identified actions are now complete.

Children's Safeguarding Work Programme

The Children's Safeguarding Work Programme sets out and NHS Improvements progress of the work for the year at the safeguarding children steering group and is divided into 2 parts.

Part 1 NHS Improvements action plans from serious case reviews, learning lesson reviews, Domestic Homicide Reviews and internal incidents.

Part 2 NHS Improvements the Trust's safeguarding children professionals' development work, the safeguarding children annual audit and assurance programme and the planned response to key national drivers which may impact on the work of safeguarding children professionals in the Trust.

Part 1 – Learning Lessons from Serious Case Reviews (SCR)

There have been 2 Serious Case Reviews published in Durham (LSCB) in 2016 in which the Trust was a partner agency: Child L; and Child N; key themes from these reviews include:

- The need to properly assess the role of males within a family setting/ household who have contact with children and young people.
- Very young children have been the subject of the review.
- Limited engagement with the Team around the Family process and Early Help assessments.
- Lack of consistent information sharing and professionals working in silo.
- Over reliance upon the social worker - lack of professional challenge.

Hartlepool LSCB has 2 Serious Case Reviews which were delayed due to the on-going criminal proceedings however the findings are due to be published in 2017. The Trust has developed an 'early learning' action plan.

Part 2 - Development Work

Children who are not brought for appointments by parents and carer's Policy

A policy has now been developed and launched across the Trust in response to a local serious case and learning lessons review. This will enable practitioners to respond appropriately and recognise possible early indicators of neglect when a child has not been brought to appointments. Work is on-going around how the Trust can identify children whose appointments are frequently rescheduled by parents/carers alongside this.

Safeguarding Children Policy

The Safeguarding Children Supervision Policy and Safeguarding Policy has been revised and ratified in 2016. The main change in the Supervision Policy is a significant move away from Senior Nurse Safeguarding case management approach towards a more reflective and autonomous framework which empowers and enables the practitioner to transfer their learning from supervision to other cases within their caseload. The revised Safeguarding Policy also ensures that Trust staff understand, and are supported in their responsibility under current legislation to safeguard and promote the welfare of children and to enable the Trust to meet its statutory duties in this regard.

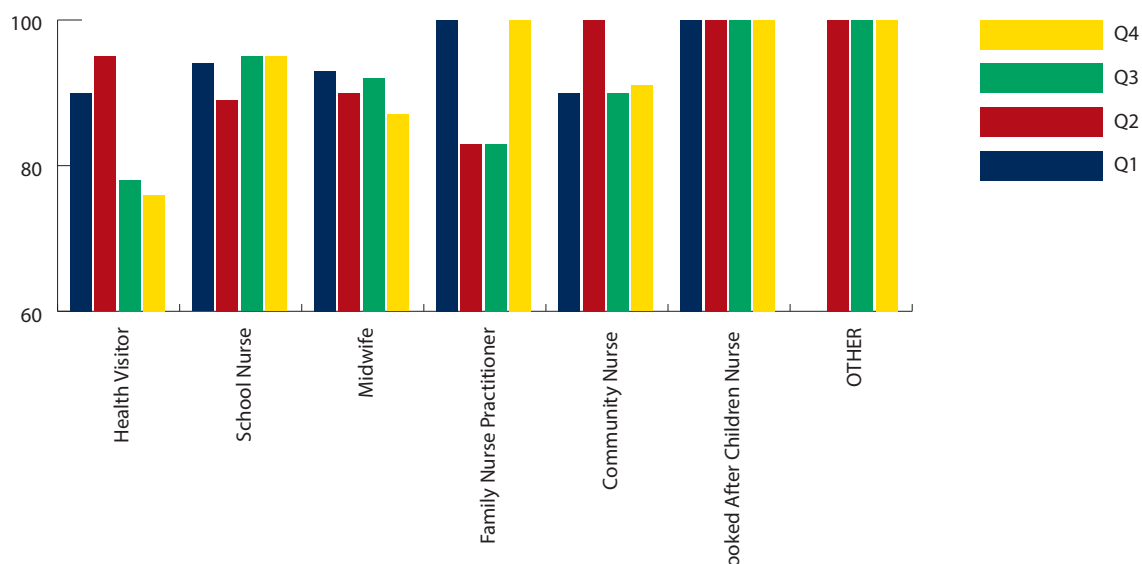
Safeguarding Children Supervision

The local quality and performance indicators include safeguarding children supervision of Trust staff. Safeguarding supervision is recognised as being fundamental for safe practice therefore the team supports this in the delivery of mandatory supervision for every staff member who has contact with children and young people within their caseload (predominantly Health Visitors, Midwives, School Nurses, Family Nurses and Community Paediatric Nurses).

1:1 supervision is undertaken with a senior nurse on a three monthly basis. Compliance is reported via the quarterly dashboard and demonstrated in the table below.

	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17
Health Visitor	90%	95%	78%	76%
School Nurse	94%	89%	95%	95%
Midwife	93%	90%	92%	87%
Family Nurse Practitioner	100%	83%	83%	100%
Community Nurse	90%	100%	90%	91%
Looked After Children Nurse	100%	100%	100%	100%
OTHER		100%	100%	100%

Safeguarding Children Supervision



North of Tees Children's Hub

The new Multi-agency Children's Hub North of Tees (Hartlepool and Stockton) went live in June 2016. This is an exciting development which has enhanced multi-agency working and information sharing, promoting early help and intervention. Health has been integral to the design of the HUB and a Senior Nurse from the Children's Safeguarding Team rotates into the HUB Team

Child Sexual Exploitation (CSE)

CSE continues to be a growing concern. The Stockton and Hartlepool VEMT (Vulnerable, exploited, missing trafficked) subgroup and the Missing Exploited group (MEG) in County Durham 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. Following the CQC Children Looked After and Safeguarding (CLAS) inspection the Trust has developed an action plan to effectively utilise CSE risk assessment tools to assist early identification of those at risk of CSE.

Domestic Violence & Abuse

The Trust is represented at Multi Agency Risk Assessment Conferences (MARAC) in Hartlepool and Stockton where high risk victims of domestic abuse are identified and safety plans put in place. A Domestic Abuse policy has been launched across the Trust. Routine and selective enquiry training has been rolled out.

Local Authority Designated Officer (LADO)

Regular meetings have been established between the Named Nurse and staff within the Human Resources (HR) department to improve communication and referrals to the (LADO). Additional safeguarding training has been delivered to Trust senior managers to increase their awareness of adult risky behaviours that may require safeguarding intervention when supporting staff during sickness/absence or capability issues.

Signs of Safety

Hartlepool and Stockton Local Authorities have implemented the Signs of Safety model in the assessment of risk and safety planning process when working with cases that reach the threshold for children's social care intervention. Frontline community health practitioners are attending training to equip them with the knowledge and skills in using this approach with children and families. The Senior Nurses in the Children's Safeguarding Team have been identified as practice leads and attend regular updates with the local authority.

Joint working with Adult Safeguarding

Joint training has been delivered between Adult and Children's Safeguarding Teams in relation to Female Genital Mutilation (FGM), Prevent, Forced Marriage and Modern Slavery and plans to work jointly in delivering safeguarding training are being developed.

Audit

The Trust work programme includes a rolling schedule of audits with a strong focus on quality and improving outcomes for children and young people.

The mnemonic 'ACHILD' was created following a recommendation from a local serious case review which is a trigger to alert staff to a concern when children attend A&E with injuries. The audit undertaken in 2016 has resulted in changes in the use and frequency of the tool and will also allow identification of vulnerable older children aged 16-18 years

A Risk Assessment Tool is completed for adults who attend A&E/Minor Injuries Unit (MIU) with key risky behaviours including domestic abuse, substance misuse and mental health. The tool is used to risk assess and inform care planning for adults and guides practitioners to identify if the patient has care of any children. This helps ensure that vulnerable families have access to specialist services, as well as promote good holistic care, in order to effectively safeguard children and young people.

Key Achievements 2016

- Temporary Appointment of additional 0.5 WTE safeguarding children's trainer to support implementation of the Graded Care Profile
- Provision of bespoke professional challenge training in response to lessons from serious case reviews.
- Appointment of a 1 WTE Specialist Safeguarding Midwife
- Launch of Children Not brought for appointments by parents/carers policy
- Development of a Safeguarding Children Resource Pack for Out of Hours Managers in the Trust
- Senior Nurses now rotating into the children's Hub to facilitate multi-agency decision making

Key Priorities 2016-17

1. Continued monitoring and audit of completed actions from the recommendations from the CQC CLAS review inspection in Hartlepool.
2. Align key priorities to the priorities of the 3 LSCBs.
3. Continue to work closely with partner agencies to drive forward the Early Help Agenda.
4. Achieve 100% compliance for all local safeguarding children quality requirements.
5. Continue to work in partnership with Hartlepool and Stockton local authorities in the North of Tees children's hub.
6. Enhance the Trust safeguarding children training program.
7. To continue to raise awareness of the VEMT agenda in the Trust utilising agreed risk assessment tools to improve outcomes for children and young people who may be vulnerable, exploited, missing or trafficked.

Safeguarding Children Training Programme

Throughout 2016 into 2017 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 health care staff; Intercollegiate Document (2014) and the Trust's Safeguarding Children Training Policy.

Overall Trust Compliance for Safeguarding Children Training

Training compliance is monitored by the Safeguarding Steering Group and an action plan has been developed to address the reduced compliance.

	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
Level 1	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	100%
Level 2	95%	94%	94%	89%	85%	86%	85%	84%	83%	83%	84%	84%
Level 3	94%	93%	91%	91%	90%	90%	93%	94%	93%	93%	93%	94%

Looked After Children (LAC)

The services and responsibilities for LAC are underpinned by legislation, statutory guidance and good practice guidance which include: "Statutory Guidance on Promoting the Health and Well-being of Looked After Children" (DH, 2015) and "Promoting the Quality of Life of Looked After Children and Young People" (NICE, 2010). The importance of the health of children and young people in care cannot be overstated; many children in care are likely to have had their health needs neglected prior to coming into care. The health of looked after children is everyone's responsibility, so partnership working is essential to ensure optimum health for each individual child and young person.

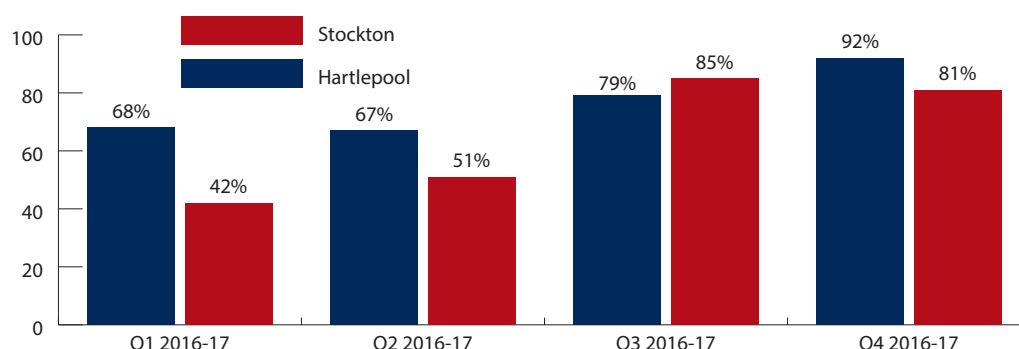
- LAC health provision is an integral part of the Trust Safeguarding and LAC Steering Group work programme which reports to the Trusts Children's Safeguarding Steering Group and Patient Safety Committee.
- To ensure quality in provision of service a Trust wide performance group has been established. Attendance includes Lead Paediatricians; Named Nurse for Safeguarding & LAC; Senior Nurses for LAC; and General Manager Women and Children's Services. Effective from March 2016 the Named Nurse now has direct line management responsibilities for the LAC Senior Nurses to promote strong leadership within the team.
- The Trust continues to be represented and is an active member of the Multi-Agency Looked After Partnership (MALAP) in Stockton.

Looked After Arrangements and Provision

Initial Health Assessments (IHA) are a statutory requirement. All LAC must be offered an IHA by a suitably qualified medical practitioner, which should result in a Health Care Plan by the time of the child's first Looked After Review (LAR) 20 working days after becoming LAC.

Table 1 below demonstrates compliance when children are notified to the service that they are in care:

LAC - Initial Health Assessments



It was recognised that as demand for IHAs increased there was a subsequent fall in compliance however this is now being addressed by regular LAC Performance Management Team Meetings which identify any predicted increases in service demand so that resilience plans can be implemented to ensure sufficient capacity to respond. The Trust is also actively seeking to recruit additional Community Paediatricians in response to increasing demand. Points to note in relation to reduced compliance include:

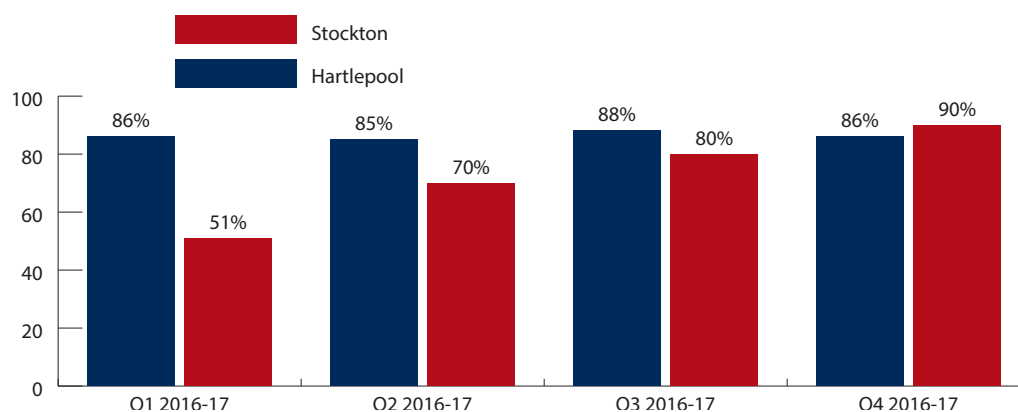
- Not receiving timely and appropriate consent for IHAs affects the overall compliance rate; however the escalation process introduced early in 2016 has improved compliance.
- Cancellations by carers continues to affect the rates of compliance; electronic monitoring and analysis of the reasons why carers cancel ensures these issues are addressed with partner agencies and carers at the time.

Review Health Assessments

- Review Health Assessments must be undertaken at 6 monthly intervals for children under five years; annually for those over five up until they turn 18 years old.
- Reviews are designed to identify and monitor health needs of LAC and are a statutory obligation. In Stockton and Hartlepool the service model includes Health Visitors and School Nurses who undertake the RHA for those LAC accessing universal services. Health Visiting and School Nursing are a Public Health commissioned service.

Table 2 below demonstrates compliance of review health assessments and Children & Young People registered with services.

LAC - Review Health Assessments

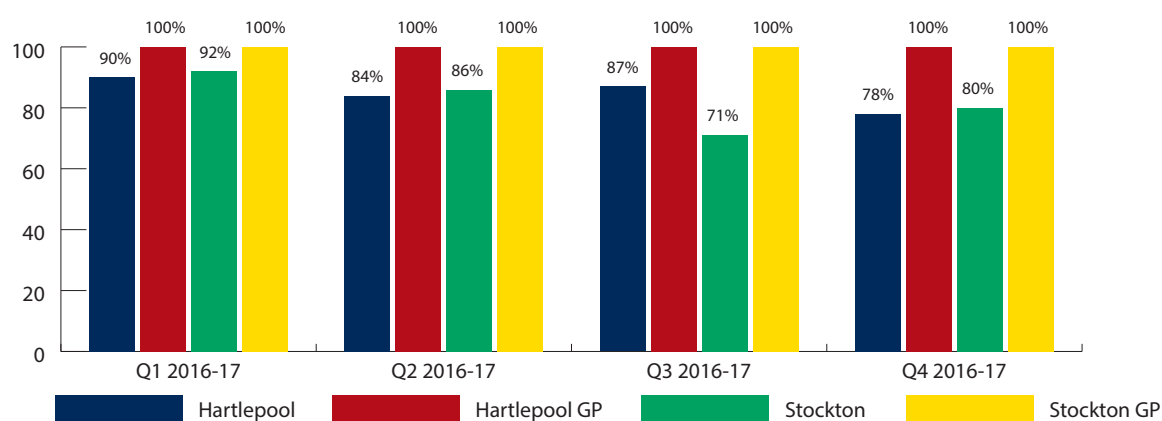


The data has identified a number of issues where compliance has not been maintained and include:

- Capacity in other services such as school health both in local services and those provided by other Trusts to undertake the RHA.
- Review assessments cancelled by carers.
- Children being unwell at the time of the appointment and movement of placement.

In response to the issues identified a process for standardised recording of information across Stockton and Hartlepool IT Systems has been developed alongside a robust action plan which will provide improved quality and consistency of data. This process was introduced through a series of awareness sessions with groups of health staff delivered by the LAC team.

LAC Registered with all 3 Services & GP Services



The above table demonstrates the number of children registered with services including GP, Optician and Dentist. It is of note that children under the age of two would not routinely be registered with either an Optician or Dentist unless there is an identified need. Those children have been included in the overall total figure which can account for the reduced compliance.

Summary

Key Achievements 2016

- On-going updates and improvements to the Electronic Health Care Record to improve the LAC processes and communication with other health services.
- Implementation of a Health Passport for Care Leavers in Stockton.
- Successful implementation of a rolling program of safeguarding supervision for the LAC Senior Nurses.
- A significant improvement in the completion of IHA's and RHA's within statutory timescales.

Sensory Loss

Legal Duties to meet individual's information and communication and support needs.

The Equality Act became law in October 2010 and is aimed to improve and strengthen patient's experiences by ensuring all service providers take steps or make reasonable adjustments in order to avoid putting a disabled person at a disadvantage when compared to a person who is not disabled and/or has some degree of sensory loss or impairment. The Act is explicit in including the provision of information in an accessible format as a reasonable step to be taken.

The Care Act 2014 details specific duties for local authority colleagues concerning provision of advice and information, additionally the NHS Constitution states that "You have the right to be involved in discussions and decisions about your health and care and to be given information to enable you to do this".

The Accessible Information Standard launched by NHS England in 2016 builds upon the existing legal duties which public sector bodies and all service providers are already obligated to follow, the aim being to improve healthcare for millions of people with sensory loss and other disabilities.

The Standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients', service users, carers and parents where their needs relate to a disability, impairment or sensory loss. The Standard required all NHS and adult social care organisations to meet the communication needs of people with a disability, impairment or sensory loss by 31 July 2017.

The Trust set up a task and finish group to oversee implementation of the Standard and is working with colleagues to meet the key milestones and to ensure compliance and achievement of the Standard where the Trust has control.

The Trust continues to make improvements to the care provided to patients with sensory loss, these include:

Identifying Patients with Sensory loss

Significant changes have been made to Core Admission Documentation to identify more clearly patients who have a sensory loss/impairment. The planning of care has also been improved to include documenting the reasonable adjustments required to support the patient during their hospital stay, with the associated care plans put into place and reviewed as part of daily intentional rounding processes. Work is also progressing to update current electronic systems used in acute and community settings to facilitate the requirements of the Accessibility Standard i.e. identifying, recording, flagging, sharing and meeting the information and communication support needs of patients', service users, carers and parents where their needs relate to a disability, impairment or sensory loss.

Patient Experience

Work has started to develop posters for all clinical areas to raise awareness of the different ways to communicate in addition to developing picture cards appropriate for the clinical area to aid communication needs.

Quarterly meetings are held with the current provider of Interpretation and Translation services, Specialist Mental Health Nurse for patients with sensory loss and Hartlepool Deaf Centre to work together on issues raised by patients and thus support service development.

Specialist Equipment

An audit of fixed hearing loop provision throughout the Trust was performed, the results highlighted which equipment required maintenance and re-siting of equipment to maximise its use in addition to raising awareness amongst staff of the equipment in their clinical areas.

The audit of portable hearing loops highlighted gaps in staff awareness and accessibility of these systems by staff. The portable hearing loops were then removed from the wards and stored in the medical equipment library so they are available to all when needed on a 24 hour basis. A Portable hearing loop is also kept in the resilience offices on both sites for emergency use.

Celebrating deaf/blind week

On an annual basis charities and local partner agencies hold information stalls at both hospital sites to raise awareness of sensory loss and celebrate the work taking place to support patients and their families. Groups involved over the course of the week include Health watch, Hartlepool Deaf Centre, Action on Hearing Loss, Guide Dogs for the Blind and local authority partners. In addition to having stalls and displays some of the restaurant food menus were presented in Braille during the week.

Staff Support

Communication is sent to staff using quarterly Trust bulletins sharing updates about the Accessibility Standard and its implications for staff, patients, carers and service users.

A eLearning package about communication needs is being developed and is planned to be rolled out to all staff during 2017.

The Accessible Information Standard Review – Survey March 2017

The survey is part of the post-implementation review of the Standard. The purpose of the review is to assess the impact of the standard and ensure it is, and continues to be, "fit for purpose". Following the review, all of the feedback will be analysed and a report will be produced. Depending on the findings, revised versions of the Specification and/or Implementation Guidance for the Standard might be issued. However it is envisaged there will be no substantive changes to the overall scope of the Standard.

All surveys are anonymous and are for health and care professionals, teams, and departments providing or commissioning NHS care or publically funded adult social care. Additionally surveys are being sent to patients, service users, carers, patients and other representative bodies.

Priority 1: Patient safety

Infection Control

4. Infection Prevention and Control

Rationale: Key stakeholders asked us to continue to report on infections of Clostridium difficile, Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia, Methicillin-Sensitive Staphylococcus Aureus (MSSA) and Escherichia coli (E.coli) in 2016-17 as these remain high on the patient safety 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 Trust and non-Trust attributed cases.
- We will undertake a multi-disciplinary Root Cause Analysis (RCA) within 3 working days for all Trust attributed cases.
- We will benchmark our progress against previous months and years.
- We will benchmark our position against Trusts in the North East and peers across England in relation to number of cases reported and number of samples tested.

Overview of how we said we would report it

- Board of Directors 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.
- Safety, Quality and Infections Dashboard
- Clinical Quality Review Group (CQRG)

Completed and reported?

- Reported at every Board of Directors meeting ✓
- Reported at every Council of Governors meeting ✓
- Discussed at each Infection Control Committee ✓
- Discussed in detail at Audit Committee and Directorate meetings ✓
- Reported in detail to NHS Improvement ✓
- Reported to the Patient Safety and Quality Standards Committee (PS & QS) ✓
- Safety, Quality and Infections Dashboard contains infection data ✓

Infection totals for 2016-17 – Hospital Acquired

Infections Category	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Total
C diff	2	4	4	3	3	3	3	5	2	4	2	4	39
MRSA						1							1
MSSA	4	4	2	1	3	0	2	2	1	0	2	0	21
E.coli	8	4	3	4	3	4	1	6	1	7	5	4	50
Grand Total	14	12	9	8	9	8	6	13	4	11	9	7	111

2016-17	2015-16	2016-17	Year to year Difference
C diff (NHS Improvement Breach 13)	36	39	+3
MRSA	2	1	-1
MSSA	24	21	-3
E.coli	44	50	+6
Grand Total	106	111	+5

Clostridium difficile infection (CDI)

Clostridium difficile is a bacterium that is found in the gut of around 3% of healthy adults. It seldom causes a problem as it is kept under control by the normal bacteria of the intestine. However certain antibiotics can disturb the bacteria of the gut and Clostridium difficile can then multiply and produce toxins which cause symptoms such as diarrhoea.

During 2016-17 the Trust did not achieve the Clostridium difficile target having reported **39** Trust attributed cases against a trajectory of **13** cases. This is disappointing given the reductions achieved in previous years and the continued efforts by staff, but not entirely unexpected as the trajectory was always going to be challenging. The Trust continues to work hard to control and reduce opportunity for infections to spread whether we treat people in our clinical premises or in their own homes. The Trust has maintained a consistent approach to cleanliness across all important areas of our environment including enhanced decontamination with hydrogen peroxide vapour and the development of a mattress decontamination facility. A greater focus has been placed on antimicrobial stewardship with the identification of 'champions' across all directorates. The importance of adherence to high standards of hand hygiene has been highlighted by the introduction of hand hygiene champions with a monthly 'champions challenge'.

The Trust improvement plan has been developed in conjunction with clinical staff and reviewed monthly. Progress against the plan is reported to the Healthcare Associated Infection Operational Group and Infection Control Committee and the document is regularly shared with commissioners.

A CDI 'summit' was held in October 2016, during which RCA documents were reviewed and a set of core standards agreed, which are now being implemented across all ward areas. The summit included Board members, governors and representatives from local commissioning groups.

How did we do?

The following table identifies the numbers of Trust attributed cases of Clostridium difficile cases reported by the Trust against the target for that period. The table also identifies the number of non-Trust attributed cases of Clostridium difficile reported by our laboratory.

Number of Trust Attributed Clostridium difficile cases

	Q1	Q2	Q3	Q4	Total
2015-16	8	10	7	11	36
2016-17	10	9	10	10	39

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

Clostridium difficile cases 2013-17

	Trust Attributed	Non-Trust Attributed
2013-14	30	95
2014-15	20	71
2015-16	36	68
2016-17	39	73

**Data obtained from HCAI data capture system*

Clostridium difficile cases and rate per 100,000 Bed Days for North East Trusts 2016-17

Trust	C Diff Cases	Trust	C Diff rate per 100,000 HES bed days
Trust 1	68	NTHFT	18.79
Trust 2	33	Trust 1	15.96
NTHFT	33	Trust 4	14.56
Trust 4	28	Trust 6	13.16
Trust 5	20	Trust 2	11.39
Trust 6	19	Trust 8	8.35
Trust 7	15	Trust 5	7.68
Trust 8	8	Trust 7	5.71

**Data obtained from the Healthcare Evaluation Data (HED) – data from April 2016 to January 2017 (Latest available)*

Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia

Staphylococcus Aureus is a bacterium commonly found on human skin which can cause infection if there is an opportunity for the bacteria to enter the body. In serious cases it can cause blood stream infection. MRSA is a strain of these bacteria that is resistant to many antibiotics, making it more difficult to treat.

Many patients carry **MRSA** on their skin and this is called colonization. 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. This measure reduces the risk of them going on to develop an infection.

How did we do?

In 2016-17 our organisation reported **1 (one)** Trust attributed MRSA, an improvement on the previous year when two cases were reported. This exceeds the national zero tolerance trajectory. However following investigation the case was found to be unavoidable and the Trust had followed policy in terms of screening and treatment for the patient.

MRSA bacteraemia cases 2013-17

	Trust Attributed	Non-Trust Attributed
2013-14	0	4
2014-15	1	2
2015-16	2	3
2016-17	1	2

**Data obtained from HCAI data capture system*

MRSA bacteraemia cases and rate per 100,000 Bed Days for North East Trusts 2016-17

Trust	MRSA Cases	Trust	MRSA rate per 100,000 HES bed days
Trust 2	7	Trust 4	2.60
Trust 4	5	Trust 2	2.42
Trust 1	5	Trust 7	1.90
Trust 7	5	Trust 1	1.17
Trust 5	3	Trust 5	1.15
NTHFT	1	NTHFT	0.57
Trust 8	0	Trust 8	0.00
Trust 6	0	Trust 6	0.00

**Data obtained from the Healthcare Evaluation Data (HED) – data from April 2016 to January 2017 (Latest available)*

Methicillin-sensitive Staphylococcus Aureus (MSSA)

MSSA is a strain Staphylococcus Aureus that can be effectively treated with many antibiotics. It can cause infection if there is an opportunity for the bacteria to enter the body and in serious cases it can cause blood stream infection.

How did we do?

In 2016-17 we reported 21 cases of Trust attributed MSSA bacteraemia. 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 continues to be a focus of for the future in an attempt to reduce the number of MSSA bacteraemia. An increase in non-Trust attributed cases was also seen this year.

MSSA bacteraemia cases 2013-17

	Trust Attributed	Non-Trust Attributed
2013-14	13	30
2014-15	18	41
2015-16	24	64
2016-17	21	57

**Data obtained from HCAI data capture system*

MSSA bacteraemia cases and rate per 100,000 Bed Days for North East Trusts 2016-17

Trust	MSSA Cases	Trust	MSSA rate per 100,000 HES bed days
Trust 1	80	Trust 1	18.78
Trust 2	28	Trust 4	10.92
Trust 7	23	NTHFT	10.82
Trust 4	21	Trust 2	9.67
NTHFT	19	Trust 7	8.76
Trust 5	17	Trust 5	6.53
Trust 8	5	Trust 8	5.22
Trust 6	5	Trust 6	3.46

*Data obtained from the Healthcare Evaluation Data (HED) – data from April 2016 to January 2017 (Latest available)

Escherichia coli (E.coli)

Escherichia coli is a very common bacterium found in the human gut which can cause serious infections such as blood poisoning.

How did we do?

The numbers of E coli bacteraemia (blood stream infection) reported across by the Trust for the year are shown in the table below. As the majority of these cases are those that are identified within the first 48 hours of hospital admission work is required across all healthcare settings to achieve improvements.

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 with only a very small percentage of cases being in patients with a urinary catheter where they may be potential for improved practices.

E.coli bacteraemia cases 2013-17

	Trust Attributed	Non-Trust Attributed
2013-14	22	169
2014-15	28	176
2015-16	44	227
2016-17	50	267

*Data obtained from HCAI data capture system

The following tables identify the performance against the eight North East Trusts in 2016-17. For E.coli, the data in the following table encompasses both Trust and Non-Trust attributed cases.

