NHS
North Tees and Hartlepool
NHS Foundation Trust

Quality Accounts
2018-19

5 Quality Report

Contents

PART 1
Statement on Quality from the Chief Executive

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

I am delighted to introduce the North Tees and Hartlepool NHS Foundation Trust Quality Accounts for 2018-19, which is a continued excellent illustration of the Trust's commitment to provide the best quality of care possible for our patients. It details our performance over the last year as well as outlining our key priorities for 2019-20.

2018-19 has seen a continuous demand for services and financial challenges placed upon the whole health and care system, which is likely to continue, however, despite this the Trust has maintained a good level of performance throughout the year. None of this would be possible without the dedication and hard work of our staff, who are highly valued. This commitment from our staff continues to be recognised throughout the year both internally and externally, including staff being nominated for various awards. As a Trust we are also very fortunate to have volunteers, governors, members and other partners who support the excellent work we do.

Julie Gillon
Chief Executive

31 May 2019

During 2018-19, there was a maintained commitment ensuring that the improved performance from previous years in relation to our Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) mortality values was maintained. This continued hard work and commitment has seen the Trust's recent HSMR and SHMI values return to around the 100 mark (where the number of people died met the expected number) and well within the 'as expected' range. I would like to thank all staff who have contributed to this valuable work. To continuously improve the good work being carried out and to constantly strive for improvement, the Trust regularly seeks assurance from external organisations.

The Trust continues to be set a very challenging Clostridium difficile target by our commissioners of no more than 13 hospital acquired infections. Despite the Trust exceeding this target, there have been a number of important initiatives undertaken to lower future infection rates which are outlined in this report.

The latest Care Quality Commission (CQC) unannounced inspection of services was undertaken in November 2017 and a Well-Led inspection in December 2017, following which the Trust has been rated as 'Good'. During 2018-19 the Trust has utilised the findings within inspections reports, building on the key successful areas, but also to look at the areas that required further improvement, this forms part of the Trust 'Journey to Outstanding' strategy.

The Trust actively engages with its key stakeholders throughout the year regarding all aspects of safety and quality work and the Quality Account priorities for 2019-20. These priorities have been jointly 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 and are currently rated as follows:

- University Hospital of North Tees is rated at **4.0** out of 5
- University Hospital of Hartlepool is rated at **4.0** out of 5

Putting patients first remains our number one priority every day, striving for excellent patient experience and patient safety for all our patients.

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

What is the Quality Report/Accounts?

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

Our Quality Pledge

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.

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 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.

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.

Unconditional CQC Registration

During 2018-19 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 most recent CQC visit took place during November 2017 utilising revised inspection format, with the well-led element taking place during the week commencing 18 December 2017. The Trust has been rated as 'Good', for all domains additional detail regarding the recent visit is located in the CQC section on page 193.

2018-19 Achievements

The monthly award has two winners, a team and an individual.

PART 2
Section 2A: 2018-19 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 2017-18. 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, governors and the public.

Presentations have been provided to various staff groups with the opportunity for staff to comment on with feedback forms provided to obtain patients views.

Progress is described in this section for each of the 2018-19 priorities.

Stakeholder priorities 2018-19

The quality indicators that our external stakeholders said they would like to see reported in the 2018-19 Quality Accounts were:

Patient Safety	Effectiveness of Care	Patient Experience
Mortality	Safety Thermometer	Palliative Care & Care for Dying Patient (CFDP)
Dementia	Discharge Processes	
Mental Health	Safety and Quality Dashboard	Is our Care Good? (Patient Experience Surveys)
Safeguarding (Adult & Children's)	Learning from Deaths	
Infections		Friends and Family Test

"Staff very hard working with attention to detail, patient's needs were at the forefront of their care." [sic]

Priority 1: Patient Safety
Mortality

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

Overview of how we said we would do it

The Trust used 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 with the North East Quality Observatory System (NEQOS) for third party assurance.

Overview of how we said we would measure it	Overview of how we said we would report it	Completed and reported?	
HSMR (Hospital Standardised Mortality Ratio)	Report to board of directors	Reported to Board of Directors	✔
SHMI (Summary Hospital- level Mortality Indicator)	Report quarterly to the commisioners	Reported to the Commissioners	✔
We will utilise nationally/regionally agreed tools to assist in assessing levels of clinical care.	Report to the Trust Outcome Performance Delivery Operational Group	Reported to the Trust Outcome Performance Delivery Operational Group	✔

The Trust Board of Directors continues to understand 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 are now consistently in the **'as expected'** range.

The Trust, while using national mortality measures as a warning sign, is investigating more broadly and deeply the quality of care and treatment provided. The Trust established a clinical link between consultants and the Trusts Coding Department, this work throughout 2018-19 has reaped great rewards in respect of depth of coding. This increase from around an average of four co-morbidities per patient to over seven, has had a profound effect on the HSMR and SHMI values, as well as giving a more accurate reflection of the patients true level of sickness.

Further progress this year will be supported by the following:

- 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.
- Twice weekly centralised mortality reviews continue to be undertaken, with mortality workshops being held once a month for clinicians to attend to gain an understanding of the Trust's position and how they play a key part in future improvements.

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 2018 to February 2019

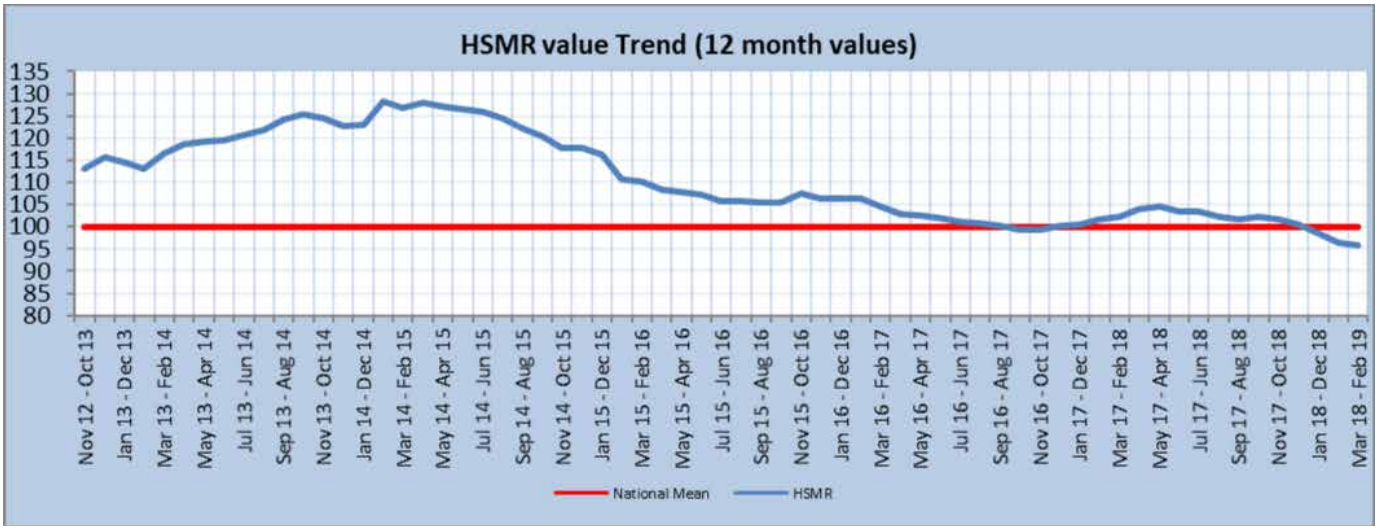
The Trust HSMR value is **95.80** for the reporting period from March 2018 to February 2019; this value continues to place the Trust in the **'as expected'** range. The National Mean is 100, which denotes the same number of people dying as expected by the calculations, any value higher means more people dying than expected.

Reporting Period	HSMR		*CMR	
Jan 17 - Dec 17	100.53		3.51%	
Feb 17 - Jan 18	101.61	↑	3.58%	↑
Mar 17 - Feb 18	102.41	↑	3.64%	↑
Apr 17 - Mar 18	104.09	↑	3.73%	↑
May 17 - Apr 18	104.54	↑	3.74%	↑
Jun 17 - May 18	103.43	↓	3.68%	↓
Jul 17 - Jun 18	103.53	↑	3.68%	↔
Aug 17 - Jul 18	102.26	↓	3.65%	↓
Sep 17 - Aug 18	101.81	↓	3.61%	↓
Oct 17 - Sep 18	102.30	↑	3.60%	↓
Nov 17 – Oct 18	101.56	↓	3.61%	↑
Dec 17 – Nov 18	100.55	↓	3.64%	↑
Jan 18 – Dec 18	98.39	↓	3.55%	↓
Feb 18 - Jan 19	96.17	↓	3.45%	↓
Mar 18 - Feb 19	**95.80**	↓	**3.41%**	↓

*Crude Mortality Rate (CMR)

Trust HSMR Continued Improvement

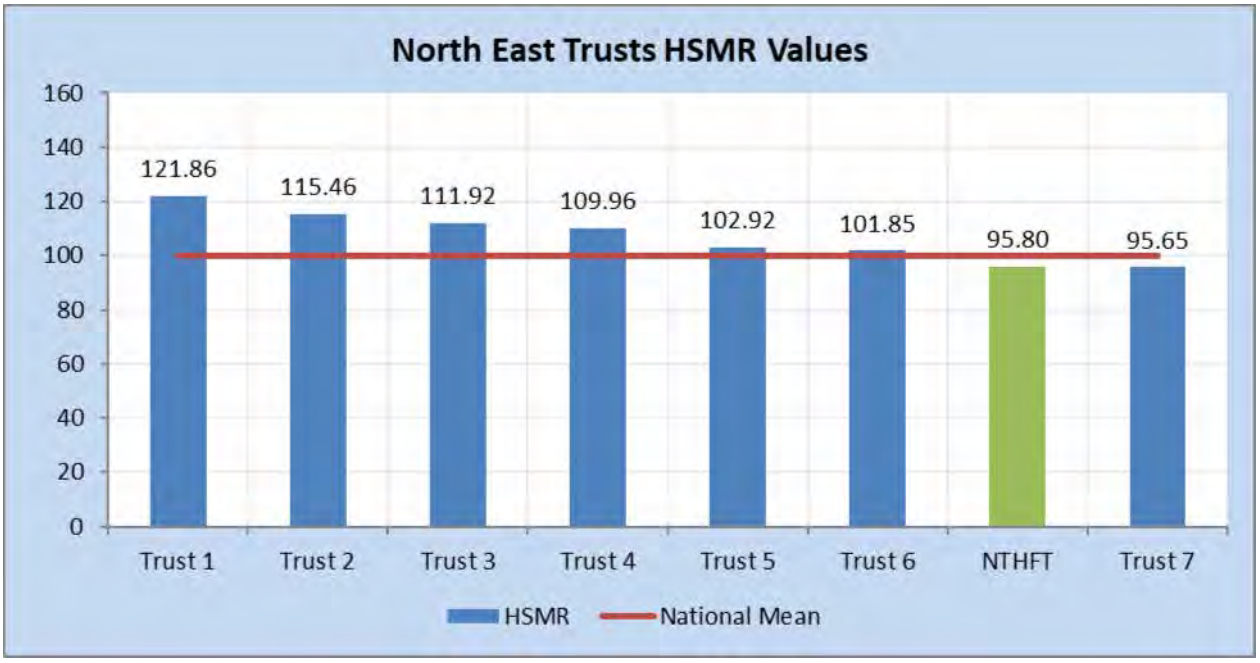
The following graphic demonstrates the Trust improvement since the high during February 2014 – January 2015, reducing the HSMR value to **95.80 (March 2018 to February 2019;)** from 128.26, the Trust continues to reside in the **'as expected'** range.



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

The following HSMR chart demonstrates the Trust's 12 month HSMR value throughout the reporting period from **March 2018 to February 2019**, benchmarked against the other North East Trusts.

The Trusts 12-month average for HSMR is currently **95.80** which is within the 'as expected' range.



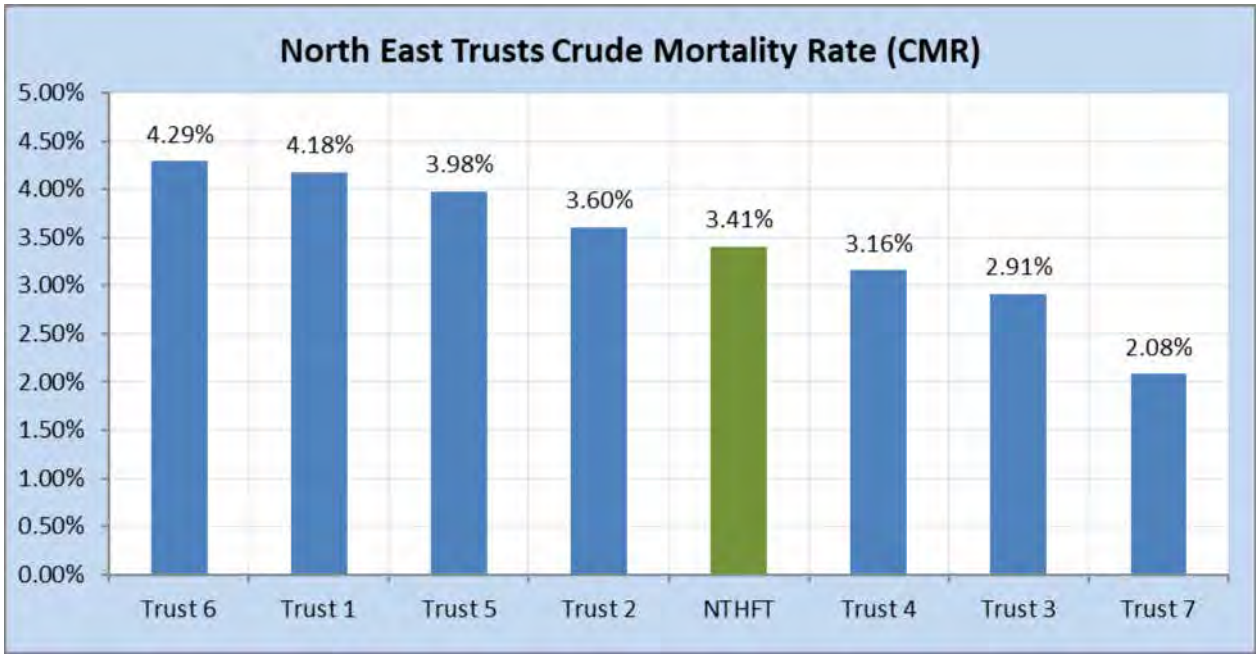
*Data obtained from the Healthcare Evaluation Data (HED)

HSMR Crude Mortality Rate - 3.41%

March 2018 to February 2019

The following HSMR chart demonstrates the Trusts 12 month Crude Mortality Rate value throughout the reporting period from **March 2018 to February 2019**, benchmarked against the other North East Trusts.

The Trusts 12-month average Crude Mortality Rate (number of deaths/number admitted*100) is currently **3.41%.**



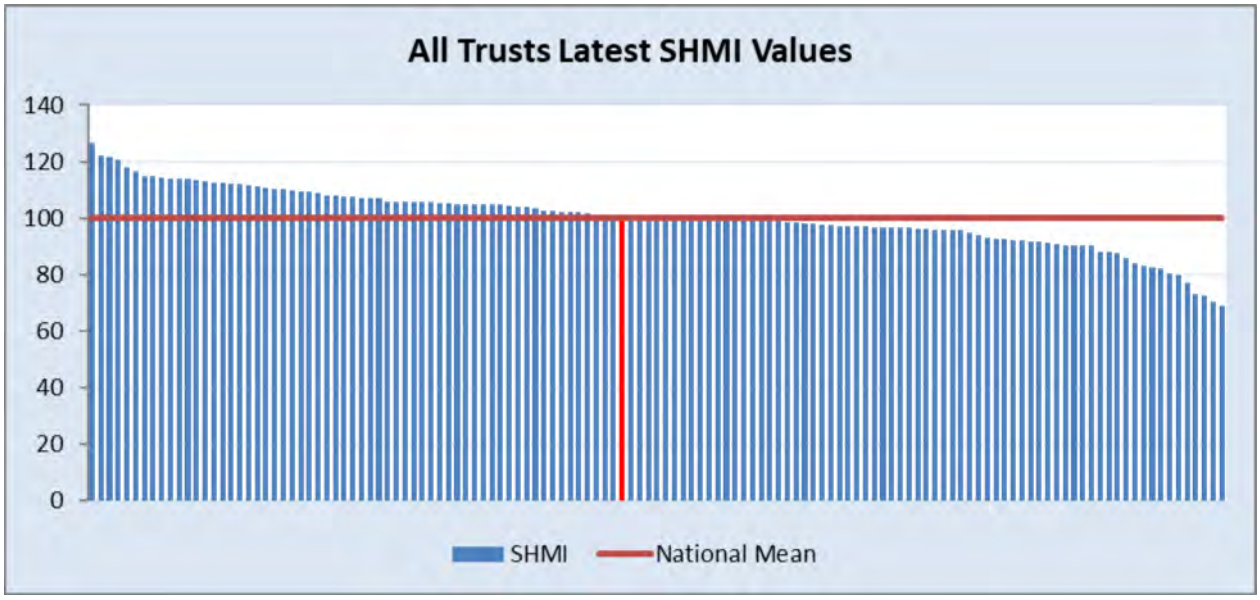
*Data obtained from the Healthcare Evaluation Data (HED)

Summary Hospital-level Mortality Indicator (SHMI)
October 2017 to September 2018

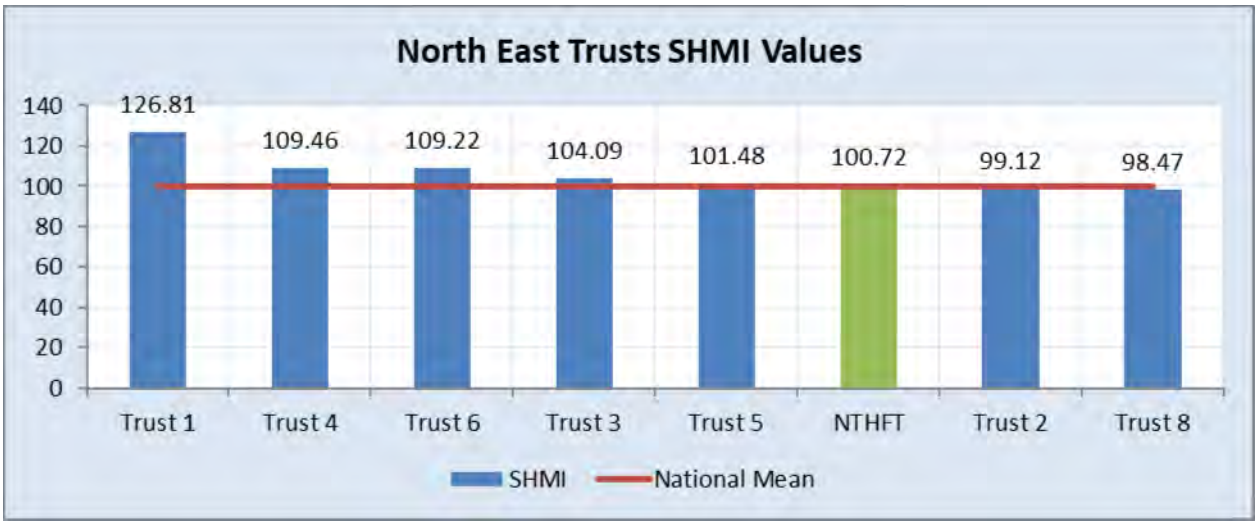
The **SHMI** indicator provides an indication on whether the mortality ratio of a provider is as expected, higher than expected or lower than expected when compared to the national baseline in England.

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

The following graphic demonstrates the Trust (red) National position with a SHMI value of **100.72 (October 2017 to September 2018)**, this value continues to reside in the **'as expected'** range.

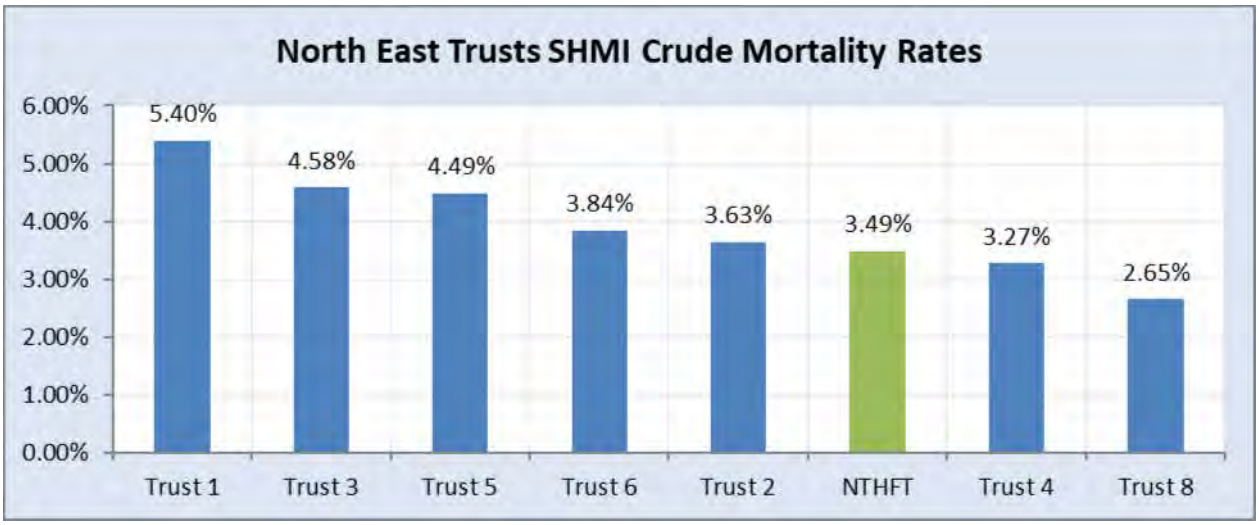


The following chart and table demonstrate the Trust's current SHMI position utilising the latest time period of **October 2017 to September 2018**, the other North East Trusts have been anonymised.