E.coli bacteraemia cases and rate per 100,000 Bed Days for North East Trusts 2016-17

Trust	E.coli Cases	Trust	E.coli rate per 100,000 HES bed days
Trust 2	373	NTHFT	144.66
Trust 1	354	Trust 5	135.17
Trust 5	352	Trust 4	132.10
Trust 7	321	Trust 2	128.76
Trust 4	254	Trust 8	124.18
NTHFT	254	Trust 7	122.28
Trust 6	148	Trust 6	102.51
Trust 8	119	Trust 1	83.10

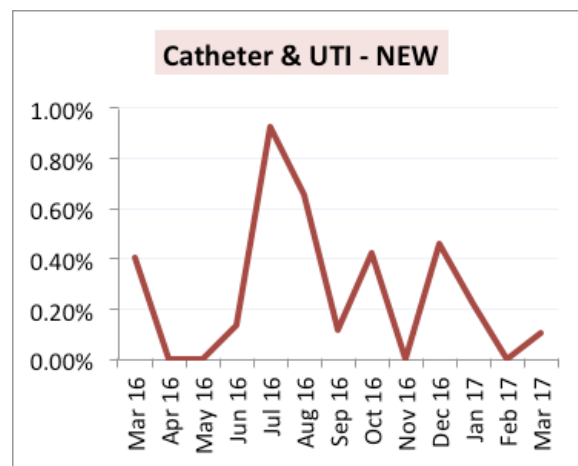
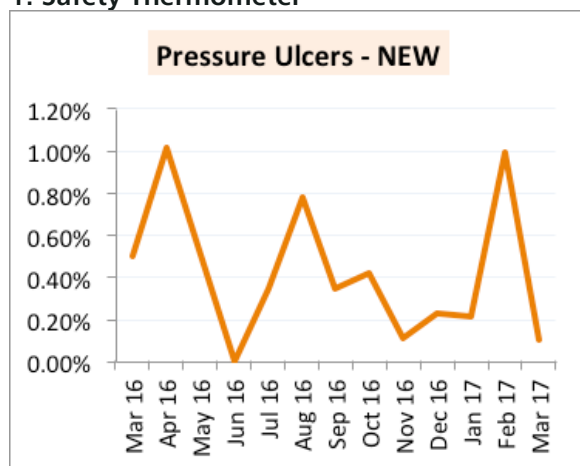
*Data obtained from the Healthcare Evaluation Data (HED) – data from April 2016 to January 2017 (Latest available)



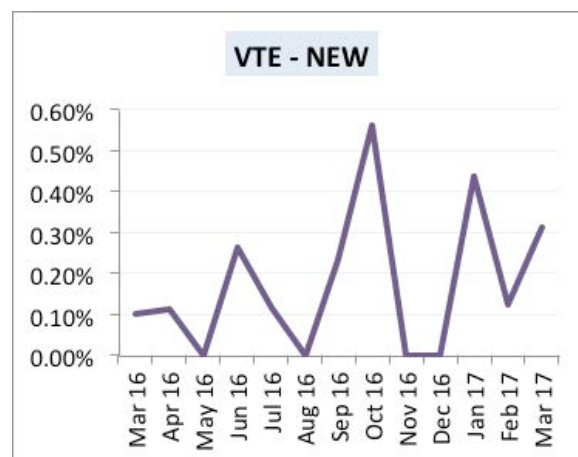
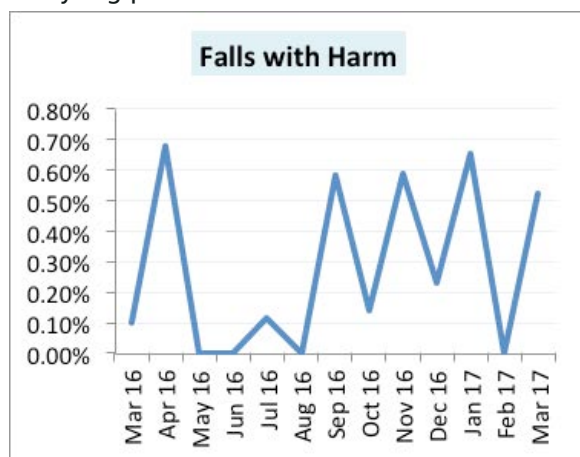
Priority 2: Effectiveness of Care

Safety Thermometer

1. Safety Thermometer



Rationale: The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care.



Overview of how we said we would do it

- The NHS Safety Thermometer provides a quick and simple method for surveying patient harms and analysing results so that you can measure and monitor local improvement and harm free care over time.

Overview of how we said we would measure it

- This indicator will continue to be audited on one day per month across the Trust and community services and the data submitted to NHS Digital.

Overview of how we said we would report it

- Report at every Board of Directors meeting
- Report at every Council of Governors meeting
- On the Safety, Quality and Infections Dashboard

Completed and reported?

- Reported at every Board of Directors meeting ✓
- Reported at every Council of Governors meeting ✓
- Reported on the Safety, Quality and Infections Dashboard ✓

National Safety Thermometer Data can be found at:

<http://content.digital.nhs.uk/searchcatalogue?q=title%3A%22nhs+safety+thermometer+data%22&area=&size=10&sort=Most+recent>

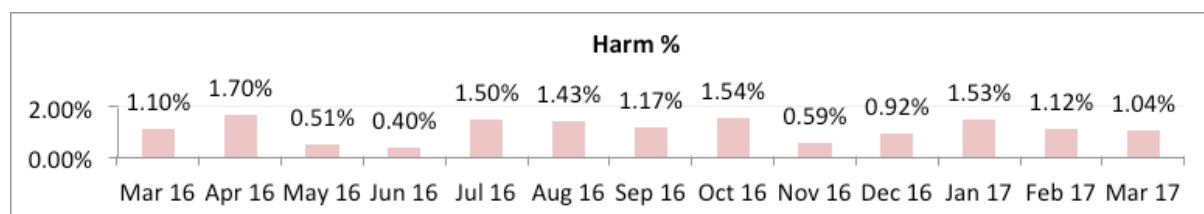
Safety Thermometer Data (classic) – March 2016 – March 2017

The following data is provided by NHS Digital:

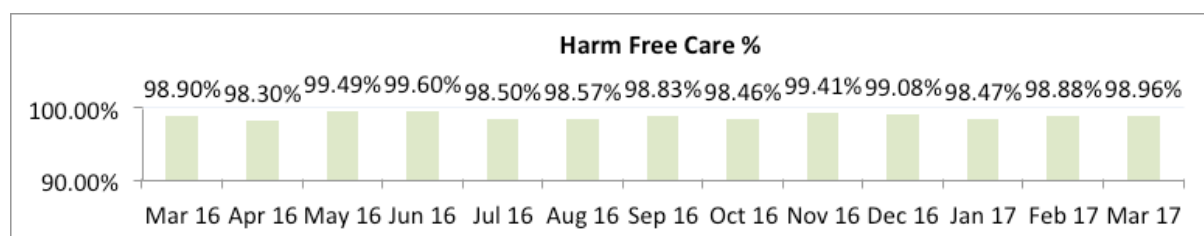
Pressure Ulcers – NEW	Catheter and Urinary Tract Infection – NEW
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Falls with HARM	Venous Thromboembolism – NEW
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Harm % Trend



Harm FREE % Trend



In addition to the Classic Safety Thermometer (see previous data), in 2016-17 additional safety thermometer measures called "new Generation Safety thermometer" are being piloted across acute and community areas of the Trust. These new safety measures, measure all harm but have specific indicators according to the specialist area, namely Medication safety thermometer, Maternity safety thermometer, Children and young people's safety thermometer.

Medication

The Medication Safety Thermometer is a measurement tool for improvement that focuses on Medication Reconciliation, Allergy Status, Medication Omission, and Identifying harm from high risk medicines in line with Domain 5 of the NHS Outcomes Framework. This is currently being piloted in 2 acute areas (medicine and surgery) and community rapid access areas with a view to rolling out across all areas during 2017.

Maternity

The Maternity Safety Thermometer has been designed to measure commonly occurring harms within maternity care and allows maternity teams to take a temperature check on harm and records the proportion of mothers who have experienced harm free care. Data collected focuses on maternal infections, perineal trauma, post-partum haemorrhage, term babies Apgar score and unexpected transfer and patients perception of safety. It supports improvements in patient care and patient experience, prompts immediate actions by healthcare staff and integrates measurement for improvement into daily routines. Currently both acute and community areas are piloting the Maternity Safety Thermometer as part of everyday activities.

Children and Young People's Services

The Children and Young People's Safety Thermometer is a national tool that has been designed to measure commonly occurring harms in children and young people's services. These harms include deterioration, extravasation, pain and skin integrity and is currently being piloted in acute children's ward areas.

Current feedback from all New Generation Pilot areas have resulted in changing of the national measuring templates within agreed limits to support them being more user friendly and thus improving accuracy of data and return of data. It is envisaged the roll out for all areas will continue throughout 2017 with view to support improvements in patient care and patient experience, prompting immediate actions by healthcare staff and integrated measurement for improvement into daily routines.

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 ✓

“Ward staff are extremely helpful. Downside is discharge arrangements where upon being informed I could go home it was 6 hours waiting for pharmacy tablets.” [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 access further information.

Work is on-going to increase awareness around medicines incident reporting and improve the way we manage the investigation process. The aim of this work is to ensure we learn from medicines incidents; share good practice and ultimately improve our processes and patient safety.

Medicines Safety

In **2015-16** there were **609** medicines related incidents reported which originated within the Trust. In **2016-17** there have been **685** medicines related incidents reported which originated within the Trust.

Type of incidents	2013-14	2014-15	2015-16	2016-17
Prescribing	124	147	224	138
Administration	256	314	321	413
Dispensing	41	43	48	72
Other	56	50	16	62
Total	477	554	609	685

* Data from the Trusts Datix system

2016-17 Trust Medication Error Categories

Trust Medication Error Category	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Administration or supply of a medicine from a clinical area	25	39	40	30	31	42	33	43	21	37	33	39	413
Medication error during the prescription process	11	11	9	12	13	14	10	10	14	10	8	16	138
Preparation of medicines / dispensing in pharmacy	5	6	8	7	1	6	9	6	5	5	10	4	72
Monitoring or follow up of medicine use	2	5	1	8	4	3	5	6	3	2	5	4	48
Patient's reaction to Medication			1	1	1					2	2	1	8
Advice		1							1	1		1	4
Supply or use of Over the Counter medicines				1		1							2
Total	43	62	59	59	50	66	57	65	44	57	58	65	685

* Data from the Trusts Datix system

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 (Omniceil) with biometric access which have been introduced in a number of areas. This has improved services through:

- Keys no longer necessary – accessed via fingerprint
- 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

Priority 2: Effectiveness of Care

Safety, Quality and Infections Dashboard

Previously Nursing and Midwifery Dashboard

Safety, Quality and Infections Dashboard

Rationale: The Safety, Quality and Infections 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

- At every Board of Directors meeting
- At every Council of Governors meeting

Completed and reported?

- Reported at every Board of Directors meeting ✓
- Reported at every Council of Governors meeting ✓

In December 2016 the Trust commenced roll out a new Safety, Quality and Infections Dashboard replacing the existing Nursing and Midwifery Dashboard.

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

The areas covered by the dashboard are:

- Nurse Staffing Rates
- Complaints, Stage 1 to 6
- Pressure Ulcers Grade 1 to 4
- Patient Falls
- Classic Safety Thermometer
- Unannounced Hand Hygiene
- Infection Control
- Friends and Family Test
- Staff, Patient Experience and Quality Standards (SPEQS)
- Medication Errors

Safety, Quality and Infections Dashboard

2016-2017

[Heat Map](#)
[Print Screen](#)
[Contact Details](#)

Select one from list below:

Trust Position

[Refresh Dashboard](#)

Last updated:

03/04/2017 08:56

North Tees and Hartlepool

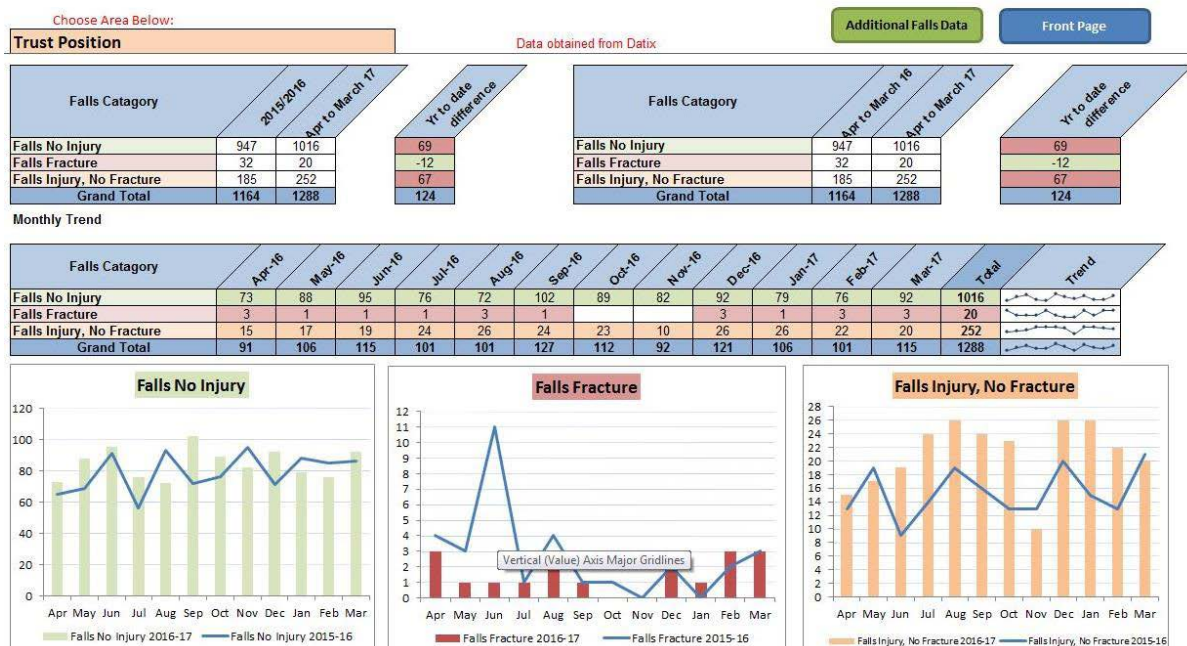
ID	Measure	Previous Period	Previous Value	Latest Period	Latest Value	vs Previous Period	Trend	2016/2017 Total (or Avg)	Drill Down
1	Fill Rate - RN Day	Feb 17	81.04%	Mar 17	81.76%	↑		80.58%	UNIFY Detail
2	Fill Rate - RN Night	Feb 17	90.79%	Mar 17	89.63%	↓		93.94%	
3	Fill Rate - HCA Day	Feb 17	123.84%	Mar 17	122.35%	↓		122.57%	
4	Fill Rate - HCA Night	Feb 17	130.05%	Mar 17	127.46%	↓		143.19%	
5	Stage 1 Complaint - Concern	Feb 17	63	Mar 17	72	↑		880	Complaints Detail
6	Stage 2 Complaint - Formal Meeting	Feb 17	2	Mar 17	3	↑		70	
7	Stage 3 Complaint - Formal Letter	Feb 17	11	Mar 17	43	↑		270	
8	Stage 4 Complaint - Consent	Feb 17	2	Mar 17	6	↑		12	
9	Stage 5 Complaint - Other Trusts	Feb 17	0	Mar 17	0	→		8	
10	Stage 6 Complaint - Duty of Candour	Feb 17	0	Mar 17	3	↑		8	
11	Total Complaints	Feb 17	78	Mar 17	127	↑		1,248	
12	Pressure Ulcer Grade 1	Feb 17	3	Mar 17	3	→		39	Pressure Ulcer Detail
13	Pressure Ulcer Grade 2	Feb 17	19	Mar 17	17	↓		126	
14	Pressure Ulcer Grade 3	Feb 17	3	Mar 17	0	↓		9	
15	Pressure Ulcer Grade 4	Feb 17	0	Mar 17	0	→		1	
16	Total Ulcers	Feb 17	25	Mar 17	20	↓		175	
17	Fall No Injury	Feb 17	76	Mar 17	92	↑		1,016	Falls Detail
18	Fall Fracture	Feb 17	3	Mar 17	3	→		20	
19	Fall Injury, No Fracture	Feb 17	22	Mar 17	20	↓		252	
20	Total Falls	Feb 17	101	Mar 17	115	↑		1,288	
21	Safety Thermometer - NEW Pressure Ulcers	Feb 17	1.00%	Mar 17	0.10%	↓		0.43%	Safety Thermometer Detail
22	Safety Thermometer - Catheter & UTI - NEW	Feb 17	0.00%	Mar 17	0.10%	↑		0.00%	
23	Safety Thermometer - Falls with Harm	Feb 17	0.00%	Mar 17	0.52%	↑		0.30%	
24	Safety Thermometer - VTE - NEW	Feb 17	0.12%	Mar 17	0.31%	↑		0.18%	
25	Safety Thermometer - Harm Free Care %	Feb 17	98.88%	Mar 17	98.96%	↑		98.85%	
26	Safety Thermometer - New Harm %	Feb 17	1.12%	Mar 17	1.04%	↓		1.15%	
27	UA Hand Hygiene Nurses	Feb 17	96.41%	Mar 17	96.54%	↑		94.87%	Hand Hygiene Compliance Detail
28	UA Hand Hygiene Doctors	Feb 17	79.63%	Mar 17	96.59%	↑		88.96%	
29	UA Hand Hygiene HCAs	Feb 17	85.14%	Mar 17	90.95%	↑		92.02%	
30	UA Hand Hygiene Physio's/Visiting Doctors	Feb 17	100.00%	Mar 17	93.56%	↓		94.69%	
31	UA Hand hygiene Others	Feb 17	92.05%	Mar 17	100.00%	↑		95.30%	
32	UA Hand Hygiene Compliance Avg	Feb 17	89.21%	Mar 17	93.92%	↑		92.11%	
33	Infection Control - C Diff	Feb 17	2	Mar 17	4	↑		39	Infections Detail
34	Infection Control - MRSA	Feb 17	0	Mar 17	0	→		1	
35	Infection Control - MSSA	Feb 17	2	Mar 17	0	↓		21	
36	Infection Control - Ecoli	Feb 17	5	Mar 17	3	↓		49	
37	Friends & Family - Would Recommend %	Feb 17	94.73%	Mar 17	94.60%	↓		94.07%	Friends & Family Detail
38	Friends & Family - Wouldn't Recommend %	Feb 17	1.26%	Mar 17	1.24%	↓		1.45%	
39	Friends & Family - Positive Comments	Feb 17	4,798	Mar 17	5,546	↑		55,501	
40	Friends & Family - Negative Comments	Feb 17	113	Mar 17	150	↑		1,560	
39	SPEQS - Safe	Feb 17	91.82%	Mar 17	91.09%	↓		89.53%	SPEQS Detail
40	SPEQS - Effective	Feb 17	86.40%	Mar 17	86.92%	↑		88.12%	
41	SPEQS - Caring	Feb 17	95.37%	Mar 17	94.21%	↓		91.92%	
42	SPEQS - Responsive	Feb 17	88.79%	Mar 17	88.62%	↓		84.86%	
43	SPEQS - Well-Led	Feb 17	88.15%	Mar 17	79.27%	↓		81.78%	
44	SPEQS - Avg Total	Feb 17	89.61%	Mar 17	88.76%	↓		88.43%	
45	Medication Errors	Feb 17	58	Mar 17	65	↑		685	Medication Errors Detail

The drill down options on the front page allow for greater detail of the individual measures to be displayed:

The following two images illustrate the greater depth of information available.

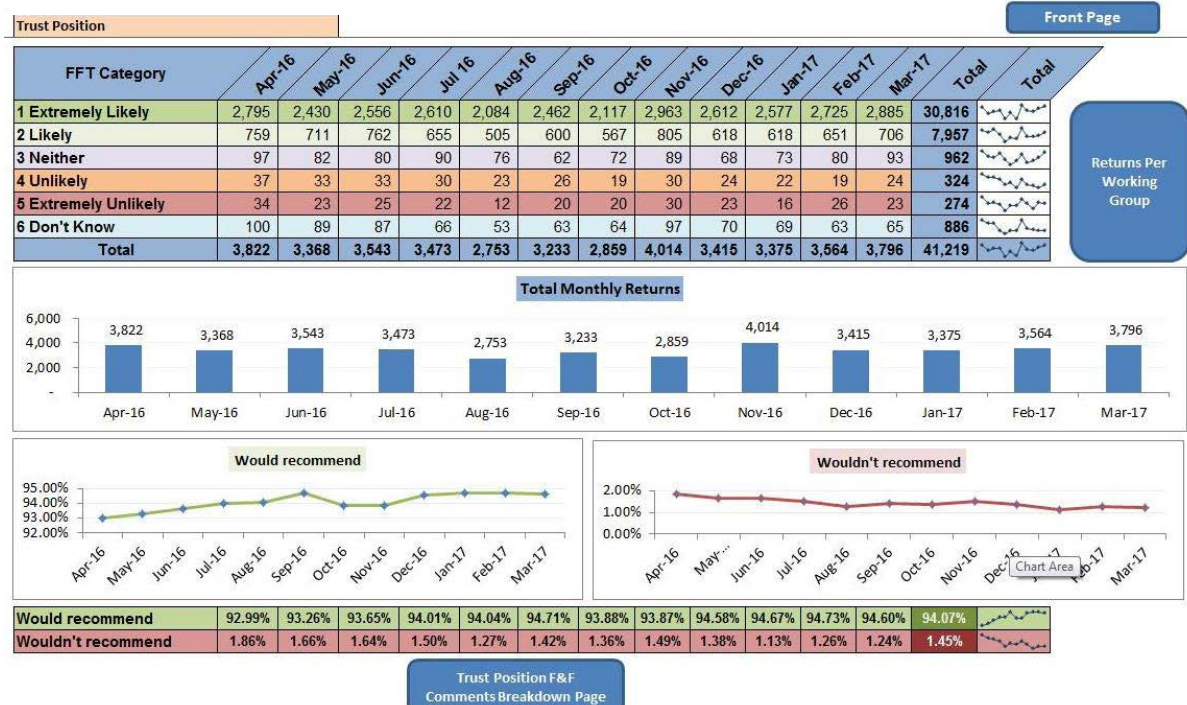
Falls Dashboard 2016-17

North Tees and Hartlepool NHS Foundation Trust



Friends and Family Dashboard 2016-17

North Tees and Hartlepool NHS Foundation Trust



Priority 3: Patient Experience

Palliative Care and Care For the Dying Patient

1. Palliative Care and Care For the Dying Patient

Rationale: The Trust used the Care For the Dying Patient (CFDP) and Family's Voice. Stakeholders and the Trust believe that this needs to remain a priority in 2016-17 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 For the Dying Patient document has now 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 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 IPB
- Annually to PS & QS

Completed and reported?

- Reported to IPB and quarterly ✓
- Reported to PS & QS annually ✓

"Our mam, who is 95 and dying, has received the best care. Her son and his wife have been treated with care and respect. The staff have been understanding and maintained mam's dignity until the very end." [sic]

Specialist Palliative Care

The Trust instigated a number of changes to the palliative care process and team during 2016-17, to improve patient experience, quality of care given and more accurate data collection

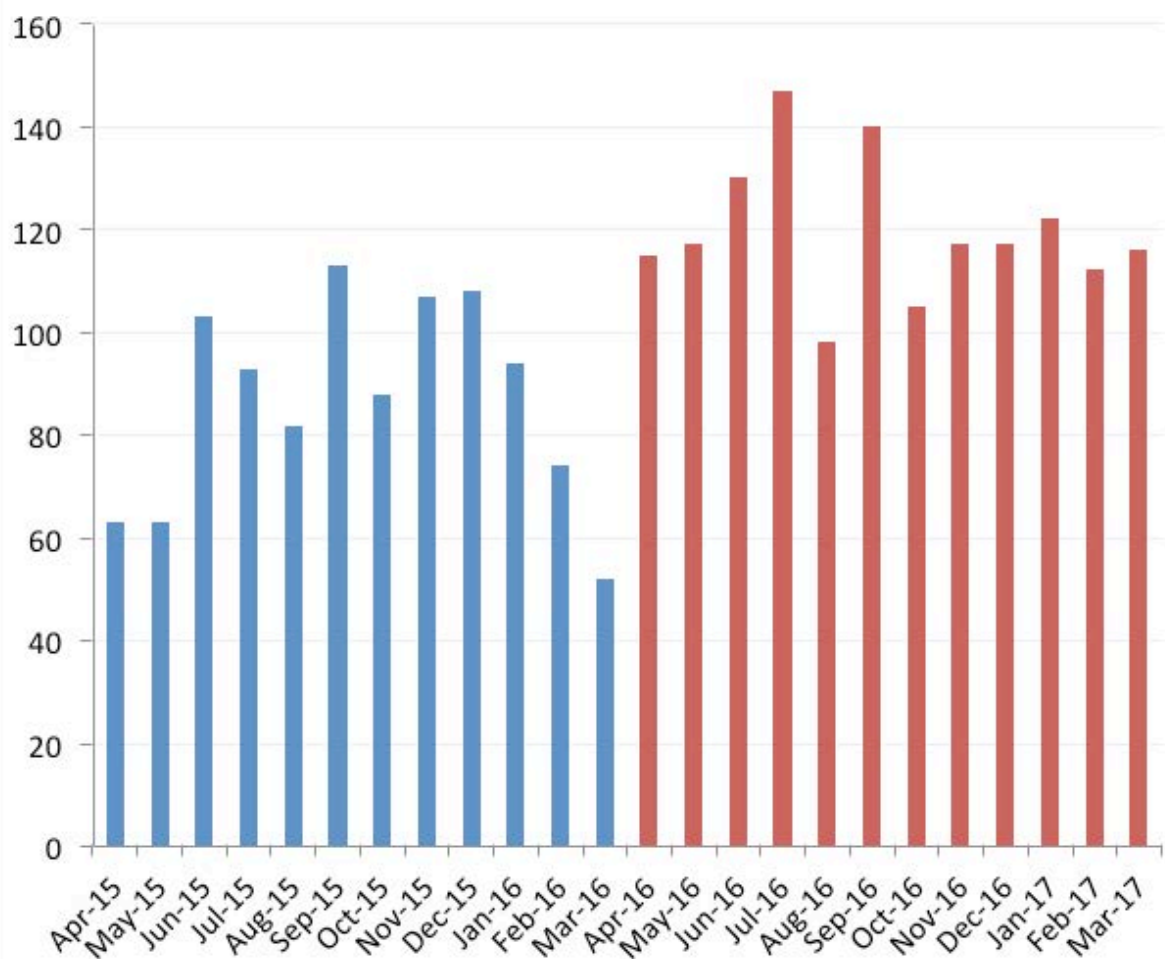
The following table demonstrates the year on year comparison from 2014-15 to 2016-17 for number of patients seen by the Specialist Palliative Care Team.

	Q1	Q2	Q3	Q4	Total
2014-15	131	129	163	181	604
2015-16	229	288	303	220	1,040
2016-17	362	385	339	350	1,436

Month	Patients Seen
Apr-15	63
May-15	63
Jun-15	103
Jul-15	93
Aug-15	82
Sep-15	113
Oct-15	88
Nov-15	107
Dec-15	108
Jan-16	94
Feb-16	74
Mar-16	52

Month	Patients Seen
Apr-16	115
May-16	117
Jun-16	130
Jul-16	147
Aug-16	98
Sep-16	140
Oct-16	105
Nov-16	117
Dec-16	117
Jan-17	122
Feb-17	112
Mar-17	116

Number of patients seen by the SPC team



**Data obtained from the Trusts SPC team*

Educational Strategy for Palliative Care

North Tees and Hartlepool NHS Foundation Trust recognises the importance of giving the best possible care to palliative patients and patients in the last days of life. Over the last year we have worked with our partners locally, regionally and nationally to ensure that we look to provide the very best care and continue to develop our strategy and Trust focus around palliative and end of life care.

Good communication skills are essential and underpin the care given. Health care professionals caring for all patients need to be trained in communication skills. However the importance of good communication becomes even more pronounced when caring for palliative patients and patients in the last days of life due to the sensitive nature of discussions. An understanding of the importance of a holistic assessment is essential. It is important that a patient's physical, psychological, spiritual and social needs are addressed and that the family and carers are well supported.

Health care professionals need to be aware of appropriate medication prescribing in palliative patients and to follow guidance on advance care planning and the management of palliative emergencies. Following funding from Macmillan Cancer Support, the Trust Specialist Palliative Care Team has established a diary of study days, aimed at nursing and medical staff from all settings, primary and secondary care, with a view to raising the profile of care delivery for patients who are in a palliative or end of life phase. In addition to this, the Trust now has Palliative and End of Life Care as a full day element of its Preceptorship programme. In an effort to support staff with difficult conversations, the SPCT also facilitate the SAGE & THYME Foundation level in communication skills on the preceptorship programme.

Aims:

- For staff to have increased knowledge and skills whilst caring for palliative and dying patients and their families.
- For staff to feel more confident in providing care for palliative patients and their families.
- For staff to feel more confident in providing care for dying patients and their families.
- To improve the care of palliative patients and their families provided by staff employed by the Trust.
- To improve the care of dying patients and their families provided by staff employed by the Trust.
- To comply with national standards for training and education around caring for palliative patients and patients in the last days of life.

Secondments with specialist palliative care team

Following a successful bid to Macmillan Cancer Support, the Trust initiated a Macmillan Development Nurse Programme, which has been funded for two years. The year 2 secondees are about to take up post in their development roles, both staff commuting from our Out of Hospital directorate. In addition, the 2 secondees from year 1, a community nurse from the Trust and a ward sister from the Trust, have both been successful in obtaining permanent positions within the Specialist Palliative Care Team as Macmillan Nurses, as part of effective succession planning.

The programme has covered a variety of clinical areas, allowed the development nurses opportunities to attend national conferences, link with cancer site specific teams both in and out with the Trust and to attend MDT and GSF meetings across the locality. Their development experience has led to them being able to hold a caseload of patients under the supervision of a Band 7 Macmillan Clinical Nurse Specialist and afforded them the skills and experience to commence their careers as Macmillan Clinical Nurse Specialists.

In addition to this, a recent 6 month secondment exchange between the Trust Out of Hospital Directorate and Butterwick Hospice was undertaken. A community nurse gained 6 months experience at Butterwick Hospice, whilst a Hospice Palliative Care Nurse gained 6 months experience within the Specialist Palliative Care Team at the Trust. It is hoped that we can develop this programme further.

Palliative Care Register and Virtual Wards

Within the Trust there is an area of development called the Trust based palliative care register. The Trust has two virtual wards.

1. A register that identifies and monitors the palliative care patients expected to be in the last year of life.
2. The virtual end of life ward.

The Trust has seen approximately 350 patients who have received end of life care on our wards in the last year. When patients are on the register they are given a green swan (identifier) on Trakcare which is the Trusts Electronic Patient Record System. The flag ensures that clinical teams are aware and can think before acting about who they are treating. Over the year the Trust has reduced the length of stay for these patients from an average of 11 days to 4, making sure patients are in hospital no longer than they should be.

For comparison, in January 2016 of this group on the register 498 (52%) died in the hospital and 455 (48%) died outside at home, in a hospice or nursing residential home. In March 2017 it is reversed, 587 (48%) died in hospital and 629 (52%) died outside of hospital.

Care For the Dying Patient (CFDP)

The diary continues to be given out to relatives within the Trust and the community.

Between April 2016 and March 2017, the Trust has handed out **171** diaries; this is the same as the previous reporting year, currently the average score has reduced to **20.40** from the previous average of 20.80.

The Trust continues to be busy with unprecedented pressures. Two research papers have been sent for publication which reports on the sixth year of this project development, with one of the papers being multi-agency.

The Trust has endeavoured to improve the uptake of the CFDP with greater support from the chaplains who review every patient on the Care of the Dying Document. If the document has not been given out, it is pointed out and the next occasion they offer to accompany the staff in giving it out. The Trust has also added the process of the diary to the SPEQS audit process, asking if the diary has been introduced and are the SPC blue drawers full with all relevant documentation.

The following are results since April 2011; these results demonstrate that a **high standard of care continues** to be provided by the Trust.

Reporting Period	Number of Patients	Average Daily Score (Max 24.00)
April 2011 to March 2012	193	20.80
April 2012 to March 2013	242	21.10
April 2013 to March 2014	170	21.60
April 2014 to March 2015	131	21.10
April 2015 to March 2016	167	20.80
April 2016 to March 2017	171	20.40

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

Complaints for end of life care increases when the diary is not introduced the level of complaints still remains below the national average of between 3-7%. The aim is also to make ward managers directly responsible for reviewing the diaries and loading the data base.

Training

We have continued to emphasise the Family Voice work in our level 1 Communications skills training using the national model of Sage and Thyme.

Sage and Thyme 2016-17

February 2017: 27 attendees

October 2016: 25 attendees

Quotes from family members/carers for the dying patient

"No nothing more could have been done The move to the Oasis room was timely. Dad passed away at 13. 50. Many thanks from ...son."[sic]

"Brilliant Compassionate staff very attentive, but still wouldn't put a bar in the corner of the room for us. LOL At this time there can still be time for humour, mum would have loved that." [sic]

"Sadly mum passed away tonight. Fortunately we were all at her bedside at the time. We can't fault the kindness, professionalism care and attention by Gail and the team. Thank you very much." [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, the Trust has routinely referred patients on the end of life care pathway to the chaplaincy team. During 2016-17, **401** 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 **4** patients declined support during the reporting year. **298** 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, 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.



Nurse on ward

Chaplain Referrals, Received more than 1 visit and Declined Support

	Referrals	Received more than 1 visit	Declined Support
Apr-16	45	35	1
May-16	33	26	1
Jun-16	36	27	0
Jul-16	43	31	0
Aug-16	18	14	0
Sep-16	37	27	0
Oct-16	24	20	0
Nov-16	26	21	0
Dec-16	20	17	0
Jan-17	38	28	0
Feb-17	49	35	1
Mar-17	32	17	1
Total	401	298	4

The following table demonstrates a year-on-year comparison:

	2013-14	2014-15	2015-16	2016-17
Referrals	397	424	437	401
Received more than 1 visit	233	272	274	298
Declined Support	3	1	3	4

**data from the Trusts chaplain service*

Multi Faith

The Trust holds a directory of all the local faith groups in the area, with a list of contacts. If someone from a different faith group wants to talk with the chaplains we would do this for all people of faith or no faith. If they request from the chaplains the Imam (Muslim) or the Hindu Priest, Buddhist or any other faith, the chaplains would contact our link person and arrange a visit.

Priority 2: Effectiveness of Care

Is our care good?

3. 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) visits
- 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

- Analysis of the feedback from SPEQS and patient experience/national surveys

Overview of how we said we would report it

- Reports to Board of Directors

Completed and reported?

- Reported to Board of Directors ✓

"After my surgery was cancelled for the second time (on my birthday), the nursing staff got me a cake, it really made my day. All staff on the ward have been brilliant, nothing was too much trouble." [sic]

"Not enough Staff. Nurses over-worked, waited over 6 hours for pain relief, asked 3 different Nurses and got ignored. " [sic]

"Even though you can see exhaustion in your faces, you are all there with smiles on your faces to try make us feel better, no matter what is thrown at you all. You're all diamonds thank-you. " [sic]

Patient Experience Surveys

Below are a list of the surveys that the Trust carried out between April 2016 and March 2017. The 'Number of patients surveyed' column shows out of how many patients were eligible to take part.

National Surveys

Survey	Month Survey published	Number of Patients Surveyed
National Cancer Patient Experience Survey 2016	July 2017	667 Current responses (69%)
CQC National Inpatient Survey 2016	June 2017	1,250 (41.2%)
CQC National Maternity Survey 2016	Late 2017	Fieldwork to start April 2017
CQC National Children's & Young Peoples survey 2016	October 2017	Fieldwork to start Jan 2017
CQC National Emergency Survey 2016	July 2017	1,177 (24.8%)

Local Surveys

Survey	Month Survey published	Number of Patients Surveyed
Local Assisted Reproduction Unit Survey 2016	Dec 2016	76/169 (45%)
Local Endoscopy Patient Survey 2016	June 2016	216/500 (43.2%)
Local Endoscopy Patient Survey 2017	April 2017	233/500 (47%)
Local Acute Oncology Survey 2016	March 2017	36/60 (60%)
Local Bariatric Surgery Survey 2016	Dec 2016	36/72 (50%) surveys
Local Upper GI Cancer Survey 2016	March 2017	37/105 (35%)
Local IBD Survey Cycle III 2017	May 2017	Current response rate 25/77 (32%)
Local Chemotherapy Survey 2017	April 2017	63/200 (32%)
Local Scan for Safety Survey 2017	Feb 2017	Fieldwork Feb 17 TBA
Local Hospital at Home Service Survey 2016-17	April 2017	93/270 (34%)
Local John's Campaign Relative/Carer Survey 2017	Summer 2017	TBA
Local Nurse Led Bone Marrow Biopsy Survey 2017	March 2017	24/46 (52%)
Discharge Drop In Sessions for relatives and carers – Survey 2017	February 2017	26 patients

“Very efficient, Staff excellent and made to feel very calm, thanks to all. Maybe public should hear about the marvellous side to the NHS. We are all very lucky.” [sic]

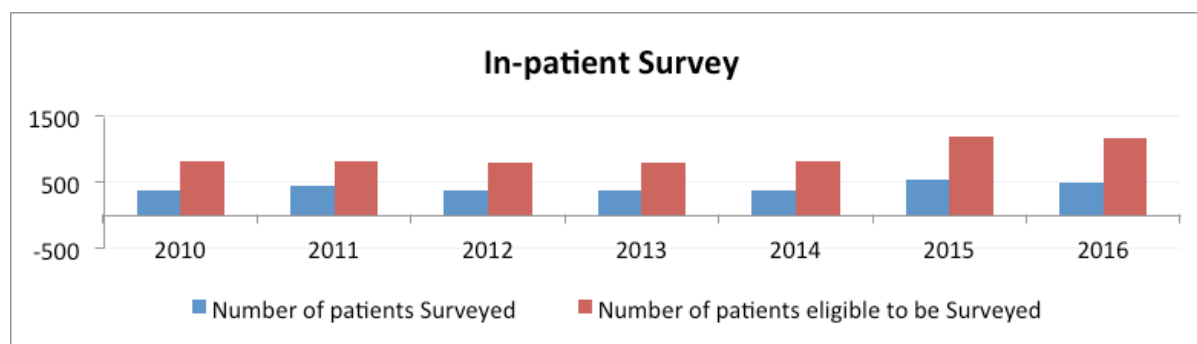
National Surveys

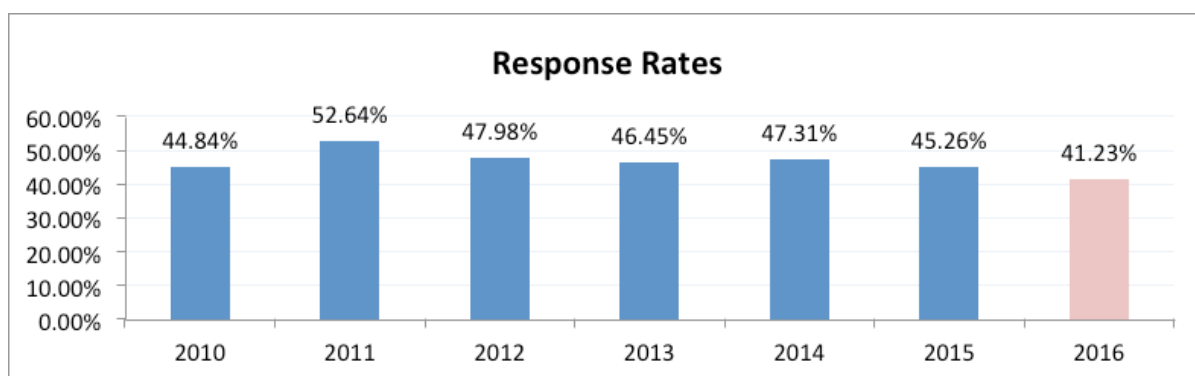
CQC National Inpatient Survey data for 2016

This survey is a Care Quality Commission (CQC) requirement for all Acute NHS Trusts. Each trust randomly selected adult inpatient admissions during July and August 2016 (age over 16 years).

There were **484** responses from the patients that received a survey, this equates to a response rate of **41.23%**

Survey Period	Number of patients eligible to be Surveyed	Number of patients Surveyed	Response Rate
2010	823	369	44.84%
2011	832	438	52.64%
2012	794	381	47.98%
2013	803	373	46.45%
2014	818	387	47.31%
2015	1,204	545	45.26%
2016	1,174	484	41.23%





National Cancer Patient Experience Programme 2016 National Survey

Fieldwork closes at the end of March 2017. To date we have a **69%** response rate against the current national response rate of 58%.

The survey was conducted with patients with a primary diagnosis of cancer who had an inpatient or day case attendance who were discharged during April, May and June 2016.

As the survey results are not expected to be published until summer 2017 here is a sample of the type of comments the Trust received in regards to cancer treatment taken from the previous National Cancer Patient Experience Programme 2015.

National Cancer Patient Experience Survey 2015

The survey was conducted in 2015-16. It was sent to all adult patients with a confirmed diagnosis of cancer discharged after an inpatient or day case patient attendance for a cancer related treatment during April, May and June 2015.

Questions	2013-14	2015-16
Patient found it easy to contact their Clinical Nurse Specialist	92%	94% Scored better than expected
Hospital staff gave information about impact cancer could have on work/education	76%	84%
Hospital staff gave information on getting financial help	60%	65% Scored better than expected
Hospital staff told patient they could get free prescriptions	75%	84%

"Specialist Breast care nurse was excellent, reassuring, professional, anticipating any needs, readily available. Exactly what a new patient needs."[sic]

"I cannot fault any of the hospital staff. They did a first rate job and took care of any problems concerning my cancer."[sic]

"More space needed for patients undergoing chemotherapy. Sitting in a chair whilst receiving your medication is not always comfortable. Some beds could be provided. " [sic]

"As a terminal patient my treatment was fantastic. Thank you."[sic]

Priority 3: Patient Experience

Friends and Family recommendation

4. 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 2016-17 Quality Accounts.

Overview of how we said we would do it

- We ask patients to complete a questionnaire on discharge from hospital

Overview of how we said we would measure it

- We analyse feedback from all Friends and Family questionnaires

Overview of how we said we would report it

- Report to Board of Directors
- Report to Council of Governors
- Safety, Quality and Infections Dashboard

Completed and reported?

- Reported at every Board of Directors meeting ✓
- Reported at every Council of Governors meeting ✓
- Safety, Quality and Infections Dashboard ✓

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.

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/>

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

Would recommend

$\frac{\text{Extremely likely} + \text{likely}}{\text{Extremely likely} + \text{likely} + \text{neither} + \text{extremely unlikely} + \text{don't know}} \times 100$

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

Wouldn't recommend

$\frac{\text{Extremely unlikely} + \text{unlikely}}{\text{Extremely likely} + \text{likely} + \text{neither} + \text{extremely unlikely} + \text{don't know}} \times 100$

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



The Friends
and Family Test

The Trust has created and developed an in-house data collection and reporting system that covers 70 areas for Friends and Family across both sites and community:

	North Tees		Hartlepool
Inpatients	Acute Cardiac Unit	Inpatients	Elective Care Unit –Ward 4
	Ambulatory		
	Discharge Lounge	Outpatients	Day Case Unit
	EAU		Endoscopy (RMU)
	Maternity (Ward 18/19)		Main Outpatients
	Mobile Rehab Day Unit		Medical Physics
	Neonatal (Ward 23)		One Life Centre
	Paediatric (Ward 15)		Orthopaedics
	Rheumatology		Paediatric
	Surgical Decisions Unit		Pregnancy Advisory Clinic
	Ward 24		Radiology (MXR)
	Ward 25		Radiology (BRS)
	Ward 26	A&E	Minor Injuries Unit
	Ward 27		
	Ward 28	Community Clinics	Audiology
	Ward 29		Children's Speech &Language
	Ward 30		Diabetics
	Ward 31		Dietetics
	Ward 32		Holdforth (Ward 3)
	Ward 33		Muscular Skeletal
	Ward 36 (SSU)		Orthotics
	Ward 37		Physiotherapy
	Ward 38		Podiatry
	Ward 39		Pulmonary Rehab
	Ward 40	Community Dental	Retinal Screening
	Ward 41		Eston Health Centre
	Ward 42		Guisborough Hospital
Outpatients	Day Case Unit		Lawson Street
	Endoscopy		North Ormesby Health Village
	Lung Health		North Tees
	Main Outpatients		One Life Centre
	Orthopaedics		
	Physio (Tatchell)		
	Radiology (BRS)		
	Radiology (MXR)		
	Radiology (USM)		
	Speech And Language Therapy		
	Walker Unit		
	Wheelchair services		
	Women's Outpatients		
A&E	Accident and Emergency		

North Tees and Hartlepool NHS Foundation Trust – Returns for April 2016 to March 2017

FFT Category	1 Extremely Likely	2 Likely	3 Neither	4 Unlikely	5 Extremely Unlikely	6 Don't Know	Total	Would recommend	Wouldn't recommend
Apr-16	2,795	759	97	37	34	100	3,822	92.99%	1.86%
May-16	2,430	711	82	33	23	89	3,368	93.26%	1.66%
Jun-16	2,556	762	80	33	25	87	3,543	93.65%	1.64%
Jul-16	2,610	655	90	30	22	66	3,473	94.01%	1.50%
Aug-16	2,084	505	76	23	12	53	2,753	94.04%	1.27%
Sep-16	2,462	600	62	26	20	63	3,233	94.71%	1.42%
Oct-16	2,117	567	72	19	20	64	2,859	93.88%	1.36%
Nov-16	2,963	805	89	30	30	97	4,014	93.87%	1.49%
Dec-16	2,612	618	68	24	23	70	3,415	94.58%	1.38%
Jan-17	2,577	618	73	22	16	69	3,375	94.67%	1.13%
Feb-17	2,725	651	80	19	26	63	3,564	94.73%	1.26%
Mar-17	2,885	706	93	24	23	65	3,796	94.60%	1.24%
Total	30,816	7,957	962	324	274	886	41,219	94.07%	1.45%

*Data from Trusts Friends and Family database

FFT Breakdown by Area – Returns for April 2016 to March 2017

FFT Category	1 Extremely Likely	2 Likely	3 Neither	4 Unlikely	5 Extremely Unlikely	6 Don't Know	Total	Would recommend	Wouldn't recommend
In-patient	5,293	1,191	138	65	53	113	6,853	94.62%	1.72%
Emergency Care	2,283	506	64	49	53	53	3,008	92.72%	3.39%
Maternity	775	159	9	3	1	9	956	97.70%	0.42%
Day Case Unit	5,988	476	31	4	25	40	6,564	98.48%	0.44%
Outpatients	7,685	2,554	424	134	103	336	11,236	91.13%	2.11%
Radiology	5,134	2,191	219	50	18	232	7,844	93.38%	0.87%
Community Clinic	2,670	590	46	12	13	80	3,511	95.70%	0.71%
Community Dental	460	71	11	1	0	11	554	95.85%	0.18%
Paediatrics	499	114	20	5	6	12	656	93.45%	1.68%

*Data from Trusts Friends and Family database

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.

To date through the Friends and Family Test (FFT), the Trust has received **55,501 positive** comments and **1,560 negative**, as detailed below (to note: it is possible to have more than one comment per FFT return).

Theme	Positive	Theme	Negative
Staff (general)	10,148	Timeliness/Wait Times	367
Friendliness	7,510	Communication	110
Care/Compassion	4,944	Staffing levels	109
Help/Support	4,721	Staff (general)	90
Service/Customer Service/Management	4,644	Parking	74
Efficiency	3,444	Service/Customer Service/Management	71
Qs Answered/Info/Advice/Explanations	2,237	Location Specific Comment	62
Miscellaneous	2,051	Efficiency	55
Professionalism	1,739	Environment	43
Reassured/Put at ease	1,403	Food	38
Politeness	1,399	Noise	36
Treatment	1,353	Qs Answered/Info/Advice/Explanations	36
Timeliness/Wait Times	1,350	Clinicians/Specialists etc.	35
Nursing/Care staff	923	Facilities	33
Location Specific Comment	854	Treatment	32
Attentiveness	667	Care/Compassion	27
Disposition of staff	563	Discharge	26
Clinicians/Specialists etc.	560	Nursing/Care staff	23
Staff Named	519	Admin and reception staff	22
Hygiene/Cleanliness	475	Medication	21
Neutral	437	Attentiveness	20
Comfort	415	Hygiene/Cleanliness	14
Convenience	295	Miscellaneous	14
Communication	212	Appointment Time	13
NHS – general comment	204	Hospital closure/new hospital etc.	13
Empathy/Understanding	199	Previous experience	13
Respect	195	Privacy/Confidentiality	12
Experience	187	Comfort	11
Food	170	Convenience	11
Facilities	158	Equality and Diversity	10
Previous experience	156	Experience	9
Environment	140	Atmosphere	8
Atmosphere	136	Empathy/Understanding	8
Admin and reception staff	128	Help/Support	8
Expertise/Proficiency	114	Politeness	8
Child Friendly	110	Equipment	7
Aftercare	99	Expertise/Proficiency	7
FFT related comment	98	Aftercare	6
Dignity	77	Moving Wards	6
Meeting and greeting	70	Transport	6
Parking	69	Disposition of staff	5
Teamwork	65	NHS – general comment	5
Unreadable	35	Respect	5
Equality and Diversity	27	Consistency	4
Patience	25	Professionalism	4
Appointment Time	24	Reassured/Put at ease	4
Hospital closure/new hospital etc.	23	Appointment Length	3

"The staff on this ward always go the extra mile to help you in whatever needs doing. Even when they are short staffed they always do what needs doing in the call of duty. I have had a number of admissions on to this ward and all the staff have been brilliant. I would like to name them but I would need a lot of paper to fit in all the names. " [sic]

"I have never been so well looked after and cared for, mostly I have been so well looked after and cared for, and mostly I have been put at ease by your Staff. Without their patience and understanding I don't think I could have got through my ordeal. Thank-you all. " [sic]

Friends and Family – Staff

The Trust continues to ask staff the Friends and Family Test, thus allowing 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**).

The following data refers to Quarters 1 to Quarter 4 of the 2016-17 financial year.

Breakdown of Responses – Care

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

How likely.... recommend?	Q1	Q2	*Q3	Q4
1 Extremely likely	54	16	139	51
2 Likely	49	13	330	58
3 Neither	20	9	188	18
4 Unlikely	9	3	46	7
5 Extremely unlikely	4	1	27	5
6 Don't know	3	1	0	1
Blank	0	0	15	0
Would recommend	74%	67%	56%	78%
Wouldn't recommend	9%	9%	12%	9%

*Data from Trusts Human Resources Department

Breakdown of Responses – Work

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

How likely.... recommend?	Q1	Q2	*Q3	Q4
1 Extremely likely	50	16	137	54
2 Likely	46	12	328	52
3 Neither	21	7	179	18
4 Unlikely	15	3	55	6
5 Extremely unlikely	6	4	31	10
6 Don't know	1	1	0	0
Blank	0	0	15	0
Would recommend	69%	65%	64%	76%
Wouldn't recommend	15%	16%	12%	11%

*Data from Trusts Human Resources Department

Part 2b: 2017-18

Quality Improvement Priorities

Introduction to 2017-18 Priorities

Key priorities for improvement for 2017-18 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 Board of Directors.

The Trust started the consultation period in September 2016 which allowed us to consult widely and provide stakeholders with significant opportunity to consider and suggest the priorities that they would like to see us address.

Quality Accounts Marketplace

The Trust held the 3rd annual Quality Accounts Marketplace in December 2016. The aim of this event was to actively 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 2016-17 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 Trust 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 Report.

We would like to thank all of those involved in setting priorities for 2017-18 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.



Infection prevention and control nurses

Stakeholder priorities for 2017-18

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

Patient Safety	Effectiveness of Care	Patient Experience
Mortality	Safety Thermometer	Palliative Care & Care For the Dying Patient (CFDP)
Dementia	Discharge Processes Medication	Is our care good? (Patient Experience Surveys)
Safeguarding	Safety, Quality and Infections Dashboard (previously Nursing Dashboard)	Friends and Family recommendation
Infections		

Rationale for the selection of priorities for 2017-18

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 2017-18 Quality accounts as the priorities.

We then chose 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 of Directors.

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.

Overview of how we 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).

Overview of how we will report it

- Report to Board of Directors meeting
- Report to Council of Governors meeting
- Report quarterly to the commissioners
- Report to Trust Outcome Performance Delivery Operational Group (TOPDOG)

Priority 2 – Improving care for people with dementia

There are currently approximately 14,000 people with a diagnosis of dementia across County 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 it will be measured

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
- Monthly UNIFY

Priority 3 – Safeguarding

The Trust will continue to work to enhance and develop standards for safeguarding adults and children across the hospital and community services.

Overview of how this will be achieved

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.

The Trust has maintained a robust board level focus on Safeguarding and Looked after Children led by the Director of Nursing, Patient Safety and Quality. A bi-monthly steering group, chaired by a Non- Executive Director maintains responsibility for the performance monitoring of the Children's Safeguarding work program.

The Trust has maintained membership and has made active contributions at senior level on the three Local Safeguarding Children Boards (LSCB), Stockton (SLSCB), Hartlepool (HSCB) and County Durham LSCB and on the HSCB Executive group.

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.

Audit results and action plans to be reported to Local Safeguarding Childrens Boards quarterly.

Priority 4 – Infection Prevention and Control

Rationale: Key stakeholders asked us to report on infections in 2017-18 due to the continued levels of infections during 2016-17.

Overview of how we will 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 will would measure performance

- 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

- Board of Director 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
- Safety, Quality and Infections Dashboard
- Clinical Quality Review Group (CQRG)

Effectiveness of Care

Priority 5 – Safety Thermometer

NHS Safety Thermometer

The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. Using the current classic Safety Thermometer, along with the new Medications, Maternity and Children & Young Persons measures.

Overview of how we will do it

This indicator will continue to be audited on one day per month across the Trust and community services and the data submitted to NHS Digital.

Overview of how we will measure it

- Monthly data collection survey of the ward areas along with community bases.

Overview of how we will report it

- Report to PS & QS
- Report to Board of Directors meeting
- Report to Council of Governors meeting
- Safety, Quality and Infections Dashboard

Priority 6 – Discharge processes – Medication

The latest national patient experience survey identified that the Trust still has 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.

We will measure it via local audits

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
- Safety, Quality and Infections Dashboard

Priority 7 – Safety, Quality and Infections Dashboard

The Safety, Quality and Infections 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 the Nursing and Allied Health Professional Interprofessional Board (IPB).

Patient Experience

Priority 8 – Palliative Care and Care For the Dying Patient

The Trust has continued the use of Care For the Dying Patient (CFDP) and Family's Voice. Stakeholders and the Trust believe that this still needs to remain a priority in 2017-18 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 IPB
- Annually to Patient Safety and Quality Standards (PS & QS)

Priority 9 – Patient Surveys

Trust and key stakeholders believe that it is important to ask the Friends and Family 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

Analysis of feedback from SPEQS and patient experience/national surveys.

Overview of how we will report it

- Reports to Board of Directors
- Reported on the Safety, Quality and Infections Dashboard

Priority 10 – Friends and Family recommendation

The Department of Health have required Trusts to ask the Friends and Family recommendation questions from April 2013.

Overview of how we will do it

We currently ask patients to complete a questionnaire on discharge from hospital for inpatients, Accident & Emergency and Maternity as well as Outpatients, Day Case Units, Community Clinics, Community Dental, Radiology and Paediatrics.

Overview of how we will measure it

Analysis of feedback from patient surveys and discharge questionnaires.

Overview of how we will report it

- Reports to Board of Directors
- Reported on the Safety, Quality and Infections Dashboard



Chief Executive Alan Foster and Patient Safety Manager Janet Alderton

Part 2c: Statements of Assurance from the Board

Review of Services

During 2016-17 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 2016-17 represents 100% of the total income generated from the provision of relevant health services by North Tees and Hartlepool NHS Foundation Trust for 2016-17.

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 2016-17 and this can be found on the following link:

<http://www.hqip.org.uk/national-programmes/quality-accounts/>

During 2016-17, **39** national clinical audits and **4** national confidential enquiries covered the relevant health services that North Tees and Hartlepool NHS Foundation Trust provides.

During 2016-17 North Tees and Hartlepool NHS Foundation Trust participated in **94%** 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 2016-17 are as follows:

Mandatory National Clinical Audits

Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)
Adult Asthma (BTS)
Asthma (paediatric and adult) care in emergency departments (RCEM)
Bowel Cancer (NBOCAP)
Case Mix Programme (CMP) (ICNARC)
Diabetes (Paediatric) (NPDA)
Elective Surgery (National PROMs Programme)
Endocrine and Thyroid National Audit
Falls and Fragility Fractures Audit programme (FFFAP) (inc. National Hip Fracture Database NHFD)
Inflammatory Bowel Disease (IBD) programme
Learning Disability Mortality Review Programme (LeDeR Programme)
Major Trauma Audit (TARN)
Maternal, Newborn and Infant Clinical Outcome Review Programme
National Audit of Dementia
National Cardiac Arrest Audit (NCAA)
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme (inc. Inpatient COPD Audit and Pulmonary Rehabilitation Audit)
National Comparative Audit of Blood Transfusion – Audit of Patient Blood Management in Scheduled Surgery

Mandatory National Clinical Audits
National Diabetes Audit – Adults
National Emergency Laparotomy Audit (NELA)
National Heart Failure Audit (NICOR)
National Joint Registry (NJR)
National Lung Cancer Audit (NLCA)
National Prostate Cancer Audit
Neonatal Intensive and Special Care (NNAP)
Nephrectomy audit (BAUS)
Oesophago-gastric Cancer (NAOGC)
Paediatric Pneumonia (BTS)
Percutaneous Nephrolithotomy (PCNL)
Rheumatoid and Early Inflammatory Arthritis
Sentinel Stroke National Audit programme (SSNAP)
Severe Sepsis and Septic Shock – care in emergency departments (RCEM)
Stress Urinary Incontinence Audit (BAUS)

National Confidential Enquiries (NCEPOD)
NCEPOD Chronic Neurodisability Study
NCEPOD Non Invasive Ventilation (NIV) Study
NCEPOD Young People’s Mental Health Study
NCEPOD Cancer in Children, Teens and Young Adults Study

The national clinical audits and national confidential enquiries that North Tees and Hartlepool NHS Foundation Trust participated in during 2016-17 are as follows:

Mandatory National Clinical Audits
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)
Adult Asthma (BTS)
Asthma (paediatric and adult) care in emergency departments (RCEM)
Bowel Cancer (NBOCAP)
Case Mix Programme (CMP) (ICNARC)
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Major Trauma Audit (TARN)
Maternal, Newborn and Infant Clinical Outcome Review Programme
National Audit of Dementia
National Cardiac Arrest Audit (NCAA)
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National Emergency Laparotomy Audit (NELA)
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Mandatory National Clinical Audits
National Joint Registry (NJR)
National Lung Cancer Audit (NLCA)
National Prostate Cancer Audit
Neonatal Intensive and Special Care (NNAP)
Nephrectomy audit (BAUS)
Oesophago-gastric Cancer (NAOGC)
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Percutaneous Nephrolithotomy (PCNL)
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Sentinel Stroke National Audit programme (SSNAP)
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National Confidential Enquiries (NCEPOD)

NCEPOD Chronic Neurodisability Study
NCEPOD Non Invasive Ventilation (NIV) Study
NCEPOD Young People's Mental Health Study
NCEPOD Cancer in Children, Teens and Young Adults Study

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 2016-17, 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.

National Clinical Audit	Participation M=Mandatory N=Non-mandatory	% cases submitted
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes (M)	Continuous monitoring
Adult Asthma (BTS)	Yes (M)	100%
Asthma (paediatric and adult) care in emergency departments (RCEM)	Yes (M)	100%
Bowel Cancer (NBOCAP)	Yes (M)	Continuous monitoring
Case Mix Programme (CMP) (ICNARC)	Yes (M)	Continuous monitoring
Diabetes (Paediatric) (NPDA)	Yes (M)	100%
Elective Surgery (National PROMs Programme)	Yes (M)	Hip replacement 97% Knee replacement 97% Groin hernia 61%
Endocrine and Thyroid National Audit – subject to confirmation	Yes (M)	Continuous monitoring
Falls and Fragility Fractures Audit programme (FFFAP) (inc. National Hip Fracture Database NHFD)	Yes (M)	100%
Inflammatory Bowel Disease (IBD) programme: Biologics Database	Yes (M)	0%
Learning Disability Mortality Review Programme (LeDeR Programme)	Yes (M)	On-going
Major Trauma Audit (TARN)	Yes (M)	Continuous monitoring
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes (M)	100%
National Audit of Dementia	Yes (M)	100%

National Clinical Audit	Participation M=Mandatory N=Non-mandatory	% cases submitted
National Cardiac Arrest Audit (NCAA)	Yes (M)	100%
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme (inc. Inpatient COPD Audit and Pulmonary Rehabilitation Audit)	Yes (M)	Continuous monitoring
National Comparative Audit of Blood Transfusion – Audit of Patient Blood Management in Scheduled Surgery	Yes (M)	100%
National Diabetes Audit – Adults	Yes (M)	100%
National Emergency Laparotomy Audit (NELA)	Yes (M)	Continuous monitoring
National Heart Failure Audit (NICOR)	Yes (M)	Continuous monitoring
National Joint Registry (NJR)	Yes (M)	Continuous monitoring
National Lung Cancer Audit (NLCA)	Yes (M)	Continuous monitoring
National Prostate Cancer Audit	Yes (M)	Continuous monitoring
Neonatal Intensive and Special Care (NNAP)	Yes (M)	Continuous monitoring
Nephrectomy audit (BAUS)	Yes (M)	Continuous monitoring
Oesophago-gastric Cancer (NAOGC)	Yes (M)	Continuous monitoring
Paediatric Pneumonia (BTS)	Yes (M)	100%
Percutaneous Nephrolithotomy (PCNL)	No (M)	Zero
Rheumatoid and Early Inflammatory Arthritis	Yes (M)	Continuous monitoring
Sentinel Stroke National Audit programme (SSNAP)	Yes (M)	Continuous monitoring
Severe Sepsis and Septic Shock – care in emergency departments (RCEM)	Yes (M)	100%
Stress Urinary Incontinence Audit (BAUS)	No (M)	Zero
National Audit of Diabetes Foot Care (NDFA)	Yes (N)	Continuous monitoring
National Diabetes Inpatient Audit (NaDIA)	Yes (N)	100%
7-day services national audit	Yes (N)	100%
Smoking Cessation Audit (BTS)	Yes (N)	100%
Safety Thermometer	Yes (N)	Continuous monitoring
Paediatric Orthopaedic Trauma Snapshot (POTS)	Yes (N)	100%
National Audit of Consultant Sign-off (RCEM)	Yes (N)	100%

National Clinical Audits

The reports of 8 national clinical audits were reviewed by the provider in 2016-17 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 Emergency Oxygen Audit (BTS)	<ul style="list-style-type: none"> One page guidance summary to be produced to act as reminder. Education in Grand Round meeting. Formal Nurse and Doctor training programme to be developed.
Venous Thrombo-embolism (RCEM)	<ul style="list-style-type: none"> Improved documentation of VTE risk assessment. Patient information leaflet to be drafted.
Procedural Sedation (RCEM)	<ul style="list-style-type: none"> Establish capnography monitoring within A&E in collaboration with Anaesthetist colleagues. Improved documentation for sedation monitoring.
Vital Signs in Children (RCEM)	<ul style="list-style-type: none"> Improved documentation of initial vital signs and timing of further monitoring.
Major Trauma Audit (TARN)	<ul style="list-style-type: none"> Improved use of trauma checklist. Collaborative work with James Cook University Hospital to develop severe head injury pathway.
National Audit of Dementia	<ul style="list-style-type: none"> Dementia Champions to raise awareness of the new document "All about me". Improved discharge planning. Educational programme to support definitive diagnosis of delirium.
Smoking Cessation Audit (BTS)	<ul style="list-style-type: none"> Increased enforcement of smoking restrictions on Trust ground. Improved documentation of non-cigarette smoking status. Increased awareness of need to offer nicotine replacement therapy to inpatients who are current smokers.
National End of Life Audit	<ul style="list-style-type: none"> Improved communication skills training.