*Data obtained from the Healthcare Evaluation Data (HED)

The following SHMI chart demonstrates the Trusts 12 month Crude Mortality Rate value throughout the reporting period from **October 2017 to September 2018**, benchmarked against the other North East Trusts. The Trusts 12-month average Crude Mortality Rate (number of deaths/number admitted*100) is currently **3.49%.**



*Data obtained from the Healthcare Evaluation Data (HED)

Trust Raw Mortality

The following table and chart demonstrates the raw number of mortalites the Trust has experienced since 2016-2017. For the current financial year of 2018-19, the Trust has experienced 1,341 mortalities, when compared to the previous year (2017-18) this is currently 109 mortalities fewer (as of end of February 2019).

	Cumulative Totals											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016-17	142	273	396	515	622	719	851	970	1114	1269	1405	1541
2017-18	126	254	357	461	566	686	807	936	1118	1312	1450	1613
2018-19	**135**	**239**	**341**	**455**	**547**	**655**	**794**	**928**	**1060**	**1209**	**1341**	**1454**
Diff	9	-15	-16	-6	-19	-31	-13	-8	-58	-103	-109	**-159**

Priority 1: Patient Safety
Dementia

Rationale: There are currently approximately 14,000 (last report 2014) 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 our hospital environment
- We will make it mandatory 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 if needed.
- Creation of a separate room in Accident and Emergency where people with acute confusion or dementia can wait to be seen in a more private and less stimulating environment than the main waiting room.
- Cross referencing people regarding a dementia diagnosis on North Tees and Hartlepool Trust Trakcare and Datix systems with (Tees, Esk and Wear Valleys NHS Foundation Trust) TEWV Paris system (electronic care record system) to confirm if a clinical diagnosis has been given by mental health services. If confirmed an alert will be added to Trakcare to ensure staff are aware of a definite diagnosis of dementia.

Overview of how we said we would measure it	Overview of how we said we would report it	Completed and reported?	
The Stirling Environmental audit assessment tool will be used to monitor the difference pre and post environmental adaptation.	Report to the Vulnerability Committee	Reported to the Vulnerability Committee	✔
Wards within the Trust have had the Stirling audit completed on them.	Monthly UNIFY	Discussed locally in Dementia groups when appropriate	✔
The percentage of patients who receive the AMT and, where appropriate, further assessment will be reported monthly via UNIFY.			
We will continue with the prevalence audit for the number of patients that have cognitive screening over the age of 75 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			

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.
- Continue to promote John's Campaign (www.Johnscampaign.org.uk) with the Trust lead. 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.
- Carers packs are now proactively delivered to the wards when a DoLS application is received by adult safeguarding that lists the cognitive problem as 'Dementia.'
- University Hospital of North Tees has become part of Dementia Friendly Stockton. The aim is to continue to develop close and consistent links with relevant local agencies.

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

***Data from Information Management Department, 2018-19 data up to end of February 2019**

The challenges the Trust faces regarding patients admitted with a diagnosis of Dementia/Delirium is an unfortunate increasing trend.

Dementia Assessment and Referral 2018-19

This data collection reports on the number and proportion of patients aged 75+ 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.

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Number to whom case finding is applied	1,240	1,354	1,328	1,220
Number of emergency admissions	1,240	1,354	1,328	1,220
Percentage to whom case finding is applied	**100%**	**100%**	**100%**	**100%**

Number who had a diagnostic assessment	221	207	310	285
Number with positive case finding question	221	207	310	285
Percentage with a diagnostic assessment	**100%**	**100%**	**100%**	**100%**

Number of cases referred	56	71	88	85
Number with a positive or inconclusive diagnostic assessment	56	71	88	85
Percentage of cases referred	**100%**	**100%**	**100%**	**100%**

***Data obtained from NHS Digital**

Dementia Training Levels

Tier 1 - Dementia Awareness Raising	Tier 2 – Knowledge, skills and attitudes for roles that have regular contact with people living with dementia	Tier 3 – Enhancing knowledge, skills and attitudes for key staff in a leadership role
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. This is constantly evaluated and updated. It is also delivered to all new recruits to the Trust- overseas nurses, newly qualified staff, students, return to practice nurses, Trust induction and can be delivered on request for team days. There has been an identified training need for the Trust volunteers in relation to dementia. We are currently planning this, and this will be based around the development of increased knowledge and practical skills to equip our volunteers with extra awareness of dementia when supporting people with a dementia diagnosis.	This is the level of 'Trust Dementia Champions' To support this level of training we have the Trust Dementia Champion programme which, following feedback, has been reviewed and now runs over two consecutive days on alternate 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 well as guest speakers. It is open to all staff, of any profession or grade, either inpatient or community. This new programme enables it to be carried out 6 times a year, as opposed to being carried out over 2 hour sessions monthly over 11 months. We are also placing more emphasis on the role of the Dementia Champions and have compiled a list of expectations which outline their responsibilities following the course.	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

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 obtaining Health Education England approval for training. This ensures 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 Tier 1	Dementia Tier 2	Dementia Tier 3
98%	90%	86%

*Data obtained from the Trust dementia training

Priority 1: Patient Safety
Mental Health

Rationale: Post Stakeholder engagement, this was decided to be a key metric going forward for measurement.

Overview of how will measure it

The Trust will benchmark current and future practice against the Treat as One Guidance; undertaking further audit in relation to recommendations in line with the above and Staff and patient engagement (survey).

Overview of how we will report it

The Trust will establish a Treat as One group chaired by an Executive Board Member; audit results will be reported to ACE Committee and Performance & Quality Standards Committee.

High quality mental healthcare offered to patients across the services we provide is our aim. Integrating mental and physical health and social care will improve patient experience and outcomes, as well as staff experience, and reduce system costs and inefficiencies. However, good integrated care for people with mental health conditions often appears to remain the exception rather than the rule, with physical healthcare and mental healthcare largely disconnected. There has been, and still are, many drivers to try and change the situation, to improve the care for this patient group.

By focusing on the whole person, healthcare professionals will be knowledgeable and confident in understanding and managing mental health conditions and knowing when and how to access mental health services for the patients they see. The integration of all healthcare professionals to provide care as needed for each patient is a crucial part of the solution to providing a higher quality of care to all patients.

Will aim to:

- embed integrated mind and body care as common practice, joining up and delivering excellent mental and physical health care, research and education so that we treat the whole person.
- improve patient care and staff experience through the sustainable provision of effective learning and development of our workforce.
- provide services where users routinely access care that addresses their physical and mental health needs simultaneously provided by services and staff who feel valued, supported and empowered to do so.

To achieve the 3 aims the objective will be to:

- Foster positive attitudes towards integrated mental and physical health, combatting stigma.
- Improve recognition and support for both the mental and physical health needs of patients.
- Assist staff to access support and resources for working with mind and body.
- Ensure that mind and body care is addressed at all levels of healthcare.
- Engage local partners in improving mind and body training and subsequently care.

Priority 1: Patient Safety
Safeguarding (Adult and Children's)

Rationale: Adult Safeguarding is defined by the Care Act (2014) and is carried out where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)—

- has needs for care and support (whether or not the authority is meeting any of those needs),
- is experiencing, or is at risk of, abuse or neglect, and
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

Overview of how we said we would do it

- Ensure staff are well equipped to deal with Adult Safeguarding issues and have a good understanding of the categories of abuse.
- Staff are aware of how to raise a safeguarding concern.
- Continue to increase the visibility of the Adults Safeguarding Team.
- Audit the policy to look at good practice and areas for improvement.
- Local quality requirements (LQR) as defined by the commissioners will be monitored on a quarterly basis.
- Quality assessment frameworks (QAF) on adult safeguarding will be produced, RAG rated and audited by Tees-wide Safeguarding Board (TSAB).

Overview of how we said we would measure it	Overview of how we said we would report it	Completed and reported?	
Audits will be carried out on DoLS and Adult Safeguarding and results reported	Audit results and action plans to be reported to Adult Safeguarding Group quarterly	Audit plans and results presented to Adult Safeguarding Group quarterly	✔
Compliance of training figures	Report activity into Teeswide Safeguarding Adults Board	The Trust reported activity into Teeswide Safeguarding Adults Board	✔
Concerns raised by the Trust and against the Trust	To submit the QAF to the TSAB	QAF has been submitted to the TSAB, awaiting formal response	✔

Safeguarding Adults

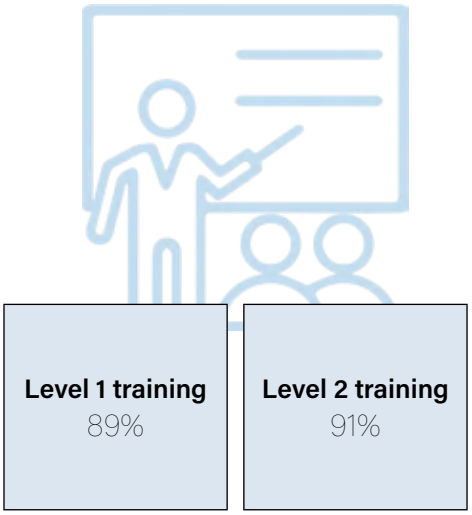
The Trust continues to work to enhance and develop standards for safeguarding adults across hospital and community services. The Care Act (2014) has been embedded in practice and close working with the Teeswide Adults Safeguarding Board has helped to update policies and procedures in a coordinated approach.

The Adults Safeguarding team continue to raise the profile and visibility of Adult Safeguarding; this is in the form of walkabouts, increased teaching and attendance at staff meetings.

The safeguarding team have developed level 2 training to give key staff more intensive training and understanding of Adult Safeguarding.

Training activity 2018-19
(up to Q3 2018-19)

Tees-wide multi agency training is undertaken at level one via 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 and level 2 has now been changed from once only to 3 yearly.



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:

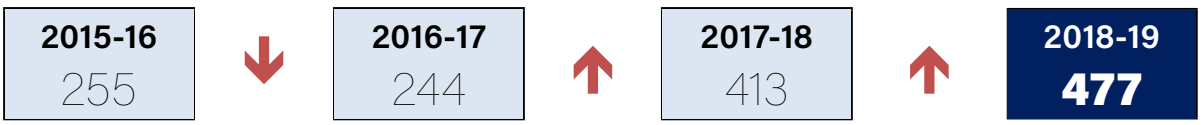
- Number of referrals
- Number of alerts raised by location
- Number of alerts raised by theme
- Incidents raised by type of abuse, Trust role and outcome

Number of Concerns

The Trust continues to use and develop further an in-house 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)

Number of Concerns/enquiries raised within the Trust

There have been 477 concerns raised by the Trust. This trend demonstrates that there has been a sharp increase in concerns in 2017-18 and is steadily continuing to increase. The rise in concerns can be attributed to a number of factors including training and awareness which is evidenced by a higher number of concerns raised by the Trust staff in 2017-18 & 2018-19 than the total number of concerns the Trust has had input with in previous years.



Types of Concerns

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.

Type of Concern	Q1	Q2	Q3	Q4	Total
Neglect and Acts of Omission	49	46	38	58	**191**
Physical	31	26	40	30	**127**
Self-Neglect	29	36	26	30	**121**
Domestic Abuse	17	8	8	6	**39**
Financial or Material	10	7	8	7	**32**
Psychological	3	5	4	11	**23**
Organisational	9	1	3	3	**16**
Sexual Abuse	3	5	1	3	**12**
Sexual Exploitation	0	1	2	1	**4**
Discriminatory	2	0	0	0	**2**
Modern Day Slavery	0	1	0	0	**1**
Total	**153**	**136**	**130**	**149**	**568**

***Data from the Trusts Adult Safeguarding database**

Concerns around physical abuse have continued to rise. The most prominent change is the large increase in concerns around neglect across all localities. Self-neglect and domestic abuse are continuing to rise, although this is to be expected as there are new categories introduced by the Care Act (2014), so this may be due to increased awareness and training.

Alerting Areas

Alerting Areas	Q1	Q2	Q3	Q4	Total
Emergency Care	25	37	32	33	**127**
Out of Hospital Care	30	25	22	32	**109**
Medicine	7	9	11	9	**36**
Surgery, Urology & Orthopaedics	4	1	6	6	**17**
Nursing Quality & Patient Safety	1	6	2	3	**12**
Anaesthetics	4	1	3	1	**9**
Allied Health Professionals	0	2	1	0	**3**
Outpatients Departments	0	0	0	3	**3**
Pharmacy	0	1	0	0	**1**
Radiology	0	0	0	1	**1**
Women's & Children's Services	1	0	0	0	**1**
Estates	0	0	0	0	**0**
Human Resources	0	0	0	0	**0**
Pathology	0	0	0	0	**0**
Total	**207**	**216**	**195**	**242**	**327**

Emergency Care continues to be the highest referrer, although this is expected as this is the main gateway into the hospital.

Number of concerns against the Trust

There have been 90 concerns against the Trust, this is the highest number of concerns raised against the Trust so far, however, this is in line with the general increase in alerts received by the local authorities, due to the raised awareness of Adult Safeguarding within the Trust and the community, the local authorities have all seen a rise in concerns.

Themes of Alerts against the Trust

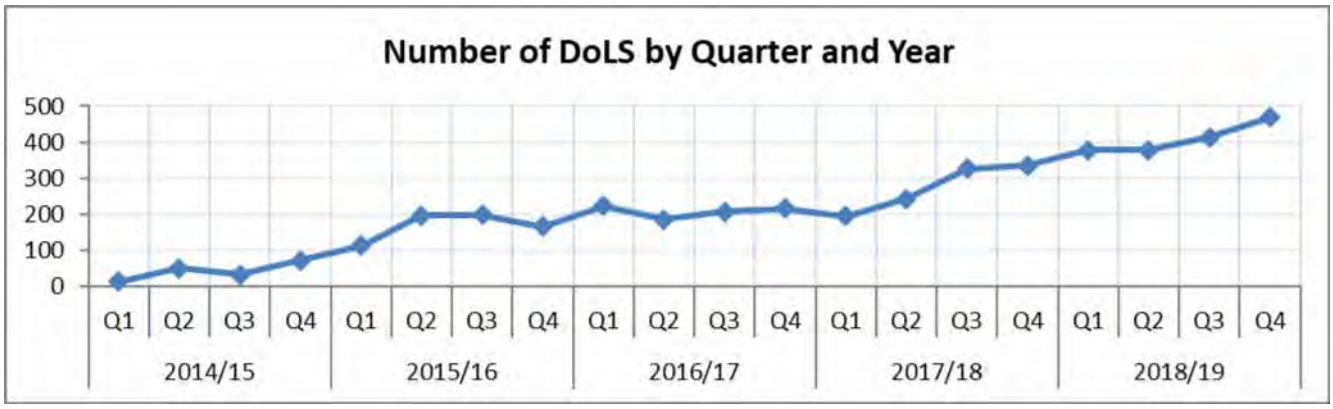
Themes of Alerts	Q1	Q2	Q3	Q4	Total
Discharge Issue	8	9	6	9	**32**
Delay / Failure of Intervention	9	5	6	8	**28**
Pressure Damage / Ulcer	5	5	5	9	**24**
Medication Error	3	2	2	5	**12**
Communication	2	5	1	3	**11**
Documentation	2	2	0	1	5
Unexplained Injury	1	0	1	3	**5**
Assault	1	1	0	2	**4**
Moving and Handling	1	0	1	0	**2**
Psychological	1	1	0	0	**2**
Acopia	1	0	0	0	**1**
Dehydrated	0	1	0	0	**1**
Self Neglect	0	0	1	0	**1**
Sexual	1	0	0	0	**1**
Unkempt	0	1	0	0	**1**
Unwitnessed fall	1	0	0	0	1
Domestic Abuse	0	0	0	0	**0**
Harassment	0	0	0	0	**0**
Material	0	0	0	0	**0**
Modern Day Slavery	0	0	0	0	**0**
Monetary	0	0	0	0	**0**
Theft	0	0	0	0	**0**
Total	**36**	**32**	**23**	**40**	**131**

***To note: 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, Nursing and Midwifery Staff to provide support and Education.

Deprivation of Liberty Safeguards (DoLS)

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 continues to provide education regarding the awareness of DoLS; improvements have been made to the paperwork to assist staff in its completion.



The Trust has seen a 48.90% increase on the total number of applications from last year. If this continues next year the Trust will be looking at 2,220 applications per annum, this is not sustainable and the Trust has been far exceeding the national increase since Cheshire West but this report suggests we have not and the increase is normal. The Trust has been seeing increases much higher than the national average.

2015-16		2016-17		2017-18		2018-19
673	↑	832	↑	1,100	↑	**1,638**

Trust Adult Safeguarding Governance Arrangements

The Director of Nursing, Patient Safety and Quality is the executive lead for safeguarding adults with the Deputy Director of Nursing Patient Safety and Quality holding 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 the Tees-wide Adult Safeguarding Board, and its subgroups.

The Trust Strategy groups for adult safeguarding, learning disability and dementia, have now been amalgamated to ensure 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.

Adult Safeguarding - Prevent

Throughout 2018-19 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.

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

An e-learning package has been developed for staff to complete. On the Trusts Training Needs Analysis (TNA) the staff that require Prevent awareness require Level 2 Adult Safeguarding Training or Level 3 Children's Safeguarding training will receive WRAP – face to face.

The 'Named Nurse' for Adult Safeguarding represents the Trust at a multi-disciplinary meeting (Silver command) around PREVENT.

Training figures 2018-19

PREVENT	WRAP
80%	74%

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, 2018. In addition, arrangements to safeguard and promote the welfare of children must also achieve recommendations set out by the CQC 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 program. 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 & Sedgefield.

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 MASH Board
- County Durham Neglect Sub 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 July 2018 Durham and Darlington locality underwent a Joint Targeted Area Inspection into Domestic Abuse. The subsequent recommendations and action plan continues to be delivered and monitored although recommendations for NTHFT were minimal.

Children's Safeguarding Work Program

The Children's Safeguarding Work Program sets out the work for the year - it is divided into 2 parts.

Part 1 Improvement - action plans from serious case reviews; learning lesson reviews, Domestic Homicide Reviews and internal incidents.

Part 2 Safeguarding children professionals' development work - the safeguarding children annual audit and assurance program 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)

In Durham the Trust has had significant involvement in one SCR. The Named Nurse and Specialist Safeguarding Midwife are members of the serious case review team which continues to meet. The findings and recommendations from this will not be published until criminal proceedings are complete

Stockton LSCB has commissioned 1 serious case review and the Named Nurse is a member of the review team which continues to meet. The findings and recommendations will not be published until the criminal proceedings are complete.

Any joint action plans, once published will be monitored through the Trust's Safeguarding Children's Steering Group and jointly through the Learning and Improvement Sub Group of the Hartlepool LSCB Board.

Part 2 - Development Work

Children Not Brought for Appointments by Parents/Carers' Policy

The policy and assurance process is embedded across the Trust in response to a local serious case and learning lessons review, enabling practitioners to respond appropriately and recognise possible early indicators of neglect when a child has not been brought to appointments. The Trust can now also identify children whose appointments are frequently rescheduled by parents/carers alongside those that do not attend.

Safeguarding Children Policy

The Safeguarding Children Supervision and Safeguarding Policy was 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 and School Nurses in Hartlepool, Midwives and Community Paediatric Nurses). Speech and Language Therapists now receive a rolling program of group supervision.

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. Staff sickness is not included in compliance figures.

Q1 2018-19	Q2 2018-19	Q3 2018-19	Q4 2018-19
98%	98%	98%	97%

North of Tees Childrens' Hub

The Trust is an integral part of the HUB and although the senior nurses in the safeguarding team are not co-located within the Hub they continue to provide support and advice remotely.

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. A CSE risk assessment is completed on all LAC children over the age of 11 years and on all children who attend unscheduled care within the Trust if they fit within an agreed criteria of risk. This risk assessment will be rolled out to other areas such as Paediatric wards and the Early Pregnancy Problem Clinic in 2019.

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 is in place across the Trust.

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 behaviors that may require safeguarding intervention when supporting staff on sickness/absence or there are 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 childrens' social care intervention. Frontline community health practitioners attended training to equip them with the knowledge and skills in using this approach with children and families. The Senior Nurses in the Childrens' Safeguarding Team have attended the five day intensive training.

Voice of the Child

Following recommendations from the CQC report 'Not Seen, Not Heard' the Trust is taking forward a number of actions to further improve how we listen to children and gain their wishes and feeling around the care they receive. This plan is monitored via the Childrens' Committee.

Bruising in Immobile Babies Policy

Bruising in non-mobile children is rare and therefore there is a significant risk that bruising may indicate abusive or neglectful care. Unfortunately nationally and locally bruising is not always responded to appropriately by health practitioners. As a result a significant number of abusive events have been missed nationally resulting in children being placed at risk, serious untoward incidents and serious case reviews. In response to this Tees Procedures Group reviewed the existing procedure and significant changes were made and ratified by all four safeguarding Boards represented in the Tees Procedures group. The immobile baby pathway is now being implemented across the Trust. This pathway requires all professionals to refer bruising in non- mobile children for assessment by a Consultant Paediatrician and Children's Social Care.

Joint working with Adult Safeguarding

A Senior Nurse in the Vulnerabilty Unit has been recruited and they provide both adult and children's safeguarding training across the Trust including Female Genital Mutilation (FGM), Prevent, Forced Marriage and Modern Slavery.

Audit

The audit forward plan has a strong focus on quality and improving outcomes for children and young people. Examples include:

Adult Risky Behaviours A&E Audit	Child Protection Flagging Audit
Staff Satisfaction Audit	Safer Referral Audit
NICE Guideline 89 Audit	On-going participation in Childrens' Hub referral audits
On-going participation in multi-agency case file audits	Immobile Baby Pathway Audit
Case file audits of 0-19 service	Children Not Brought for Appointments by Parents/ Carers Policy Audit

Key Achievements 2018

- Provision of bespoke training in response to lessons from a serious untoward incident investigation
- Recruitment of a Senior Nurse to the Vulnerabilty Unit who provides both adult and children's safeguarding training
- The introduction of scenario based safeguarding children's training with a requirement to complete a Safer Referral
- Sustained high compliance for safeguarding supervision
- A robust Children Not Brought to Appointments by Carer's/Parents Policy strengthened by a new system to identify those appointments that are repeatedly cancelled or rearranged
- Successful implementation of the Bruising in Immobile Baby Pathway
- The introduction of a rolling program of safeguarding supervision for Speech and Language Therapists

Key Priorities 2019

1. Align key priorities of the Trust to the priorities of the 3 LSCBs
2. Achieve 100% compliance for all local safeguarding children quality requirements
3. Continue to enhance the Trust safeguarding children training program
4. 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
5. To continue to develop and monitor any action plans following recommendations from the Joint Targeted Area Inspections and local SCR's
6. To continue to monitor progress of the Voice of the Child Action Plan via the Childrens' Committee

Safeguarding Children Training Programme

Throughout 2018 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. This includes:

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

Level 1 and 2 Safeguarding Children Training is also aligned to the regional Core Skills Framework.