Local Clinical Audits

The reports of 132 local clinical audits were reviewed by the provider in 2016-17 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
Adequacy of Documentation of Spinal Anaesthetic for Caesarean Sections	<ul style="list-style-type: none"> Improvement required in documentation of the processes in emergency caesarean sections.
Dental Decontamination Audit	<ul style="list-style-type: none"> Review of Tees Decontamination – Infection Control Policy and updating of protocols relating to infection control.
Management of Paediatric Sepsis	<ul style="list-style-type: none"> Sepsis tool being adapted for use jointly by Paediatrics and Emergency Medicine.
Management of Patients Presenting with Transient Loss of Consciousness (TLoC)	<ul style="list-style-type: none"> Teaching on TLoC to be included in teaching programmes.
Patient Information Leaflets in Surgery	<ul style="list-style-type: none"> Leaflet update to note that patients can contact Surgical Decisions Unit (SDU) for up to two weeks after discharge.
Shoulder Dystocia Management	<ul style="list-style-type: none"> The shoulder dystocia proforma to be covered in simulation sessions as part of mandatory training.
Elective Cost in Orthopaedics	<ul style="list-style-type: none"> All patients to be provided with a copy of the completed consent form.
Joint Revision Infection Rates Audit	<ul style="list-style-type: none"> A Trust protocol is to be developed for suspected joint arthroplasty infection.

Audit title	Actions taken/in progress
Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP)	<ul style="list-style-type: none"> Management team to continue to visualise notes on a daily basis and provide individual staff members with feedback.
Oral Bisphosphonate Prescribing	<ul style="list-style-type: none"> Night staff education session to ensure administration of oral bisphosphonate thirty minutes before breakfast.

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 four national confidential enquiries (100%) that it was eligible to participate in, namely:

National Confidential Enquiries (NCEPOD):

NCEPOD study title	Participation M=Mandatory N=Non-mandatory	% cases submitted
NCEPOD Chronic Neurodisability Study	Yes (M)	Data collection on-going
NCEPOD Non Invasive Ventilation (NIV) Study	Yes (M)	Data collection on-going
NCEPOD Young People's Mental Health Study	Yes (M)	Data collection on-going
NCEPOD Cancer in Children, Teens and Young Adults Study	Yes (M)	Data collection on-going

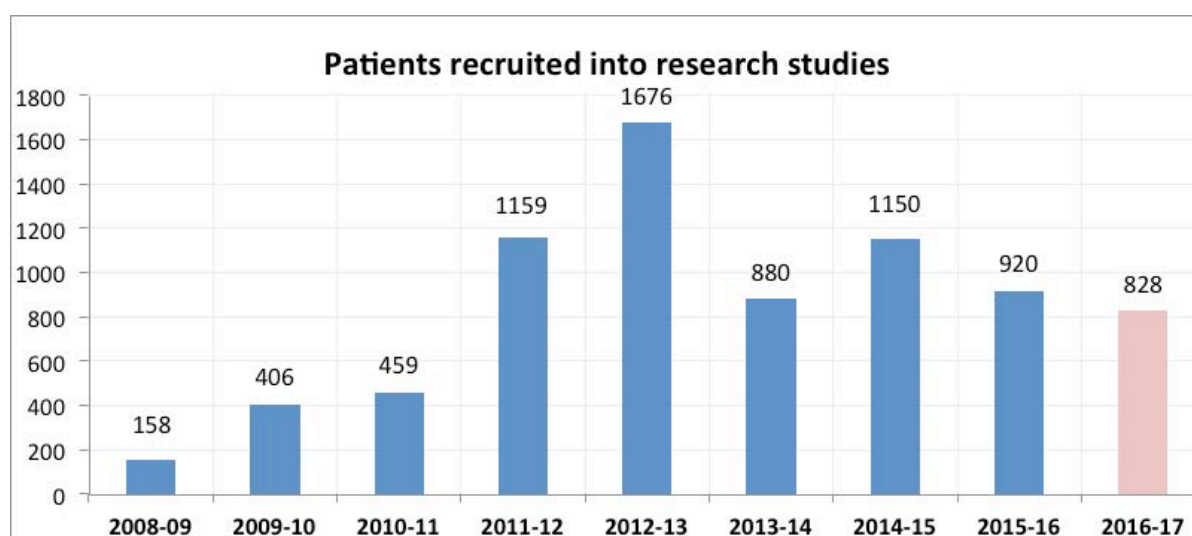
Patients recruited into research

The Government indicated in 2009 that it wanted to see a dramatic and sustained improvement in the performance of providers of NHS services in initiating and delivering clinical research. The aim was 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

The number of patients receiving relevant health services provided or subcontracted by North Tees and Hartlepool NHS Foundation Trust in 2016-17 that were recruited during that period to participate in research approved by a research ethics committee was 828 (target for 2016-17 was 818).

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



Regionally there has been a significant decrease in the total numbers of patients being recruited this year. The reasons are multifaceted and due to fewer large observational studies, increased participation in more complex interventional studies (with lower recruitment targets) and delays in anticipated study start up due to the new national Health Research Approval (HRA) process.

Within the Trust, whilst our overall recruitment figures are lower, the trials we are participating in are more complex and we are accruing year on year additional follow-up burden for patients in existing trials.

2016-17 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. 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.

For 2016-17, of the patients recruited so far, 51% were recruited into interventional studies with 49% recruited into observational studies. Within the North East and North Cumbria, our Trust has the highest proportion of interventional studies as a proportion of the total studies they participate in. Average for the region is 40% interventional studies.

Study participation – number of studies open

Study Type		Number of Studies	Actively recruiting patients	In follow-up
NIHR portfolio	Observational	66	122	44
	Interventional	100		
Non-portfolio	Observational	34	34	6
	Interventional	6		
Total	Observational	100		
	Interventional	106		

National position / ranking for number of studies conducted

Year	Overall national position
2012-13	101 st out of 394 organisations
2013-14	157 th out of 454 organisations
2014-15	141 st out of 445 organisations
2015-16	92 nd out of 459 organisations
2016-17	Not available

Performance in Initiation and Delivery of research (PID data)

From 2013, government funding for research to the Trust has become conditional on meeting national benchmarks. 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	9	
No	10	1 NHS delay 6 Sponsor delay 3 Neither – no eligible patients seen/consented

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

Time and target met	No of Studies	Reason
Yes	6	
No	4	1 study – PI left the Trust – no replacement available for a long time 1 study – patients more likely to be seen in primary care 1 study – patient population rare, difficult to find 1 study – staffing issues

*Principal Investigator (PI)

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 have not been met; the Research & Development 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 department (R&D) continue to work 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 we have been able to help to develop staff knowledge and skills to enable them to lead and/or be involved in research studies. The fund has provided the following support in this year:

Purpose of application	Funding amount (£)
Part-funding of course fees for PhD at Durham University	2,026
Course fees for Stage 1 of Doctor of Health & Social Care Professional Programme, Teesside University	2,250
1 year clinical backfill to support the preparation of NIHR Programme Grant	11,500
Three allocations of 0.5PA for "Green Shoot" awards (£5,500 each)	16,500

We currently have **138 members of staff with valid Good Clinical Practice (GCP) training**. Most specialisms and all directorates are now participating in research to a greater or lesser degree. The few exceptional areas where activity is non-existent are in active discussion with the R&D department, specifically to identify potential studies that might be relevant.

There are **93 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, midwives, data assistants, team leader and Pharmacy technician) two of whom are 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.

Commercially Sponsored Studies

We continue to increase our participation in commercially sponsored studies. We now have **20 commercially sponsored studies** active within the Trust in this year (16 last year) within Respiratory Medicine, Paediatrics, Neonates, Cardiology and more recently Gastroenterology, Obstetrics & Gynaecology and Cancer.

Our respiratory and cardiology research teams continue to develop their reputation as a "preferred site" for commercially sponsored research studies.

Awards and accolades

Certificates of Excellence were awarded from Teesside University to the following staff for their support to student nurses whilst on their service improvement placement within R&D:

- **Wendy Cheadle** Research Nurse, **Jane Greenaway** R&D Manager, **Helen Talbot** R&D Facilitator, and **Pauline Shepherd** R&D Administrator.

Two of our teams received "performance flow-through funding" from the Clinical Research network as determined by performance against their "Recruitment to Time and Target". The **Respiratory Team** were awarded 2 sets of performance flow-through funding as they recruited to time and target for the SIROCCO and FLAME commercial studies. The **Surgical Research** team received a payment for their successful recruitment to the REGENERYS study.

We held a joint Conference with Education and Organisational Development “Improving Patient Care through Research and Education” which was a great success. Using the newly refurbished lecture theatre we were able to highlight some of the recent Trust developments and innovations in both departments as well as identify opportunities for future working. Delegates felt the day was useful to their role and enjoyed the workshop sessions in the afternoon. Professor Pali Hungin’s key note address on how we can develop collaborations with local Universities was well received and sparked a renewed vigour for cross-organisation developments.

Commissioning for quality and innovation (CQUIN)

A proportion of North Tees and Hartlepool NHS Foundation Trust income in 2016-17 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.

2015-16 income

The total income received through achievement of CQUIN goals in 2015-16 was **£3,697,653** from the total amount available of **£5,141,601**.

Further details of agreed goals for 2016-17 and the following 12 month period are available electronically at:

<https://www.england.nhs.uk/nhs-standard-contract/cquin/>

2016-17 income

The total income received through achievement of CQUIN goals in 2016-17 is **£2,605,314** from **£2,764,504** available; **Data for Q1 to Q3 only available at time of print and provided by the Trust's finance department.**

This value was conditional upon achieving quality improvement and innovation goals.

	Achievement (%)			
	Q1	Q2	Q3	*Q4
Introduction of staff health & wellbeing initiatives	100%	100%	100%	
Healthy food for NHS staff, visitors and patients	100%	100%	100%	
Improving the uptake of flu vaccinations for frontline clinical staff	100%	100%	100%	
Timely identification and treatment for sepsis in emergency department	100%	100%	100%	
Timely identification and treatment for sepsis in inpatient settings	100%	100%	100%	
Reduction in antibiotic consumption per 1,000 admissions	100%	100%	100%	
Empiric review of antibiotic prescriptions	100%	100%	100%	
Undertake a root-cause analysis on all long waiters and a clinical harm review where there is a positive diagnosis.	100%	100%	100%	
Reducing inappropriate hospital utilisation through the installation and implementation of a Clinical Utilisation Review (CUR) system over two years.	90%	90%	100%	
Increase awareness and capability of workforce in CHC (Continuing Healthcare) pathways to improve effectiveness of CHC Checklist completion and CHC process efficiency	100%	100%	100%	
Intervention Planning for People who Frequently Attend A&E (Supporting Regular Attenders to Receive Appropriate Care and Treatment)	100%	100%	100%	
Diabetes transformation	100%	100%	100%	
Increase update of diabetic eye screening for young people	100%	100%	100%	
Critical care	100%	100%	100%	
Dose banding	100%	100%	100%	

*Q4 data 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 (CQC) and its current registration status is **registered without conditions for all services provided**.

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.

The CQC has not taken enforcement action against North Tees and Hartlepool NHS Foundation Trust during 2016-17.

The CQC inspection team visited the Trust in July 2015 to undertake the mandated inspection that all Trusts must have.

The CQC inspection looks at five domains, asking are services safe, caring, responsive, effective and well-led and rates each of them from inadequate, requiring improvement, good and outstanding.

Overall ratings for the Trust

Overall rating for this Trust	Requires improvement
Are services at this Trust safe?	Good
Are services at this Trust effective?	Requires improvement
Are services at this Trust caring?	Good
Are services at this Trust responsive?	Good
Are services at this Trust well-led?	Requires improvement

The full inspection report can be found on the CQC website:

<http://www.cqc.org.uk/provider/RVW>

The following tables demonstrate the ratings for the North Tees and Hartlepool sites, Minor injuries unit/One Life Centre and community health services.

University Hospital of North Tees

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Medical care	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Good	Good	Good	Good	Requires improvement	Good
End-of-life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Good	Good	Good	Requires improvement	Good
Overall	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

University Hospital Hartlepool

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Inadequate	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Requires improvement	Not Rated	Good	Requires improvement	Requires improvement
Services for children and young people	Good	Good	Good	Good	Requires improvement	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Requires improvement	Good
Overall	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement

Minor Injuries Unit, One Life Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Not Rated	Good	Good	Good
Overall	Good	Good	N/A	Good	Good	Good

Community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good	Good	Good	Good	Requires improvement	Good
Community health services for children	Good	Requires improvement	Good	Good	Good	Good
End-of-life care	Good	Good	Good	Good	Good	Good
Community dental services	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Following the announced inspection in July 2015, where an overall 'Requires Improvement' rating was received, the Trust has **fully addressed** the 14 areas stated to be 'must do' actions. In addition, **all 50** 'should do' actions **have been reviewed**, with much work having been completed.

A key element of making changes and developing services is on-going monitoring and assurance; each clinical area has a programme of audit and assurance work which enables demonstration of achievement of expected outcomes. A quantity of this work is undertaken by the clinical areas themselves, but additional assurance is achieved by some external audit from other specialities. A central electronic area is currently being prepared for launch to enable evidence from the programme of audit and assurance work to be stored and readily available for access to internal stakeholders; access can be arranged for designated external stakeholders such as commissioners and inspectors.

There are some areas of development work which remain in progress, including completing recruitment to safeguard delivery of the critical care outreach service, completion of scoping 7 day service-delivery of Specialist Palliative Care and development of television screens around the Trust to enable delivery of health-related messages and waiting time information.

CQC Contact and Communication

The Trust has regular engagement meetings with our CQC Relationship Manager. In addition to these meetings, regular telephone contact is maintained. Prior to the engagement meetings, the Trust shares a comprehensive monitoring document. The document is based around the five domains and encompasses details related to incidents, complaints, staffing, and also allows the Trust to share any information it wishes. This has included examples of excellence in practice, awards Trust staff have been short-listed for and major developments within service delivery.

As part of the engagement meetings, there has been the opportunity for CQC staff to make informal visits to clinical areas at their request.

Some information related to the Trust's CQC actions is available to the public on the Trust's website <http://www.nth.nhs.uk/patients-visitors/cqc/>

Quarterly news bulletins are being published and are available to the public on the Trust's website. <http://www.nth.nhs.uk/patients-visitors/cqc/news-bulletin/>

The Trust has not been informed of a date for a re-inspection. When this is given, there will be notice given to the Trust that this is due. Until the re-inspection and issuing of the report from this has taken place, the Trust will remain rated 'Requires Improvement'.

Duty of Candour

Duty of Candour is the process of being open and transparent with people who use the Trusts services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. Trusts are set specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

From the time of the final consultation in relation to the regulations, the Trust reviewed its processes already in place for 'Being Open' (National Patient Safety Agency - NPSA). Once the regulations were approved through Parliament the Trusts policy was in place and in use. The Trust policy details how application of the regulations should be recorded; this is supported by the provision of a healthcare document to be completed and stored in the patients' records, full completion of this record sheet will ensure all of the necessary regulatory points are recorded.

On a weekly basis the Trust's Safety Panel reviews all incidents where harm has been reported as moderate harm or above. This highlights cases to the panel members and provides details of the application of the regulations within clinical areas; where necessary challenges may be made around these decisions.

Monitoring of compliance is reported to the Board of Directors and also to the Trust's Commissioners; there have been two cases where the Trust could not evidence that the regulations had been applied in full. The evidence required is very specific and the Trust is confident that although this written evidence was not available there was the required level of discussions with the patients involved at the time. The Trust prides itself in its approach to being open and honest, and as a result of the lack of evidence in these cases the policy is being reviewed in order to ascertain if any changes need to be made to the processes to support full compliance. There are continuing training and update sessions available to all staff in relation to Duty of Candour and details of any external seminars are shared to enhance our wider knowledge of the regulations.

The Trust policy and the application of this was reviewed by the Trust's internal auditors at the end of 2015-16; the report was published in quarter 1 and this recognised there was a significant level of assurance in relation to compliance with this policy and the legal requirements. Currently, there have been no concerns raised through the CQC in relation to the application of these regulations within the Trust.

Sign Up to Safety

The Trust's Sign up to Safety campaign aims to reduce the incidence of avoidable harm that occurs to service users within the organisation by 50% over the next 3 years, with a specific focus on:

- Reducing pressure ulcers
- Reducing falls with fracture
- Reducing Obstetric Birth Injuries
- Reducing surgical complications
- And Reducing Pressure damage

Whilst this is an overall aim, there will be focussed areas of work undertaken to examine specific areas of high risk. These have been identified through analysis of data available from current and past harm reporting from complaints, incidents and claims. In the lifetime of this strategy on-going monitoring of trends associated with harm will be used to identify areas for action as the data analysis evolves.

During September 2016, the Trust held a Patient Safety week to recognise service improvements made as a result of safety issues identified through incident reporting and analysis. The displays were visited by a wide range of colleagues including the Chief Executive; Director of Nursing, Patient Safety and Quality; governors; staff and also a representative for the NHSLA's Safety and Learning team.

Commissioners Assurance

During 2016-17 the Trust had 5 unannounced Commissioner Assurance visits.

These unannounced visits took place on Ward 26 in April, the Holdforth Unit in June 2016, Ward 40 in September 2016, Ward 27 in November 2016, Ward 40 in January 2017 and Paediatric Day Unit Hartlepool and Out-patients Hartlepool in March 2017.

An action plan has been developed for any issues identified at each of these visits and these have 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 members of the Council of Governors are encouraged to test the data reports they receive through participation in the 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 One. 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 2016-17 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	99.10	Percentage for admitted patient care	100
Percentage for outpatient care	100	Percentage for outpatient care	100
Percentage for accident and emergency care	99.30	Percentage for accident and emergency care	100

**Data for April 2016 to March 2017*

Information governance (IG)

Information governance means keeping information safe. This relies on good systems, processes and monitoring. Every year we audit the quality of information governance through the national information governance toolkit. The Toolkit is an online system which allows NHS organisations and partners to assess themselves against Department of Health Information Governance policies and standards.

The Trust continues to provide assurance to the Board of Directors that we are constantly assessing and improving our systems and processes to ensure that information is safe.

North Tees and Hartlepool NHS Foundation Trust Information Governance Assessment report overall score for 2016-17 was 80% and was graded as "Satisfactory" Green, this gives assurance that quality standards are being maintained. The expected level of compliance (level 2) has been achieved against all Toolkit standards and higher level 3 compliance has been achieved against fifteen of the forty five requirements to date.

The 2016-17 toolkit was also subject to external audit, twelve requirements were audited by Audit One during March 2017 and the Trust continues to be awarded 'full assurance' with no remedial actions for the second consecutive year.

The Trust was also subject to a consensual data protection audit by the Information Commissioners Office (ICO) during January 2017, the ICO's overall conclusion was that *"there is a high level of assurance that processes and procedures are in place and are delivering data protection compliance. The audit has identified only limited scope for improvement in existing arrangements and as such it is not anticipated that significant further action is required to reduce the risk of non-compliance with the DPA"*.

Staff training and awareness of Information Governance is a key indicator, in 2016-17 we again had to ensure that 95% of all of our staff had received information governance training. The training compliance as at the end of March 2017 was 95% for the sixth year running.

Requirement	2012-13	2013-14	2014-15	2015-16	2016-17
Information governance management	93%	100%	100%	93%	93%
Corporate Information Assurance	66%	77%	77%	77%	77%
Confidentiality and Data Protection assurance	79%	87%	91%	70%	79%
Clinical information assurance	93%	93%	86%	73%	80%
Secondary use assurance	83%	83%	79%	79%	75%
Information security assurance	75%	75%	84%	75%	80%
Overall Assessment	81%	84%	86%	77%	80%

A "Satisfactory" green rating is achieved where Trusts achieve Level 2 or above on all requirements; a "Not Satisfactory" red rating is achieved where Level 2 or above is not evidenced for all requirements.

*The IG toolkit is available on the Connecting for Health website:

www.igt.connectingforhealth.nhs.uk

The Trust continues to respond to Freedom of Information requests from members of the public on a range of topics across all services and departments, complying with the 20 working day limit to do so. The act is regulated and enforced by the Information Commissioners Office (ICO). The ICO hold powers to enforce penalties against the Trust when it does not comply with the act, including but not limited to monetary fines. The current compliance level for responding to requests within timescale is 90%; for the year 2016-17 the Trust received 551 requests with a compliance level of 82% which it has as an improvement target for 2017-18.

In order to be transparent about information the Trust are asked to provide, a virtual reading room has been developed on our Trust internet site. Since 1 January 2012, the Trust 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 Foundation Trust was not subject to the Payment by Results clinical coding audit during 2016-17 by the Audit Commission.

The Audit Commission no longer audits every Trust every year where they see no issues. The in-house clinical coding audit manager conducts a 200 episode audit every year as part of the IG Toolkit and also as part of continuous assessment of the auditor.

	2015-16	2016-17
Primary diagnoses correct	91.5%	91%
Secondary diagnoses correct	89.94%	87.65%
Primary procedures correct	91.43%	92.74%
Secondary procedures correct	83.41%	87.5%

The services reviewed within the sample were 200 finished consultant episodes (FCEs) in consultant episodes taken from a random sample of all specialties. 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. External monthly coding audits are undertaken to provide assurance that coding reflects clinical management. Any issues are taken back to the coder or clinician depending on the error. The clinical coders also attend the mortality review meetings to ensure the correct coding of deceased patients.

Our coders organise their work so that they are closer to the clinical teams. This results in sustained improvements to clinical documentation and 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.

Specific issues highlighted within the audit have been fed back to individual coders and appropriate training planned where required. North Tees and Hartlepool NHS Foundation Trust will be taking the following actions to improve data quality. The Trust has recruited and trained 6 additional coders to start coding all inpatient activity from notes. This started in January with the Emergency Assessment Unit and is to be rolled out over the remaining wards during 2017. This will improve the capture of additional co-morbidities that are used to calculate HSMR and SHMI.

Diagnosis Coding Depth – North East Trusts (February 2016 to January 2017)

Trust	Total Activity	Diagnosis Coding Depth	Average Diagnosis Coding Depth
Trust 1	140,410	766,198	5.46
NTHFT	113,013	589,887	5.22
Trust 3	46,206	237,620	5.14
Trust 4	184,476	917,208	4.97
Trust 5	83,077	401,393	4.83
Trust 6	247,092	1,112,877	4.50
Trust 7	136,066	596,222	4.38
Trust 8	169,793	707,202	4.17

**Data taken from Data Quality Clinical Coding in HED*

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)

SHMI Definition

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It includes deaths which occur in hospital and deaths which occur outside of hospital within 30 days (inclusive) of discharge.

Summary Hospital-level Mortality Indicator (SHMI) – Deaths associated with hospitalisation, England, **October 2015 – September 2016**

Time period	Over-dispersion banding	Trust Score	National Average	Highest – SHMI Trust Value in the country	Lowest – SHMI Trust Value in the country
Jul 2014 – Jun 2015	Band 1 (Higher than Expected)	1.209	1.00	1.209	0.661
Oct 2014 – Sept 2015	Band 1 (Higher than Expected)	1.177	1.00	1.177	0.651
Jan 2015 – Dec 2015	Band 1 (Higher than Expected)	1.173	1.00	1.173	0.669
Apr 2015 – Mar 2016	Band 1 (Higher than Expected)	1.132	1.00	1.178	0.678
Jul 2015 – Jun 2016	Band 2 (As Expected)	1.118	1.00	1.171	0.694
Oct 2015 – Sept 2016	Band 2 (As Expected)	1.119	1.00	1.1638	0.6897

SHMI Regional – October 2015 – September 2016

Trust	Trust Score	OD banding
South Tyneside NHS Foundation Trust	1.1597	1
North Tees and Hartlepool NHS Foundation Trust	1.1195	2
County Durham and Darlington NHS Foundation Trust	1.0667	2
South Tees Hospitals NHS Foundation Trust	1.0438	2
Northumbria Healthcare NHS Foundation Trust	1.0337	2
City Hospitals Sunderland NHS Foundation Trust	0.9988	2
Gateshead Health NHS Foundation Trust	0.9934	2
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	0.9720	2

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 indicator. The Secretary of State for health has introduced a requirement for all Trusts to undertake mortality reviews; this has been supported by the CQC and a national system for recording mortality reviews is to be introduced over 2017-18. The Trust introduced mortality reviews in 2014 and continues to undertake these over two sessions each week, this has been supported by the inclusion of the mortality reviews in the quality work undertaken by all consultants as part of their annual appraisal.

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's review process is linked closely with the work being undertaken regionally and the Trust is working jointly with local trusts to utilise a web based system to store mortality reviews that can be linked into the national system once this is agreed and in place. All trusts in the region are undertaking reviews and the Trust staff meet with them on a regular basis to share best practice and to also consider areas of focus across the region as well as locally.

Over the last year the Trust continues to review 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. The Specialist team have been involved in the care of an increasing number of patients over this last year. The Trust has also been running update sessions for consultant staff who are not part of the Specialist Palliative Care team in order to ensure the care given to all of our patients, who are reaching the end of their lives, is of the highest standard regardless of whether they are seen by the specialist team.

The Trust continues to take a key role in regional Community Acquired Pneumonia Project which is running in conjunction with other North East Trusts; the Trust has also joined the Serious Infections – SEPSIS Project with informatics performed by Clarity in both instances. The results from the data collection demonstrate continued improvement over this year; the projects are continuing currently.

Finally, the Trust has closed the Keogh Delivery Group and replaced it with a streamlined Trust Outcome Performance Delivery Operational Group (TOPDOG); this group looks at mini projects that can be undertaken throughout the year, as well as providing the support and guidance to areas that want to improve services and processes within the Trust. The multiple work streams that have been delivered during 2016-17 have continued to make an impact on the HSMR and SHMI values, and have led to both of these statistics being reported as being "within expected" ranges. Whilst the Trust recognises that this is an excellent reduction the actions already initiated are being followed to completion and there are further areas being identified for review, and potential improvement work, from the analysis of a wide variety of data and information sources on a regular basis.

Measure	Measure Description	Data Source
1b	The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust	NHS DIGITAL

Percentage of deaths with palliative care coding, October 2015 – September 2016

Time period	Diagnosis Rate	Diagnosis Rate National Average	Highest – Diagnosis Rate	Lowest – Diagnosis Rate	Combined Rate	Combined Rate National Average	Highest – Combined Rate	Lowest – Combined Rate
Oct 2014– Sep 2015	18.40	25.74	48.30	0.00	18.40	25.89	48.30	0.00
Jan 2015– Dec 2015	30.84	27.57	54.75	0.19	30.84	27.70	54.75	0.19
Apr 2015– Mar 2016	35.06	28.67	54.60	0.58	35.06	28.82	54.60	0.58
Jul 2015 – Jun 2016	35.88	29.39	54.83	0.57	35.88	29.55	54.83	0.57
Oct 2015– Sep 2016	36.42	29.60	56.27	0.39	36.42	29.70	56.27	0.39

Latest Time Period benchmarking position – October 2015 – September 2016

Trust	Diagnosis Rate	Combined Rate
Northumbria Healthcare NHS Foundation Trust	1.1597	1
North Tees and Hartlepool NHS Foundation Trust	1.1195	2
South Tees Hospitals NHS Foundation Trust	1.0667	2
County Durham and Darlington NHS Foundation Trust	1.0438	2
South Tyneside NHS Foundation Trust	1.0337	2
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	0.9988	2
City Hospitals Sunderland NHS Foundation Trust	0.9934	2
Gateshead Health NHS Foundation Trust	0.9720	2
NATIONAL AVERAGE	29.60	69.70

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 had remained static over a number of years, processes and procedures were reviewed in 2015-16 and improved again in 2016-17.

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.

In an effort to visibly support clinical teams, the Specialist Palliative Care Team are promoting a more proactive approach to identification and support of those patients who may be dying. There is a holistic approach taken to their care, with the host team remaining key workers with the support of Specialist Palliative Care Clinicians, Clinical Nurse Specialists, End of Life Co-ordinator and Chaplaincy in advisory and supportive roles. All patients who may be dying or have an uncertainty to their recovery can be identified through TRAKCARE via the Palliative Care Alert, or the End of Life Care Alert, or can be referred to the service directly by any staff member. Over the last year the Trust continues to review 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. To promote appropriate and timely referral, the Trust has provided a detailed training course facilitated by the Specialist Palliative Care team to increase education for senior clinical staff, this along with the changes made to documentation will improve the quality of documentation and in turn the quality of the Trusts clinical coding. The Specialist Palliative Care Team follow up on all patients who are referred through the various methods and advise, support and signpost accordingly.

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 on-going 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, this in turn helping 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	NHS DIGITAL	Adjusted average health gain EQ-5D Index

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

April 15 to March 16	Groin hernia	Varicose vein	Hip replacement - Primary	Hip replacement - Revisions	Knee replacement - Primary	Knee replacement - Revisions
Trust Score	0.022	No data	0.438	No data	0.334	No data
National Average	0.088	0.094	0.439	0.284	0.321	0.260
Highest National	0.135	0.130	0.520	No data	0.412	No data
Lowest National	0.010	0.037	0.359	No data	0.207	No data

April 16 to Sept 16	Groin hernia	Varicose vein	Hip replacement - Primary	Hip replacement - Revisions	Knee replacement - Primary	Knee replacement - Revisions
Trust Score	0.80	No data	No data	No data	0.368	No data
National Average	0.89	0.099	0.449	0.285	0.337	0.289
Highest National	0.162	0.152	0.525	No data	0.430	No data
Lowest National	0.30	0.016	0.330	No data	0.286	No data

The **North Tees and Hartlepool NHS Foundation Trust** considers that this data is as described for the following reasons. The Trust continues to have a lower than the national average 'adjusted average health gain' score in relation to groin hernia surgery, however the position is improving. In relation to primary knee replacement, the Trusts position continues to demonstrate good results.

The **North Tees and Hartlepool NHS Foundation Trust** has taken the following actions to improve this score. The Trust continues to carry out multiple reviews, the reviews occur at 6 weeks and 6 months with the final review being at 12 months. The reviews will be carried out by the joint replacement practitioners unless otherwise identified.

The Trust continues to use 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.	NHS DIGITAL

Age Group	Value	Data for 2012-13 standardised to persons 2016-17	Data for 2011-12 standardised to persons 2007-08	Data for 2010-11 standardised to persons 2007-08	Data for 2009-10 standardised to persons 2007-08	Data for 2008-09 standardised to persons 2007-08
0 to 15	Trust Score	Not Available	8.79	11.39	12.05	11.73
	National Average	Not Available	10.01	10.15	10.18	10.09
	Band	Not Available	B5	A1	A1	A1
	Highest National	Not Available	14.94	25.80	22.53	22.73
	Lowest National	Not Available	0.00	0.00	0.00	0.00

Age Group	Value	Data for 2012-13 standardised to persons 2016-17	Data for 2011-12 standardised to persons 2007-08	Data for 2010-11 standardised to persons 2007-08	Data for 2009-10 standardised to persons 2007-08	Data for 2008-09 standardised to persons 2007-08
16 or over	Trust Score	Not Available	10.72	10.26	10.07	9.82
	National Average	Not Available	11.45	11.42	11.16	10.90
	Band	Not Available	A5	W	W	A5
	Highest National	Not Available	17.72	23.99	16.82	24.43
	Lowest National	Not Available	0.00	0.00	0.00	0.00

To Note: Please note that this indicator was last updated in December 2013 and future releases have been temporarily suspended pending a methodology review.

The **North Tees and Hartlepool NHS Foundation Trust** considers that this data is as described for the following reasons. The Trust monitors and reports readmission rates to the Board of Directors and directorates on a monthly basis. The November 2016 position (latest available data) indicates the Trust has an overall readmission rate of 8.33% against the internal stretch target of 7.70%, indicating the Trust's readmission rates have increased by 1.15% compared to the same period in 2015. Audits are being undertaken at specialty level to identify areas for improvement and gaps in services to address across the system.

The **North Tees and Hartlepool NHS Foundation Trust** has taken the following actions to improve the rate and preventing avoidable readmissions within 30 days of discharge. This continues to present 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 a continued improvement to the elective and emergency readmission position.

Patient pathways continue to be redesigned to incorporate an integrated approach to 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 including: a discharge liaison team of therapy staff to actively support timely discharge, working closely with the patient flow managers; inclusion of social workers within the hospital teams to facilitate discharge with appropriate packages of care to prevent readmission; the redesign of integrated care pathways for long term conditions by direction and delivery through an executive director led programme; utilisation of ambulatory care facilities; emergency care therapy team in A&E to facilitate discharge and prevent admissions; community matrons attached to care homes and the community integrated assessment team supporting rehabilitation to people in their own homes including care homes.

Measure	Measure Description	Data Source
4	The Trusts responsiveness to the personal needs of its patients	NHS DIGITAL

Period of Coverage	National Average	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST (out of 100)
*2016-17	Not available	Not available
2015-16	69.60	67.70
2014-15	68.90	68.10
2013-14	68.70	69.00
2012-13	68.10	68.70

*2016-17 data not available at the time of print

Benchmarked against over North East Trusts for 2016-17;

Trust	Overall Score
	(out of 100)
Northumbria Healthcare NHS Foundation Trust	Not available
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	Not available
South Tees Hospitals NHS Trust	Not available
Gateshead Health NHS Foundation Trust	Not available
South Tyneside NHS Foundation Trust	Not available
County Durham and Darlington NHS Foundation Trust	Not available
City Hospitals Sunderland NHS Foundation Trust	Not available
North Tees and Hartlepool 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 and personal needs, helping us to understand how well we are performing.

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

Measure	Measure Description	Data Source
5	The percentage of 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.	NHS DIGITAL

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 modeling 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.

Trust Name	Survey Year					
	2011	2012	2013	2014	2015	2016
Trust 1	59	63	59	65	70	70
Trust 2	49	50	57	53	61	59
Trust 3	73	69	70	75	76	81
North Tees and Hartlepool	63	61	57	54	62	64
Trust 4	70	69	77	70	85	82
Trust 5	69	74	76	80	72	73
Trust 6	63	68	64	53	62	59
Trust 7	79	86	87	84	89	91
North East	66	67	68	67	72	72
England	62	65	67	67	70	70
National High	-		94	93	93	92
National Low	-		38	36	37	56

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	74%	67%	56%	78%
Percentage Not Recommended – Care	9%	9%	12%	9%

*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	69%	65%	64%	76%
Percentage Not Recommended – Work	15%	16%	12%	11%

*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 2016-17, 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. The Trust continue to actively engage with and encourage staff to complete and return the 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. This year marked a significant improvement in the response rate for the Staff Survey at 61% compared to 45% the previous year.

The **North Tees and Hartlepool NHS 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.

National Staff Survey

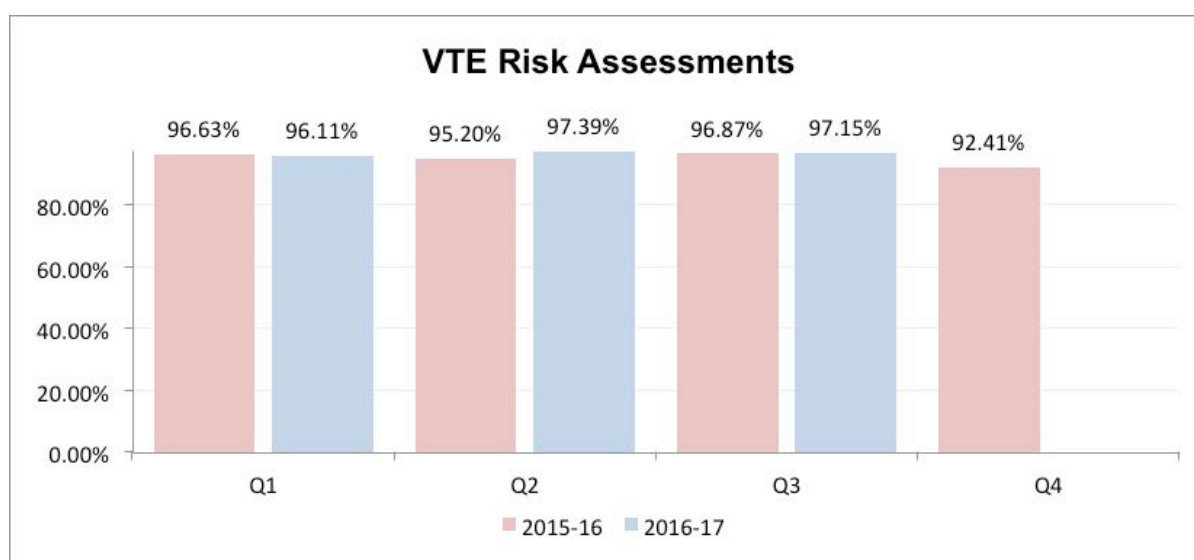
Percentage of *staff experiencing harassment, bullying or abuse from staff in the last 12 months*

2014	2015	2016	2016 National Average
21%	26%	20%	23%

Percentage believing that *Trust provides equal opportunities for career progression or promotion*

2014	2015	2016	2016 National Average
90%	90%	90%	87%

Measure	Measure Description	Data Source
6	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE)	NHS DIGITAL



Two year reporting trend

Measure	Report- ing Year	2015-2016				2016-2017			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	*Q4
Venous Thrombo-embolism	Value	96.63%	95.20%	96.87%	92.41%	96.11%	97.39%	97.15%	
	National Average	96.05%	95.86%	95.61%	95.53%	95.73%	95.51%	94.23%	
	Highest National	100%	100%	100%	100%	100%	100%	100%	
	Lowest National	86.08%	75.04%	78.50%	78.06%	80.61%	72.14%	76.48%	

*Q4 data no available at time of print

North East Trust benchmarking 2016-17

Trust	2016-17			
	Q1	Q2	Q3	*Q4
North Tees and Hartlepool NHS Foundation Trust	96.11%	97.39%	97.15%	
City Hospitals Sunderland NHS Foundation Trust	98.33%	98.43%	98.68%	
South Tees Hospitals NHS Trust	96.04%	95.50%	95.26%	
South Tyneside NHS Foundation Trust	96.29%	96.37%	95.75%	
County Durham and Darlington NHS Foundation Trust	96.56%	96.92%	97.01%	
Gateshead Health NHS Foundation Trust	97.83%	97.88%	98.55%	
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	91.70%	95.83%	96.85%	
Northumbria Healthcare NHS Foundation Trust	93.63%	94.56%	94.29%	

*Q4 data no available at time of print

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

The **North Tees and Hartlepool NHS Foundation Trust** has taken the following actions to continue to improve this percentage, and so the quality of its services, by updating the training booklets to keep them relevant, ensuring that it is part of the mandatory training and providing guidance on the importance of VTE risk assessment at induction of clinical staff. Consultants continue to monitor performance in relation to VTE risk assessment on a daily basis.

The Trust ensures that 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:

Requiring Training	Trained	% Compliance
1,328	1,261	95%

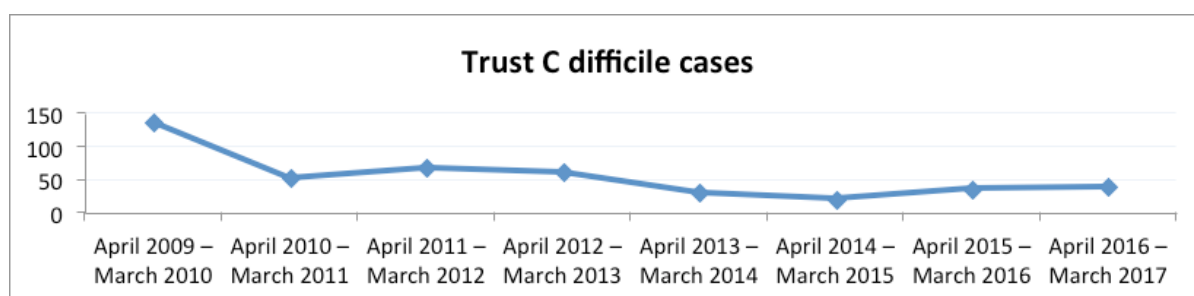
*data for 2016-17

Measure	Measure Description	Data Source
7	The rate per 100,000 bed days of cases of C difficile infection that have occurred within the Trust amongst patients aged 2 or over during the reporting period.	NHS DIGITAL

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 2015 – March 2016	39	Not Available	Not Available	Not Available	Not Available
April 2015 – March 2016	36	17.70	14.90	66.00	0.00
April 2014 – March 2015	20	10.40	15.10	62.20	0.00
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

*2016-17 data not available at the time of print



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

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

- Enhanced ward cleaning and decontamination of patient equipment, including the use of steam, hydrogen peroxide and Ultraviolet (UV) light. A project with NHS Improvement looking at a specific role to clean patient equipment was completed and rollout across all wards is now being explored.
- The continued use of the mattress decontamination service to reduce the risk of infection and improve quality of service to patients.
- Raised awareness and audit of antimicrobial prescribing and stewardship including the identification of antibiotic champions for each directorate and the introduction of competency assessments for prescribers. The Trust participated in European Antibiotic Awareness day and also submitted data to the Public Health England point prevalence survey which included antibiotic prescribing.
- A continued emphasis on high standards of hand hygiene for staff and patients, utilising hand hygiene champions and a monthly RAG report.
- Daily monitoring of affected patients to ensure good clinical management and the reduction in risk of cross infection.
- The reintroduction of regular infection prevention and control training for all staff and the development of an e-learning package on C difficile.

The Trust intends to continue with these measures and will explore every opportunity to minimise C difficile cases in the future.

Measure	Measure Description	Data Source
8	The number and, where available, rate of patient safety incidents that occurred within the Trust during the reporting period, and the percentage of such patient safety incidents that resulted in severe harm or death.	NHS DIGITAL

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

Provider: Acute (Non Specialist) – Organisational incident data by organisation in 6-month period, **October 2015 – March 2016**

Report period	Based on occurring dataset (Degree of Harm – All)		National Degree of harm Severe or Death			Our Trust Degree of harm Severe or Death	
	Number of incidents occurring	Rate per 1,000 Bed Days	Average %	Highest %	Lowest %	Number of incidents	%
Oct 15 – Mar 16	2,916	26.50	0.16	0.97	0.00	3	0.10
Apr 15 – Sep 15	3,117	32.30	0.43	2.92	0.07	7	0.22
Oct 14 – Mar 15	3,074	30.40	0.50	5.19	0.05	7	0.23
Apr 14 – Sep 14	3,068	32.40	0.49	82.86	0.00	8	0.26

Regional Benchmarking

Trust	October 2015 – March 2016	
	Degree of Harm (All) – Rate per 1,000 bed days	Degree of Harm (Severe or Death) %
Gateshead Health NHS Foundation Trust	30.90	0.61
South Tees Hospitals NHS Trust	32.80	0.46
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	28.90	0.44
County Durham and Darlington NHS Foundation Trust	38.90	0.42
South Tyneside NHS Foundation Trust	33.90	0.37
Northumbria Healthcare NHS Foundation Trust	43.90	0.32
North Tees and Hartlepool NHS Foundation Trust	26.50	0.10
City Hospitals Sunderland NHS Foundation Trust	63.50	0.09

*Data for Oct 15 – Mar 16

The **North Tees and Hartlepool NHS Foundation Trust** considers that this data is as described for the following reasons. The Trust endeavours to foster and promote a positive culture of reporting across all teams and services. This is enhanced by encouraging timely reporting of incidents, regardless of level of harm and reinforcing that the purpose of reporting is to learn from investigation of incidents and to promote a culture of openness and honesty across the organisation. The investigations undertaken support the development of systems and processes to prevent future patient harm. The quality of the incident reporting is checked at various stages of the reporting and investigation process.

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

It is acknowledged that a positive safety culture is associated with increased reporting and as such, the Trust continuously monitors the frequency of incident reporting and strives to increase reporting in all areas. The Trust is targeting the reporting of no and low harm incidents, which can provide valuable insights into preventing future incidents of patient harm. In relation to frequently occurring incidents such as falls, pressure damage and discharge problems; there are also additional processes in place for reviewing the root causes of incidents, developing improvements and to evaluate the impact on these.

All reported incidents are reviewed internally within the local departments for accuracy in regards to the level of harm, and there are various processes in place in the organisation to provide assurance that the recorded level of harm reflects the nature of the incident.

The weekly multidisciplinary Safety Panel reviews all incidents of moderate harm or above, the panel agrees the level of investigation and reviews the application of Duty of Candour regulations by the clinical directorates. Where there is any discrepancy, the investigating team are asked to provide further details for review and discussion. In complex cases, where the identification of the required level of investigation is unclear, the incident, and all evidence collated through the investigation to date, is reviewed by the Medical Director and/or Director of Nursing, Patient Safety and Quality for a decision. Incidents of significant harm are managed within the National Framework for Serious Incidents and the current requirements for both the national NHS contract and the local Clinical Commissioning Groups (CCGs).

On conclusion of a Serious Incident investigation, the weekly Safety Panel reviews and approves the Comprehensive Investigation report which is developed from the internal investigation, and reviews the actions that have been initiated to seek assurance that these will reduce the risk of future recurrence. Once agreed by the panel, the reports and action plans are forwarded to the CCG for external review and approval prior to closure. Information in relation to the root cause of an incident, the recommendations made following investigation and actions initiated are recorded on the national Strategic Executive Information System (STEIS). This allows NHS Improvement and the Care Quality Commission (CQC) to review overall learning and identify any trends that may require inclusion in national action.

The Trust works in close collaboration with the local CQC inspectors in relation to incident reporting and regularly communicates in relation to serious incident investigations and also overall trend in incident reporting.

Where an incident does not meet the criteria within the national framework for serious incidents, but the Trust identifies that lessons can be learnt locally within a team or wider across the organisation, an internal process of investigation is initiated which mirrors the national framework. This proactive approach to safety and quality allows the Trust to internally consider areas of service provision with recourse to escalate more serious concerns if they become apparent through the investigation.

The Trust reports all patient related reported incidents into the National Learning and Reporting System (NRLS), this allows a national view to be obtained in relation to all patient safety incidents reported, regardless of harm level. The national analysis of this information provides information for NHS Improvement to review and consider where actions need to be taken in relation to national trends in lower level incidents. This analysis can lead to a national safety alert being published; the Trust is fully compliant with all of the National Patient Safety Alerts that have been published in relation to this analysis. Processes are in place to ensure there is continual review of processes in order to provide on-going assurances.

To support the Trust's drive to increase reporting and create a positive safety culture across all departments, there is on-going education and updating of relevant staff groups including students, new starters, and managers. The emphasis is on proactive reporting of all types of safety incidents, those with harm or the potential for harm to one or more patient, with the emphasis within the investigation to be on the learning for the individual, the team and the organisation as a whole.

Part 3a: Additional Quality Performance measures during 2016-17

This section is an overview of the quality of care based on performance in 2016-17 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 2016-17 has been positive overall.

The following data is a representation of the data presented to the Board of Directors on a monthly basis in consultation with relevant stakeholders for the year 2016-17. 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.

Patient Safety

Falls

Why/How we chose this measure.

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

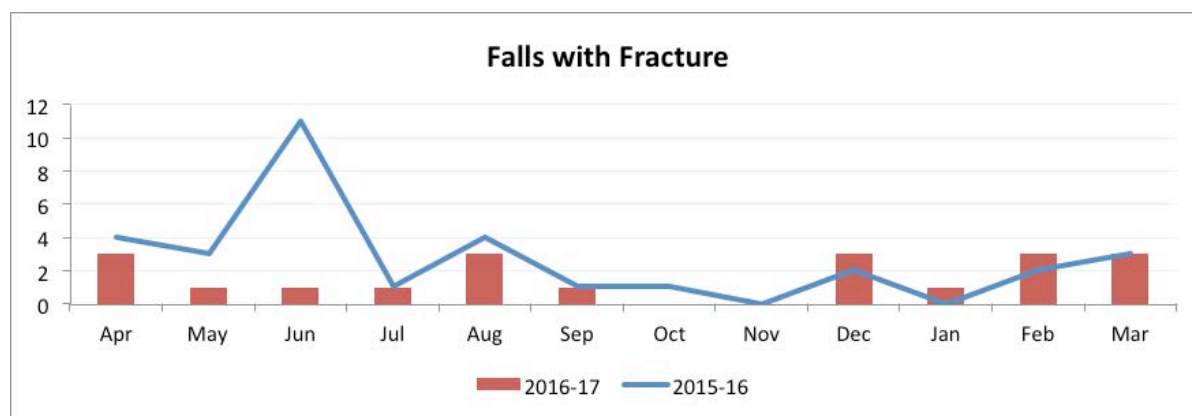
Patients aged 65 years and over are at highest risk of falling and patients aged 85 and over are at highest risk of injury from a fall.

Falls with Fracture

During 2016-17 the Trust has experienced 20 falls resulting in fracture; this has decreased from 32 in the 2015-16 reporting period.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2013-14	1	2	1	1	4	4	4	1	1	0	1	1	21
2014-15	1	4	2	9	1	4	3	5	3	3	3	4	42
2015-16	4	3	11	1	4	1	1	0	2	0	2	3	32
2016-17	3	1	1	1	3	1	0	0	3	1	3	3	20

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



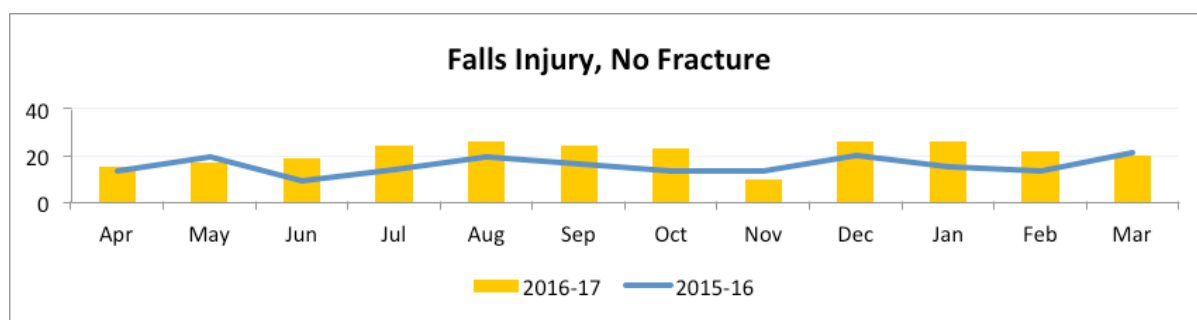
The Trust has a robust system in place to understand the background to all falls that result in significant injury; these incidents are shared with staff for future learning.

Falls Injury, No Fracture

During **2016-17** the Trust has experienced **252** falls resulting in an injury and no fracture; this has *increased* from 185 in the 2015-16 reporting period.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2013-14	28	21	27	35	22	37	23	26	31	30	24	26	330
2014-15	25	27	19	29	33	29	27	31	33	37	40	25	355
2015-16	13	19	9	14	19	16	13	13	20	15	13	21	185
2016-17	15	17	19	24	26	24	23	10	26	26	22	20	252

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

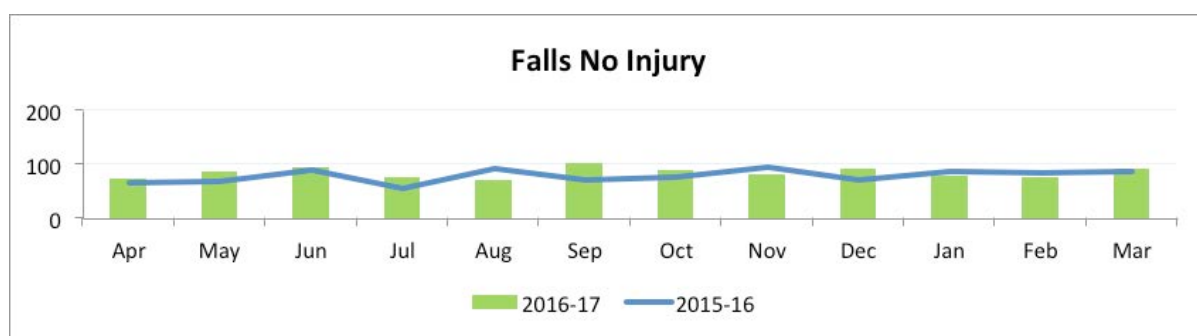


Falls with No Injury

During **2016-17** the Trust has experienced **1,016** falls resulting in no injury; this has *increased* from 947 in the 2015-16 reporting period.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2013-14	100	110	67	98	71	80	84	96	88	101	78	70	1,043
2014-15	120	87	66	84	108	93	97	84	88	85	100	82	1,012
2015-16	65	69	91	56	93	72	76	95	71	88	85	86	947
2016-17	73	88	95	76	72	102	89	82	92	79	76	92	1,016

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



The Trust is reporting more falls with injury, but these injuries do not include any significant harm which would increase the patient's hospital stay or require the patient to receive any on-going treatment.

The number of falls that have resulted in no harm has increased, additional work is being undertaken by all areas to assess and manage those patients at high risk of falls. This includes assessment of risk within 6 hours of admission and continued assessment throughout the patients' journey. Interventions such as one to one care for patients identified as high risk of falls, medication review and mobility assessment has improved the Trust's performance.

For 2017-18 the Trust aims to introduce a post falls checklist to ensure all patients receive excellent care following a fall and further work will be undertaken to share any learning from incidents related to falls.

Never Events

The Trust continues to work hard to improve patient safety therefore stakeholders and the Board of Directors 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 2013 the Trust has had 5 Never Events and they are broken down as follows:

Reporting Year	Number of Never Events
2013-14	1
2014-15	1
2015-16	2
2016-17	1
Totals:	5

There has been one Never Event reported in the period of 2016-17; this incident related to wrong site surgery, the patient involved is fully aware of the incident and has been involved in and has been given feedback in relation to the investigation findings. As a result of this incident there has been a continued focus on the Trusts use of the World Health Organisation (WHO) Surgical Checklist in order to reduce the risk of any further never events occurring to a minimum. The incident has been reported to NHS England and the Trusts Commissioners on the Strategic Executive Information System (STEIS), the CQC and NHS Improvements as required.

The NHS England report can be accessed via:

<http://www.england.nhs.uk/ourwork/patientsafety/never-events/ne-data/>

Effectiveness of Care

Discharge processes

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 concerns and/or incidents raised onto Trusts Datix system

Overview of how we said we would measure it

- Quarterly analysis of discharge incidents on Datix

Overview of how we said we would report it

- To the Discharge Steering Group

Completed and reported?

- Reported to the Discharge Steering Group ✓

Patient Discharge Incidents

The number of discharge incidents has reduced in Q3 which is reflective of the hard work and efforts in improving safe discharging for our patients. Of those patients discharged in Q3 only 0.2% of patients had an issue with discharge identified and reported on Datix. The Trust continues to develop relationships with providers to build confidence and communication between teams and to ensure any issues that do arise are dealt with swiftly to minimise the risk of reoccurrence. A number of initiatives in the Trust work towards improving discharge planning further and ensure the patient experience is seamless.

Patient Flow Reforms

There are a number of discrete teams with a key remit of facilitating patient flow and timely discharge. These include the Discharge Liaison Team (DLT), the Patient Flow Team, the Discharge Lounge, the Clinical Site Managers and the Emergency Care Therapy Team (ECTT). Work is now underway to consider how these teams can work together as a more coordinated unit. The Trust has identified an area to co-locate teams to promote timely engagement and action, teams are now co-located. The Patient Flow Team is also currently exploring the opportunities that Trakcare affords in relation to monitoring patient flow, on-going work with Trak team to provide a system where the principles of the SAFER bundle can be utilised to assist patient flow i.e. those most sick, those for discharge etc. Ward huddles are well embedded and key in driving forward the SAFER bundle. The teams continue to promote earlier in the day discharge.

NESTA 100 day challenge

There is a new initiative in Stockton called the NESTA 100 day challenge which began on 23 January 2017 – this involves a mix of acute, community, social care and local authority and governor colleagues keen to improve processes and challenges in the system. There are 3 groups (2 out of hospital and 1 acute) each with specific goals to either improve discharge from hospital or prevent unnecessary hospital admissions.

Integrated Discharge team

The Trust are in the process of establishing the Integrated Discharge Team made up of health and social care professionals. This will ensure that teams are working closely together to discharge patients safely and efficiently. Hartlepool Borough Council social care workers have moved into the hospital in January and we are working with Stockton as part of the 100 day challenge to look at new ways of working.

Volunteers in Discharge Lounge

The Trust is due to introduce two volunteers who will work in the discharge lounge to provide support and friendly dialogue to patients before they leave the Hospital. It is hoped that the patients will feel comfortable talking to our volunteers and we might be able to signpost them to appropriate voluntary and third sector organisations in the community.

Patient Choice Policy

The Policy has been revised and agreed with our key external stakeholders. The policy now gives clear guidance as to what should occur when the patient's first choice of nursing or residential home is unavailable and also covers the process to follow in those circumstances when a patient, or their family or carers, do not work with the Trust to facilitate discharge from hospital.

Patient information to support the new policy has also been approved and ward staff are involved in implementing the policy with the support from their senior clinical matron and discharge liaison team, especially in relation to the family meetings. It is embedded with clinical teams and feedback and monitoring is through the Discharge Steering Group. This policy continues to be managed by staff to support discharge from hospital to care homes.

Delays Database

The DLT are now utilising and populating, on a daily basis, a database that tracks all delayed discharges. The DLT are now able to capture and categorise all delays in discharge, including those that are internal to the Trust. This will allow us to track patients and target our intervention more appropriately. The recent introduction of an expected date of discharge for all patients will support this. The database will also allow us to more effectively measure and audit the efficacy of any new initiatives introduced to reduce delays in discharge.

Out of Hospital Care Clinical Strategy

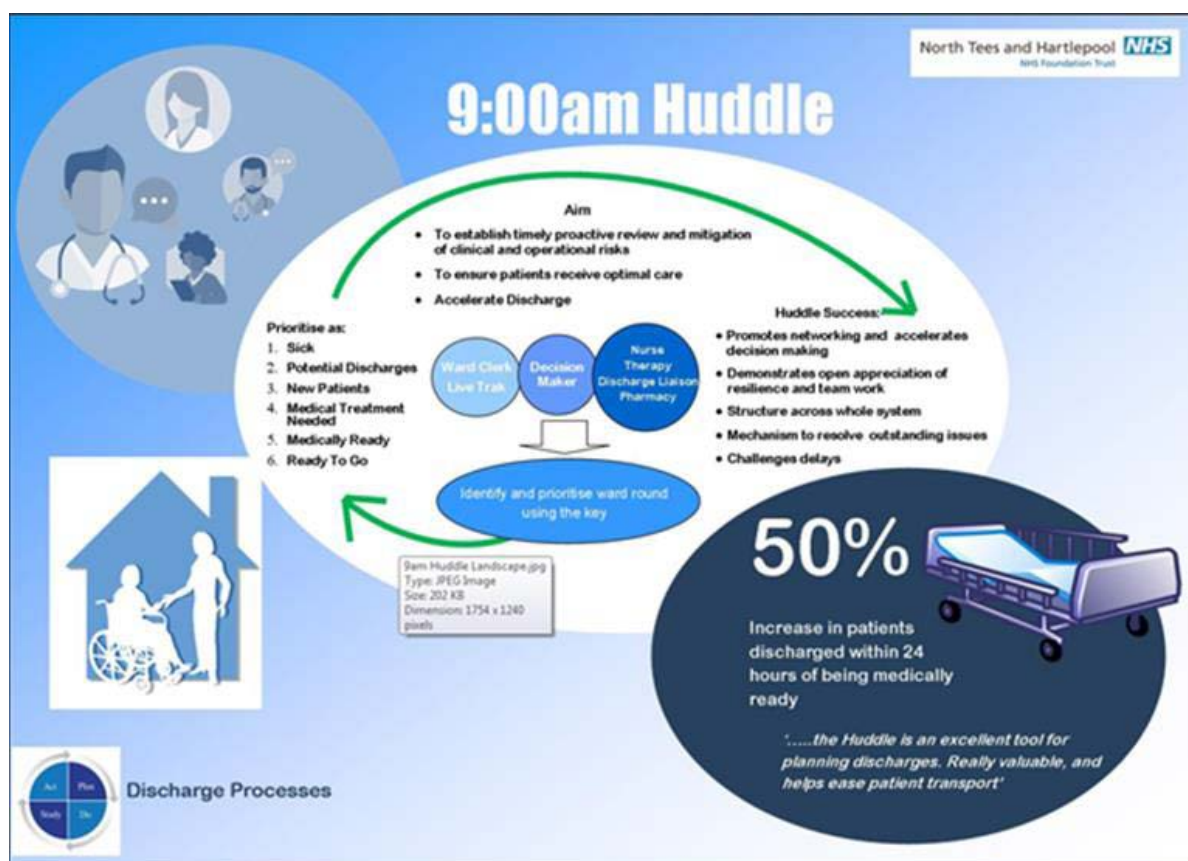
The strategy incorporates plans to provide some nursing interventions in the community that until now have only been provided in the acute setting. These plans include the administration of long line IV antibiotics, IV diuretics and subcutaneous fluids. These proposals are at the developmental stage, but have been well received by commissioning colleagues; once implemented there will be a cohort of the current inpatient caseload who could be safely managed in the community, thereby enabling earlier discharge and reducing demand for inpatient beds.