Level 3 Safeguarding training content has been refreshed and now includes scenario based training with the requirement to complete a Safer Referral included.

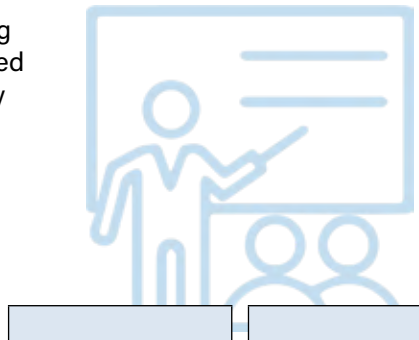
Where appropriate staff are required and supported to attend multi-agency training provided by the LSCB and other external providers and this is a mandatory requirement for those staff groups identified as requiring Level 3 plus competencies.

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

The Safeguarding Children Trainers co-facilitate a core foundation multiagency training course with Hartlepool and Stockton LSCB and are involved in developing and facilitating LSCB Active Learning Events. The Safeguarding Children Trainer and Named Clinician also jointly facilitate Safeguarding Babies training for Stockton and Hartlepool LSCB.

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. ESR competency reporting covers compliance for 12 months.



Level 1	Level 2	Level 3
93%	85%	89%

*Data obtained from the Trust safeguarding training

Looked After Children (LAC)

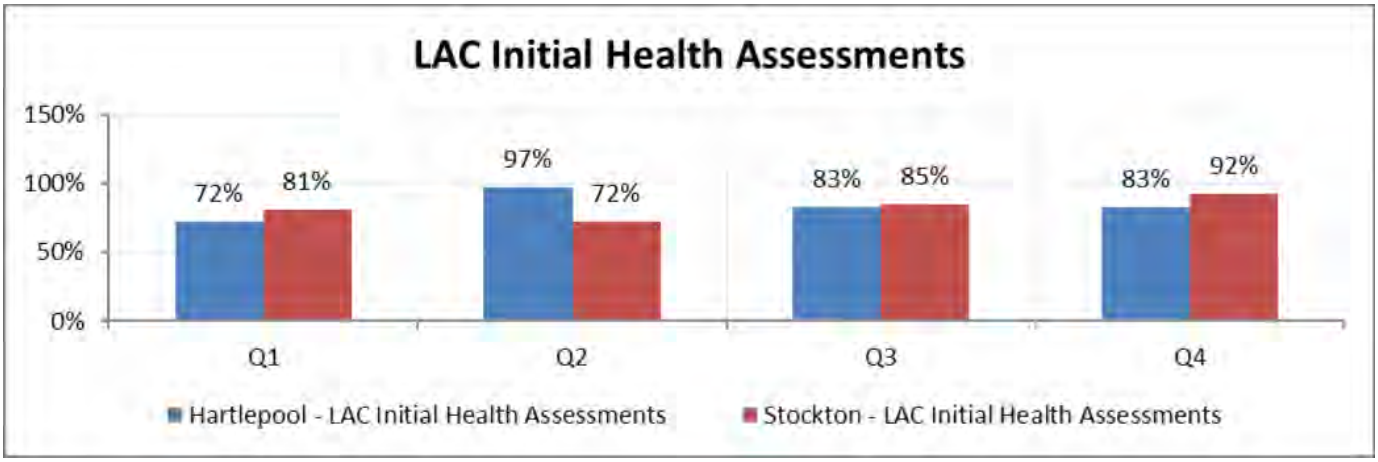
The services and responsibilities for LAC are underpinned by legislation, Statutory guidance and good practice guidance which include: "Statutory Guidance on Promoting the Health and Well-being of Looked After Children" (DH, 2015) and "Promoting the Quality of Life of Looked After Children and Young 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.
- The Trust continues to be represented and is an active member of the Children in Our Care Council in Stockton and Corporate Parenting Group in Hartlepool.

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:



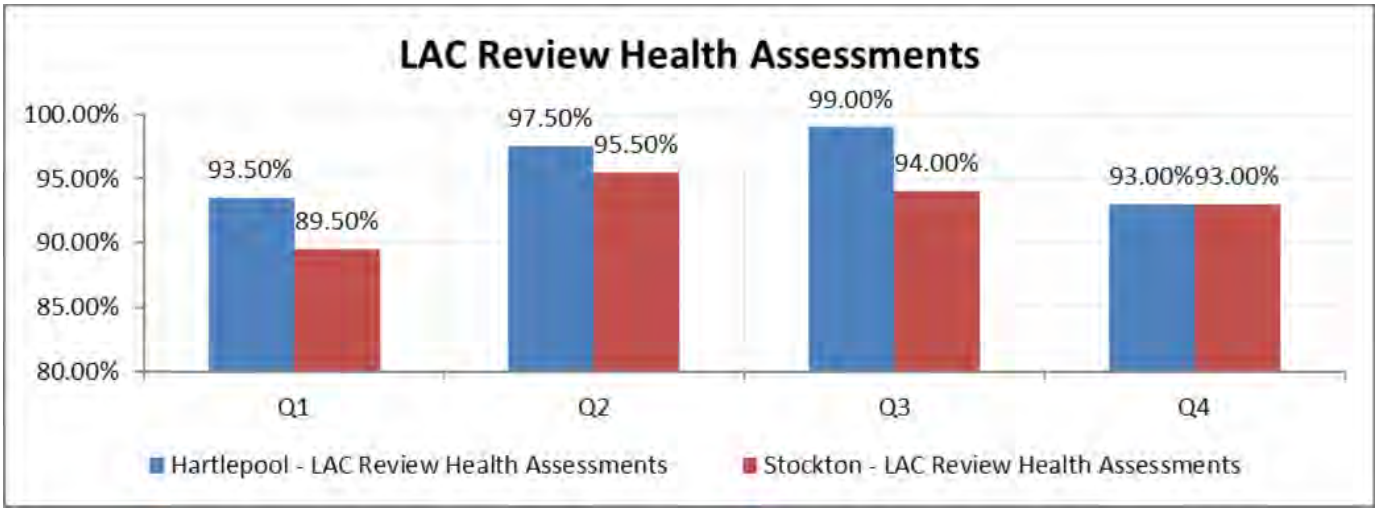
Regular LAC Performance Management Team Meetings identify any predicted increases in service demand so that resilience plans can be implemented to ensure sufficient capacity to respond. Points to note in relation to reduced compliance include:

- Not receiving timely and appropriate consent for IHAs affects the overall compliance rate and;
- Cancellations by carers continue to affect the rates of compliance. 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 and 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 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. In Hartlepool the IHA's are undertaken by The Trust's LAC team. To support this activity additional staff nurses have been recruited

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



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

- Capacity to undertake the RHA in services provided by out of area Providers
- Review assessments cancelled by carers
- Movement of placement without notification to the LAC Team

In response to the issues identified the Standard Operational Procedure was reviewed and updated. More recently an escalation pathway is sent out with every out of area request so that all agencies are aware of expected timescales and actions our LAC team will take if the RHA cannot be completed within timescales.

Closer working with current providers of the Stockton IHAs has been enhanced with the agreement of the LAC Service Specification.

Key Achievements 2018-19

- Ongoing updates and improvements to the Electronic Health Care Record to improve the identification of health trends in the LAC population;
- The sustained significant improvement in the completion of IHAs and RHAs within statutory timescales;
- All new LAC are now flagged within the child's health care record, including Systmone and Trak enabling early identification of vulnerability;
- CSE screening tool used on all LAC children over the age of 11 and;
- The recruitment of additional staff nurses to support the improvements to quality and timeliness of RHA's in Hartlepool.

Sensory Loss

The Trust has legal duties to meet individual's information, communication and support needs.

The Equality Act became law in October 2010; the act is aimed to improve and strengthen patients experiences by ensuring all service providers take steps to 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 has worked with colleagues to meet the key milestones and to ensure compliance and achievement of the Standard within the Trust's sphere of 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 document has also been improved to include recording in relation to any reasonable adjustments required to support the patient during their hospital stay. This is followed by the provision and application of associated care plans; these are reviewed and evaluated as part of daily assessments and rounding by the Matrons. Work is also progressing to update current electronic systems used in acute and community settings to ensure inclusion of the requirements of the Accessibility Standards 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

Sensory loss resource packs have been provided to all clinical areas to support staff and raise awareness of the different ways to communicate in addition to further specialist training sessions for nominated staff champions. There are plans to develop this further and to examine the feasibility of the provision of sensory loss packs containing relevant equipment that can be available at all times for immediate use.

Specialist Equipment

A previous audit of fixed hearing loop provision throughout the Trust highlighted the need to maintain and review the placement of the equipment to maximise its use. Since this audit there has been some focussed work to raise awareness amongst staff in relation to what equipment is available in their clinical areas.

Following the audit the portable hearing loops were 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. Over the coming year the Trust will be repeating the audit of hearing loops but also looking at what other specialist equipment is available for use.

Care Quality Commission Equality Objectives

CQC is legally required under the Equality Act 2010 to set quality objectives at least every four years. The new objectives for 2017 -19 include a section on Accessible information and communication.

The section examines how well providers meet the standard as part of CQC Regulation using agreed measures of success. It is proposed that providers meeting this standard can help improve:

- Access to services;
- How people experience care and treatment;
- The outcomes people receive; and
- The recent CQC inspection awarded the Trust an overall rating of **Good**.

Priority 1: Patient Safety
Infections

Rationale: The Trust continues to report on infections of:

- Clostridium difficile (C.diff),
- Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia;
- Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia; and
- Escherichia coli (E.coli)
- Klebsiella species (Kleb sp) bacteraemia; and
- Pseudomonas aeruginosa (Ps a) bacteraemia.

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	Overview of how we said we would report it	Completed and reported?	
We will monitor the number of Trust and non-Trust attributed cases	Report to Board of Directors	Reported to Board of Directors	✔
We will undertake a multi-disciplinary Root Cause Analysis (RCA) within 3 working days for all Trust attributed cases	Council of Governor meetings (CoG)	Reported at every Council of Governors meeting	✔
We will benchmark our progress against previous months and years	Infection Control Committee (ICC)	Discussed at each Infection Control Committee	✔
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	Patient Safety and Quality Standards Committee (PS & QS)	Reported to the Patient Safety and Quality Standards Committee (PS & QS)	✔
	To frontline staff through Chief Executive brief	Reported in detail to NHS Improvement	✔
	Safety, Quality and Infections Dashboard	Safety, Quality and Infections Dashboard contains infection data	✔
	Clinical Quality Review Group (CQRG)	Discussed in detail at Audit Committee and Directorate meetings	✔

Infection totals for 2018-19 - Hospital Acquired

The following demonstrates the total number of Hospital Onset infections the Trust acquired during 2018-19.

Infection	Infection Abbreviation	2018-19 Number of Hospital Onset Infections
*Clostridium difficile	C.diff	31
Methicillin-Resistant Staphylococcus Aureus bacteraemia	MRSA	0
Methicillin-Sensitive Staphylococcus Aureus	MSSA	21
Escherichia coli	E.coli	39
Klebsiella species bacteraemia	Kleb sp	20
Pseudomonas aeruginosa bacteraemia	Ps a	9

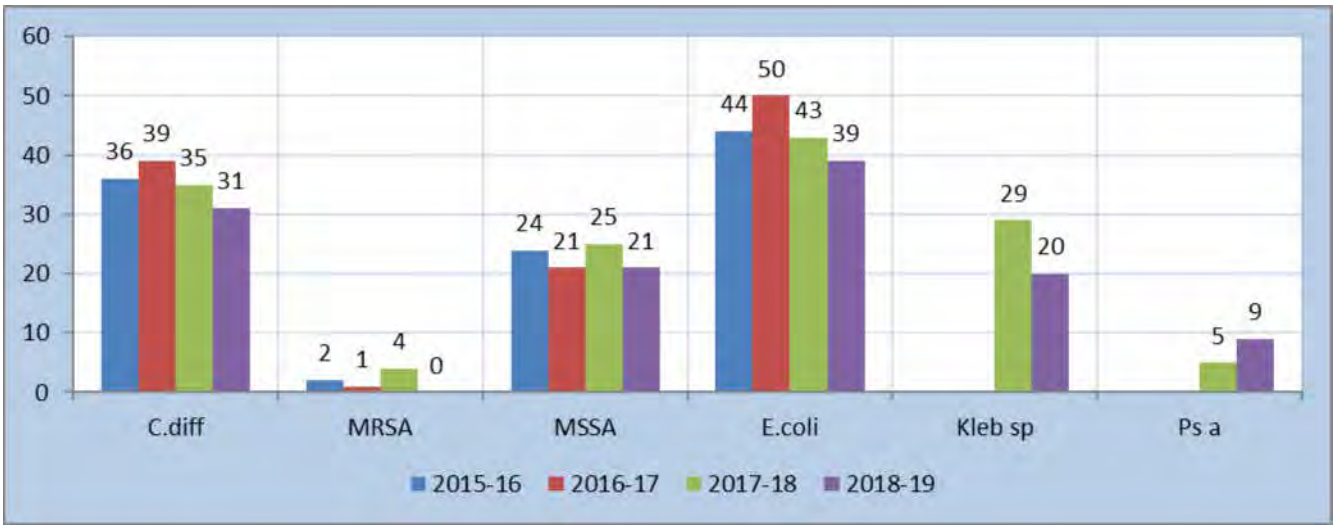
*NHS Improvement Objective 12

Hospital Acquired Infection Trends from 2015 to 2019

The following tables demonstrate the last three years of reporting for the six infections:

Infection Abbreviation	2015-16	2016-17	2017-18	2018-19	Trend
*Clostridium difficile	36	39	35	31	
Methicillin-Resistant Staphylococcus Aureus bacteraemia	2	1	4	0	
Methicillin-Sensitive Staphylococcus Aureus	24	21	25	21	
Escherichia coli	44	50	43	39	
Klebsiella species bacteraemia			29	20	
Pseudomonas aeruginosa bacteraemia			5	9	

**Data from Trust Infections team database



Clostridium difficile (C.difficile)

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 2018-19 the Trust did not achieve the Clostridium difficile objective having reported 31 Trust attributed cases against a trajectory of 12 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. However in this reporting year we have seen an improvement compared to the previous year. Our staff continue with all efforts 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 areas of our environment including enhanced decontamination with hydrogen peroxide vapour, the introduction of alternative technologies such as Ultra Violet light and the continued improved use of the internal mattress decontamination facility. The focus on antimicrobial stewardship has continued with the identification of further 'champions' across all directorates with a wider group of staff volunteering and Antibiotic Guardians in line with the Public Health England campaign. The importance of adherence to high standards of hand hygiene has continued to be a core element of our strategy and our hand hygiene champions are issued a monthly challenge to undertake to raise awareness and knowledge.

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

The following table identifies the number of hospital and community onset cases of C.difficile reported by our laboratory.

	Hospital Onset	Community Onset
2013-14	30	95
2014-15	20	71
2015-16	36	68
2016-17	39	73
2017-18	35	60
2018-19	**31**	**83**

***Trust Clostridium difficile cases 2013-19**

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

NHS Improvement have published the new CDI objectives for 2019-20. The changes are:

- Adding a prior healthcare exposure element for community onset cases
- Reducing the number of days to identify hospital onset cases from ≥3 days to ≥2 days following admission.

There will now be four categories for cases to be assigned:

1. Healthcare onset healthcare associated – these are cases that are identified 3 or more days after admission with the day of admission being day 1.
2. Community onset healthcare associated – these are cases that occur in the community or within 2 days of admission but where the patient has been in the trust in the previous 4 weeks
3. Community onset indeterminate association – these are cases that occur in the community or within 2 days of admission but where the patient has been in the trust in the previous 12 weeks but not the previous 4 weeks
4. Community onset community associated – these are cases that occur in the community or within 2 days of admission where the patient has not been admitted to the trust in the previous 12 weeks

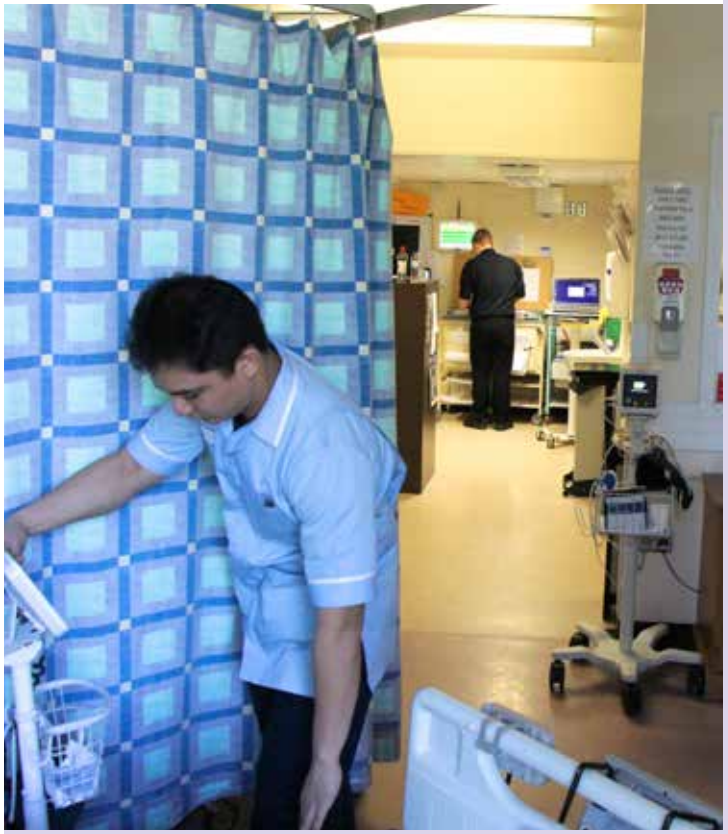
The Trust objective for 2019-20 will be **56** cases and will encompass cases that fall into categories 1 and 2. This will continue to be a challenging reduction objective for the Trust and work is underway to identify any additional actions required as a result of the changes.

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 colonisation. It is important that we screen some groups of high risk 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 an infection developing.

In 2018-19 our organisation reported zero hospital onset cases of MRSA bloodstream infection, which is an improvement on the previous year and in line with the national zero tolerance trajectory. No community onset cases have been reported this year.



	Hospital Onset	Community Onset
2013-14	0	4
2014-15	1	2
2015-16	2	3
2016-17	1	2
2017-18	**4**	**2**
2018-19	**0**	**0**

***Trust MRSA bacteraemia cases 2013-19**

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

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.

In 2018-19 we reported 21 cases of hospital onset MSSA bacteraemia. This is an improvement on the previous year. 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 further improvement can be achieved in this infection and increased emphasis on clinical practices continues to be a focus of our work to reduce the number of MSSA bacteraemia. A significant increase in community onset cases was seen this year. This may be due in part to an increased use of the sepsis screening protocol and an increase in the number of blood cultures sampled.The Trust will work with commissioners to understand why cases have increased.

	Hospital Onset	Community Onset
2013-14	13	30
2014-15	18	41
2015-16	24	64
2016-17	21	57
2017-18	25	71
2018-19	**21**	**93**

***Trust MSSA bacteraemia cases 2013-19**

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

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.

The numbers of E coli bacteraemia (blood stream infection) reported across 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. A national objective to reduce gram negative blood stream infections (E coli, Klebsiella and Pseudomonas) by 50% by 2021 is in place and within this to reduce E coli bacteraemia by 10% each year.

Root cause analysis is completed for cases deemed to have been hospital onset 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 there may be potential for improved practices. In 2018-19 the Trust participated in an initiative facilitated by NHS Improvement to reduce urinary tract infections (UTI) and our projects were very successful, achieving an 80% reduction in UTI for residents of the pilot care home. The lessons learned are now being rolled out further.

	Hospital Onset	Community Onset
2013-14	22	169
2014-15	28	176
2015-16	44	224
2016-17	50	267
2017-18	43	304
2018-19	**39**	**317**

***Trust E.coli bacteraemia cases 2013-19**

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

Klebsiella species (Kleb sp) bacteraemia

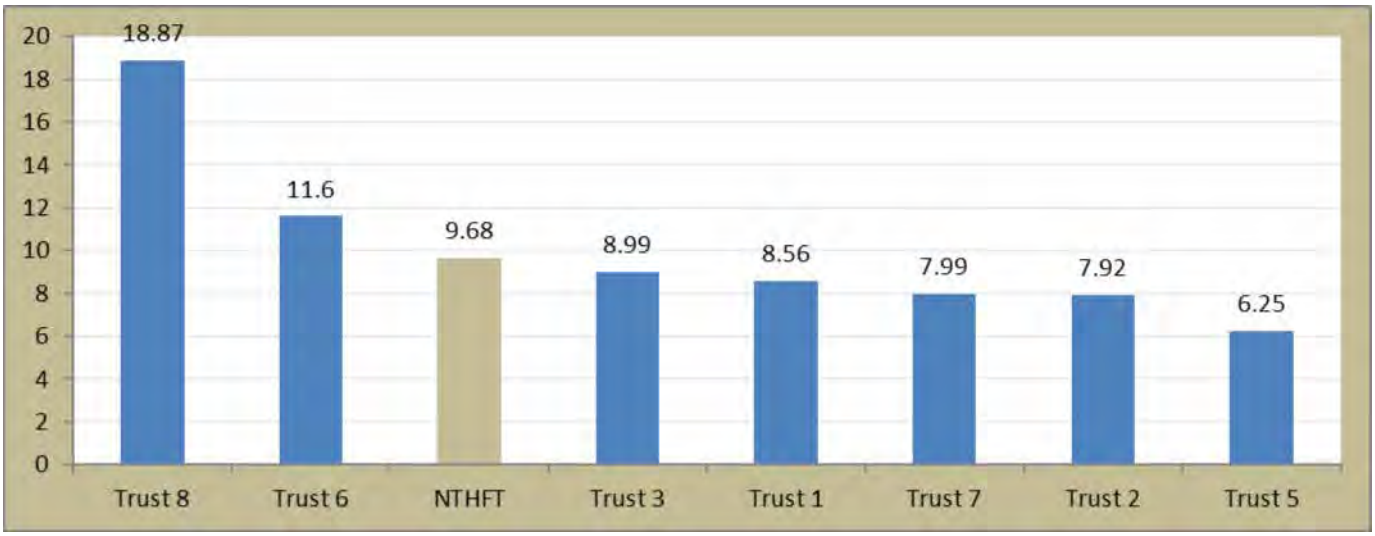
Klebsiella species are a type of bacteria that are found everywhere in the environment and also in the human gut, where they do not usually cause disease. These bacteria can cause pneumonia, bloodstream infections, wound and surgical site infections and can be associated with invasive procedures such as venous cannulation or urinary catheterisation.