Respiratory "Hospital at Home" Service (HAH)

The service accepts GP referrals for a cohort of patients with COPD who would previously have been admitted to hospital. These patients will be managed in the community by the new multidisciplinary team. This initiative will not only prevent admissions, but will also facilitate earlier supported discharge for some patients. This service is available across both localities 7 days per week. The team can support early discharge from hospital, taking referrals up to 6pm every evening. This continues to be a valuable team to safely support early discharge from hospital. This continues to be a successful service and has received very positive praise from peer, patients and relatives.

Seven day working

Work is on-going to progress to a position where the Trust and our partner organisations manage the discharge of patients as effectively on a weekend, as happens during the working week.



THINK **'HOME IS BEST'**

for **FRAIL** patients



H = Hotline

- Have you discussed with **SPA Clinical Triage**? Able to offer support from other services in the community
- Tel number 01429 522277 (8am – 10pm)



O = OT/Physio

- Have you discussed with **ECTT**? Able to offer guidance on management plans
- Bleep #6920 (08:30-19:00)



M = Mental health

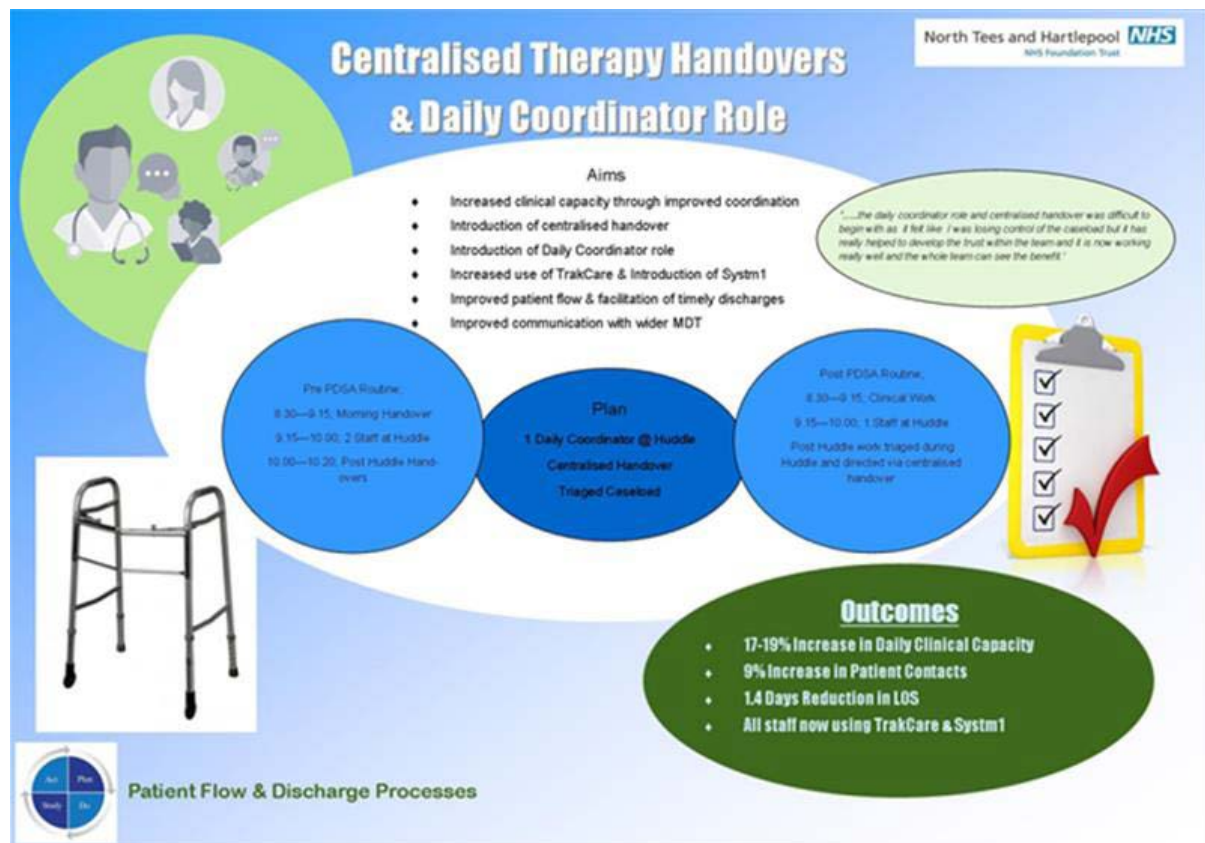
- Have you discussed with **Psychiatry Liaison**? Able to check any known management plan or offer support (Frailty Nurse assessment 'in hours' and information sharing 'out of hours'). Contact 01642 624318 - this number is active 24/7



E = Elderly care

- Have you considered a **Rapid Access Clinic referral**? Mon to Fri clinics for assessment by an Elderly Care Physician. Forms in A&E.

"E.D. phone HOME"



Staff, Patient Experience and Quality Standards (SPEQS)

Staff and patient experiences are what drive 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 Trust has commenced the newly revised (from August 2016) SPEQS process utilising the five CQC domains of:



Due to the increase in the number of metrics being measured, the scoring system has changed; therefore the ability to achieve a score of 100% is more challenging.

The current data is for inpatients areas with; further SPEQS assessment frameworks being developed from April 2017 for day case / outpatient Emergency Care, Maternity and Community.

The SPEQS led by the *Director or Deputy Director of Nursing, Patient Safety and Quality* is 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. Each visit of the ward/area is documented on a standard SPEQS template and is input into the SPEQS database when reporting back the results.

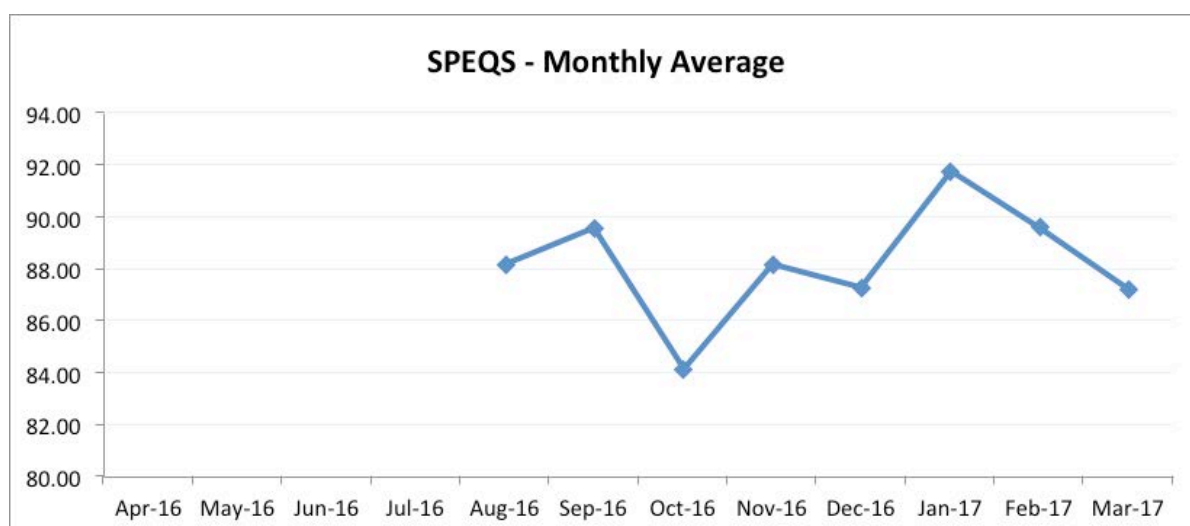
Reports from the SPEQS reviews are provided to the Board of Directors and to the Council of Governors periodically.

The following table provides data (**inpatients only**) relating to the **91** visits undertaken during the 2016-17 visits:

SPEQS CQC Domains	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total
Safe (%)	Not In Use During This Period				89.01	87.29	86.52	90.59	86.53	93.39	91.82	91.09	89.53
Effective (%)					87.69	91.19	84.87	89.18	84.20	94.48	86.40	86.92	88.12
Caring (%)					90.99	85.48	91.77	90.37	96.42	90.71	95.37	94.21	91.92
Responsive (%)					92.66	84.57	70.36	81.76	88.79	83.35	88.79	88.62	84.86
Well-Led (%)					79.65	84.27	75.79	81.30	77.98	87.85	88.15	79.27	81.78
Monthly Average (%)					88.16	89.59	84.13	88.18	87.27	91.77	89.61	88.76	88.43

Commodities Clean %	Not In Use During This Period	90.00	88.89	80.00	82.50	58.33	97.30	90.00	96.00	86.24
Toilet Clean %		92.31	92.86	100.0	96.08	100.0	100.0	97.78	100.0	97.39

*Data obtained from the Trusts internal SPEQS visits database



Clinical Effectiveness Indicators

Why/How we chose this as a priority.

The Trust has decided to include more detail around some of the Clinical Effectiveness indicators; this will be built on year on year, including more detailed data around the NHS Improvement 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 2015-16 data and against the 2016-17 performance target.

	2015-16 Performance	2016-17 Target	Q1	Q2	Q3	Q4	2016-17 Performance
Stroke – 80% of people with stroke to spend at least 90% of their time on a stroke unit	80%	80%	88.20%	92.50%	91.50%	94.98%	91.80%
Percentage high risk TIA cases treated within 24 hours	75%	75%	85.70%	92.60%	89.70%	93.94%	90.49%

Patient Experience

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.

Complaints

Complaints process

The Trust continues to use three complaints streams:

- **Stage 1** – Informal; to be dealt with by the Patient Experience Team (PET) or at the time of complaint at ward level.
- **Stage 2** – Formal; 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.

Stage	Number of Complaints
Stage 1 (Informal)	880
Stage 2 (Formal Meeting)	70
Stage 3 (Formal Chief Exec Letter)	270
Total	1,220

2016-17 Complaints by complaint type:

From the **1,220** complaints received in 2016-17 there are **983** with a sub-subject description.

Please see the following breakdown of the **top 10 complaint types**.

Sub-subject Description	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Communication – Insufficient	11	17	14	10	24	18	19	21	22	24	23	27	230
Attitude – unprofessional	8	14	7	6	6	10	9	11	3	10	13	12	110
Treatment and procedure delays	6	8	3	10	16	14	12	9	8	5	3	14	108
Outpatient delay	6	3	5	11	16	18	10	6	2	4	5	11	96
Outpatient cancellation	10	2	3	2	8	10	4	3	3	5	4	8	62
Competence of staff member	6	1	3	5	3	6	6	2	2	5	4	10	53
Delay to diagnosis	5	1		4	2	2		4	3	3	4	9	37
Receptionist/ administration staff incl. attitude and communication	2	2	3	7	2	1	3	4		4	4	1	33
Discharge arrangements	1	2	4	2		3	4	2	5	1		5	29
Pain Management	5		1	3	1	4	3	1		2	1		21

*Data for 2016-17 obtained via the Safety, Quality and Infections Dashboard – via Datix

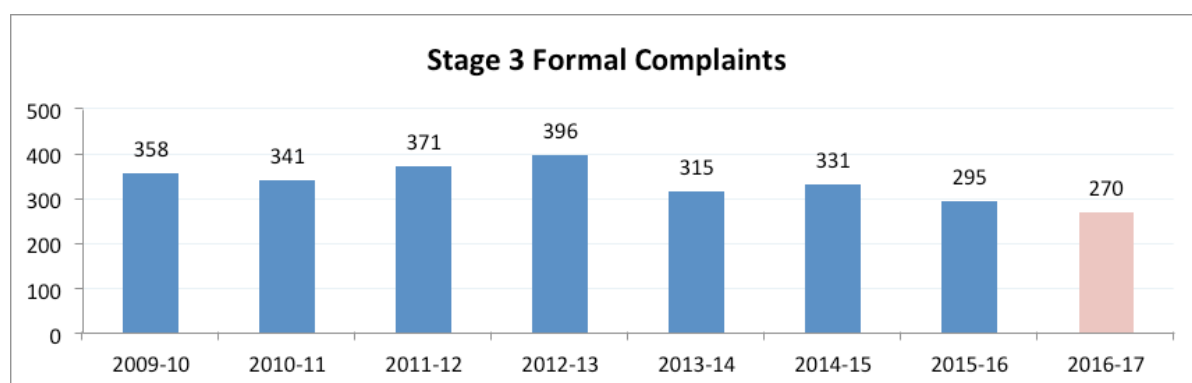
Since the 1st April 2016, the Trust has received **1,220** complaints of which **270** have gone onto Stage 3 of the complaints process, this only equates to **22.13%** of the complaints.

Stage 3 – Formal Complaints

The number of formal complaints received over the last 7 years is shown in the following table:

	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Stage 3 Formal Complaints	358	341	371	396	315	331	295	270

*Data obtained via the Trusts Incident Reporting via Datix



The following table trends the 2016-17 formal complaints by quarter.

	2016-17 Q1	2016-17 Q2	2016-17 Q3	2016-17 Q4	Total
Totals	75	74	53	68	270

*Data obtained via the Trusts Incident Reporting via Datix

All lessons learned from complaints are taken back into the clinical teams and managed proactively.

The themes are collated and aggregated analysis is considered in the Trust's quarterly Complaints, Litigation, Incidents and Performance (CLIP) report. The Directorates identify the top themes within their area and provide actions for improvement which is then followed up in the subsequent quarterly CLIP report.

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.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Compliance Rate (%)	82	76	100	93	96	92	100	95	92	92	100	95

*Data obtained from Trust complaints dept.

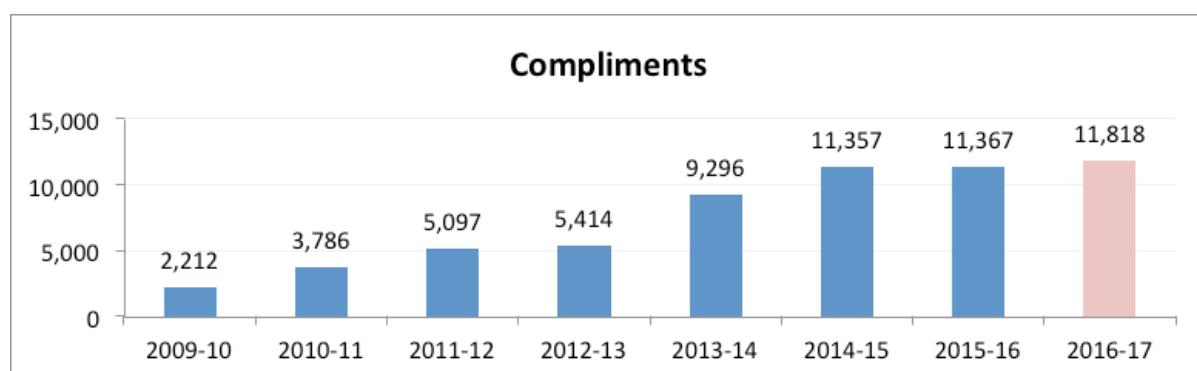
The Trust Complaints dashboard produces a weekly report; this data details the number of open complaints and which stage they fall under, the report also details the number of days open. The report is circulated to the Patient Safety Co-ordinators in each directorate to review the cases to see if they can be closed.

Compliments

In 2009-10 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.

	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Compliments	2,212	3,786	5,097	5,414	9,296	11,357	11,367	11,818



Pressure ulcers (also known as decubitus ulcer or pressure sores)

Why / How we chose this as a priority.

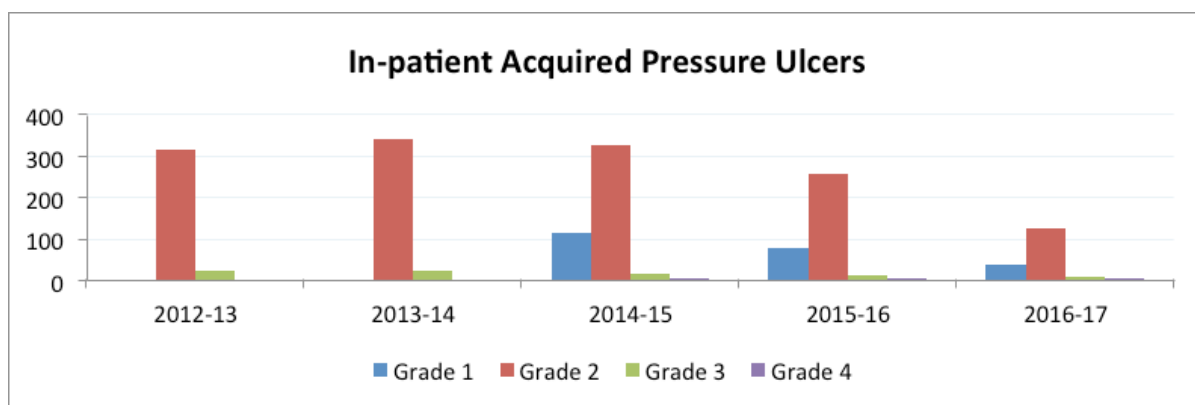
Following consultation with key stakeholders it was evident that pressure ulcers continue to be one of the Trusts key measures for improvement, therefore it was agreed to retain this indicator as rolling priority for our patients.

To note: prior to 2014-15 reporting year, Pressure ulcers were classified as **Grade 2 and below** and **Grade 3 and above**, this explains the N/A values in the above table for 2012 to 2014.

Year on Year Comparison – In-Hospital Acquired

Reporting Period	2012-13	2013-14	2014-15	2015-16	2016-17
Grade 1	N/A	N/A	114	78	39
Grade 2	317	343	326	258	126
Grade 3	25	25	18	12	9
Grade 4	N/A	N/A	2	1	1
Total	342	368	460	349	175

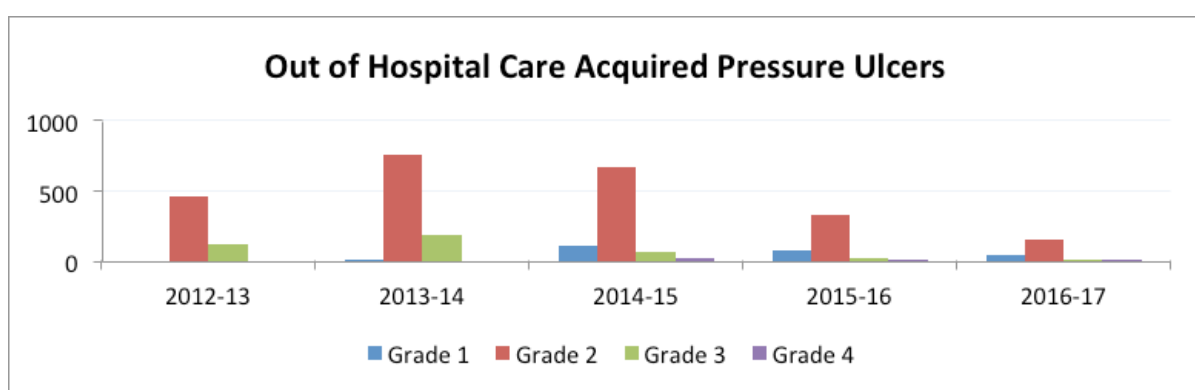
*Data obtained via the Trusts Incident Reporting database (Datix) data as of end of March 2017



Year on Year Comparison – Out of Hospital Acquired

Reporting Period	2012-13	2013-14	2014-15	2015-16	2016-17
Grade 1	N/A	3	118	83	68
Grade 2	458	759	667	337	253
Grade 3	124	187	74	21	36
Grade 4	N/A	N/A	25	8	5
Total	582	949	884	449	362

*Data obtained via the Trusts Incident Reporting database (Datix) data as of end of March 2017



Actions taken by the Trust:

In 2016 the Trust participated in a regional collaborative pressure ulcer improvement project, with two wards participating; the aim being to rollout improvement actions to all areas. Part of the project involved using the hand symbol from the SSKIN (surface inspection, skin inspection, keep moving, incontinence and nutrition) bundle as a visual reminder of patients who are at risk and require appropriate position changes and assessment. This collaborative project is planned to roll over to a second year and is being led by the Academic Health Sciences Network. The aim of the project is to reduce avoidable pressure ulcers to zero.

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.

A weekly review panel discusses all incidents of skin damage and agrees which of them require reporting through the Serious Incident Framework. Reports on these cases are presented to the Serious Untoward Incident panel prior to submission to commissioners. Learning from incidents is shared via directorate meetings and newsletters.

The Integrated Professional Board continues to oversee the Tissue Viability Operational Group which has the remit of reviewing the Trust action plan and Trust policies and guidelines to pursue continuous improvement in performance. The Tissue Viability Operational Group has been renamed from the Pressure Ulcer Operational Group to correctly reflect that all skin damage is considered by the Trust, not just that caused by pressure.

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.

After a successful pilot of an updated pressure ulcer prevention care bundle, the updated care bundle will be rolled out from April 2017. The care bundle has been extensively trialed with valuable feedback obtained from the pilot areas. Use of this care bundle in this Trust and others has proven to reduce the numbers of pressure ulcers occurring. The updated version reinforces the Registered Nurses responsibility for setting the frequency of care delivery for that patient.

The Tissue Viability team continue to deliver the Trust's "Shining the light on skin integrity" training. This is an intensive training afternoon presented by internal and external speakers. The training is very clinically focused and the feedback from the attendees is always very good indeed. The Trust continue to offer this training to local care and nursing home staff to help prevent pressure ulcers in the wider health community.

The Tissue Viability team, with the help of departmental staff and managers, maintain a network of link workers – Tissue Viability Champions. The Champions meet bi-monthly for updates on wound care and all matters related to tissue viability. This meeting is well attended and the training topics at the meetings are chosen by the Champions themselves and delivered by either the Tissue Viability team or colleagues from the wound care industry.

The Trust is involved in a regional, NHS England led, project on leading change, adding value, improving wound care. There are 2 main work streams in this project which focus on improving leg ulcer treatment and educational competencies in wound care assessment. This project aims to contribute towards achievement of CQUIN targets related to wound assessment.

A new carers and relatives patient information leaflet has been developed to give information on skin damage and care of skin. Delivering information to carers and relatives is vital to promote skin health.

The Trust once again this year participated in the regional "Stop the pressure" conference. A regional event was held at Sunderland Football Stadium and staff from the Trust attended to partake the conference which related to pressure ulcers and their prevention. To support the regional study day local information stands were set up throughout the Trust on Stop the Pressure week. The pledge board was once again very popular with staff from across the Trust giving their pledges on what they will do throughout the year to continue to reduce avoidable pressure ulcers.

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).

<http://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	2016-17 Target	2016-17 Performance	2015-16 Performance	Achieved (cumulative)
Clostridium Difficile – meeting the C.Diff objective (Apr 16 – Mar 17)	13	39	36	✗
MRSA – meeting the MRSA objective (Apr 16 – Mar 17)	0	1	2	✗
Cancer 31 day wait for second or subsequent treatment – surgery (Apr 16 to Mar 17)	94%	97.9%	100%	✓
Cancer 31 day wait for second or subsequent treatment – anti cancer drug treatments (Apr 16 – Mar 17)	98%	99.9%	100%	✓
Cancer 31 day wait for second or subsequent treatment – radiotherapy	94%	N/A	N/A	N/A
Cancer 62 Day Waits for first treatment (urgent GP referral for suspected cancer) (Apr 16 – Mar 17)	85%	86.4%	82.19%	✓
Cancer 62 Day Waits for first treatment (from NHS cancer screening service referral) (Apr 16 – Mar 17)	90%	96.9%	96.43%	✓
Cancer 31 day wait from diagnosis to first treatment (Apr 16 – Mar 17)	96%	99.7%	99.04%	✓
Cancer 2 week wait from referral to date first seen, all urgent referrals (cancer suspected) (Apr 16 – Mar 17)	93%	94.3%	93.03%	✓
Cancer 2 week wait from referral to date first seen, symptomatic breast patients (cancer not initially suspected) (Apr 16 – Mar 17)	93%	96.9%	93.61%	✓
Maximum time of 18 weeks from point of referral to treatment in aggregate, patients on incomplete pathways (Apr 16 – Mar17)	92%	Ⓜ 92.91%**	92.21%	✓
Referral to Treatment 52 Week Waits	0%	0	0	✓
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge (April 16 – Mar 17)	95%	Ⓜ 94.23%	94.60%	✗
Community care data completeness – referral to treatment information completeness (Mar 17)	50%	97.45%	95.38%	✓
Community care data completeness – referral information completeness (Mar 17)	50%	95.88%	93.40%	✓
Community care data completeness – activity information completeness (Mar 17)	50%	95.95%	93.66%	✓
Community care data completeness – patient identifier information completeness (Shadow Monitoring) (Mar 17)	50%	95.95%	93.66%	✓

Monitor Compliance Framework Indicators	2016-17 Target	2016-17 Performance	2015-16 Performance	Achieved (cumulative)
Community care data completeness – End of life patients deaths at home information completeness (Shadow Monitoring) (Mar 17)	50%	86.62%	88.64%	✓
Compliance with access to healthcare for patients with learning disabilities	100%	Full compliance	Full compliance	✓
Other National and Contract Indicators	2015-16 Target	2015-16 Performance	2014/15 Performance	Achieved
Cancelled Procedures for non-medical reasons on the day of op (Apr 16 to Mar 17)	0.80%	0.54%	0.44%	✓
Cancelled Procedures reappointed within 28 days (Apr 16 to Mar 17)	100%	99.08%	96.91%	✗
Eliminating Mixed Sex Accommodation (Apr 16 to Mar 17)	Zero cases	0	0	✓
A&E Trolley waits > 12 hours (Apr 16 to Mar 17)	Zero cases	0	0	✓
Choose and Book slot issues (Jan 17)	<4%	1.60%	No data	✓
Stroke - 90% of time on dedicated Stroke unit (Apr 16 – Mar 17)	80%	91.69%	87%	✓
Stroke - TIA assessment within 24 hours (Apr 16 – Mar 17)	75%	90.20%	82%	✓
Delayed transfers of care (Apr 16 – Mar 17)	<3.5%	4.11%	1.63%	✗
Number of Diagnostic waiters over 6 weeks (Apr – Mar 17)	99%	99.41%	99.65%	✓
Retinal Screening - offered an appointment within 48 hours (March 17)	95%	99.75%	92.91%	✓
VTE Risk Assessment (Apr 16 - Mar 17)	95%	97.09%	95.57%	✓

* Retinal Screening can have more than 1 offer per patient; therefore can be greater than 100%

** The indicator percentage has been restated following external assurance procedures from 92.75% to 92.91%.

Additional Assurance:

A The following indicators for 2016-17 have been subject to limited assurance procedures by the independent auditors PricewaterhouseCoopers LLP:

Further assurance indicators	Definition
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period ("incomplete pathways indicator")	<p>The Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report:</p> <ul style="list-style-type: none"> 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 2016 to March 2017; 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.
Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge ("4 hour A&E waiting times indicator")	<p>The Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report:</p> <ul style="list-style-type: none"> The indicator is defined within the technical definitions that accompany Everyone counts: planning for patients 2014/15 - 2018/19 and can be found at www.england.nhs.uk/wp-content/uploads/2014/01/ec-tech-def-1415-1819.pdf Detailed rules and guidance for measuring A&E attendances and emergency admissions can be found at https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/03/AE-Attendances-Emergency-Definitions-v2.0-Final.pdf with the exception of the following: <ul style="list-style-type: none"> For ambulance arrivals, the Trust always records the arrival time at the point of hand over from the Ambulance Trust.

Annex A: Third party declarations

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

Collaborative statement from NHS Hartlepool and Stockton-On-Tees Clinical Commissioning Group (HAST) and Durham, Dales, Easington and Sedgefield (DDES) Clinical Commissioning Group, for NHS North Tees and Hartlepool Hospital Foundation Trust (NTHFT) Quality Account 2016-17– 03 May 2017

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 2016-17. The CCGs would like to provide the following statement.

The quality of services delivered and associated performance measures are the subject of discussion and challenge at the Clinical Quality Review Group (CQRG) meetings. These provide an opportunity for CCGs and Trust to gain assurance that the systems and processes in place to promote the delivery of safe, effective and high quality care are effective. We are happy to see that Quality remains the Trust's number one priority for 2017/18 and it is reassuring to see that the priorities identified for 2017/18 are also reflective of the CCG's priorities.

We are pleased that the Chief Executive's overview to the Quality Account emphasises the important contribution of the Trust's staff and other stakeholders, in working together to achieve high performance and good outcomes for patients across the Trust. It is also encouraging to see that number of staff have been formally recognised for their contributions to patient care.

The CCG's notes the improvements which the Trust has made during the year following the CQC inspection in July 2015 and subsequent actions implemented during 2016. The CCG's will continue to support and collaborate with the Trust to ensure that changes are made to support delivery of the improvements identified.

The CCGs acknowledge that mortality performance is demonstrating signs of improvement and recognises the hard work the Trust has undertaken to improve these metrics; in particular the work to improve governance arrangements in relation to mortality reviews; workshops and developmental work underway on end of life pathway improvements in collaboration with Primary Care and CCG colleagues. The CCGs will continue to provide robust scrutiny and challenge in relation to this during 2017-18 and will work with the Trust to identify opportunities for shared learning across the health economy.

The CCG's are very pleased to see the continued focus on improving care for people with dementia. The Trust has demonstrated important improvements in dementia care and is to be commended on the work undertaken to improve screening rates and referrals onwards into specialist services such as memory services and delirium management.

The CCGs are pleased to see a positive focus on Health Care Associated Infection (HCAI) in the report and the continuation of HCAI as a priority patient safety focus is welcomed. We acknowledge the challenging target for Clostridium Difficile infection, however, it is disappointing to see that the rates of Trust attributed Clostridium difficile cases has increased during 2015-16 and 2016-17. The CCG supports this priority and will continue to work collaboratively with the Trust in the delivery of this quality priority.

The CCGs welcome improving discharge continues to be a priority focus for 2017/18 with particular reference to medications. It is acknowledged that the Trust has undertaken a number of improvements to support improved medication practices across the Trust.

During 2016-17 the Trust has also made a number of advances in the robustness of the Safety, Quality and Infections dashboard replacing the previous Nursing and Midwifery Dashboard. It is noted that good progress has been made with the data which is now collected and trends and themes are clearly visible. The CCGs look forward to the further development of this clinical monitoring to inform improvements to patient safety and outcomes.

It is encouraging to see that there is to be a continued commitment to Care for the Dying Patient and embedding use of the Family's Voice both in hospital and community settings, and that the number of patients being seen by the Specialist Palliative Care Team are continuing to increase year on year. The continued focus on this area of care and improvements to the Trust based Palliative Care register including the establishment of links to the electronic care system for ease of identification are all positive improvements in care coordination. We also note the Trust's involvement in national surveys and local clinical audits and the continued focus on Patient Surveys and Friends and Family recommendations for 2017/18. The CCGs would have liked to have seen some specific actions identified to improve the Friends and Family response rates which have remained below the England average across 2016-17.

The CCGs are pleased to note that the Trust continues to be committed to the national 'Sign up to Safety' campaign and as a result of incident reporting and analysis was able to inform improvements and themes which were shared across the Trust during a Patient Safety week held in September 2016.