In 2018-19 the Trust reported 20 Klebsiella species bloodstream infections which is an improvement on the previous year. There is no reduction target associated with this infection currently. Enhanced data collection is carried out on each case to understand if there are any common themes to the infections. This allows us to target our efforts effectively to reduce the number of cases further.

	Hospital Onset	Community Onset
2017-18	29	42
2018-19	***20***	***40***

***Trust Kleb sp bacteraemia cases 2017-19**

*Data obtained from Healthcare Associated Infections (HCAI) data capture system and
**Data obtained from the Healthcare Evaluation Data (HED) Apr 18 – Jan19



Pseudomonas aeruginosa (Ps a) bacteraemia

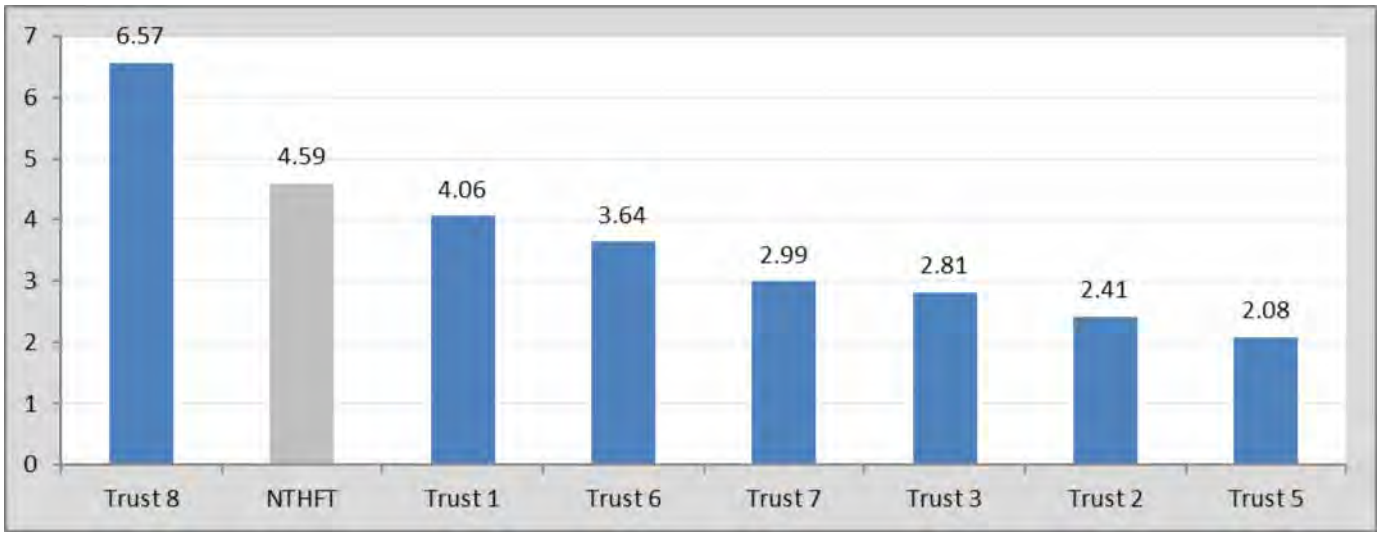
Pseudomonas aeruginosa is a bacterium often found in soil and ground water. It rarely affects healthy individuals but can cause a wide range of infections particularly in those with a weakened immune system. P aeruginosa is resistant to many commonly used antibiotics.

In 2018-19 the Trust reported **9** Trust attributed cases of Pseudomonas aeruginosa bloodstream infections which is an increase on the previous year, although still very small numbers. Many of these cases are considered to be unpreventable As with Klebsiella there is no reduction target assigned and enhanced data collection continues to better understand the sources of these infections.

	Hospital Onset	Community Onset
2017-18	5	19
2018-19	**9**	**20**

***Trust Ps a bacteraemia cases 2017-19**

*Data obtained from Healthcare Associated Infections (HCAI) data capture system and
**Data obtained from the Healthcare Evaluation Data (HED) Apr 18 – Jan19



Sepsis

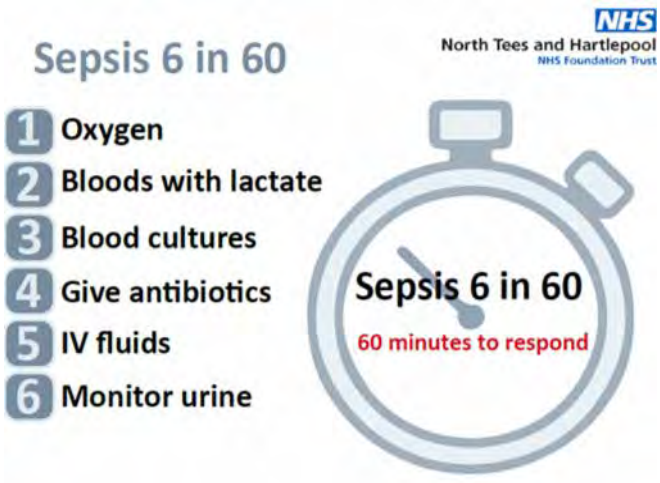
Sepsis, also known as blood poisoning, is the immune system's overreaction to an infection or injury. Normally the immune system fights infection, but sometimes for reasons that are not yet understood, it attacks the body's own organs and tissues. If not treated, sepsis can result in organ failure and death. Yet with early diagnosis it can be treated with antibiotics

In 2018-19 the Trust participated in data collection for a sepsis CQUIN, reviewing records from emergency care and in patient areas to assess compliance with screening processes, timely treatment and appropriate senior review of antibiotics. This information has been used to target education and awareness raising around sepsis. The compliance data can be seen below

	Q1	Q2	Q3	Q4
Number of cases reviewed	300	321	304	305
Number eligible for screening	289	296	273	275
screening compliance %	73%	73%	78%	85%
Treatment within 1 hour %	85%	89%	82%	89%
Antibiotic review within 24-72 hours	89%	99%	99%	99%

Actions taken to improve the recognition and treatment of sepsis include:

- Review of the sepsis screening tool with regional agreement on a standard approach
- Introduction of an e observation programme
- Introduction of electronic prescribing and medication administration (EPMA) system which improves accuracy of records and facilitates audit
- Introduction of the NEWS2 observation record with training to support this
- Introduction of changes to ICE laboratory system to ensure requests for blood cultures now automatically results in a request for lactate level
- Identification of directorate sepsis champions with responsibility for prospective communication, audit and training
- Teaching sessions on sepsis diagnosis and management
- Use of a sepsis reminder as a screensaver




Laparoscopy Suite

Priority 2: Effectiveness of Care
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	Overview of how we said we would report it	Completed and reported?	
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	Report to Board of Directors	Reported to Board of Directors	✔
	Report at every Council of Governors meeting	Reported at every Council of Governors meeting	✔
	On the Safety, Quality and Infections Dashboard	Reported on the Safety, Quality and Infections Dashboard	✔

Safety Thermometer Data

The Safety Thermometer data can be found at: https://www.safetythermometer.nhs.uk/index.php

Safety Thermometer is split into five audits; these are Classic, Medication, Mental Health, Maternity and Children & Young People. The Trust does not partake in the Mental Health survey, as the Trust is not a Mental Health Trust, the audits the Trust participates in are as follows:

The Classic Safety Thermometer is a measurement tool for improvement that focuses on the four most commonly occurring harms in healthcare: pressure ulcers, falls, UTI (in patients with a catheter) and VTEs.

Data is collected through a point of care survey on a single day each month on 100% of patients. This enables wards, teams and organisations to: understand the burden of particular harms at their organisation, measure improvement over time and connect frontline teams to the issues of harm, enabling immediate improvements to patient care.

The Classic Safety Thermometer is a measurement tool for improvement that focuses on the four most commonly occurring harms in healthcare: pressure ulcers, falls, UTI (in patients with a catheter) and VTEs.

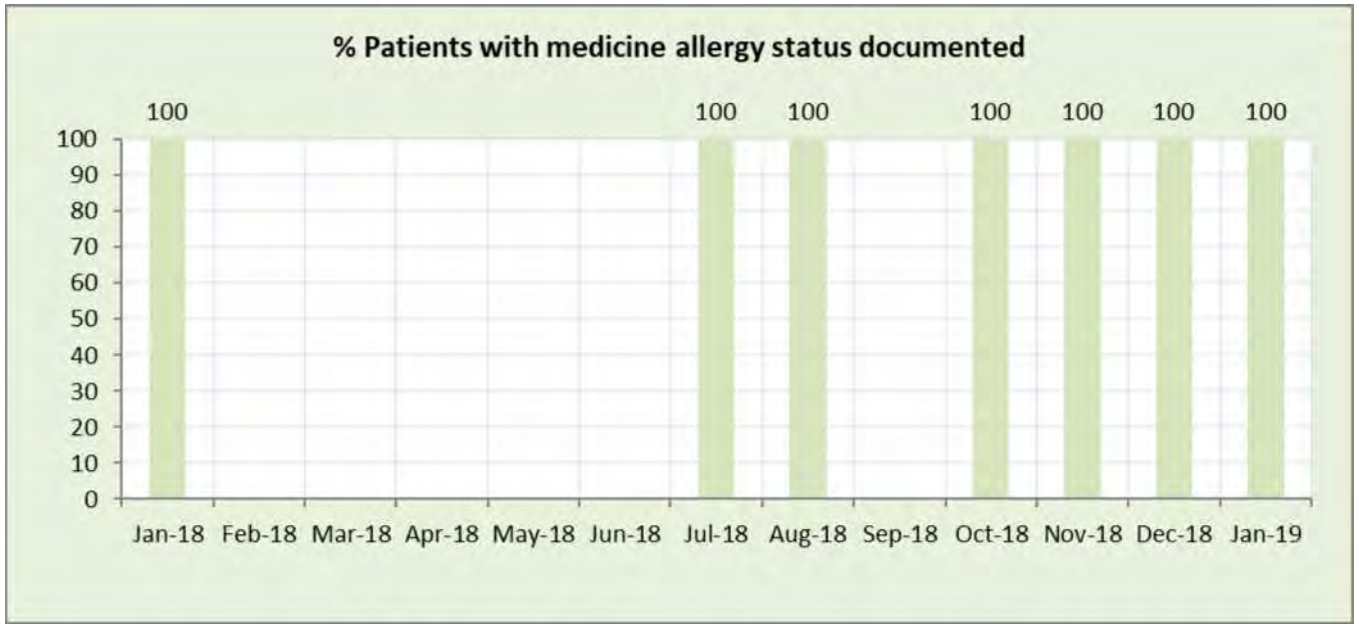
	Jan-18	Feb 18	Mar-18	Apr-18	May 18	Jun-18	Jul-18	Aug 18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
Harm Free %	**98.70**	**97.29**	**97.82**	**98.57**	**98.12**	**97.32**	**98.55**	**98.42**	**98.57**	**98.13**	**98.47**	**97.95**	**97.86**
Ulcer %	0.36	0.25	0.48	0.66	0.71	1.22	0.22	0.61	0.39	0.23	0.71	1.03	1.18
Falls %	0.00	1.11	1.45	0.33	0.47	0.37	0.34	0.00	0.26	0.35	0.12	0.39	0.00
VTE %	0.71	0.49	0.12	0.22	0.47	0.73	0.45	0.85	0.39	0.70	0.59	0.26	0.85
UTI %	0.24	0.98	0.12	0.33	0.24	0.61	0.45	0.12	0.39	0.58	0.12	0.39	0.11

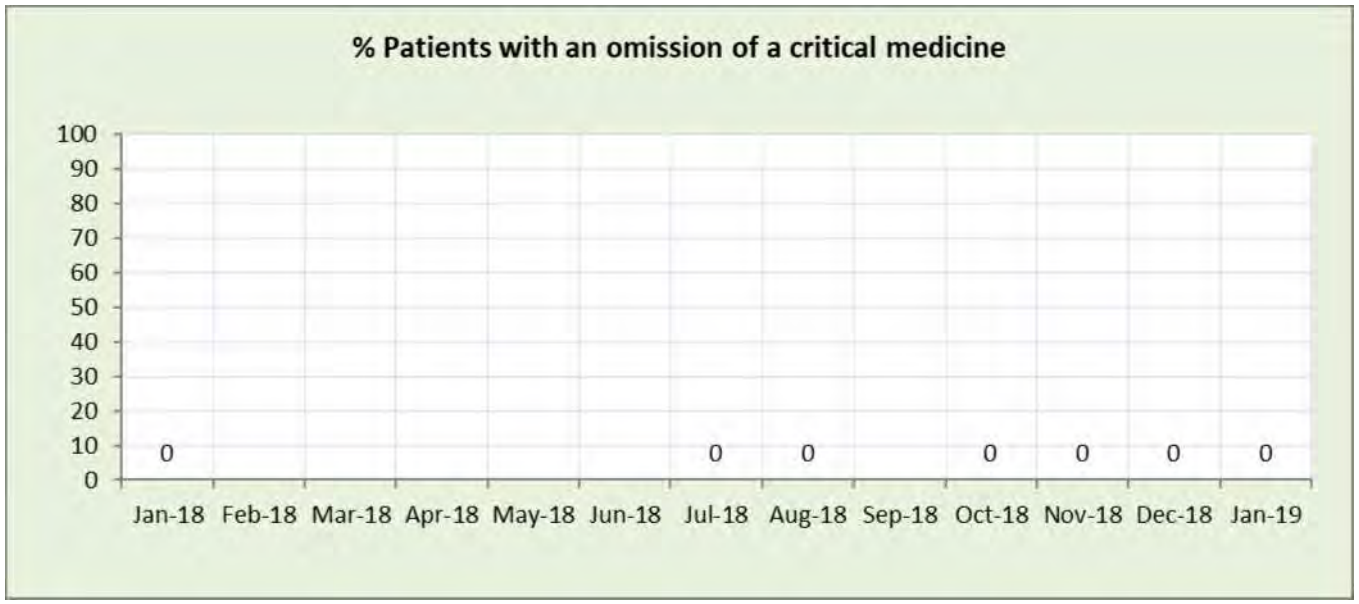
*All data from www.safetythermometer.nhs.uk/index.php

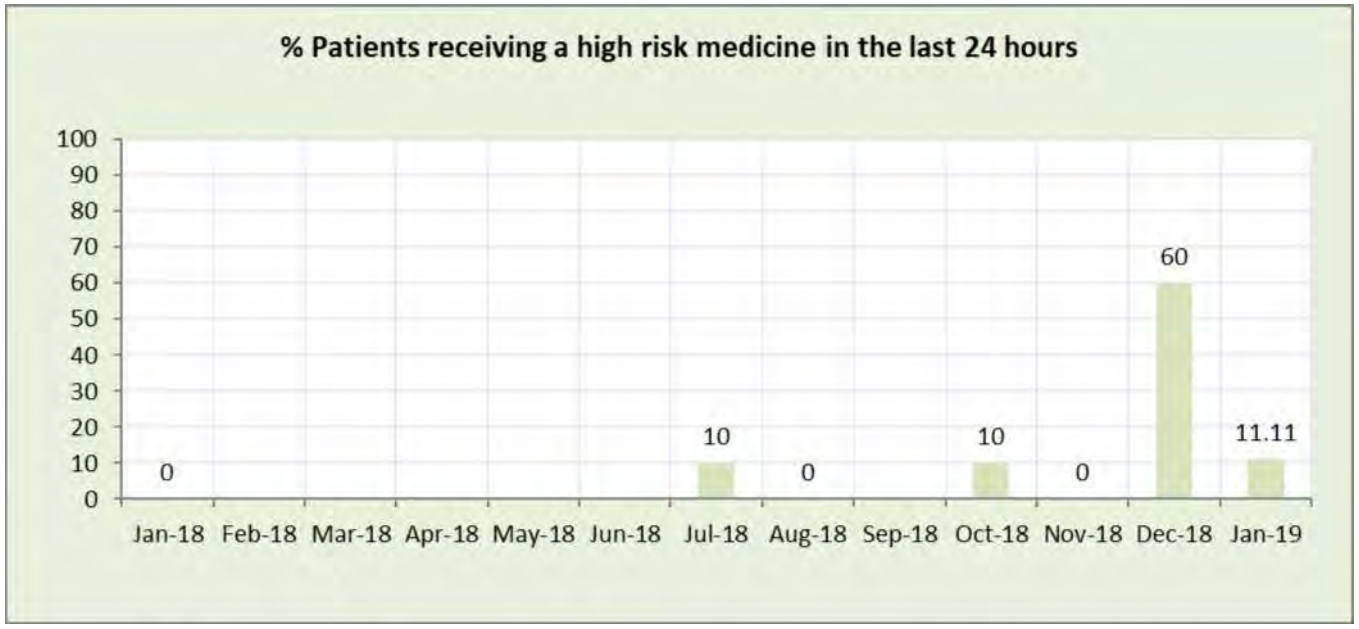
The Medication Safety Thermometer is a measurement tool for improvement that focuses on: medication reconciliation, allergy status, medication omission, and identifying harm from high risk medicines.

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
% Patients with medicine allergy status documented	100						100	100		100	100	100	100
% Patients with an omission of a critical medicine	0.00						0.00	0.00		0.00	0.00	0.00	0.00
% Patients receiving a high risk medicine in the last 24 hours	0.00						10	0.00		10	0.00	60	11.11

For the month of Feb 18 to Jun 18 and Sept 18 – no data was returned
*All data from www.safetythermometer.nhs.uk/index.php


% Patients with medicine allergy status documented
100
100
100
100
100
100
100
100
100
90
80
70
60
50
40
30
20
10
0
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19

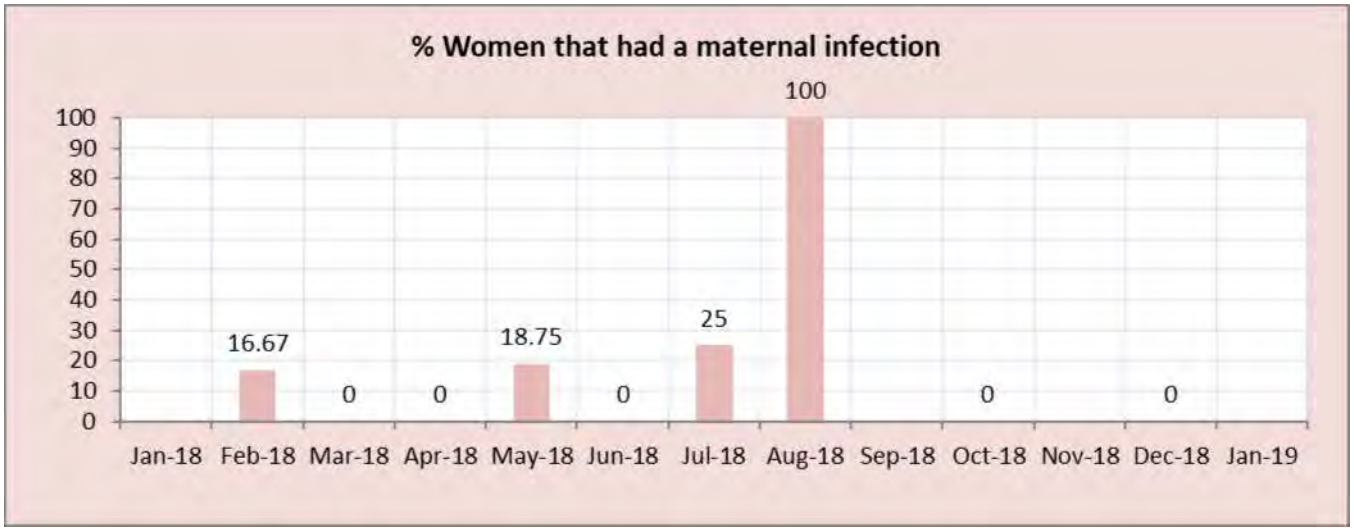

% Patients with an omission of a critical medicine
0
0
0
0
0
0
0
100
90
80
70
60
50
40
30
20
10
0
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19


% Patients receiving a high risk medicine in the last 24 hours
0
10
0
10
0
60
11.11
100
90
80
70
60
50
40
30
20
10
0
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19

The Maternity Safety Thermometer is a measurement tool for improvement that focuses on: perineal and abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety.

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
% Women that had a maternal infection		16.67	0	0	18.75	0	25	100		0		0	
% women who were left alone at a time that worried them		0	14.29	0	0	11.11	0	0		0		0	

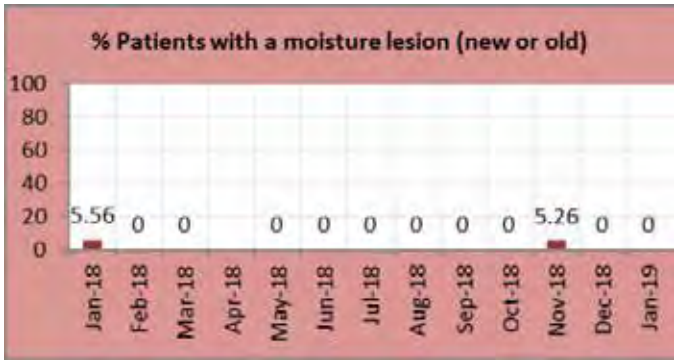
For the months of Jan 18, Sep 1, Nov 18 and Jan 19 – no data was returned
*All data from www.safetythermometer.nhs.uk/index.php

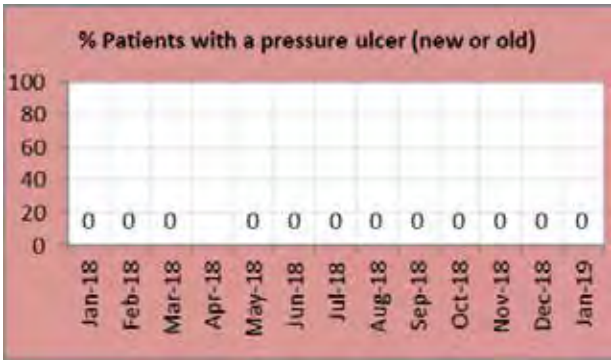


The Children and Young People's Services Safety Thermometer is a national tool that has been designed to measure commonly occurring harms in people that engage with children and young people's services.

	Jan-18	Feb 18	Mar-18	Apr-18	May 18	Jun-18	Jul-18	Aug 18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
% Harm Free Care	72.22	38.46	72.22		80.00	92.31	16.67	100.00	61.54	100.00	57.89	100.00	83.33
% Patients with a moisture lesion (new or old)	5.56	0	0		0	0	0	0	0	0	5.26	0	0
% Patients with a pressure ulcer (new or old)	0	0	0		0	0	0	0	0	0	0	0	0

For the month of Apr 18,– no data was returned
*All data from www.safetythermometer.nhs.uk/index.php





Priority 2: Effectiveness of Care

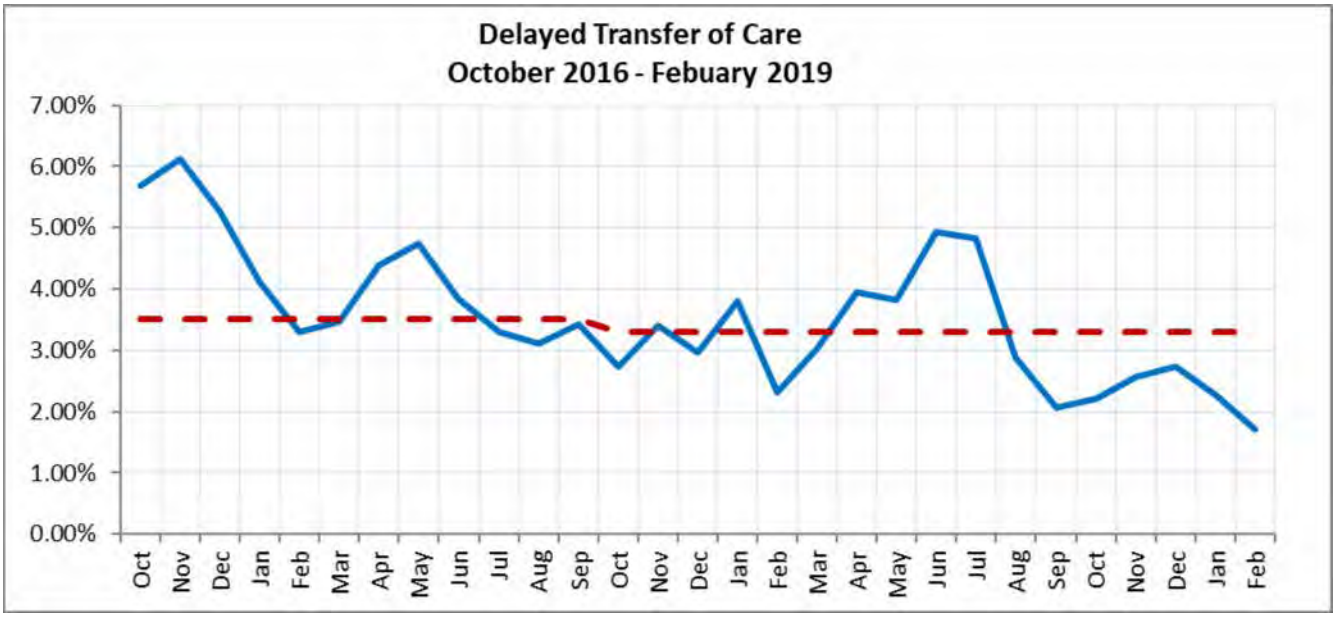
Discharge Processes

Rationale: All patients must have a safe and timely discharge once they are able to go back home.

Overview of how we said we would measure it	Overview of how we said we would report it	Completed and reported?	
Via national and local patient surveys Quarterly analysis of discharge incidents on Datix	National inpatient survey report to PS & QS	Reported National inpatient survey report to PS & QS	✔
	To the Discharge Steering Group	Reported to the Discharge Steering Group	✔

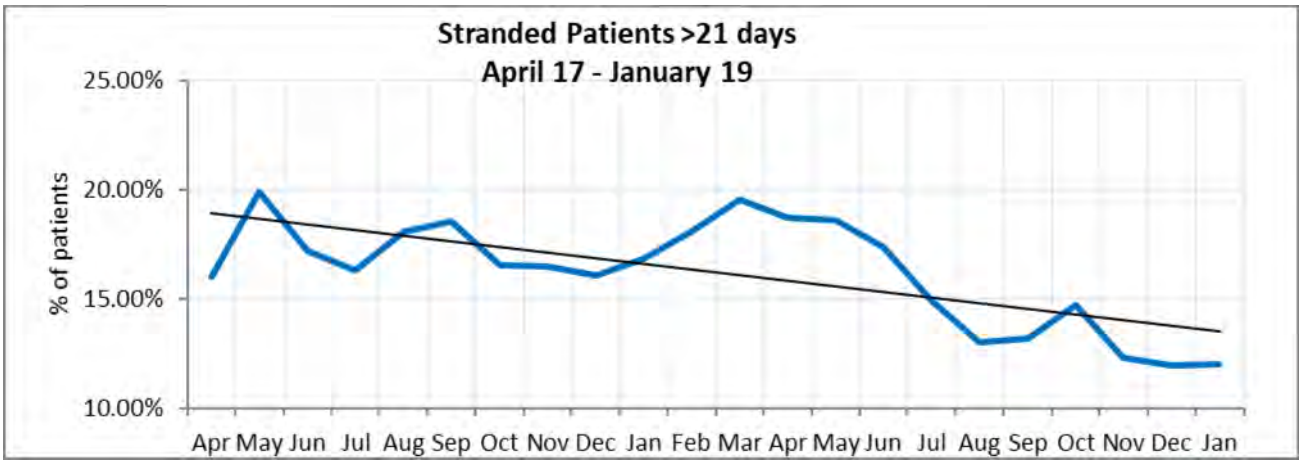
Delayed transfers of care (DToC) – October 2016 to February 2019

The Trust and our partners in social care and commissioning have worked together to reduce the number of delayed transfers of care from our Hospitals. The graph below demonstrates the significant reduction in delayed discharges and this is testament to all of the hard work in this area.



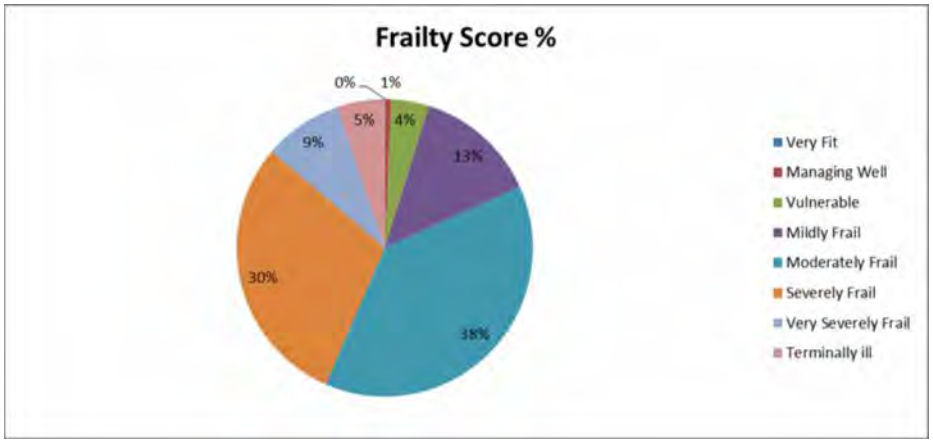
Super stranded patients

The graph below demonstrates the continued reduction of patients that remain in hospital after 21 days. The Organisation has worked hard to implement a weekly super stranded audit to understand why patients are in hospital for prolonged periods of time and to take actions to influence any themes that have been identified. This approach has been recognised by NHS Improvement and our front line teams are embracing the weekly review.



Frailty Coordinators

The frailty coordinator pilot was introduced in January 2018 and has been extended to the present time. To date the coordinators have had involvement with over 1300 patients. The coordinators work across 7 days and support both admission avoidance work as well as expediting discharge from in hospital areas. The graph below demonstrates the severity of the frailty that this cohort of patients has presented with as well as the average Length of Stay (LOS) for each patient. The pilot has been extended to support the winter months due to the positive feedback the service has had from patients, their families and carers and staff across the areas.



NHSi Allied Health Professional (AHP) Challenge

A team of Physiotherapists and Occupational Therapists took part in the 90 day challenge to deliver an improvement project to support patient flow. The team led by one of the Trust's Frailty coordinators delivered a project looking at getting patients home before 12pm. The team focused on two in hospital areas and 'tested' out short cycles of improvement looking at therapy led discharge, facilitating transport home and working with other members of the multidisciplinary team to remove any barriers. The team have attended an improvement summit in Birmingham and will be working with stakeholders to role this approach out to other areas.

Low level support pathways

During 2018 – 19 the integrated discharge team have been supported by teams from local communities to facilitate low level practical support when people are leaving hospital. The schemes were very well received by the staff and patients, the support workers were able to take patients home and check they had everything they needed to manage back in their home environments.

Help Force

North Tees and Hartlepool have been successful in securing a partnership with Help Force the national organisation for volunteers working in the NHS. The project will be led by the Trust's Volunteer coordinator who will be delivering a 'Home in time for lunch – buddy volunteer' service that will support patients to get home in a safe and timely manner. The scheme which is due to go live in April 2019 will be supported by existing Trust volunteer drivers and additional volunteers that will be recruited as part of the project.

New discharge pathways

In December 2018 the Trust launched new discharge pathway arrangements in partnership with local authorities. The drivers behind the changes were to increase the number of patients being discharged safely to their usual place of residence and to reduce the number of continuing healthcare assessments completed in hospital. The referral process has been streamlined and this is saving time for ward staff giving them more time to care for their patients. Evaluation of the changes will happen in due course however early indications suggest that key performance metrics are heading in the right direction.

7 day working for therapy service

The Physiotherapy and occupational therapy teams started to work across 7 days in December 2017. The team work across all in hospital areas to support patient flow, remove barriers for discharge and where possible prevent admissions. The support on a weekend has been very well received by nursing and medical staff and we continue to work with colleagues in hospital to embed weekend huddles.

Community integrated assessment team (CIAT)

CIAT a team of therapists, nurses and therapy assistants provide a 7 day extended hour service to emergency care and community areas. The team work together with community teams to prevent patients being admitted to hospital and respond to crisis in the community. Recently, the team have been working with the North East Ambulance Service (NEAS) to avoid patients arriving at emergency care inappropriately when care can be delivered in the community. The team are building on the work that the emergency care therapy team have been delivering for several years. In July 2018 a rapid response nurse joined the team and has been working with acute based medical and nursing teams to encourage care in the community.

Integrated single point of access pilot (ISPA)

Out of hospital care staff are working closely with staff from Hartlepool Borough Council to pilot an integrated approach to supporting patients and their families. The drivers behind the project have been to stream line services for our people, preventing a duplicated approach to care and ensuring patients receive the right care in the right place delivered by the right people. The pilot is supporting hospital staff in terms of facilitating discharge.

Priority 2: Effectiveness of Care

Safety and Quality Dashboard

Rationale: The Safety and Quality 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	Overview of how we said we would report it	Completed and reported?	
Senior Clinical Matrons (SCMs) will monitor ward areas to ensure that data is up to date, accurate and displayed in a public area	Report to Board of Directors	Reported to Board of Directors	✔
	Report at every Council of Governors meeting	Reported at every Council of Governors meeting	✔

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:

- Complaints, Stage 1 to 3
- Patient Falls
- Pressure Ulcers Grade 1 to 4
- Infection Control
- Medication Errors
- Falls Audit Information
- Patient and Staff Experience Surveys
- Hand Hygiene Audit
- Nurse Staffing Rates (UNIFY Data)
- Temporary Staffing
- Sickness Rates (%)
- Appraisal Rates (%)
- Friends and Family Test
- Learning Environment (Student placement feedback)
- Safety Thermometer

Trust_Position

Trust Position

Safety & Quality Dashboard

NHS North Tees and Hartlepool NHS Foundation Trust

Heatmap | Open Incidents | Open Complaints | Print Page

Previous 6 days | Latest | Month on Month

Complaints	Tuesday 28/08/2018	Wednesday 29/08/2018	Thursday 30/08/2018	Friday 31/08/2018	Saturday 01/09/2018	Sunday 02/09/2018	Monday 03/09/2018	August	September	Vs Previous Month	Financial Year to date	
Stage1 - Informal	5	2	4	3				77	0	⇩	306	Complaints Dashboard
Stage2 - Formal meeting								6	0	⇩	42	
Stage3 - Formal CE letter	2	1						15	0	⇩	73	

Falls	Tuesday 28/08/2018	Wednesday 29/08/2018	Thursday 30/08/2018	Friday 31/08/2018	Saturday 01/09/2018	Sunday 02/09/2018	Monday 03/09/2018	August	September	Vs Previous Month	Financial Year to date	
Patient Fall NO Injury	3	4	4		2	1		79	3	⇩	484	Falls Dashboard
Patient Fall Injury NO Fracture		1						7	0	⇩	99	
Patient Fall FRACTURE								0	0	⇨	6	

Pressure Ulcers	Tuesday 28/08/2018	Wednesday 29/08/2018	Thursday 30/08/2018	Friday 31/08/2018	Saturday 01/09/2018	Sunday 02/09/2018	Monday 03/09/2018	August	September	Vs Previous Month	Financial Year to date	
Grade 1								18	0	⇩	94	Pressure Ulcers Dashboard
Grade 2	5	2	2	3	2			88	5	⇩	357	
Grade 3			1	1	2			18	3	⇩	78	
Grade 4					1			0	1	⇧	9	

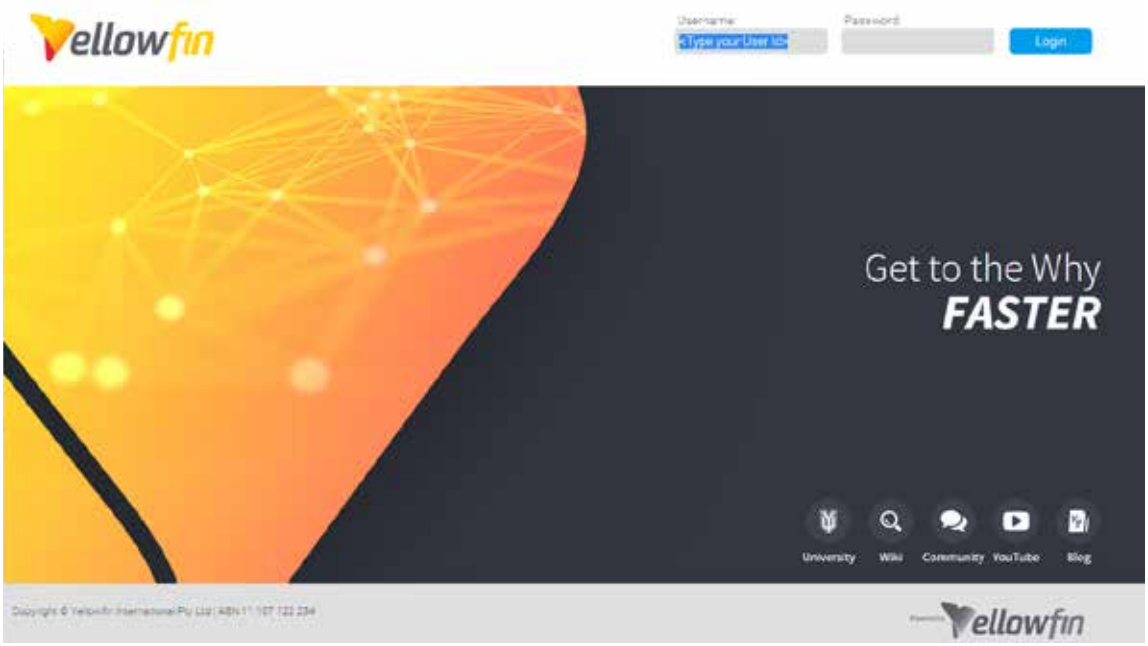
Infections	Tuesday 28/08/2018	Wednesday 29/08/2018	Thursday 30/08/2018	Friday 31/08/2018	Saturday 01/09/2018	Sunday 02/09/2018	Monday 03/09/2018	August	September	Vs Previous Month	Financial Year to date	
Cdiff		1						4	0	⇩	12	Infections Dashboard
MRSA								0	0	⇨	0	
MSSA								2	0	⇩	6	
Ecoli								1	0	⇩	19	
Klebsiella species (Kleb sp)								1	0	⇩	8	
Psuedomonas aeruginosa (Ps a)								0	0	⇨	2	
CAUTI								0	0	⇨	55	

Medication Errors	Tuesday 28/08/2018	Wednesday 29/08/2018	Thursday 30/08/2018	Friday 31/08/2018	Saturday 01/09/2018	Sunday 02/09/2018	Monday 03/09/2018	August	September	Vs Previous Month	Financial Year to date	
Number of Medication Errors	1	1	1			1		42	1	⇩	286	Medications Dashboard

Business Inteligence (BI)

During quarter 4 2018-19 the Trust procured a dedicated Business Intelligence software product, Yellowfin. This software will be used to create dashboards within the organisation, to automate reporting of some data, reduce manual intervention and to move the Trust forward in how data is used, displayed and understood throughout the organisation.

There is a programme of works which has been established to rollout differing dashboards throught the new financial year.



Priority 2: Effectiveness of Care
Learning from Deaths

Learning from deaths of people in their care can help providers improve the quality of the care they provide to patients and their families, and identify where they could do more.

In March 2017, the National Quality Board (NQB) introduced new guidance for NHS providers on how they should learn from the deaths of people in their care.

For overiew of how we said we would do it, see page 182.

During **April 2018 to March 2019**, 1,462 of North Tees and Hartlepool NHS Foundation Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

342 in the first quarter;
317 in the second quarter;
406 in the third quarter;
397 in the fourth quarter.

By **31 March 2019**, 194 case record reviews and **16** investigations have been carried out in relation to **194** of the deaths included above.

In **16** cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

4 in the first quarter;
9 in the second quarter;
0 in the third quarter.
3 in the fourth quarter.

0 representing **0%** of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. To date there remain 5 investigations that are ongoing.

In relation to each quarter, this consisted of:

0 representing **0%** for the first quarter;
0 representing **0%** for the second quarter;
0 representing **0%** for the third quarter;
0 representing **0%** for the fourth quarter;

This number have been identified using the "Prism 2" methodology; this provides a structured review of a case record, carried out by clinicians, to determine whether there were any problems in care. Where a case has also been reported as a Serious Incident, a comprehensive investigation is completed to identify the root cause of the case and identify service and care delivery problems where improvements may be required.

Learning Disabilities

The Trust has continued to be involved in the national Learning Disabilities Mortality Review (LeDeR) process specifically looking at all deaths of people with a learning disability, these reviews are comprehensive, looking at the full life span of the person and identifying areas where care could be improved to enable the person to live a longer life, we also identify good practice.

Nationally these reviews have been scrutinised and four areas for development have been identified with actions being developed regionally and nationally. The areas are:

- aspiration pneumonia
- easy read health promotion
- constipation
- carers recognising the deteriorating patient.

Fact sheets have been developed by LeDeR for these four areas and are available on the national LeDeR website. Regionally, the Learning Disability team have developed a STOP and WAIT tool to work with non-hospital carers to help identify deteriorating patients to then ensure appropriate and timely access to health care.

Within the Trust reviews we have identified good practice, including evidence of multi-agency work to reduce the risk of self-neglect behaviour with good effect and excellent evidence of using community services to help complex patients avoid a hospital admission. We have identified one area for action, which was the follow up treatment and advice for someone who was obese and presenting to hospital. As a result of looking at this from a multi-agency point of view, we have identified that North of Tees Learning Disability Community Team does not have a specialist dietician where equivalent regional teams have this provision.

In order to encourage people with a learning disability to access bowel screening, the Trust bowel screening team

have completed a refresh of their website which includes easy read information and accessible information. This has been shared with community learning disability teams, local carers groups and local Learning Disability Partnership boards for information and feedback.

In order to increase overall knowledge and awareness the Trust is also including Learning Disability and Autism awareness sessions as part of the mandatory training for all staff groups during 2019-20.

Avoiding admissions in the frail and elderly

The Trust has also become part of collaborative work with the local care homes based around improving care to frail, elderly patients and reducing the need to admit these patients into hospital. The North Tees and Hartlepool Education Alliance is a partnership of local care providers (NHS, charitable and private), commissioners and local authorities which aims to transform the care provided across all sectors.

The overall aims of this alliance are:

- Promotion of well-being for residents within care homes
- To improve quality of care provision
- Equip staff with the knowledge to recognise signs and symptoms of deterioration within the residents
- Reduce admissions and readmissions to hospital
- Increase the confidence and knowledge of staff when referring to other services
- Encourage collaborative working

In order to assist in achieving this, the Trust is coordinating the provision of training around various topics and the Alliance is continually evaluating the overall impact; one of its measurable outcomes it the reduction of emergency admissions from care home and it has been identified that this has already been achieved. The Alliance will be continuing to ensure this positive improvement on the care provided to the frail and elderly continues.