Never Events are Serious Incidents (SIs) which are wholly preventable with appropriate procedures in place. We are pleased to see that this is identified as an additional priority area following the Trust's one Never Event reported in 2016-17. Is it reassuring to see that the Trust has identified that improvements were required to the use of the 'WHO' checklist as learning from this Never Event. The CCG's look forward to seeing the outputs of this learning demonstrated in improved systems to promote the quality and safety of care across other areas of the Trust to prevent such a reoccurrence.

We look forward to continuing to work in partnership with the Trust in delivering high quality effective care for patients.

Yours sincerely

Ali Wilson
Chief Officer
NHS Hartlepool and Stockton-on-Tees CCG

Gillian Findley
Director of Nursing, Patient Safety and Quality
NHS Durham, Dales, Easington and Sedgefield CCG

Hartlepool Healthwatch – 02 May 2017

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. 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 the addressing our concerns regarding the safe handling of medication given the Trust has had highest recorded incidents albeit Healthwatch welcome the appointment of an associated safety officer. On-going concern must also be raised with regards to discharge and would hope the safeguarding alerts in respect of discharge could be improved as a matter of urgency. Healthwatch would also welcome robust information confirming patients are being allowed to die in their place of choice.

We welcome the reduction in mortality rates as this has been of great concern to Healthwatch Hartlepool over recent years and would hope this could improve further. Other areas Healthwatch would welcome further input would be in respect of Medical Care, where improvement is required in four of the six domains and also Maternity Services. Members have raised concern that expectant mothers are not being given the full choice of births as advertised by the Trust and are encouraged to utilise the North Tees site to the detriment of Hartlepool, given the national trend is to move Maternity to midwifery led units. Accessibility and the current transport provision continues to concern Healthwatch. The Trust are failing to adhere to the Equality Act 2010 and the patient cannot be priority if a preferential booking system is operated for staff.

Healthwatch have had a meaningful relationship with the Trust over the last year and welcomed our inclusion within the Quality Standards Steering Group, especially our ability to respond to the NICE guidelines in respect of 'Care for the Dying'. 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.

Yours Faithfully,

Margaret Wrenn – Chair HealthWatch Hartlepool

Stockton Healthwatch – 27 April 2017

Healthwatch Stockton-on-Tees 3rd Party Declaration 2016-17

'Healthwatch Stockton-on-Tees acknowledges the progress made by the Trust across a wide area of Quality Improvement Priorities, and the outcomes of the CQC inspection and the subsequent information published. Some of the areas identified for further improvement and investigation reflect similar results found by Healthwatch Stockton-on-Tees in its own investigations. It is felt that a brief summary of activity in each speciality would be beneficial, such as numbers attending Accident and Emergency and numbers of specific operations, for example hip replacements. It is also noted that others choose the priorities each year but the same priorities arise and many other important issues are perhaps neglected. There remain a number of areas for further improvement, such as discharge arrangements, identification of those with dementia and outpatient services. The Trust have welcomed support from Healthwatch in its future work'.

Statement from Adult Services and Health Select Committee, Stockton-on-Tees BC – 28 April 2017

The Committee again welcomes the opportunity to consider and comment on the quality of services at the Trust. The Committee has met twice with Trust representatives to consider the Quality priorities and overall performance. This year there has also been discussion on the Trust's new Clinical Services Strategy, and the Committee monitored the development of the new Urgent Care service which the Trust will now be providing in partnership.

The Trust's Quality Priorities have been broadly similar for several years. This brings the benefit of being able to track and embed improvements over a longer period of time, but the Committee wanted to check that no other high priority issues were being missed. Members were informed that although the Trust selected their priorities purely on the basis of feedback from stakeholders including the Committee, the Trust's priorities were also supported by the Trust's clinicians. The Trust may want to give further consideration to the process of selecting priorities to secure greater engagement from stakeholders.

Members have been pleased to observe the improving **mortality data**. The latest data available to the Committee on both the HSMR and SHMI indicators showed that the Trust was now in the 'as expected' range. This is a significant improvement on the figures previously reported to the Committee and Members hope to consider further improvements next year. The Committee recognises the significant, clinically-led work that has gone into improving the mortality figures, and it was noted that the Trust intends to widen the focus of this work to better understand the impact of conditions such as sepsis and kidney injury.

The priority on **Infections** was re-introduced with the Committee's support in 2016-17 following the increase cases of C. Difficile. Whilst recognising the challenging nature of the Trust's target, the levels of infections (including E coli) remains of concern.

The Committee was pleased to see evidence of the C.diff Improvement Plan, and received assurance that the Trust is working with NHS Improvement, NHS England and also commissioners to further review what steps can be taken.

Discharge arrangements have again been an area of interest for the Committee. The Committee has considered two reports from Healthwatch: the operation of the Discharge Lounge, and the arrangements for discharge into Rosedale. These highlighted the wider issues around ensuring a safe and timely discharge for all patients.

Members have been informed of a range of work being undertaken to improve services and improve medication and communication issues, and reduce the number of discharge incidents.

The Trust and local authorities have been working together through the development of a new Integrated Discharge Team, the 100 Day Challenge, and the aim of moving towards discharge taking place on a seven-day basis. The Committee will be keen to see evidence in future Quality Reports on the impact of this work.

Specifically in relation to the Discharge Lounge, following the concerns raised by Healthwatch the Committee wrote to the Trust to seek further information. The Committee has since been pleased to see the improvements planned and introduced over the previous 12 months. Although it was clear that staff were already working hard, a new approach to the Lounge should greatly improve the experience for patients, including an improved environment and facilities, a move towards a pharmacy-led approach, increased use of volunteers to engage with patients and collect medication, and the provision of food parcels for those who need them.

The information on **Dementia** would benefit from further detail on work done relating to delirium.

The Trust was within the 'expected limits' for **stroke** mortality during 2015-16, however the Committee was concerned to see media reports of delayed scans for patients with suspected stroke. The Trust instituted a new policy from November 2016 that will see CT scanning for relevant patients take place within one hour, and consideration was being given to improving staffing levels in the Stroke Unit.

The Committee requested further information on this and were pleased to see consistent improvement since November 2016; the new one hour standard was being met in 67% of cases in January and 80% of cases in February. The Committee would request to see further information on this during 2017-18 and the Trust may wish to include further information on stroke services in the 2017-18 Quality Report.

A key event last year was the publication of the **CQC Inspection Report** with the overall rating of Requires Improvement. During 16-17 the Committee noted that the Action Plan to address identified issues was progressing well, and the CQC had reduced its monitoring contacts from two-monthly to quarterly. At the time of compiling this Statement (April 2017), the Trust was within the timescale for a re-inspection and the Committee will consider the results in due course.

An on-going issue in the NHS as a whole is the **recruitment and retention of staff**. The Committee is fully aware that the region in particular faces challenges in retaining its clinical workforce.

The Committee was therefore pleased to see that the Trust received positive feedback from the latest GMC trainee survey, with the Trust placed highest in the country for surgery.

We would suggest that the Trust revises its approach to reporting on **safeguarding** issues. This information (and the section relevant to Looked After Children) is currently summarised within the information on the priority Safeguarding Adults with Learning Disabilities. It would be appropriate to provide more information specifically in relation to progress on that priority and care for people with learning disabilities, and include a separate section on safeguarding/LAC as a whole.

Improvements to the text could include: ensuring all terminology is Care Act compliant, separating out the safeguarding statistics into the three local authority areas (reflecting the lead role of Local Authorities), separating out the information on Concerns and Enquiries, and greater analysis to balance out the focus on compliance.

We again encourage the Trust to ensure the **published version is as accessible as possible**, including consideration of best practice, and that summary / easy-read versions are produced.

The Trusts Council of Governors – 28 April 2017

Council of Governors

(Third party declaration)

On behalf of the Council of Governors, members of the Quality Account Working Group confirm that Governors have been involved in the preparation of the Trust's Annual Quality Account and have been briefed throughout 2016-17 in respect of specific aspects of its content regarding performance.

A successful market place event was held on 14 December 2016 to obtain the views from Governors and key stakeholders, in relation to the Quality Account and to help define the key priority areas to be included for the forthcoming year. The role of the Governor Quality Accounts Working Group is to act on behalf of the Council of Governors in reviewing the draft Annual Quality Account, providing challenge and seeking assurance regarding its content, in addition to making constructive comments in respect of design, layout and language.

In order to ensure the Council of Governors are kept fully informed and briefed on priority areas and key issues of interest, development and information sessions have been facilitated throughout the course of the year. Topics that have been covered in these development sessions included: Sustainability and Transformation Plan; Clinical Services Strategy; Annual Operational Plan; Business Planning; Mortality; Cancer Services; Digital Strategy: Quality an on-going process in respect to recommendations following the Care Quality Commission Inspection and subsequent report in 2015-16. The sessions allowed a detailed review of important issues and provided assurance to Governors regarding work being undertaken in these areas.

Regular reports presented to the Council of Governors highlight the performance, compliance and quality of the services provided by the Trust against the range of indicators and targets that are measured by NHS Improvement and the Care Quality Commission. The reports ensure that the Governors are appraised of the valuable improvements being made to patient care and pathways, including the work surrounding the Corporate Strategy and Clinical Services Strategy, as well as being aware of the challenges that the Trust faces on an on-going basis. The reports also keep Governors updated on any areas of quality which may warrant improvement actions. The past year has been very challenging for the health service within a national context of rising demand for services, increased performance standards and continued financial pressures. The Trust has risen well to the challenges and ensured quality remains the top priority; the meetings provide an opportunity for the Governors to review recent performance and seek assurance on actions, openly challenge the Board of Directors and raise any concerns.

The programme of Governor Sub-committees continued throughout 2016-17, which includes: Nominations Committee; Travel and Transport Committee; Membership Strategy Committee, and Strategy and Service Development Committee, and provide the opportunity for detailed debate and discussion regarding key topics, allowing the Governors to take an active part in shaping Trust strategies.

The Strategy and Service Development Committee's remit is to keep Governors updated regarding service developments and future vision. Presentations included: Trust's Corporate Strategy; Outpatient Services; Clinical Services Strategy; Research and Development; Action on Accident and Emergency Services; and update on actions from the Care Quality Commission Inspection in 2015.

Governors have also been assisting with the recruitment and engagement of new members, and the development of a membership strategy and action plan that looks at on-going recruitment and retention of membership numbers overall with a wider representation from the communities served. Governors are involved in a number of other groups; the Menu Review Group, Patient Information Evaluation Group and the Healthcare User Group, and ad-hoc working groups covering a range of topics and service issues.

Governors are invited to take part in the Staff, Patient Experience, Quality and Standards (SPEQS) panels, which include senior nursing staff and are led by the Director of Nursing, Patient Safety & Quality. They provide the opportunity for panel members to visit clinical areas and speak directly with patients, visitors and staff about their experiences at the Trust. The panel reviews the standards of care given to our patients both in hospital and the community, and allows Governors to witness this first hand. The process was updated in 2016 to provide more in-depth scrutiny and now utilises the five Care Quality Commission domains of Safe, Effective, Caring, Responsive and Well-Led. Reports and feedback from the visits are shared at every Council of Governors meeting.

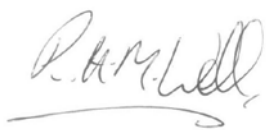
Hartlepool Borough Council – Audit and Governance Committee – 27 April 2017

Hartlepool Borough Council's Audit and Governance Committee on the 16th February 2017 received an update on the North Tees and Hartlepool NHS Foundation Trust's Quality Account for 2016-17. The Committee focussed on two areas within the Quality Account and made the following comments for inclusion in the Committee's Third Party Declaration:-

(a) Data was provided to the Committee on the Friends and Family Tests undertaken which showed that 93.94% of those who had undertaken the test would recommend the Trust to others with 1.49% who would not. Members were informed that the Friends and Family survey was given to all patients on wards and those attending Accident and Emergency. If a patient was unable to complete the survey, a friend or relative would be asked to complete it on their behalf. A number of people in attendance at the meeting commented that they had not received a questionnaire to complete; despite a number of attendances at hospital, and that questionnaires were not readily available in locations around the hospital. The Committee was informed that a Trust representative would investigate these concerns.

(b) Members were informed that, overall, over 30,000 responses had been received in response to the Friends and Family surveys. The Committee questioned how this figure equated to the total number of patients that attended the hospitals. Members were informed that the percentage of completed surveys was low in comparison to the overall numbers; this was because some people did not complete the surveys, particularly, regarding maternity services, as people were asked the same questions several times throughout their pregnancy. Therefore, the Trust was looking at alternative ways of gathering the information.

The Committee welcome the information that is shared with them regarding the Quality Account and hope that this continues throughout the 2017-18 Municipal Year.



Councillor Ray Martin-Wells

Chair of the Audit and Governance Committee

Healthcare User Group (HUG) – 27 April 2017

Third Party Statement from the 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. We achieve this through independent visits to inpatient wards and outpatient clinics, talking to staff and patients, reporting our findings to staff and senior management. HUG is also represented on a number of Trust committees including the Audit & Clinical Effectiveness Group (ACE), Quality Standards Steering Group (QSSG), Discharge Steering Group, Infection Control Committee (ICC) and Patient Quality & Safety Standards Group (PS & QS). A HUG representative also attends the Trust Board.

We have reviewed the Quality Accounts for 2016/2017 and conclude that they are representative of the findings from our visits and discussions with patients and staff.

The significant improvement in mortality rates is pleasing and reflects the processes in place to aid the reduction of mortality within the Trust. The work carried out by the Trust in providing for end of life care for the dying patient is a continuation of the emphasis on providing and improving patient experience and quality of care.

The emphasis on Patient Safety continues within the Trust, and we have observed this during our visits to various wards, especially relating to dementia and safeguarding adults and children with learning difficulties. We have noted the focus on staff training, and screening and referral of dementia patients. There has been emphasis on addressing PREVENT within the adult safeguarding portfolio and we acknowledge the training of staff and the processes in place to identify good practice and communications.

Whilst the Trust failed to meet the very challenging clostridium difficile target, we know that stringent efforts have been made by staff to mitigate these infections and the on-going development of the Trust improvement plan, together with other initiatives, can help to control the number of cases.

The Trust continues to allow HUG to fulfil its function and we acknowledge the support from staff and the contribution they have made in achieving the high performance to provide good outcomes for patients.

HUG supports the priorities selected for 2017/18 and as a stakeholder, has had the opportunity to influence these priorities.

Bill Johnson.
Healthcare User Group
April 2017

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.

NHS Improvement has issued guidance to NHS foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) 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 2016-17 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 2016 to April 2017
 - papers relating to Quality reported to the Board over the period April 2016 to April 2017
 - collaborative feedback from NHS Hartlepool and Stockton-On-Tees Clinical Commissioning Group (HAST) and Durham, Dales, Easington and Sedgfield (DDES) Clinical Commissioning Group dated 03 May 2017
 - feedback from governors dated 02 May 2017
 - feedback from local Hartlepool Healthwatch dated 02 May 2017
 - feedback from local Stockton Healthwatch dated 27 April 2017
 - feedback from Overview and Scrutiny Committee dated 28 April 2017
 - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated Q3 2016-17
 - the latest national patient survey 2016
 - the latest national staff survey 2016
 - the Head of Internal Audit's annual opinion over the Trust's control environment dated May 2017
 - CQC Quality Report – Inspection Report 03 February 2016
- 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 NHS Improvements annual reporting guidance (which incorporates the Quality Accounts Regulations) as well as the standards to support data quality for the preparation of the quality report

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

By order of the Board

Date 31 May 2017

Chief Executive.....



Date 31 May 2017

Chairman.....



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

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 2017 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance (the "specified indicators") marked with the symbol **A** in the Quality Report, consist of the following national priority indicators as mandated by Monitor:

<i>Specified Indicators</i>	<i>Specified indicators criteria</i>
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period ("incomplete pathways indicator")	Page 107 - 108
Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge ("A&E four hour indicator")	Page 107 - 108

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 for foundation trusts 2016/17" issued by Monitor (operating as NHS Improvement) ("NHSI").

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 the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2016/17";
- 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 set out in the FT ARM and the "Detailed requirements for external assurance for quality reports for foundation trusts 2016/17".

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2016/17"; 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 and papers for the period April 2016 to April 2017;
- Papers relating to Quality reported to the Board over the period April 2016 to April 2017;
- Collaborative feedback from NHS Hartlepool and Stockton-On-Tees Clinical Commissioning Group (HAST) and Durham, Dales, Easington and Sedgfield (DDES) Clinical Commissioning Group dated 03 May 2017;
- Feedback from governors dated 27 April 2017;
- Feedback from local Hartlepool Healthwatch dated 02 May 2017;
- Feedback from local Stockton Healthwatch dated 27 April 2017;
- Feedback from Overview and Scrutiny Committee dated 28 April 2017;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated Q3 2016-17;
- The latest national patient survey 2015;
- The latest national staff survey 2016;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated May 2017; and
- CQC Quality Report – Inspection Report 03 February 2016.

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.

Our Independence and Quality Control

We applied the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics, which includes independence and other requirements founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour. We apply International Standard on Quality Control (UK & Ireland) 1 and accordingly maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Use and distribution of the report

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 2017, 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 (Revised) 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000 (Revised)'). Our limited assurance procedures included:

- reviewing the content of the Quality Report against the requirements of the FT ARM and the “Detailed requirements for quality reports for foundation trusts 2016/17”;
- 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 and "Detailed requirements for quality reports for foundation trusts 2016/17" and the Criteria referred to above.

The nature, form and content required of Quality Reports are determined by NHSI. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

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.

Basis for Qualified Conclusion - Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

NHS England's definition for "the Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge" specifies that the clock start time for patients arriving by ambulance is when hand over occurs, or 15 minutes after the ambulance arrives at A&E, whichever is earlier.

Although the Trust receives data from the Ambulance Trust, the Trust always records the arrival time at the point of hand over from the Ambulance Trust, rather than when hand over occurs or 15 minutes after the ambulance arrives at A&E.

Ambulance arrivals made up 24% of the total indicator population North Tees and Hartlepool NHS Foundation Trust during 2016/17. Based upon monthly summary data received from the Ambulance Trust showing the percentage of handovers which occurred within 15 minutes, the Trust have calculated the maximum impact of not using Ambulance Trust data in relation to handover time to be 0.28% of the

total indicator population. Based on this calculation the Trust have assessed that the maximum impact on reported performance would be to decrease reported performance from 94.23% to 93.95%.

Conclusion

Based on the results of our procedures, except for the matter described in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that for the year ended 31 March 2017:

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2016/17";
- 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 set out in the FT ARM and the "Detailed requirements for external assurance for quality reports for foundation trusts 2016/17".

PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP

Newcastle upon Tyne

31 May 2017

The maintenance and integrity of the North Tees and Hartlepool NHS Foundation Trust's 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 & 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 & 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**

Glossary

A&E	Accident and Emergency
ACE Committee	Audit and Clinical Effectiveness Committee – the committee that oversees both clinical audit (i.e. monitoring compliance with agreed standards of care) and clinical effectiveness (i.e. ensuring clinical services implement the most up-to-date clinical guidelines)
ACL	Anterior Cruciate Ligament – one of the four major ligaments of the knee
AMT	Abbreviated Mental Test
AquaA	Advancing Quality Alliance
CABG	Coronary Artery Bypass Graft (or “heart bypass”)
CFDP	Care For the Dying Patient
CCG	Clinical Commissioning Group
CDI	Clostridium difficile Infection
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
DLT	Discharge Liaison Team
DoLS	Deprivation of Liberty Safeguards
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
FGM	Female Genital Mutilation
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 (A major provider of healthcare information and benchmarking)
HEE	Health Education England
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
IPB	Integrated Professional 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
LAC	Looked After Children
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
MIU	Minor Injuries Unit
MINAP	The Myocardial Ischaemia National Audit Project
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
NEEP	North East Escalation Plan
NEPHO	North East Public Health Observatory
NEQOS	North East Quality Observatory System
NEWS	National Early Warning Score
NHS Improvements	The independent regulator of NHS foundation Trusts
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
NTHFT	North Tees and Hartlepool Foundation Trust
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
RAG	Red, Amber, Green chart denoting level of severity
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
SCMOoH	Senior Clinical Matron Out-of-Hours
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
SPEQS	Staff, Patient Experience and Quality Standards
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
STEIS	Strategic Executive Information System
STERLING	Environmental Audit Assessment Tool
TRAKCARE	Electronic Patient Record System
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

UNIFY	Unify2 is an online collection system used for collating, sharing and reporting NHS and social care data.
UHNT	University Hospital of North Tees
VENT	Vulnerable, exploited, missing, trafficked
VSGBI	The Vascular Society of Great Britain and Ireland
VTE	Venous Thromboembolism
WRAP	Workshop to Raise Awareness of PREVENT
WTE	Whole Time Equivalent - is a unit that indicates the workload of an employed person in a way that makes workloads or class loads comparable

AUDIT AND GOVERNANCE COMMITTEE

14 February 2018



Report of: SCRUTINY MANAGER

Subject: NORTH EAST AMBULANCE SERVICE NHS
FOUNDATION TRUST – QUALITY ACCOUNT
2017/18 – COVERING REPORT

1. PURPOSE OF REPORT

1.1 To:

- i) Introduce representatives from the North East Ambulance Service NHS Foundation Trust who will be in attendance at today's meeting to assist and inform discussions in relation to the Trust's Quality Accounts for 2017/18; and
- ii) Seek views / comments from the Audit and Governance Committee on the Quality Accounts to be included within the third party declaration being prepared by the North East Joint Health Scrutiny Committee

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 North East Ambulance Service NHS Foundation Trust's Quality Accounts have been considered annually by the North East Joint Health Scrutiny Committee, as the Joint Committee covers a large proportion of the population served by the Trust. The North East Joint Health Scrutiny Committee, will be receiving a presentation from the North East Ambulance Service regarding their Quality Accounts. Following the presentation, the Committee will utilise comments and views from the Joint Committee and individual scrutiny committees across the region to formulate the Joint Committee's third party declaration.

- 2.3 A presentation will be given at today's meeting by representatives from the North East Ambulance Service NHS Foundation Trust. The representatives present at today's meeting 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 which will be utilised in conjunction with the draft version of the Quality Accounts (2017/18), timetabled for April 2018, to be included within the third party declaration being prepared by the North East Joint Health Scrutiny Committee.
- 2.4 Given the timescale for the development and submission of the declaration, following today's presentation approval is sought for the finalisation of the Committee's views and comments to be delegated to the Chair of the Committee in consultation with the Statutory Scrutiny Officer.

3. RECOMMENDATIONS

- 3.1 That the Audit and Governance Committee:-
- (i) Consider the presentation, seeking clarification on any issues from the representatives from the North East Ambulance Service NHS Foundation Trust present at today's meeting;
 - (ii) Formulate views and comments on the information presented at today's meeting, which will be included within the third party declaration being prepared by the North East Joint Health Scrutiny Committee; and
 - (iii) Delegate finalisation of the views and comments to the Chair of the Committee in consultation with the Statutory Scrutiny Officer

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

BACKGROUND PAPERS

No background papers were used in the preparation of this report.

Audit and Governance Committee

14 February 2018



Report of: Scrutiny Manager

Subject: TEES, ESK AND WEAR VALLEYS NHS
FOUNDATION TRUST – QUALITY ACCOUNT
2017/18 – COVERING REPORT

1. PURPOSE OF REPORT

1.1 To:

- i) Introduce representatives from Tees, Esk and Wear Valleys NHS Foundation Trust who will be in attendance at today's meeting to assist and inform discussions in relation to the Trust's Quality Accounts for 2017/18; and
- ii) Seek views / comments from the Committee on the Quality Accounts to be included within the third party declaration being prepared by the Tees Valley Joint Health Scrutiny Committee.

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 Tees, Esk and Wear Valleys NHS Foundation Trust's Quality Accounts have been considered annually by the Tees Valley Joint Health Scrutiny Committee, as the Joint Committee covers a large proportion of the population served by the Trust. Last year, each of the Tees Valley Local Authorities contributed to the preparation of the Joint Committee's third party declaration.

- 2.3 A presentation will be given at today's meeting by representatives from Tees, Esk and Wear Valleys NHS Foundation Trust. The representatives present at today's meeting 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 which will be utilised in conjunction with the draft version of the Quality Accounts (2017/18), timetabled for April 2018, to be included within the third party declaration being prepared by the Tees Valley Joint Health Scrutiny Committee.
- 2.4 Given the timescale for the development and submission of the declaration, following today's presentation approval is sought for the finalisation of the Committee's views and comments to be delegated to the Chair of the Committee in consultation with the Statutory Scrutiny Officer.

3. RECOMMENDATIONS

3.1 That the Audit and Governance Committee:-

- (i) Consider the presentation, seeking clarification on any issues from the representatives from Tees, Esk and Wear Valleys NHS Foundation Trust present at today's meeting;
- (ii) Formulate views and comments on the information presented at today's meeting, which will be included within the third party declaration being prepared by the Tees Valley Joint Health Scrutiny Committee; and
- (iii) Delegate finalisation of the views and comments to the Chair of the Committee in consultation with the Statutory Scrutiny Officer.

Contact Officer:- Joan Stevens – Statutory Scrutiny Officer
Chief Executive's Department – Legal Services
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BACKGROUND PAPERS

No background papers were used in the preparation of this report.

AUDIT AND GOVERNANCE COMMITTEE

14 February 2018



Report of: Scrutiny Manager

Subject: SIX MONTHLY MONITORING OF AGREED
SCRUTINY RECOMMENDATIONS

1. PURPOSE OF REPORT

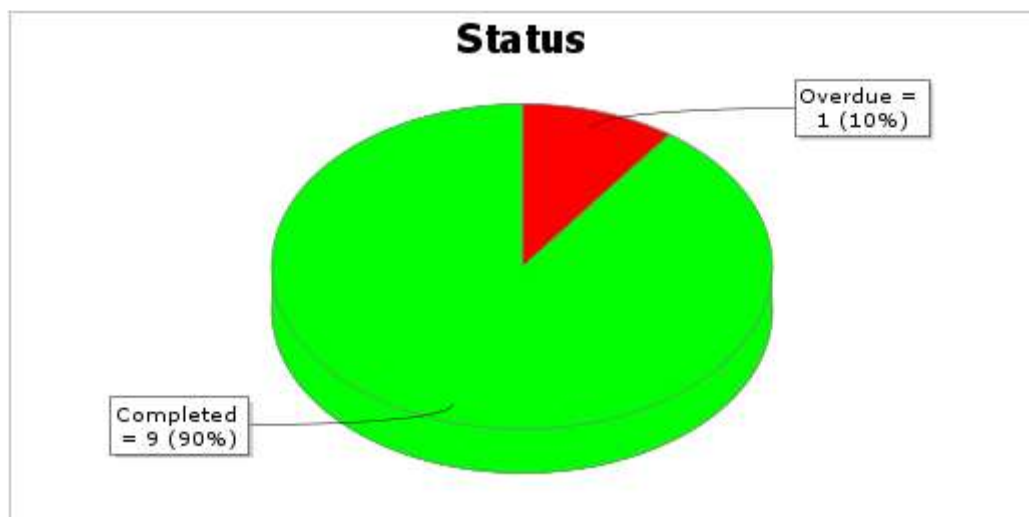
- 1.1 To provide Members with the six monthly progress made on the delivery of scrutiny recommendations that fall within the remit of this Committee.

2. BACKGROUND INFORMATION

- 2.1 This report provides details of progress made against the investigations undertaken by this Committee in the 2014/15 and 2015/16 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 October 2017.


Audit and Governance Committee - Health and Crime and Disorder

Generated on: 19 January 2018



Year 2014/15 Investigation CVD

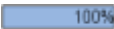
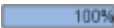
Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress
SCR-HS/3a/i That CVD provision commissioned by HBC be reviewed to ensure that it is effectively joined up and integrated to take advantage of the opportunities across service areas, with regard	SCR-HS/3a/i Ensure future CVD provision is considered as part of future developments across all service areas, including BCF.	Louise Wallace	31-Mar-2017	31-Mar-2017	14-Sep-2017 As the current service provision of healthy heart checks is under review it is suggested that future development across service areas wait until the review is complete	<div> <div></div> <div>0% Overdue</div> </div>




Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress
to the work being undertaken in relation to the BCF; SCR-HS/3a/iIt is effectively joined up and integrated to take advantage of the opportunities across service areas, with due regard to the wider piece of work being undertaken in relation to the Better Care Fund;						
SCR-HS/3a/ii That community provision for the delivery of Healthy Heart Checks is developed and the use of community buildings, such as community centres and libraries be explored to improve accessibility and sustainability of services and facilities	SCR-HS/3a/ii Ensure Health Check delivery is integrated into the proposed model for community hubs and is better aligned with existing health and social care services in the community.	Louise Wallace	31-Mar-2017	31-Mar-2017	14-Sep-2017 In addition to provision of healthy heart checks in GP practice we continue to commission healthy heart checks in the community through the nurse bank as in the past, but now hosted by Redcar and Cleveland Council. The first delivery of checks in Community Hubs are scheduled for September, October and November 2017 – 2 days in each venue. All service providers in the hubs have been made aware of the checks in order to maximise appointments by raising awareness with own clients.	 Completed

Year 2015/16

Investigation Access to Transport for people with a disability

Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress
SCR-HS/4a/i That a mapping exercise be undertaken to explore the viability of a travel membership club for people with disabilities to access, as and when, with a exploration of the following areas, Identification of the actual number of people affected	SCR-HS/4a/i/i A consortium of local businessmen were considering the option of developing and investing in a local scheme to support local citizens, however following due diligence they concluded that there was little evidence to suggest it would be successful or cost neutral.	Neil Harrison	31-Jul-2017	31-Jul-2017	13-Jan-2017 Consortium agreed this was not a viable option. no further meetings planned	<div><div>100%</div></div> Completed
SCR-HS/4a/i That a mapping exercise be undertaken to explore the viability of a travel membership club for people with disabilities to access, as and when, with a exploration of the following areas, Identification of the actual number of people affected	SCR-HS/4a/i/ii One private provider is keen to purchase a vehicle has experience of transporting adults with a disability and is keen to use this experience to set up an alternative travel service.	Neil Harrison	31-Jul-2017	31-Jul-2017	13-Jan-2017 Update reported to adult services committee, provider intends to purchase vehicle.	<div><div>100%</div></div> Completed
SCR-HS/4a/i That a mapping exercise be undertaken to explore the viability of a travel membership club for people with disabilities to	SCR-HS/4a/i/iii Community Travel Clubs - Clubs can be established in geographical areas by a number of community groups, Transport Champions or Parish Councils ect to consider the travel needs of	Neil Harrison	31-Jul-2017	31-Jul-2017	25-Sep-2017 Pauls Travel have purchased 2 wheelchair accessible vehicles and set up a community travel club. 01-Sep-2017 An updated report was presented to adult services committee, presented information on the new Pauls Travel scheme, the uptake of	<div><div>100%</div></div> Completed

Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress
access, as and when, with a exploration of the following areas, Identification of the actual number of people affected		individuals within their community. The travel club will determine the needs of its members and the Local Authority can provide the service required.			volunteer drivers and the work of the North east talking travel network	
SCR-HS/4a/i That a mapping exercise be undertaken to explore the viability of a travel membership club for people with disabilities to access, as and when, with a exploration of the following areas, Identification of the actual number of people affected	SCR-HS/4a/i/iv	The Council Passenger Transport Service has a variety of vehicles available to support the scheme, ranging from 67 seat coaches, 33 seat bus and 17 seat minibuses, including vehicles suitable for those using mobility aids. These vehicles will be available to travel clubs outside of school travel times, evenings and weekends.	Neil Harrison	31-Jul-2017	31-Jul-2017	13-Jan-2017 information on community travel club is on the Hartlepool now website.  Completed
SCR-HS/4a/i That a mapping exercise be undertaken to explore the viability of a travel membership club for people with disabilities to access, as and when, with a exploration of the following areas, Identification of the actual number of people affected	SCR-HS/4a/i/v	The transport provision will be flexible and delivered on a demand lead basis across a varied geographical area. The cost of each journey will be predetermined and shared between the patrons using the service.	Neil Harrison	31-Jul-2017	31-Jul-2017	25-Sep-2017 Pauls Travel have purchased 2 wheelchair accessible vehicles and operate a community travel club. 01-Sep-2017 Paul's travel, presented information on the new community travel service at the Hartlepool Learning Disability Partnership Board. information relating to the costs of journeys etc where shared. Paul's Travel are looking to expand the service with the potential to purchase an additional vehicle if demand reflects this. An updated report was presented to Adult Services Committee in August 2017  Completed

Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress
SCR-HS/4a/i That a mapping exercise be undertaken to explore the viability of a travel membership club for people with disabilities to access, as and when, with a exploration of the following areas, Identification of the actual number of people affected	SCR-HS/4a/i/vi There is interest from a provider operating a Patient transport service in Durham (NHS-transport) has a number of vehicles and volunteer drivers, they are keen to explore options to extend into Hartlepool.	Neil Harrison	31-Jul-2017	31-Jul-2017	06-Nov-2017 information from adult services committee reported to CCG. 06-Nov-2017 Information on the service has been shared with committee members and NHS commissioners. There has been an increase in the number of volunteer drivers recruited in the area. At a previous adult services committee members of the public provided feedback to the CCG in respect of the Hospital to Home service, the CCG agreed to feed this back to transport providers with an aim to improve the service for the people of Hartlepool.	 Completed
SCR-HS/4b That the potential of accessing/expanding existing Charity run schemes in the region be explored.	SCR-HS/4b/i RSVP (Retired and Senior Volunteer Program) runs many driving schemes across the UK which provide free or low-cost door-to-door service for older or more vulnerable people.	Neil Harrison	31-Jul-2017	31-Jul-2017	04-May-2017 Details of regional volunteer driver and travel clubs have been uploaded onto the Hartlepool Now website 04-May-2017 -- enter new status update --	 Completed
SCR-HS/4b That the potential of accessing/expanding existing Charity run schemes in the region be explored.	SCR-HS/4b/ii NEAS - Ambulance Car Service Drivers (ACS) are volunteers who use their own vehicles to help with the transportation of patients to and from hospitals and clinics, thereby leaving ambulances free for emergencies and for patients too ill to travel by car. Over 150 volunteers helping out throughout the North	Neil Harrison	31-Jul-2017	31-Jul-2017	06-Nov-2017 Information on the challenges faced by people requiring hospital to home transport has been fed back to the CCG. 06-Nov-2017 Details of the service have been added to the Hartlepool Now Website. A North East talking travel network meeting was held at the CIL in Hartlepool. At a previous adult services committee the CCG were informed of the views of people accessing hospital to home transport provision.	 Completed

Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress
	East. Volunteers are not paid for their time, however they do receive out of pocket expenses for their mileage.					

3. RECOMMENDATIONS

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 25 October 2017.

6. CONTACT OFFICER

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AUDIT AND GOVERNANCE COMMITTEE

14th February 2018



Report of: Director of Regeneration and Neighbourhoods

Subject: SAFER HARTLEPOOL PARTNERSHIP
PERFORMANCE

1. PURPOSE OF REPORT

- 1.1 To provide an overview of Safer Hartlepool Partnership performance for Quarter 3 – October 2017 to December 2017 (inclusive).

2. BACKGROUND

- 2.1 The updated Community Safety Plan 2017-20 published in 2017 outlined the Safer Hartlepool Partnership strategic objectives, annual priorities and key performance indicators 2017-18.

3. PERFORMANCE REPORT

- 3.1 The report attached (**Appendix A**) provides an overview of Safer Hartlepool Partnership performance during Quarter 3, comparing current performance to the same time period in the previous year, where appropriate.
- 3.2 In line with reporting categories defined by the Office for National Statistics (ONS), recorded crime information is presented as:

Victim-based crime – All police-recorded crimes where there is a direct victim. This victim could be an individual, an organisation or corporate body. This category includes violent crimes directed at a particular individual or individuals, sexual offences, robbery, theft offences (including burglary and vehicle offences), criminal damage and arson.

Other crimes against society - All police-recorded crimes where there are no direct individual victims. This includes public disorder, drug offences, possession of weapons and other items, handling stolen goods and other miscellaneous offences committed against the state.

The rates for some crime types within this category could be increased by proactive police activity, for example searching people and finding them in possession of drugs or weapons

4. PROPOSALS

- 4.1 No options submitted for consideration other than the recommendations.

5. EQUALITY AND DIVERSITY CONSIDERATIONS

- 5.1 There are no equality of diversity implications.

6. SECTION 17

- 6.1 There are no Section 17 implications.

7. RECOMMENDATIONS

- 7.1 The Audit and Governance Committee note and comment on partnership performance in Quarter 3.

8. REASONS FOR RECOMMENDATIONS

- 8.1 The Audit and Governance Committee has within its responsibility to act as the Councils Crime and Disorder Committee and in doing so scrutinise the performance management of the Safer Hartlepool Partnership.

9. BACKGROUND PAPERS

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

Safer Hartlepool Partnership – Community Safety Plan 2017-20

10. CONTACT OFFICER

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Safer Hartlepool Partnership Performance Indicators – Quarter 3 - 2017/18Strategic Objective: Reduce Crime & Repeat Victimisation

Indicator Name	Baseline 2016/17	Local Directional Target 2017/18	Oct – Dec 2016	Current Position Oct – Dec 17	Actual Diff	% Diff
All Recorded Crime	9008	Reduce	2224	2734	510	23%
Domestic Burglary	330	Reduce	142	286	144	101%
Vehicle Crime	857	Reduce	190	381	191	101%
Shoplifting	1256	Reduce	298	353	55	18%
Local Violence	2147	Reduce	555	572	17	3%
Repeat Cases of Domestic Violence – MARAC	29%	Reduce	21%	50%	9	150%

Strategic Objective: Reduce the harm caused by Drugs and Alcohol

Indicator Name	Baseline 2016/17	Local Directional Target 2017/18	Oct – Dec 2016	Current Position Oct – Dec 17	Actual Diff	% Diff
Number of substance misusers going into effective treatment – Opiate	653	3% increase	644	633	-11	-2%
Proportion of substance misusers that successfully complete treatment - Opiate	4.1%	12%	5.9%	6.2%	0.3%	5%
Proportion of substance misusers who successfully complete treatment and represent back into treatment within 6 months of leaving treatment	25%	10%	33.3%	33%	-0.3%	0%
Reduction in the rate of alcohol related harm hospital admissions	148	Reduce	Data unavailable	Data unavailable		
Number of young people found in possession of alcohol	2	Reduce	2	0	-2	-100%

Strategic Objective: Create Confident, Cohesive and Safe Communities

Indicator Name	Baseline 2016/17	Local Directional Target 2017/18	Oct – Dec 2016	Current Position Oct – Dec 17	Actual Diff	% Diff
Anti-social Behaviour Incidents reported to the Police	7171	Reduce	1665	1662	-3	0%
Deliberate Fires	444	Reduce	135	99	-36	-27%
Criminal Damage to Dwellings	630	Reduce	156	168	12	8%
Hate Incidents	155	Increase	31	25	-6	-19%

Strategic Objective: Reduce Offending & Re-Offending

Indicator Name	Baseline 2016/17	Local Directional Target 2017/18	Oct – Dec 2016	Current Position Oct – Dec 17	Actual Diff	% Diff
Re-offending rate of young offenders*	Data not published yet	Reduce	Data not available	Data not available		
First-Time Entrants to the Criminal Justice System	40	Reduce	13	4	-9	-69%
Offences committed by Prolific & Priority Offenders	286	Reduce	54	33	-21	-39%
Number of Troubled Families engaged with	530	769	420	662	242	58%
Number of Troubled Families where results have been claimed	210	368	112	330	218	195%

* Re-offending figure is based on Cohort tracking – new cohort starts every quarter and this cohort (i.e. of Young Persons) is then tracked for a period of 12 months. Example: Jul 2013 to Jun 2014 and tracked until end of Jun2015

Recorded Crime in Hartlepool October 17 – December 2017**Victim-based crime**

All police-recorded crimes where there is a direct victim. This victim could be an individual, an organisation or corporate body. This category includes violent crimes directed at a particular individual or individuals, sexual offences, robbery, theft offences (including burglary and vehicle offences), criminal damage and arson.

Publicly Reported Crime (Victim Based Crime)				
Crime Category/Type	Oct 16 - Dec 16	Oct 17 – Dec 17	Change	% Change
Violence against the person	555	572	17	3%
Homicide	1	0	-1	-100%
Violence with injury	229	226	-3	-1%
Violence without injury	325	346	21	6%
Sexual Offences	58	57	-1	-2%
Rape	21	19	-2	-10%
Other Sexual Offences	37	38	1	3%
Robbery	15	24	9	60%
Business Robbery	2	4	2	100%
Personal Robbery	13	20	7	54%
Acquisitive Crime	991	1502	511	52%
Domestic Burglary	142	286	144	101%
Other Burglary	63	123	60	95%
Bicycle Theft	42	46	4	10%
Theft from the Person	18	16	-2	-11%
Vehicle Crime (Inc Inter.)	190	381	191	101%
Shoplifting	298	353	55	18%
Other Theft	238	297	59	25%
Criminal Damage & Arson	406	391	-15	-4%
Total	2025	2546	521	26%

Other crimes against society

All police-recorded crimes where there are no direct individual victims. This includes public disorder, drug offences, possession of weapons and other items, handling stolen goods and other miscellaneous offences committed against the state.

The rates for some crime types within this category could be increased by proactive police activity, for example searching people and finding them in possession of drugs or weapons.

6.8 APPENDIX A

Police Generated Offences				
Crime Category/Type	Oct 16 - Dec 16	Oct 17 – Dec 17	Change	% Change
Public Disorder	83	87	4	5%
Drug Offences	74	48	-26	-35%
Trafficking of drugs	29	13	-16	-55%
Possession/Use of drugs	45	35	-10	-22%
Possession of Weapons	12	19	7	58%
Misc. Crimes Against Society	30	34	4	13%
Total Police Generated Crime	199	188	-11	-6%
TOTAL RECORDED CRIME IN HARTLEPOOL	2224	2734	510	23%

Recorded Crime in Cleveland October 17 – December 17**Victim-based Crime**

Publicly Reported Crime Oct 17 - Dec 17										
Crime Category/Type	HARTLEPOOL		REDCAR		MIDDLESBROUGH		STOCKTON		CLEVELAND	
	Crime	Per 1,000 pop	Crime	Per 1,000 pop	Crime	Per 1,000 pop	Crime	Per 1,000 pop	Crime	Per 1,000 pop
Violence against the person	572	6.3	600	4.5	1220	9.0	1004	5.3	3396	6.2
Homicide	0	0.0	1	0.0	1	0.0	0	0.0	2	0.0
Violence with injury	226	2.5	262	2.0	451	3.3	382	2.0	1321	2.4
Violence without injury	346	3.8	337	2.5	768	5.6	622	3.3	2073	3.8
Sexual Offences	57	0.6	78	0.6	131	1.0	133	0.7	399	0.7
Rape	19	0.2	41	0.3	62	0.5	41	0.2	163	0.3
Other Sexual Offences	38	0.4	37	0.3	69	0.5	92	0.5	236	0.4
Theft	1526	16.8	1326	9.9	2281	16.8	1806	9.6	6939	12.6
Domestic Burglary	286	7.1	252	4.2	453	7.9	257	3.2	1248	5.3
Other Burglary	123	1.4	94	0.7	134	1.0	107	0.6	458	0.8
Bicycle Theft	46	0.5	37	0.3	93	0.7	59	0.3	235	0.4
Theft from the Person	16	0.2	16	0.1	61	0.4	34	0.2	127	0.2
Robbery – Personal	4	0.0	17	0.1	39	0.3	23	0.1	99	0.2
Robbery - Business	20	0.2	4	0.0	7	0.1	8	0.0	23	0.0
Vehicle Crime (Inc Inter.)	381	4.2	183	1.4	358	2.6	221	1.2	1143	2.1
Shoplifting	353	3.9	348	2.6	668	4.9	691	3.7	2060	3.8
Other Theft	297	3.3	375	2.8	468	3.4	406	2.2	1546	2.8
Criminal Damage & Arson	391	4.3	579	4.3	899	6.6	729	3.9	2598	4.7
Total	2546	28.0	2583	19.3	4531	33.3	3672	19.5	13332	24.3

Other crimes against society

Police Generated Offences Oct 17- Dec 17										
Crime Category/Type	HARTLEPOOL		REDCAR		MIDDLESBROUGH		STOCKTON		CLEVELAND	
	Crime	Per 1,000 pop	Crime	Per 1,000 pop	Crime	Per 1,000 pop	Crime	Per 1,000 pop	Crime	Per 1,000 pop
Public Disorder	87	1.0	53	0.4	238	1.7	157	0.8	535	1.0
Drug Offences	48	0.5	45	0.3	133	1.0	73	0.4	299	0.5
Trafficking of drugs	13	0.1	12	0.1	26	0.2	16	0.1	67	0.1
Possession/Use of drugs	35	0.4	33	0.2	107	0.8	57	0.3	232	0.4
Possession of Weapons	19	0.2	11	0.1	27	0.2	23	0.1	80	0.1
Misc. Crimes Against Society	34	0.4	26	0.2	69	0.5	74	0.4	203	0.4
Total Police Generated Crime	188	2.1	135	1.0	467	3.4	327	1.7	1117	2.0
TOTAL RECORDED CRIME	2734	30.0	2718	20.3	4998	36.7	3999	21.3	14449	26.3

Anti-social Behaviour in Hartlepool October 17 – December 17

Incident Category	Oct 16 - Dec 16	Oct 17 - Dec 17	Change	% Change
AS21 - Personal	574	508	-66	-11%
AS22 - Nuisance	1063	1117	54	5
AS23 - Environmental	28	37	9	32
Total	1665	1662	3	0%

Anti-social Behaviour in Cleveland October 17 – December 17

Incident Category	HARTLEPOOL		REDCAR		MIDDLESBROUGH		STOCKTON		CLEVELAND	
	ASB	Per 1,000 pop	ASB	Per 1,000 pop	ASB	Per 1,000 pop	ASB	Per 1,000 pop	ASB	Per 1,000 pop
AS21 - Personal	508	5.6	709	5.3	968	7.1	878	4.7	3084	5.6
AS22 - Nuisance	1117	12.3	1652	12.3	2409	17.6	2119	11.3	7328	13.3
AS23 - Environmental	37	0.4	32	0.2	59	0.4	28	0.1	157	0.3
Total	1662	18.2	2393	17.9	3436	25.1	3025	16.1	10569	19.2
Quarterly Year on Year Comparison	No change		Increased by 6%		Increased by 5%		Reduced by 8%		Increased by 1%	

TEES VALLEY HEALTH SCRUTINY JOINT COMMITTEE

11 October 2017

PRESENT -**Representing Darlington Borough Council:**

Councillors Newall (in the Chair), J Taylor and L Tostevin.

Representing Hartlepool Borough Council:

Councillor Cook.

Representing Middlesbrough Borough Council:

Councillors E Dryden and J McGee.

Representing Redcar and Cleveland Council:

Councillor I Jeffrey.

Representing Stockton-on-Tees Borough Council:

Councillors E Cunningham, L Grainge and L Hall.

APOLOGIES – Councillor B Harrison (Hartlepool Borough Council) and Councillor D Rooney (Middlesbrough Council)

OFFICERS IN ATTENDANCE – K Graves (Darlington Borough Council), L Stones (Hartlepool Borough Council), C Breheny (Middlesbrough Borough Council), A Pearson (Redcar and Cleveland Borough Council), P Mennear (Stockton-On-Tees Borough Council).

EXTERNAL REPRESENTATIVES –**Middlesbrough Borough Council –**

J Chidanyika, Public Health Advanced Practitioner.

North East Ambulance Service (NEAS) –

M Cotton, Director of Communications and Engagement.

Tees Esk and Wear Valley Foundation Trust –

David Brown, Director of Operations for Teesside.

12. DECLARATIONS OF INTEREST – There were no declarations of interest reported at the meeting.

13. MINUTES – Submitted – The Minutes (previously circulated) of the meeting of the Tees Valley Health Scrutiny Joint Committee held on 20 July 2017.

RESOLVED – That, with the addition of Joint Work of the Prison Service and TEWV in relation to the Mental Health of Prisoners to the Work Programme, the Minutes be approved as a correct record.

14. MATTERS ARISING – There were no matters arising.

15. SUICIDE PREVENTION PLANS WITHIN THE TEES VALLEY – Joe Chidanyika, Public Health Advanced Practitioner, Middlesbrough Borough Council gave a PowerPoint presentation outlining both the Tees Suicide Prevention Strategic Plan 2016/17 to 2020/21 and Darlington's Suicide Prevention Plan and, in doing so, advised Members that suicides were not only due to poor emotional health but were complex often having many factors including social and health inequalities with people often being reluctant to access services due to the stigma involved.

Multi-agency working was key to preventing suicides and the Tees Suicide Prevention Taskforce currently has 43 active Task Force members from 20 organisations on Teesside including, Fire Brigade, Police, Prisons and Cruse Bereavement Care.

The projected cost to the North East economy of suicide in 2012 was £410.8 million, £1.67m per case, with many cases being preventable. The Preventing Suicide in England: a cross government Strategy to save lives is a national, all age prevention Strategy that identifies six key areas, to support the overall objective of the Strategy, to reduce the suicide rate and provide better support for those bereaved or affected by suicide.

Details were provided on how Teesside was addressing the key areas of the Strategy which are to reduce the risk of suicide in key high-risk groups; tailor approaches to improve mental health in specific groups; reduce access to the means of suicide; provide better information and support to those bereaved or affected by suicide; support the media in delivering sensitive approaches to suicide and suicidal behaviour; and support research, data collection and monitoring.

It was highlighted that groups at high risk of suicide comprised young men between 20 and 59 years of age and specific occupational groups including doctors, nurses, farmers and armed forces. The Tees Mental Health Training Hub offered a range of accredited mental health training to organisations or groups working with members of the public across Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton-on-Tees to raise mental health awareness and ensure employers become more proactive and sign post their employees to services.

The approach to improve public mental health needs to be applied across the life course, starting from pre-birth all the way to the older age groups and should include a blended approach that combines universal with targeted approaches especially for high risk and vulnerable groups. It was reported that 40 per cent of people who take their own lives were not previously known to Agencies; that the number of people with long term conditions in Tees Valley was high; and that the BME community presented its own challenges. The key point was to get people to talk, ensure a referral to the correct services and break the cycle of regular presenting at A&E Departments.

One of the most effective ways to prevent suicide is to reduce access to high-lethality means of suicide and it was reported that the methods most amenable to intervention

include hanging and strangulation, self-poisoning, high risk locations and those on the rail and underground networks. Work is ongoing with the Samaritans, British Transport Police and Network Rail to reduce suicide on railways; local hotspots are being identified using the suicide prevention audit and early alert system; and pharmacy leads are encouraging the return of unused medication.

Bereavement support is key for family and friends bereaved by a suicide as they are at increased risk of mental health and emotional problems and may be at higher risk of suicide themselves. In the Tees Valley an early alert system will be re-established to allow the suicide prevention taskforce to monitor patterns of suicide and instigate prevention and early intervention at the earliest opportunity. Consideration also needs to be given to children who may need help from an early age which will help to prevent issues as the child gets older. It was stated that there was no longer an 18 month delay of information from the Coroner relating to suicide and as such support can be quickly put in place to help the family bereaved by a suicide.

Particular reference was made to the media's influence on behaviour and attitudes and to compelling evidence that media reporting and portrayals of suicide can lead to copycat behaviour, especially among young people and those already at risk. With the increasing popularity of social media further work needs to be done to make this safer especially for young people who can easily be influenced or affected by information communicated through these channels. The stigma of mental health had a negative impact on a person who was feeling suicidal and work has been undertaken with the media to ensure sensible reporting and promotion of mental health services.

The National Strategy supports research, data collection and monitoring and intelligence and surveillance of suicides. Self-harm and mental health are the foundations of suicide prevention efforts and across the Crisis Concordat all data is shared. There are a number of agencies that collect self-harm data with Tees admissions for self-harm being among some of the highest in the Country and further analysis is required to help inform targeted preventative action.

It was reported that the Police take away people attempting suicide but they actually need support, James Cook A&E Department had 52 presenters who had attempted suicide with trends changing and people getting younger. It was acknowledged that self-harmers could lead to suicide if the correct help and support was not provided. Bullying was also an issue for young people with three recent suicides in Stockton being attributed to bullying. The cases treated at James Cook were approximately 50 per cent male and 50 per cent female, which was different to the overall data that showed deaths from suicide were 2.8 male deaths for every female death and this indicated more analysis of the data would be useful.

Details of the suicide prevention governance arrangements across the Tees Valley were provided and Members were informed that the Teesside Suicide Prevention Partnership Network was being actively built and included lollipop ladies and hairdressers.

It was queried whether there was any protocol for people who have attended or provided traumatic services and it was reported that it was now standard to have an auto-referral to the Psychosis Team. It was again reiterated that there was a stigma

around mental health and some professionals thought it could be looked upon badly if they had suicidal thoughts. Work was ongoing with Cleveland Police who were trained in Talk Down and it was recognised that first responders to a traumatic situation needed support.

Concerns were expressed that GP's couldn't sleep due to possible mistakes made and that three of the high risk suicide locations were in Redcar. Reference was also made to the Marmot Review in relation to austerity, the difficulties faced by some people and to life expectancy in Redcar getting worse. Concerns were also voiced that benefits had been capped, Universal Credit had added to debt worries and that suicide rates in prisons were alarming. In relation to young women, body image was a material factor in self-harming with suicide rates in Universities and schools being high especially during April and May exam time.

Clarification was sought on how the £1.67m cost per suicide case was calculated; how a suicide impulse would pass and why the strategic plan made reference to this; how mental health issues could be addressed in a growing ethnically diverse population; and whether further controls would deter cyber bullying.

Committee also requested more up to date statistics on means of suicides with a gender split, how some key risk groups were disproportionately affected locally such as farm workers, doctors and nurses, an updated response regarding the local picture around impact of austerity and welfare reforms on suicide.

David Brown of Tees, Esk and Wear Valleys Foundation Trust reported that re-energising the Task Force had been fantastic and whilst there was better information now than there had ever been there were huge numbers of self-harmers and it was difficult to identify potential suicides. He also reported that there was a real commitment to train people to highlight suicides and multi-agencies were now used to engage with individuals to ensure support can be provided. Members also noted that 40 per cent of children now start school without having reached development milestones and this could cause problems later in life.

RESOLVED (a) That the thanks of this Scrutiny Committee be extended to Joe Chidanyika for his interesting and informative presentation.

(b) That the work of the Suicide Prevention Taskforces be supported.

(c) That the wider determinants and their impacts relating to suicide be addressed by the Taskforces.

(d) That the Teesside Suicide Prevention Action Plan be submitted to a meeting of this Scrutiny Committee in twelve months.

16. NEAS QUARTERLY REPORT, UPDATE FROM CQC REVIEW AND IMPLEMENTATION OF NEW AMBULANCE STANDARDS – The Assistant Director of Communications and Engagement provided Scrutiny Committee with a PowerPoint presentation outlining Progress and Improvements in NEAS, Challenges Still to Overcome, Performance and New Ambulance Response Standards.

It was reported that since 2013/14 Hear and Treat callouts had increased by 96 per cent; See and Treat had increased by 15 per cent; See Treat and Convey had decreased by 25 per cent; and See and Convey to an Emergency Department had decreased by four per cent. Overall the number of serious calls was not much greater, increases had occurred in relation to long term conditions and the complexity of patients and although a patient was not necessarily taken to an A&E Department there was a need to support patients no matter what service was requested.

In relation to NHS 111 calls being referred to an Emergency Department, Committee was informed that investment from Commissioners had resulted in an assessment service with nurses in the 111 Control Room and specialists on call who could provide help, for example, on a weekend, pain relief could be given for a dental problem with an appointment being made with a Dentist for Monday. Currently being piloted was a Dental Hub although this was reliant on Dentist availability.

Since October 2014 to June 2017 the number of staff that would recommend NEAS as a place to work had increased from over 20 per cent to over 80 percent, a clear indication that morale amongst staff had vastly improved.

Due to funding of £3.4m from Commissioners, an additional £1.50 per head of North East population, the workforce numbers had increased by 42 additional paramedics, 42 additional Emergency Care Technicians, an expanded Integrated Urgent Care Hub with specialist staff including GP's and additional Advanced Practitioners. These measures would also provide an extra seven ambulances. It was further reported that benchmarking relating to staff turnover was very low and the vacancy rate was now coming down.

In order to reduce sickness absence rates, support mechanisms had been introduced with an objective to achieve five per cent target. The two main reasons for sickness absence were stress and musculoskeletal, however, investments had been made into an in-house Occupational Health Team and Counselling Services for paramedics attending traumatic incidents and NEAS was working with Trade Unions to address sickness absence.

Members noted the handover delays at the regional Trusts and, following a question by Councillor Dryden, Committee was reassured that there had never been an issue at James Cook Hospital and although there had been possible spike days of between nine and twelve ambulances queuing this was not a regular occurrence.

The Committee was advised that an inspection by the CQC had been undertaken in November 2016 and NEAS had received a 'Good' rating. CQC had stated that NEAS had a lot of to be proud of and there were clearly many areas of good practice.

Inspectors also found a general culture of passion and enthusiasm at the Trust and it was clear that everyone's first priority was the patient.

In relation to reference costs which indicate the cost-effectiveness of an NHS Service Members noted that, although NEAS operated at the lowest funding of £89 during 2015/16, it had received a rating of 'Good'. The North East also had the lowest urgent and emergency income per head of population of £27.7 whilst on the South East Coast income was £36.6 per head. If NEAS received additional funding it would be able to provide more ambulances and paramedics.

Current response time standards for Red 1 and 2 (funded) and Green 1 to 4 (non-funded) calls were highlighted and, following a question, it was confirmed that Redcar and Cleveland were struggling although rural areas were worse as they received fewer calls and the response rates would not be able to meet the standard.

Ambulance performance standards have not changed for over forty years and have always measured response time and not clinical outcome of the patient which has led to the inefficient use of ambulances and the knock-on effect of 'hidden waits'. The new standards will ensure that the best clinical outcome for patients is the most appropriate response and not the fastest response. These standards are significant especially as 999 call volumes have increased by 60 per cent nationally in the past decade.

During Quarter 1 of 2017/18 there had been 29,922 red incidents which had been responded to within eight minutes and the rise in red incidents, serious non-breathing patients, gave NEAS concerns.

Councillor Jeffrey queried whether obesity had an impact on the service and was advised that patients presented with various conditions including diabetes, cancer and COPD and any one of those conditions could be exacerbated but not necessarily due to obesity.

All North East CCG's performed better on Red 1 than the National Average of 75 per cent, Darlington 80 per cent, Hartlepool 87 per cent, Middlesbrough 82 per cent, Stockton-on-Tees 82 per cent and Redcar and Cleveland 70 per cent. Although still above the NEAS Trust wide average, Red 2 performance was declining with last month's performance being Darlington at 69 per cent, Hartlepool 67 per cent, Middlesbrough 62 per cent, Redcar and Cleveland 53 per cent and Stockton-on-Tees 65 per cent.

Under the new system of Ambulance Performance Standards call handlers will have more time, in minute segments up to four minutes, to determine the need of the caller. It is expected that the new system will provide early identification of life-threatening conditions, particularly cardiac arrest, and also free up more vehicles and staff to respond to emergencies. Clinicians have developed a set of Questions to determine the Nature of Call and this is being piloted in some, not all, services. Formal performance monitoring by the regulators of new standards will be from April 2018.

New Standards now specify that every case counts and there are no targets. The average response time is seven minutes although this could be anywhere between four and ten minutes. Rural areas will still have a longer response time but these will

become the exception. Scrutiny was advised that NEAS will never achieve 100 per cent but 90 per cent was achievable.

A detailed description was given of all new Ambulance Standards Call Type Category together with call definition, time to take a decision and at what point the clock was stopped.

At 82 per cent, NEAS was above the national average of 74 per cent of the number of patients who have suffered a specific type of heart attack and required a 'stent' fitted to free a blockage in their heart within two and a half hours of their 999 call. It was stressed that the service relied on patients to make the call early to ensure they had the best chance.

At 49 per cent, NEAS was below the national average of 52 per cent of the number of patients who have suffered a confirmed stroke and eligible for treatment with a clot-busting drug within 60 minutes of a 999 call.

The Director of Communications and Engagement stated that NEAS was working to ensure that it had the best model for its patients, looking at its data for 999 calls and establishing what response was needed to ensure the standards were met. The data also indicated the vehicle and staff needs for the service and in this regard a report was to be prepared around Christmas with a view to meeting with Commissioners. The Director of Communications and Engagement said that while there were no national standards for staffing levels in the ambulance service, NEAS believed that the current staffing mix needed to change from 55 per cent paramedics and 45 per cent non-paramedics to a ratio closer to 70 per cent paramedics and 30 per cent non-paramedics.

New standards were beginning to be implemented and NEAS had been given dispensation to fully implement up to March 2018, however, it was believed that more time was required as it takes two years to get paramedics and nine months to build an Ambulance.

Following a question from the Chair it was confirmed that St. John's Ambulances, trained to technician level, were still operating on a reduced level although were still part of the Trusts plans for surge periods.

It was clarified that the paramedic profession had changed, a Foundation Degree was now required and the profession attracted special status especially in relation to immigration. Collaboration with the Fire Service commenced a year ago as a co-responder if a defibrillator was required and that service was closer to the patient. This support was withdrawn for all of England following Union concerns although as the Cleveland Fire Service have been following this procedure for ten years they have continued.

During Holiday periods (Christmas and New Year), demand is high and all staff, including Managers, are fully on board, rotas are kept at 100 per cent although on New Year's Day this is 110 percent but demand will still exceed. Some regions also attract tourists and seasonal demands will fluctuate.

It was confirmed that the NEAS contract was shared between the eight CCG's that cover the North East region with four lead commissioners and that it was important to have conversations with all individual commissioners. NHS England was exploring a Single Operating Model for the commissioning of ambulance services but more details were required.

RESOLVED – (a) That the thanks of this Scrutiny Committee be extended to the Director of Communications and Engagement for his informative and interesting presentation.

(b) That a further report be submitted to a future meeting of this Scrutiny Committee once the new Ambulance Standards are embedded.