End of Life care

Subsequent to learning from mortality reviews, end of life care planning across the organisation, supported by the Specialist Palliative Care Team (SPCT) as a part of the Out of Hospital Care Directorate (OOHC) has continued to develop and progress.

This has included work undertaken to update the Trust Resuscitation policy; with an addendum now added to enable suitably trained Senior Nurses, Clinical Nurse Specialists and Allied Healthcare Professionals (AHP's) to be able to complete regional Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms. Advance Care Planning remains a priority topic in teaching across the organisation and beyond and is now delivered to nurses, medics and students across the disciplines. This includes the proposed Trust-wide rollout of the AMBER Care Bundle.

Changes to the way we use our IT Systems has enabled integration into the Trust SystmOne modules, the ability to pass "Special Patient Notes" directly to the North East Ambulance Service (NEAS) Control Room via secure electronic system. This is promoting greater partnership working and also improved patient experience should our emergency service colleagues need to attend the patient in their place of residence.

To enable and empower patients and those close to them to tell of their experience around palliative and end of life care, the Trust continues to be part of the Palliative & End of Life Project (PEOLC) run by Care Opinion/ Hospice UK, supported by the Scottish Government. The project is supporting 12 clinical teams, selected through an application process and representing a diversity of hospice, hospital and community care services in different parts of the UK, with North Tees & Hartlepool NHS Foundation Trust being one of the 12.

The Care Opinion project has encouraged patients, and those close to them, to share their stories of palliative and end of life care. Whilst there are only few stories to date, they have started to tell us what we do well and what could be done better. Reviewing this information in such a timely manner has enabled us to look at making improvements quickly as issues come to light.

To ensure there is additional resilience in the Specialist Palliative Care Team to be able to support clinical teams with end of life care, we developed an innovative approach of a Specialist Palliative Care Nursing Bank. We have become the first Trust regionally to establish Specialist Bank staffing in partnership with NHS Professionals.

Greater work on pathway design and strategic development around palliative and end of life care services continues to be ongoing between the organisation and strategic stakeholders across the North Tees & Hartlepool NHS Foundation Trust geographical footprint.

The introduction of the "e-observations" module as part of the electronic patient record will support improvements in the identification and monitoring of the deteriorating patient. This will potentially highlight patients who may then be identified as approaching end of life care, through the decision to stop routine clinical physiological observation. We are looking to work with IT colleagues to introduce monitoring of 'Comfort Observations' at that time; these observations will look at

comfort, symptoms and care of the patient and family, in accordance with the regional 'Caring for a Dying Patient Document (CDP).

There are further plans to enhance the collaborative working between the specialist palliative and end of life care team (SPCT) and Critical Care Outreach Team (CCOT), this is in order to improve and support smoother transition of care, ceilings of treatment, management planning and identification of patients with uncertain recovery. This will be developed alongside the planned stratified introduction of the AMBER Care Bundle across the inpatient areas of the organisation.

The development of an End of Life Forum within the organisation has been identified as a key priority for the coming year; this work will be led by the Macmillan Lead Nurse for End of Life Care & the Lead Chaplin. This will support the development of 'Role Champions' across all clinical areas to raise the profile of Palliative and End of Life care which is also planned across the coming year.

In a drive to improve awareness around the importance of palliative and end of life care, in conjunction with our communications team colleagues, the SPCT will be developing a strategy to improve public facing information around palliative care, end of life care, Advance Care Planning and Priorities of Care. This will include the development of a 'Care Opinion Wall', social media campaign and events in the annual 'Dying Matters Week.'

The Trust will be continuing its on-going commitment to supporting national developments around uncertain recovery, palliative care and end of life care with representation in the AMBER Care Bundle Strategic Network, along with a clinical advisor representative in the national EOLC Practitioners Network, being developed by NHS Improvement. Education of staff across all professional groups will continue to remain a high priority around end of life care, with study days and opportunities planned throughout the coming year, including a Collaborative GP/Consultant event.

Engagement with families/carers

The Trust has for the last 2 years actively encouraged feedback from families and carers in relation to how they feel bereavement is handled. All families are provided with a "bereavement survey" to complete, when they feel ready, to provide information on their experiences and if they think there is something staff can do to improve care and communication at such a difficult time.

Since the introduction of the survey there have been 151 completed and returned to date. The majority of these provide very positive feedback about the care provided and this is passed on to the relevant ward and staff involved. There are others where concerns have been identified; these have been shared with the relevant areas and also the Trusts Patient Experience team, a number of these have been handled through the Trusts complaints process. Many of the issues raised through the survey relate to communication and compassion; these are disseminated across the organisation for overall learning but are also taken into account through the updates and training provided by the SPCT as described in the previous section.

The survey also gives families an opportunity to request that a mortality review is completed by the Trust; families are asked to supply the details of the patient to support this. To date in 2018-19, 20 such requests have been made. Many of the requests for reviews are made despite positive feedback being provided on the survey; there are also a significant number of surveys returned where concerns are raised but no details are given to support identifying the patient involved. As a result the Trust is looking at changing the wording on the survey to help support families and carers. All requests for reviews are followed up and completed; to date none have had to be escalated as a result of possibly being preventable.

Perinatal Mortality Review Tool

In response to the recommendations of the MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK) reports, the Department of Health on December 2017 issued guidance that all Trusts should ensure that all stillbirths and neonatal deaths are reviewed by an appropriate multidisciplinary team using a standardised mortality review tool and process. Recommending that MBRRACE-UK should work closely with Trusts in order to build on the skills and experience developed through stillbirth audit to establish a process for ongoing quality assurance of local mortality to identify learning from cases.

The standardised Perinatal Mortality Review tool (PMRT) has been introduced to support this work and the Trust has implemented the use of this tool to support the completion of high quality reviews of stillbirths and neonatal deaths. The PMRT is designed to facilitate robust, systematic, multidisciplinary reviews with parental involvement and come to a clear understanding of why each baby died and whether with different actions the death of their baby might have been prevented. The tool development is an iterative process with on-going opportunities to develop and improve the tool during the two-year pilot 2018-20.

The overall aim of the clinical review process for stillbirths is to try to explain to parents why their baby may have died and secondly, to support the Trust to identify areas for learning. The use of tools such as PMRT, as a framework to support case review, is standardising processes and preventing conclusions

being drawn without full analysis of the facts. However, the value of multi-professional, cross organisational discussions is central to good review of care. External review to provide objectivity undoubtedly has a role to play in quality assuring processes, and also demonstrating transparency to families and the wider public. It is necessary that only those staff with in-depth local knowledge of systems, processes and culture will be able to provide the appropriate context and understanding required to identify and solve problems. Relevant clinical staff may benefit from additional training to lead and/or participate in reviews and this will be examined as this work progresses.

Sepsis diagnosis and management

As a result of undertaking mortality reviews, the Trusts Sepsis group have further enhanced multiprofessional education and training in relation to sepsis screening, supporting rapid recognition and management. The Sepsis guidance is being reviewed; this is based on the regional guidance. Across the Trust there are "Sepsis Champions" identified to support application of these guidelines; however the Trust recognises the importance of this being a multidisciplinary approach and that all staff have responsibility for this.

Part of the ongoing work in relation to sepsis is to examine ways of promoting early recognition of sepsis. The Trust will be continuing engagement with primary care professional teams and NEAS to support this, alongside the work being undertaken by the Alliance as described earlier.

The Trust are planning to hold a "Sepsis" week in September, this is being timed to coincide with World Sepsis Day. On this day the Trust will be focussing on raising awareness with patients, the public and staff. A specific multiprofessional Sepsis training day is also being planned to include awareness/teaching sessions and clinical simulation opportunities.

Intensive Treatment Unit

The Intensive Treatment Unit (ITU) team undertake mortality reviews for all patients that pass away in the department; these form the larger part of the Trusts agreed mandatory reviews. Many of the patients who die on ITU are there for short periods, often being admitted to the Trust in a critical condition with a high risk of a poor outcome. However, there are a small number of patients who have a prolonged stay on the unit having active treatments for their illness.

As a result of undertaking the mortality reviews, the ITU team have identified that there were occasionally inconsistent management plans and communication in relation to patients who had prolonged stays in the unit. In order to impact upon this the team have

introduced the need for a multidisciplinary team (MDT) planning meeting for all of these patients to occur every Wednesday. This MDT planning meeting includes an update on progress, details of what has been discussed with the patients' family, agreement in relation to MDT decision making and agreements about the levels of care to be offered/provided.

The current evaluation from staff involved in these MDT planning meetings is that these are having a positive impact and that the team approach has led to fewer isolated decisions being made. There has been suggestion made by the team that a fixed proforma to record the discussion should be developed to reduce discussion duplication and confirm previous agreed action points. It is hoped that this approach will support the families and carers of the patient during this time by ensuring there is consistent communication during this difficult period of time and also allowing them to feel they have been included in planning. Currently the evaluation has been from staff as the process has been developed; the feedback from families will be reviewed over the coming year.

Urinary Tract Infections

Over the last 2-3 years the Trust has completed record reviews where patients had been admitted and diagnosed with urinary tract infections (UTI). Following analysis of the reviews completed it was identified that all of the patients involved were frail and elderly; and in around 50% of cases the diagnosis of a UTI had not been confirmed and it was possible that some of these patients may not have needed admission into hospital.

Part of the improvements suggested from the reviews was for the Trust to examine ways of improving the diagnosis and management of UTI in the elderly. The Trust participated in a UTI Collaborative facilitated by NHS Improvement, with the outcomes of two change projects presented in January 2019.

The initial projects related to care home and in-patient ward settings. A reduction in inappropriate urine samples and an 81% reduction in treatment for UTI in the pilot care home were noted. In January 2019, the project was extended to a further 3 care homes, with support from the community dementia nurse. Other homes are also independently implementing aspects of the project to improve hydration in their residents and increase awareness of recognition and diagnosis of UTI. The hospital based project saw a 70% reduction in catheter associated UTI on a pilot ward, comparing a 3 month baseline period with October – December 2018. This project has now been extended to a second ward and once data collection is complete a cost benefit analysis will be undertaken prior to a decision on further rollout.

The quality of diagnosis and management of suspected UTIs continues to be a high priority for the Trust, and is subjected to regular audit against NICE standards (Quality Standard 90). The latest audit was completed in 2018, and overall showed several areas of improvement compared to the previous audit. These overall results were presented to a general medical audience in July 2018 where areas requiring further improvement were also highlighted.

The Trust is also taking part in a trial regarding antibiotic prescription, the ARK (Antibiotic Review Kit) trial. This trial addresses the issue of antibiotic stewardship, with the intention of promoting effective antibiotic prescription and the empowerment of clinicians to stop antibiotics when appropriate. While relevant to all antibiotic prescriptions, this is of direct relevance to those with suspected UTI. The results of this trial will inform changes in practice as they are identified.

Acute Kidney Injury

As part of another focused review of deaths where the patients had been recorded as being admitted with acute kidney injury (AKI, also referred to as acute renal failure); it was identified that the group of patients represent a population of frail, elderly patients with multiple significant co-morbidities including for many of them, chronic kidney disease. Analysis of the review findings identified that many of the patients may have had renal failure when they were admitted into the Trust; this was treated appropriately and the patients later died as a result of one of their other long term co-morbidities or a secondary illness.

The Trust has undertaken a programme of quality improvement over the last 2-3 years in relation to effectively identifying patients with AKI; which as a result has impacted on the overall management of this. A number of clinical audits undertaken over this time have shown key areas of improvement that have been supported by a statistical reduction in deaths of patients who were admitted with AKI. The quality improvement work in relation to AKI is to continue however this repeat focused case review has assisted in the positive evaluation of the work being undertaken across the Trust.

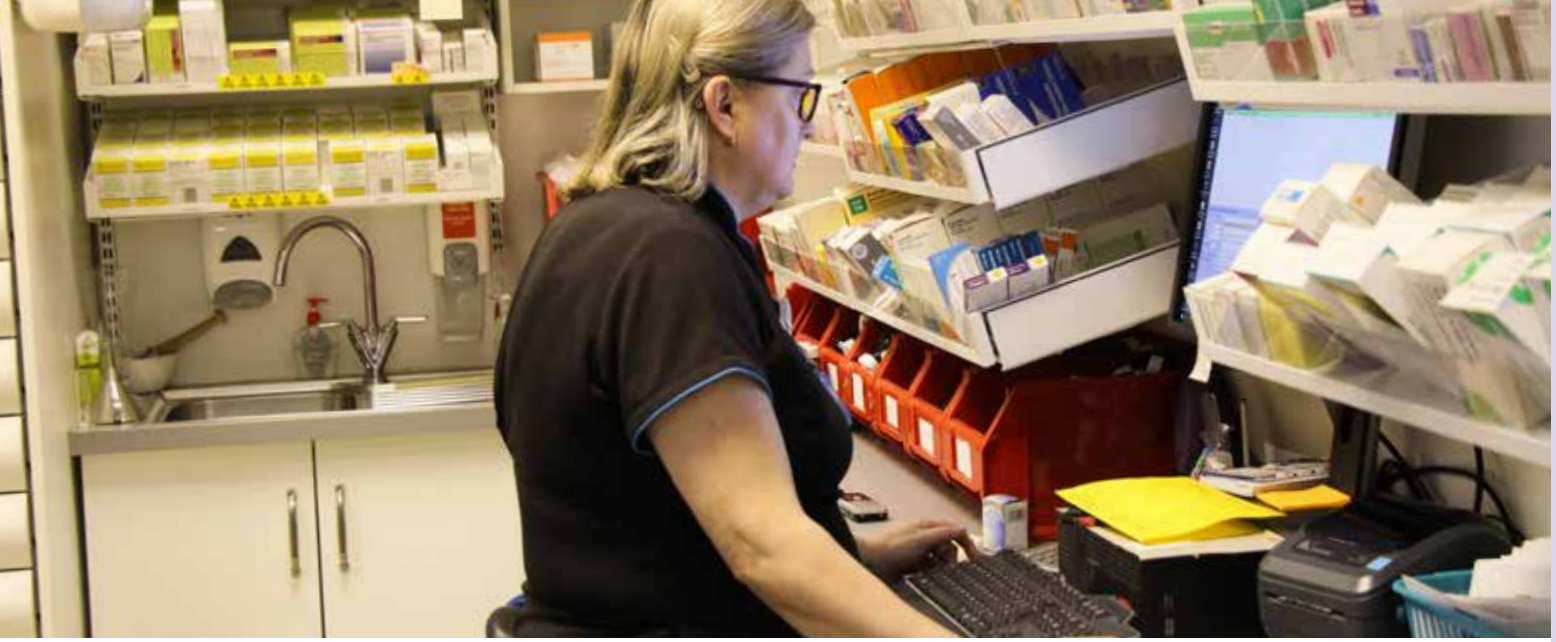
Clinical documentation and coding

The overall focus of all of the mortality reviews is to support the Trust in identifying areas where clinical practice or services can be changed to enhance the overall quality and safety of the care given to patients anywhere in the Trust and to also support patients, carers and staff when managing care when the overall outcome of their illness may be uncertain.

The Trust has in the past been reported as having increased Hospital Standardised Mortality Rates (HSMR) and Standardised Hospital Mortality Indices. These are both nationally agreed figures that use some areas of healthcare data (Charlson co-morbidities) to assist in benchmarking Trusts nationally. By examining ways of making improvements, in these nationally published measures, the Trust feels that it has not only improved quality and safety, but has also helped to allay some concerns patients, families and carers may have as a result of media coverage, during times of critical illness.

As a result of the mortality reviews it has been identified that records made may not fully reflect all health problems (co-morbidities) an individual patient has or that the records may not clearly identify the diagnosis of the problems being treated. This impacts on communication of management plans between healthcare professionals providing care across primary and secondary areas, but can also impact on the healthcare data collected for national statistical analysis.

In order to improve the records made and to support clearer communication a number of teaching sessions have been held with various clinical teams. The sessions



are multi-disciplinary and raise awareness around the importance of accurately and comprehensively recording co-morbidities. They cover the mortality indicators and demonstrate the positive impact it has on trust HSMR and SHMI rates when the coding gives an accurate clinical picture of the patients who are treated in hospital. The depth (number of codes for each patient) of coding of co-morbidities is monitored on a monthly basis, with particular emphasis being placed on the depth of coding for Charlson co-morbidities. Following regional benchmarking it showed the Trust was falling behind in the recording of chronic kidney disease (CKD), metastatic cancer and hemiplegia. The Trust has implemented some remedial actions to resolve the issues identified and the impact of these will be monitored closely.

Following various internal focused reviews of groups of cases where there has been a clinical diagnosis linked to senility, pneumonia or stroke; audits have been completed to ensure all conditions documented within the case notes have been coded. Following the coding review clinician validation has been introduced to ensure all relevant co-morbidities and conditions have been documented. A recent analysis has shown the average Charlson co-morbidity score for pneumonia patients has increased from 12.2 to 13.3. For stroke patients the average Charlson co-morbidity score has increased from 10.1 to 14.5. Also any patient who dies in hospital, who has a primary diagnosis of delirium or dementia assigned, the coding will be sent to be validated by a clinician.

As a result of the ongoing work examining areas where quality and safety of care can be enhanced; and also because of the improvements in clinical documentation and consequently the clinical coding; the Trusts HSMR and SHMI rates have been within the national "as expected" range for 12 consecutive quarters.

Medical Examiners

Over recent years a national Coronial review has been completed; this review identified a variety of recommendations one of which relates to the introduction of a "Medical Examiners" (ME) role that is responsible for reviewing deaths and speaking with families in relation to any concerns they may have. The role of the ME has been extensively discussed at the Regional Mortality meeting, which the Trust is part of, however, no consensus has been reached. A neighbouring Trust has already successfully implemented a ME team; some Trusts are not planning on developing this role until there is clarity around funding or if it is mandated. The Trust feels that we should develop this role in order to improve quality of death certification and also improve liaison with the bereaved.

At this time a business case to support implementation over the next year is currently being developed for consideration through the normal Trust procedures. It is envisaged that as this role is implemented, there will be changes to the mortality review processes already in place; however it is considered that this will only improve the overall analysis of mortalities.

86 case record reviews and **6** investigations were completed after 31 March 2018, which related to deaths which took place before the start of the reporting period.

0 representing **0%** of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the "Prism 2" methodology; this provides a structured review of a case record, carried out by clinicians, to determine whether there were any problems in care. Where a case has also been reported as a Serious Incident, a comprehensive investigation is completed to identify the root cause of the case and identify service and care delivery problems where improvements may be required.

0 representing **0%** of the patient deaths during January to March 2018 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Priority 3: Patient Experience

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 2018-19 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	Overview of how we said we would report it	Completed and reported?	
We will evaluate feedback in relation to pain, nausea, breathlessness restlessness, care for the patient and care for the family	Quarterly to IPB	Reported to IPB and quarterly	✔
	Annually to PS & QS	Reported to PS & QS annually	✔

"No – Excellent care. We were involved in every aspect of care. The Oasis suite is fabulous and all the staff today have been caring and compassionate. Mam died so peacefully." [sic]

Specialist Palliative Care

Trust instigated a number of changes to the palliative care process and team during 2018-19, to improve patient experience, quality of care given and more accurate data collection.

The number of patients seen by the Specialist Palliative Care Team has seen a year on year increase for 2014-15 to 2016-17, with a decrease occurring in 2017-18 and 2018-19. The decrease in numbers has been attributed to the way the data is being captured. A full process review is underway to ensure that the data capture is robust and consistent as in previous years.

2015-16		2016-17		2017-18		2018-19
1,040	↑	1,436	↑	1,108	↓	**1,072**

*Data obtained from the Information Department

Educational Strategy for Palliative Care

North Tees and Hartlepool NHS Foundation Trust continues to recognise the importance of delivering the best possible care to palliative patients and patients in the last days of life. Specialist Palliative Care, alongside the greater Out of Hospital Care Directorate are working alongside other stakeholders locally, regionally and nationally, to continue developing 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.

Education continues to be delivered by members of the Specialist Palliative Care Team, alongside colleagues from Chaplaincy and Mortuary & Bereavement services, to both Trust and non-Trust staff across the Trust geographical area. These sessions are aimed to improve understanding around the importance of communication, identification and planning of care for patients who may be palliative or at the end of their life.

Development Nurse Programme

The Macmillan supported 'Development Nurse Programme' for interested and experienced band 5 or above nurses, to develop skills and knowledge required for a CNS role, has enabled effective succession planning. The 2 year programme supporting the Out of Hospital Care Directorate to provide Clinical Nurse Specialist development within Specialist Palliative Care has now come to an end, with all of those who undertook the programme moving into Clinical Nurse Specialist roles.

AMBER Care Bundle

Following a successful pilot of the use of the AMBER Care Bundle on three of its wards in medicine, the Trust is looking to develop a Trust-wide implementation of the AMBER Care Bundle in the coming 12-24 months. The AMBER care bundle improves the quality of care of people in hospital whose recovery is uncertain. It is for people who are at risk of dying during their current episode of care despite receiving active treatment. The AMBER care bundle helps identify patients who may have end of life care needs and looks to supports staff to be clear about the plan of care, to start conversations about uncertainty and gives patients, carers and others close to them time to prepare.

Palliative Care Register

We continue to develop the Trust Palliative Care Register and by utilising the Supportive & Palliative Care Indicator Tools (SPICT), encourage teams to identify patients they feel are palliative earlier in their illness.

Virtual Wards

Alongside the development of the Palliative Care Register, the use of the Trust Virtual Wards as part of on-going Trakcare development is essential. There are now three virtual wards used by the team – the Palliative Register (Green Swan), AMBER Care Bundle (Amber Swan) and End of Life Care (Red Tree). These virtual wards enable staff to identify inpatients who may need support or guidance through their admission.

Care Opinion/Hospice UK Palliative & End of Life Care National Project

Now in it's 2nd year, this is a UK wide project being run by Care Opinion and Hospice UK. Supporting 12 clinical teams for two years, this innovative programme is a partnership with Hospice UK and supported by the Scottish Government. The teams were selected in an open, competitive application process and represent a diversity of hospice, hospital and community care services in different parts of the UK, with North Tees & Hartlepool NHS Foundation Trust being one of the 12.

DNACPR signing by specialist Nurses

In an effort to improve patient safety, experience and outcomes, a small working group has looked at a policy amendment to empower senior nurse specialists across the organisation to sign DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) forms. Given the nurse specialist is often the staff member most involved in planning and co-ordinating care, they have often broached the difficult conversations and the move sits very well into the regional Deciding Right approach.

Locality--wide Specialist Palliative Care MDT

The Locality wide SPC MDT meeting held weekly, video-conferenced between both hospital sites discussing complex patient management with core membership of:

Specialist Palliative Care Consultants, Clinical Nurse Specialists, Allied Health Professionals, Psychology, Chaplaincy and both Alice House & Butterwick Hospices.

This Specialist MDT promotes best practice, good clinical governance and shared decision making, is held as best practice, with recognition regionally and nationally of benefits seen by patients.

North of Tees Palliative Transformation & Locality Group

Reporting into the regional Supportive, Palliative & End of Life Care Group, this locality group is made up of all key stakeholders in Palliative & End of Life Care from the Trust, CCG, hospices, patient groups and local authority. Whilst it is seen as the 'Gold Standard' in regional and locality development of services, there has been regional recognition for North of Tees Palliative Transformation & Locality Group being the only locality able to achieve the group.

Specialist Nursing bank development with NHS Professionals

We continue to follow the innovative approach to ensuring Specialist Palliative Care provision is robust across the Trust. Working closely with our NHSP partners, we have become the first Trust regionally to establish Specialist Bank staffing in partnership with NHS Professionals.

Presenting at National and Regional Conferences

Mel McEvoy, Nurse Consultant and John Sheridan, Macmillan Lead Nurse, End of Life Care have both been involved in presenting on Palliative and End of Life Care issues, both regionally and nationally.

Mel McEvoy, Nurse Consultant had his work highlighted at the Kate Granger Compassionate Care Awards. Mel was presented with a finalist trophy and certificate at the NHS England annual general meeting & National Health and Care Innovation Expo 2018 for work setting up the Family's Voice diary, which was part of the last week.

"It was as caring, helpful compassionate and cheerful as it could be." [sic]

"Today my mam passed away. Amazing support from staff." [sic]

Care for the Dying Patient (CFDP)

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

Between April 2018 and March 2019, the Trust has handed out 134 diaries, currently the average score has decreased to 20.51 from the previous average of 20.60.

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 following are results since April 2014; there has been a significant fall in giving out the Family's Voice. The current rate compared to previous years is as follows:

Reporting Period	Number of Patients	Average Daily Score (Max 24.00)
April 2014 to March 2015	131	21.10
April 2015 to March 2016	167	20.80
April 2016 to March 2017	171	20.40
April 2017 to March 2018	147	20.60
April 2018 to March 2019	134	20.51

*Data obtained from the Trusts Family's Voice database

"Mum has been much more settled today after such a distressing week. The staff have been friendly and professional throughout and have respected my families wishes without question." [sic]

"The staff on ward 25 have gone above and beyond the call of duty to care for my mam (Thank You)" [sic]

"Disappointed have not received information regarding last days of life. Leaflet was not explained" [sic]

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

In March 2015, the NHS England published NHS Chaplaincy Guidelines. The guidelines recognise the development of chaplaincy in a range of specialties including General Practice and in areas such as Paediatrics and Palliative care, describing the importance of spiritual and religious support to patients approaching end of life. The guidelines support and promote 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 2018-19, **302** 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. **6** patients declined support during the reporting year. **198** 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.

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.

Chaplain Referrals, Received more than 1 visit and declined support

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

	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
Referrals	397	424	437	401	359	**302**
Received more than 1 visit	233	272	274	298	244	**198**
Declined Support	3	1	3	4	2	**6**

*Data from the Trusts chaplain service

Multi Faith

The Trust holds a directory of all the local faith groups in the area, If there is a request for the Imam (Muslim) or the Hindu Priest, Buddhist or any other faith, the chaplains would contact the Trust link person and arrange a visit.

Priority 3: Effectiveness of Care
Is our care good?

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 Patient and Staff Experience Survey visit
- 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	Overview of how we said we would report it	Completed and reported?	
Analysis of the feedback from the Patient and Staff experience/ national surveys	Reports to Board of Directors	Reported to Board of Directors	✔

"Every team member were efficient, a really nice ward, has a great atmosphere and very clean." [sic]

"Problem wasn't resolved, not very understanding to needs. Some very nice nurses" [sic]

"North Tees hospital literally saved my life again and the nurses and doctors do a wonderful job. The nursing staff are especially helpful and caring." [sic]

Patient Experience Surveys

Below are a list of the surveys that the Trust carried out between April 2018 and March 2019. The 'Number of patients surveyed' column shows the number of patients who were eligible to take part.

National Surveys

Survey	Month Survey published	Number of patients surveyed
National Cancer Patient Experience Survey 2017	September 2018	694 (68%)
CQC National Inpatient Survey 2017	June 2018	1,250 (39%)
CQC National Maternity Survey 2018	January 2019	300 (34%)
CQC National Inpatient Survey 2018	June 2019	1,250 (43%)
CQC National Emergency Survey 2018	Autumn 2019	893 (32%)
CQC National Children and Young People's Survey 2019	Autumn 2019	1250 (Fieldwork in progress)
NACEL Care of the Dying Survey for Relatives/Carers	February 2019	45 (11%)

Local Surveys

Survey	Survey results compiled	Number of Patients Surveyed
Endoscopy Patient Survey 2018	April 2018	499 (40%)
Shoulder school 2018/19	January 2019	44 surveys
Acute Oncology Survey 2018	November 2018	75 (49%)
Upper GI Cancer Survey 2018	March 2019	113 (33%)
Tissue Viability Nurse Survey 2019	March 2019	70 (fieldwork in progress)
Bereavement Survey 2018/2019	January 2019	1,400 (9%)
Surgical Decisions Unit Survey 2019	March 2019	200 (fieldwork in progress)
CQUIN Bowel Screening Awareness Survey 2018	February 2019	220 surveys
Colposcopy Survey	November 2018	166 (100%)
Orthopaedic Virtual Clinics – Patient Survey	November 2018	150 (26%)
Stop smoking Survey	August 2018	190 (89%)
Family Health Counselling Survey	September 2018	41 surveys
Dexa Scan Survey	August 2018	138 (30%)
Inflammatory Bowel Disease Survey	June 2018	88 (31%)

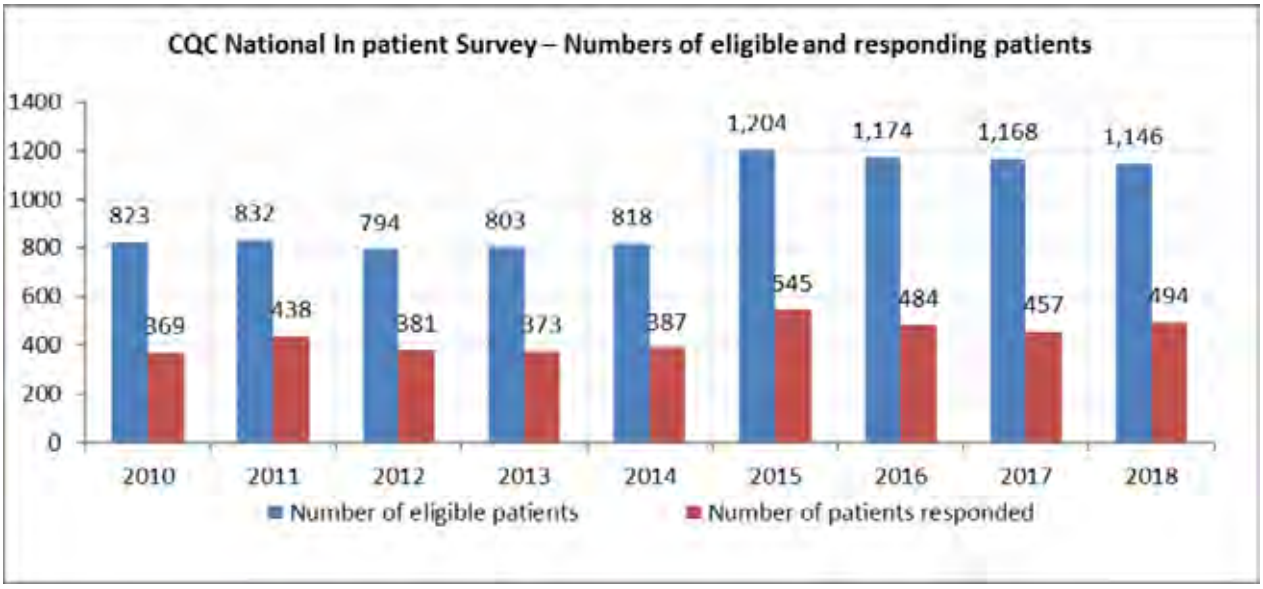
National Surveys

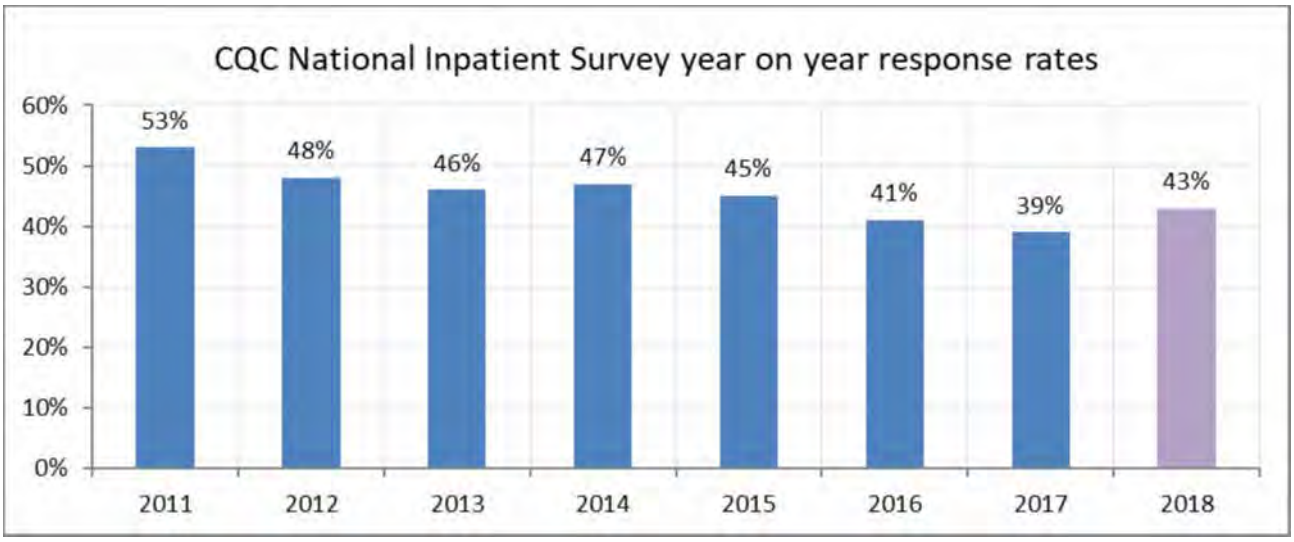
CQC National Inpatient Data 2018

This survey is a Care Quality Commission (CQC) requirement for all Acute NHS Trusts. Each Trust randomly selects adults who are inpatient admission during July 2018 (age over 16 years).

There were **494** responses from the patients that received a survey, this equates to a response rate of **43%.** Results are not published until June 2019.

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%
2017	1,168	457	39.13%
2018	**1,146**	**494**	**43.10%**





CQC National Inpatient Survey 2017: Key Results

Please note that results are only available for the 2017 survey. 2018 results will not be available until June 2019.

Where we have improved: Discharge

All Scores out of 10

	2013	2014	2015	2016	2017
Discharge delayed due to wait for medicines / to see doctor/ for ambulance?	**6.5**	**5.8**	**6.4**	**6.4**	**7.2** (significantly improved)
How long was the delay to discharge?	**7.6**	**7.1**	**7.8**	**7.7**	**8.3** (significantly improved)
Did you get enough support from health and social care professionals to help you recover & manage your condition?	Question not asked		**6.9**	**7.2**	**7.5**
When you transferred to another hospital or went to a nursing or residential home, was there a plan in place for continuing your care?	Question not asked		**7.8**	**6.9**	**7.1**

Where we could be better:

	2013	2014	2015	2016	2017
Did the hospital staff explain the reasons for being moved during the night in a way you could understand? (answered only by those respondents who moved wards during night)	Question not asked				**5.9**
Q.40 Were you given enough privacy when being examined or treated?	**9.4**	**9.3**	**9.5**	**9.5**	**9.3**

National Cancer Patient Experience Programme 2018 National Survey

We have a **65%** response rate against the current national response rate of 63%.

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 2018.

The 2018 results will not be published until August or September 2019.

National Cancer Patient Experience Survey 2017

As the 2018 survey results are not expected to be published until August 2019 below are some key results taken from the National Cancer Patient Experience Programme 2017. This survey 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 2017. Our response rate was 68%, (national average response rate was 63%).

38% of questions asked scored "better than expected", 62% of questions scored "within expected range" and 0% of questions scored "worse than expected".

Below are questions where we scored better than expected for a trust of our size and profile.

Questions	2017	National Score
Patient thought they were seen as soon as necessary	88%	84%
The length of time waiting for the test to be done was about right	92%	88%
Patient completely understood the explanation of what was wrong	79%	73%
Patient felt that treatment options were completely explained	88%	83%
Possible side effects explained in an understandable way	84%	73%
Patient given practical advice and support in dealing with side effects of treatment	75%	67%
Patient definitely told about side effects that could affect them in the future	65%	56%
Patient definitely involved in decisions about care and treatment	83%	79%
Patient found it easy to contact their CNS	94%	86%
Hospital staff gave information on getting financial help	67%	58%
Patient had confidence and trust in all ward nurses	83%	76%
Patient was able to discuss worries or fears with staff during inpatient visit	61%	53%
Patient was able to discuss worried or fears with staff during day patient / outpatient visit	79%	71%
Doctor had the right notes and other documentation with them	98%	96%
Beforehand patient had all information needed about radiotherapy treatment	95%	87%
Patient given understandable information about whether radiotherapy was working	69%	59%
Beforehand patient had all information needed about chemotherapy treatment	90%	84%
Hospital and community staff always worked well together	69%	62%
Overall the administration of the care was very good / good	93%	90%
Length of time for attending clinics and appointments was right	83%	69%

Below is a selection of questions where we scored within the expected range for a trust of our size and profile.

Questions	2017	National Score
Patient given the name of the CNS who would support them through their treatment	88%	91%
Hospital staff told patient they could get free prescriptions	79%	81%
Patient's family definitely had opportunity to talk to doctor	74%	73%
Patient definitely given enough care from health or social services during treatment	57%	53%
Patient definitely given enough care from health or social services after treatment	47%	45%
Patient given a care plan	35%	35%
Q.58 Taking part in cancer research discussed with patient	25%	31%

National Maternity Survey 2018

This annual CQC national survey asked women who had a live birth during February 2018 about their antenatal, labour and postnatal experiences. The survey was published in January 2019. 101 women responded to the survey, a response rate of 34% (national response rate was 36.8%).

There were no questions that scored "better" when compared to other trusts nationally. There were 2 questions that the trust score was significantly better when compared to the results of the 2017 survey.

Questions	*2018
During your antenatal check ups, did a midwife ask you how you were feeling emotionally?	8.2
At the very start of your labour, did you feel you were given appropriate advice and support when you contacted a midwife or the hospital?	9.0

***All Scores out of 10**

There were 2 questions that scored **"worse"** when compared to other trusts nationally.

Questions	*2018
Care during hospital stay after birth: Were you able to get a member of staff to help you within a reasonable time?	6.3 (Scored significantly worse than 2017)
Were you told who you could contact if you needed advice about any emotional changes you might experience after the birth?	**6.3**

***All Scores out of 10**

The remaining questions of the survey scored **"about the same"** as other trusts nationally.

Priority 3: Effectiveness of Care

Friends and Family Test

Rationale: The Department of Health require Trusts to ask the Friends and Family recommendation questions from April 2013. Stakeholders agreed that this continues to be reported in the 2018-19 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	Overview of how we said we would report it	Completed and reported?	
We analyse feedback from all Friends and Family questionnaires	Reports to Board of Directors	Reported to Board of Directors	✔
	Report at every Council of Governors meeting	Reported at every Council of Governors meeting	✔
	On the Safety, Quality and Infections Dashboard	Reported on the Safety, Quality and Infections Dashboard	✔

"Professional, kind and thank you for looking after me. Lovely Staff. Thank you." [sic]

"Lack of adequate bedding, noisy ward and freezing during the night. The heating was clearly switched off." [sic]

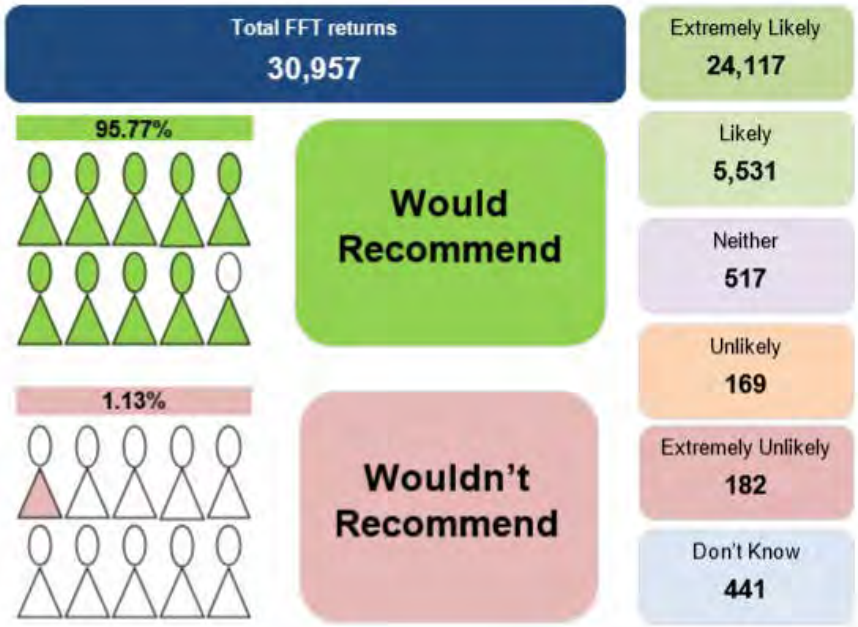
The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.

The Friends and family data can be found at:
https://www.england.nhs.uk/fft/friends-and-family-test-data/

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 and Hartlepool NHS Foundation Trust
Returns for April 2018 to March 2019

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.



*Data from Trusts Friends and Family database

North Tees and Hartlepool NHS Foundation Friends and Family word bubble

What our patients have said about their hospital experience
(taken from the Trust's Friends and Family Test Comments April 2018 – March 2019)

"Staff in colposcopy clinic were amazing! Made me feel at ease and lovely ladies. Nothing was too much trouble. Thank you" [sic]

"No receptionist available and had to wait over 10 mins for one to appear. Large queue had formed." [sic]

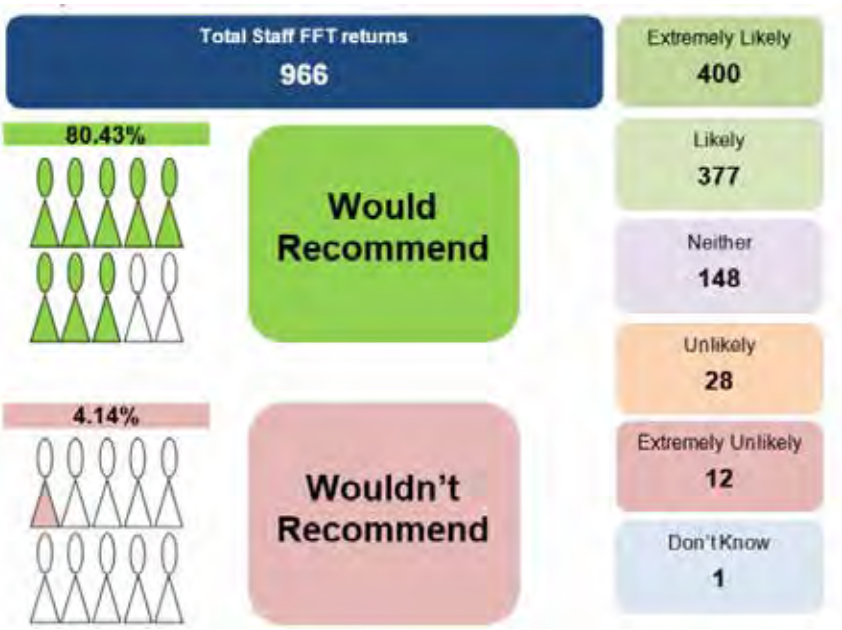
"Delay in time even though appointment was 09.00." [sic]

Staff - Friends and Family Test

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).**

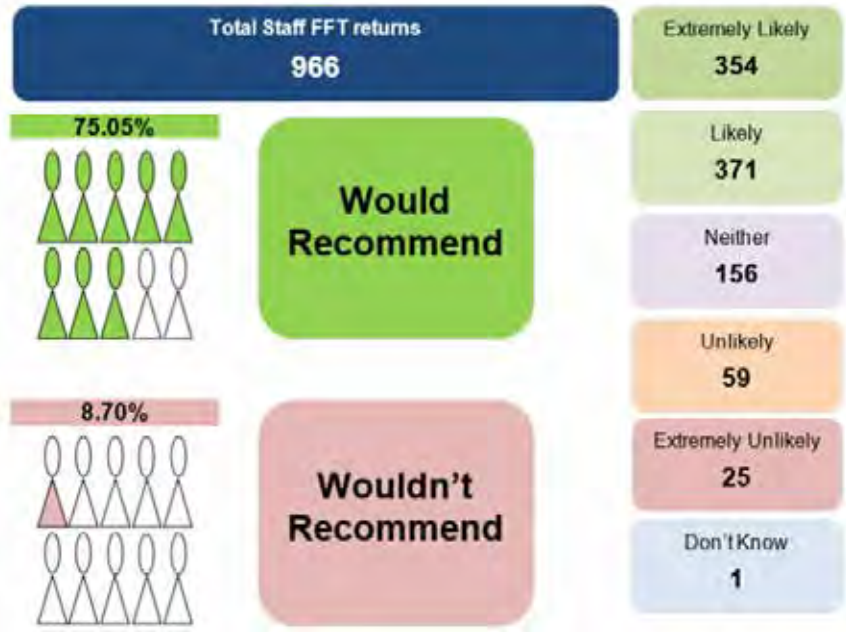
The following data refers to the full 2018-19 financial year.



*Data from Trusts Human Resources Department data

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.'



*Data from Trusts Human Resources Department data

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.'

"The service I received when I am here is excellent and staff are very friendly" [sic]

Section 2B: 2019-20 Quality Improvement Priorities

Introduction to 2019-20 Priorities

Key priorities for improvement for 2019-20 have been agreed through numerous consultation events with our patients (via surveys), staff, governors, Healthwatch colleagues, commissioners, local health scrutiny committees, healthcare user group and the Board of Directors.

Consultation commenced in December 2018 allowing stakeholders a significant opportunity to consider and suggest priorities that they would like to see the Trust address.

Stakeholder Priorities for 2019-20

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 Dying Patient (CFDP)
Dementia	Discharge Processes	
Mental Health	Safety and Quality Dashboard	Is our Care Good? (Patient Experience Surveys)
Safeguarding (Adult & Children's)	Learning from Deaths	
Infections		Friends and Family Test

Rationale for the selection of priorities for 2019-20

Through the Quality Accounts stakeholder meetings and other engagement events we provided an opportunity for stakeholders, staff and patients to suggest what they would like the Trust to prioritise in the 2019-20 Quality Accounts.

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

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

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

Patient Safety

Priority 1 - Mortality

To reduce avoidable deaths within the Trust.

Overview of how we will do it
We will review all available indicators

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.

Overview of how will measure it
We will monitor mortality within the Trust using the two national measures of Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI).

Overview how we will monitor it
Monitored by the Mortlaity Dashboard

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 - Dementia

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

Overview of how we will do it
We will use the Stirling Environmental Tool to adapt our hospital environment.

We will make it mandatory 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 if needed.

We will ensure that we have the most up to date information for patients with a diagnosis of dementia by accessing Datix systems and the Tees Esk Wear Valleys Foundation Trust Paris system. This will confirm if the patient has a clinical diagnosis from mental health services. If confirmed an alert will be added to Trakcare to ensure staff are aware of the diagnosis of dementia.

Overview of how we will measure it
The Stirling Environmental audit assessment tool will be used to monitor the difference pre and post environmental adaptation.

Wards 36, 37, 39 & 40 and 42 have been adapted to be dementia friendly; Wards 24, 25, 26, 27, and 29 have had the Stirling audit complete. Any improvements will be in line with the audits recommendations.

The percentage of patients who receive the Abbreviated Metal Test and, where appropriate, further assessment will be reported monthly via UNIFY.

We will continue with the prevalence audit for the number of patients that have cognitive screening over the age of 75 admitted as an emergency that are reported as having a known diagnosis of dementia, or have been asked the dementia case finding questions.

We will continue to undertake the National Audit for dementia.

Overview how we will monitor it
Monthly data from the Trust Inforamtion Management Department.

Overview of how we will report it
Vulnerability Committee
Monthly UNIFY

Priority 3 - Mental Health

To achieve high quality mental health healthcare offered to patients who access general hospital services achieving parity of physical health needs with mental health needs across the Trust; healthcare professionals in general secondary care will feel knowledgeable and confident in understanding and managing mental health conditions and knowing when and how to access mental health services for the patients they see. The integration of all healthcare professionals to provide care as needed for each patient is a crucial part of the solution to providing a higher quality of care to all patients.

The Trust will review and implement recommendations from the NCEPOD guidance Treat as One. The Trust will identify and involve all stakeholders in reviewing the Treat as One guidance and undertaking a gap analysis to develop appropriate work streams; including but not exclusive to:

- Patients who present with known co-existing

mental health conditions should have them documented and assessed along with any other clinical conditions that have brought them to hospital;
- Liaison psychiatry review should provide clear and concise documented plans in the general hospital notes at the time of assessment;
- All Trust staff who have interaction with patients, including clinical, clerical and security staff, should receive training in mental health conditions;
- In order to overcome the divide between mental and physical healthcare, liaison psychiatry services should be fully integrated into the Trust. The structure and staffing of the liaison psychiatry service should be based on the clinical demand both within working hours and out-of-hours so that they can participate as part of the multidisciplinary team;
- Record sharing (paper or electronic) between mental health hospitals and the Trust will be improved. As a minimum patients should not be transferred between the different hospitals without copies of all relevant notes accompanying the patient.

Overview of how will measure it
The Trust will benchmark current and future practice against the Treat as One Guidance; undertaking further audit in relation to recommendations in line with the above and Staff and patient engagement (survey).

Overview of how we will report it
The Trust will establish a Treat as One group chaired by an Executive Board Member; audit results will be reported to ACE Committee and Performance & Quality Standards Committee.

Priority 4 - Safeguarding

The Trust continues to work to enhance and develop standards for safeguarding adults and children.

Overview of how we will do it
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 will measure it
Audits will be carried out and improvements undertaken.

Overview how we will monitor it
Monitored by audit result improvement plans

Overview of how we will report it
Audit results and improvement plans will be reported to Adult Safeguarding Group.

Audit results and improvement plans will be reported to the three Local Safeguarding Childrens Boards.

Priority 5 - Infections

Key stakeholders asked us to report on infections in 2019-20 due to the increase in Ecoli infections and scrutiny towards Cdifficile.

Overview of how we will do it
We will closely monitor testing regimes, antibiotic management and repeat cases to ensure we understand and manage the root cause wherever possible.

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

Overview how we will monitor it
Monitored by the Safety and Quality Dashboard

Overview of how we will 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 and Quality Dashboard and Clinical Quality Review Group (CQRG)

Effectiveness of Care

Priority 6 - Safety Thermometer

The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. Using the classic Safety Thermometer survey, 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 the data submitted to NHS Digital.

Overview of how will measure it
Monthly data collection survey.

Overview how we will monitor it
Monitored by the Safety and Quality Dashboard

Overview of how we will report it
Report to PS & QS;
Report to Board of Directors meeting;
Report to Council of Governors meeting ; and
Safety and Quality Dashboard

Priority 7 - Discharge Processes

Overview of how we said we would do it
All patients should have a safe and timely discharge.
All concerns and/or incidents raised onto the Trust's Datix system.

Overview of how we said we would measure it
Via national and local patient surveys.
Quarterly analysis of discharge incidents on the Datix system.

Overview how we will monitor it
Monitored by the Senior Clinical Professionals weekly huddle

Overview of how we said we would report it
National inpatient survey report to PS & QS.
To the Discharge Steering Group.

Priority 8 - Safety and Quality Dashboard

The Safety and Quality 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 used during the weekly Quality Reference Group meetings with the wards/areas. Quarterly meetings with wards/areas will be held to ensure that data is up to date, accurate and displayed in public areas.

Overview how we will monitor it
Monthly dashboard analysis to the Director of Nursing, Patient Safety and Quality

Overview of how we will report it
Weekly data presented from the dashboard in the Quality Reference Group
Health Professional Interprofessional Board (IPB)
Report to Board of Directors meeting
Report to Council of Governors meeting

Priority 9 - Learning from Deaths

Within the National Guidance on learning from deaths there is now a mandated requirement to report learning from deaths in the Quality Accounts.

Overview of how we will do it
By undertaking twice weekly mortality review sessions
By allowing Directorates to undertake their own mortality reviews (as long as the person reviewing was not part of that patients final care episode)

Overview of how we will measure it
All data will be captured on the Trusts Clarity ® mortality learning from deaths database

Overview how we will monitor it
Monitored by the Mortality Dashboard

Overview of how we will report it
Report to Board of Directors meeting

Patient Experience

Priority 10 - Palliative Care and Care for the Dying Patient (CFDP)

The Trust has continued to use the Care for the Dying Patient (CFDP) and Family's Voice. Stakeholders and the Trust believe that this still needs to remain a priority in 2019-20.

Overview of how we will do it
We will continue to embed the use of the Family's Voice in hospital and monitor use in 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 how we will monitor it
Monitored by the Safety and Quality Dashboard

Overview of how we will report it
Quarterly to IPB
Annually to Patient Safety and Quality Standards (PS & QS)

Priority 11 - Is our care good? (Patient Experience 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 every patient interviewed in the Patient and Staff Experience reviews. We will also ask the question in all Trust patient experience surveys, along with monitoring patient feedback from national surveys.

Overview of how will measure it
Analysis of feedback from Staff and Patient Experience reviews along with feedback from the patient experience/national surveys.

Overview how we will monitor it
Monitored by the Safety and Quality Dashboard

Overview of how we will report it
Reports to Board of Directors

Priority 12 - Friends and Family Test

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 in-patients, 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
We will analyse feedback from patient surveys and discharge questionnaires.

Overview how we will monitor it
Monitored by the Safety and Quality Dashboard

Overview of how we will report it
Reports to Board of Directors
Reported directly back to ward/areas.

Section 2C: Statements of Assurance from the Board

Review of Services

During 2018-19 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 2018-19 represents **100%** of the total income generated from the provision of relevant health services by the North Tees and Hartlepool NHS Foundation Trust for 2018-19.

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 2018-19 and this can be found on the following link:

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

During 2018-19, **39** national clinical audits and **5** national confidential enquiries covered the relevant health services that North Tees and Hartlepool NHS Foundation Trust provides.

During 2018-19, North Tees and Hartlepool NHS Foundation Trust participated in **97%** 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 2018-19 are as follows:

Mandatory National Clinical Audits
Adult Community Acquired Pneumonia (BTS)
BAUS Urology Audit - Nephrectomy
ICNARC Case Mix Programme (CMP)
Elective Surgery (National PROMs Programme)
Falls and Fragility Fractures Audit Programme (FFFAP)
Feverish Children (care in emergency departments)
Inflammatory Bowel Disease programme / IBD Registry
Learning Disability Mortality Review Programme (LeDeR)
Major Trauma Audit (TARN)
MBRRACE-UK Maternal, Newborn and Infant Clinical Outcome Review Programme
Myocardial Ischaemia National Audit Project (MINAP)
National Asthma and COPD Audit Programme (NACAP) ▪ Adult Asthma ▪ Paediatric Asthma ▪ Adult COPD ▪ Adult Pulmonary Rehabilitation

Mandatory National Clinical Audits
National Audit of Breast Cancer in Older People (NABCOP)
National Audit of Care at the End of Life (NACEL)
National Audit of Dementia
National Bariatric Surgery Registry (NBSR)
National Bowel Cancer Audit (NBOCAP)
National Cardiac Arrest Audit (NCAA)
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)
National Comparative Audit of Blood Transfusion programme
National Diabetes Audit – Adults
National Emergency Laparotomy Audit (NELA)
National Heart Failure Audit
National Joint Registry (NJR)
National Lung Cancer Audit (NLCA)
National Maternity and Perinatal Audit (NMPA)
National Neonatal Audit Programme (NNAP)
National Oesophago-gastric Cancer (NAOGC)
National Paediatric Diabetes Audit (NPDA)
National Prostate Cancer Audit
Non-Invasive Ventilation - Adults (BTS)
Sentinel Stroke National Audit programme (SSNAP)
Seven Day Hospital Services
Vital Signs in Adults (care in emergency departments)
VTE risk in lower limb immobilisation (care in emergency departments)
National Audit of Seizure Management in Hospitals (NASH)

National Confidential Enquiries (NCEPOD)
Heart Failure
Peri-operative Diabetes
Pulmonary Embolism
Acute Bowel Obstruction Study
Long Term Ventilation Study

The national clinical audits and national confidential enquiries that North Tees and Hartlepool NHS Foundation Trust participated in during 2018-19 are as follows:

Mandatory National Clinical Audits
Adult Community Acquired Pneumonia (BTS)
BAUS Urology Audit - Nephrectomy
ICNARC Case Mix Programme (CMP)
Elective Surgery (National PROMs Programme)
Falls and Fragility Fractures Audit Programme (FFFAP)
Feverish Children (care in emergency departments)
Inflammatory Bowel Disease programme/IBD Registry
Learning Disability Mortality Review Programme (LeDeR)
Major Trauma Audit (TARN)
MBRRACE-UK Maternal, Newborn and Infant Clinical Outcome Review Programme
Myocardial Ischaemia National Audit Project (MINAP)
National Asthma and COPD Audit Programme (NACAP) ▪ Adult Asthma ▪ Paediatric Asthma ▪ Adult COPD ▪ Adult Pulmonary Rehabilitation
National Audit of Breast Cancer in Older People (NABCOP)
National Audit of Care at the End of Life (NACEL)
National Audit of Dementia
National Bariatric Surgery Registry (NBSR)
National Bowel Cancer Audit (NBOCAP)
National Cardiac Arrest Audit (NCAA)
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)
National Comparative Audit of Blood Transfusion programme
National Diabetes Audit – Adults
National Emergency Laparotomy Audit (NELA)
National Heart Failure Audit
National Joint Registry (NJR)
National Lung Cancer Audit (NLCA)
National Maternity and Perinatal Audit (NMPA)
National Neonatal Audit Programme (NNAP)
National Oesophago-gastric Cancer (NAOGC)
National Paediatric Diabetes Audit (NPDA)
National Prostate Cancer Audit
Non-Invasive Ventilation - Adults (BTS)
Sentinel Stroke National Audit programme (SSNAP)
Seven Day Hospital Services
Vital Signs in Adults (care in emergency departments)
VTE risk in lower limb immobilisation (care in emergency departments)
National Audit of Seizure Management in Hospitals (NASH)

National Confidential Enquiries (NCEPOD)
Heart Failure
Peri-operative Diabetes
Pulmonary Embolism
Acute Bowel Obstruction Study
Long Term Ventilation 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 2018-19, 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.

Mandatory National Clinical Audits	Participation	% cases submitted
Adult Community Acquired Pneumonia (BTS)	Yes	100%
BAUS Urology Audit - Nephrectomy	Yes	100%
ICNARC Case Mix Programme (CMP)	Yes	100%
Elective Surgery (National PROMs Programme)	Yes	Hip replacement: 98% Knee replacement: 99%
Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	100%
Feverish Children (care in emergency departments)	Yes	100%
Inflammatory Bowel Disease programme/IBD Registry	Yes	0%
Learning Disability Mortality Review Programme (LeDeR)	Yes	100%
Major Trauma Audit (TARN)	Yes	100%
MBRRACE-UK Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	100%
Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%
National Asthma and COPD Audit Programme (NACAP) ▪ Adult Asthma ▪ Paediatric Asthma ▪ Adult COPD ▪ Adult Pulmonary Rehabilitation	Yes	100%
National Audit of Breast Cancer in Older People (NABCOP)	Yes	100%
National Audit of Care at the End of Life (NACEL)	Yes	100%
National Audit of Dementia	Yes	100%
National Bariatric Surgery Registry (NBSR)	Yes	100%
National Bowel Cancer Audit (NBOCAP)	Yes	100%
National Cardiac Arrest Audit (NCAA)	Yes	100%
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	Yes	Ongoing
National Comparative Audit of Blood Transfusion programme	Yes	100%
National Diabetes Audit – Adults	Yes	Ongoing
National Emergency Laparotomy Audit (NELA)	Yes	100%
National Heart Failure Audit	Yes	100%
National Joint Registry (NJR)	Yes	100%
National Lung Cancer Audit (NLCA)	Yes	100%
National Maternity and Perinatal Audit (NMPA)	Yes	100%
National Neonatal Audit Programme (NNAP)	Yes	100%
National Oesophago-gastric Cancer (NAOGC)	Yes	100%
National Paediatric Diabetes Audit (NPDA)	Yes	100%
National Prostate Cancer Audit	Yes	100%
Non-Invasive Ventilation - Adults (BTS)	Yes	100%
Sentinel Stroke National Audit programme (SSNAP)	Yes	100%
Seven Day Hospital Services	Yes	100%
Vital Signs in Adults (care in emergency departments)	Yes	100%
VTE risk in lower limb immobilisation (care in emergency departments)	Yes	100%
National Audit of Seizure Management in Hospitals (NASH)	Yes	Ongoing

National Clinical Audits

The reports of **16** national clinical audits were reviewed by the provider in 2018-19 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
Major Trauma Audit (TARN)	Case ascertainment requires improvement.
National Pulmonary Rehabilitation Audit	Increasing delivery of local education programme for patients, including COPD app.
Sentinel Stroke National Audit Programme (SSNAP)	Business case in process to improve shortfalls in Physiotherapy and Speech & Language Therapy input.
NCEPOD Non Invasive Ventilation	Working on prioritisation of training programme with clinical teams. Updating trust NIV protocol and observation chart.
National Dementia Audit	Working with clinical teams to improve documentation of issues relevant to dementia.
National Red Cell and Platelet Transfusion Audit	Local blood transfusion guideline being drafted.
NCEPOD Mental Health in Acute Hospitals	"Treat as one" group established, across organisations in the region to support consistent approach to care.
Transfusion Associated Circulatory Overload (TACO)	Developing a blood transfusion "bundle".
National Hip Fracture Database	Implementing new anticoagulation pathway.
National Maternity and Perinatal Audit (NMPA)	Improvement plan to promote breast feeding is required.
National Emergency Laparotomy Audit (NELA)	Pathway to be in place to support achievement of the upcoming Best Practice Tariff.
ICNARC Case Mix Programme (CMP)	Re-admission rates to be reviewed.
Paediatric Community Acquired Pneumonia Audit	New local guideline drafted to improve consistency of diagnosis and management.
National COPD Audit	Timely identification of new admissions required in order to support achievement of the Best Practice Tariff.
NCEPOD Chronic Neurodisability Study	Outpatient and Emergency Care systems need improvement to allow for more comprehensive coding. Specialist Nursing input required.
National Falls and Fragility Fracture Audit Programme	Better identification of incidental vertebral fractures required. Patient follow-up after osteoporosis diagnosis requires improvement.

Local Clinical Audits

The reports of **156** local clinical audits were reviewed by the provider in 2018-19 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
Sedation in Children and Young People – (NICE CG 112) - Community Dental	All staff and dental core trainees to be made aware of updated policy on inhalational sedation.
Management of Supracondylar Fractures in Children (BOAST 11)	Ankle fracture surgery to be prioritised on the trauma theatre lists. Poster developed to effectively summarise neurovascular screening examination in upper limb injuries.
Paediatric community acquired pneumonia audit	Reduced the amount of blood tests in uncomplicated pneumonia as they are not required.
Blood Usage in Elective Orthopaedic Surgery	Reduce unnecessary intra-operative blood transfusions.
Paediatric Urinary Tract Infection Audit	The trust follows the Newcastle regional guideline variation rather than NICE guidance. The audit showed that treatment of 9 children would have been missed if NICE had been followed. The Clinical Effectiveness Advisor and Lead Clinician wrote to NICE to share local evidence gained from this audit to challenge the current NICE guidance.
Fluid balance audit	Training to be incorporated into Registered Nurse clinical days and Acute Kidney Injury specific study days, to improve awareness of documentation.
Acute Kidney Injury and Sepsis Audit	Task and finish group to be established to work on improved recognition and timely treatment of patients before deterioration.
Hypertension in Pregnancy (NICE CG 107 & QS 35)	Discharge proforma to be produced.
Quitting smoking in pregnancy and following childbirth (NICE PH 26)	Monitor carbon monoxide readings on all antenatal admissions.
Coding in elective orthopaedic procedures	Improvements required in specificity of discharge diagnosis, which will lead to increase in income for episode of care.

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

National Confidential Enquiries (NCEPOD):

NCEPOD study	Participation	% cases submitted
Heart Failure	Yes	100%
Peri-operative Diabetes	Yes	100%
Pulmonary Embolism	Yes	Ongoing
Acute Bowel Obstruction Study	Yes	Ongoing
Long Term Ventilation Study	Yes	Ongoing

* Data as of 17 April 2019

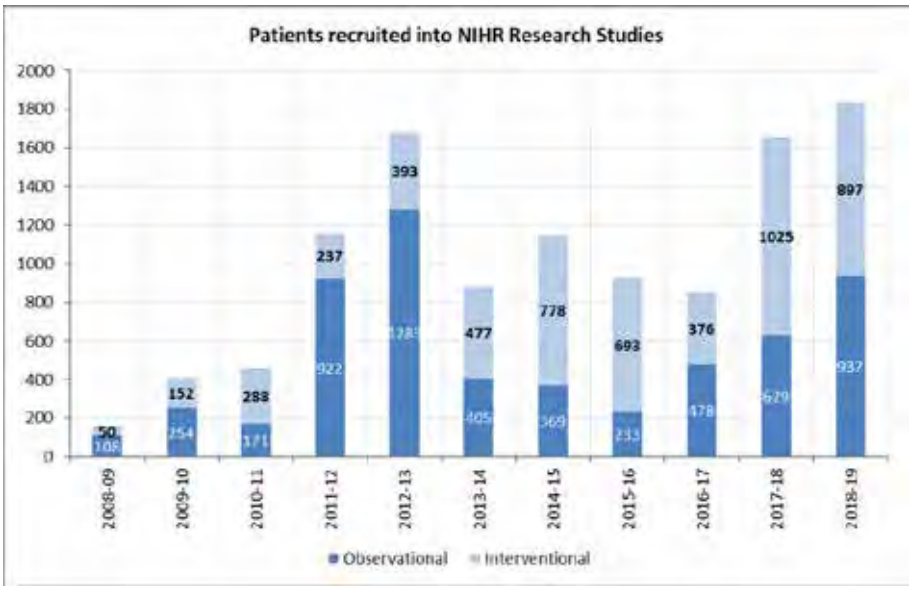
Research Performance Data

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.

26 research staff are employed within the Trust contributing to the delivery of research. 89% of the funding for these posts is from external sources (NIHR Clinical Research Network: North East North Cumbria (CRN:NENC) or commercial income).

The number of patients receiving relevant health services provided or sub-contracted by North Tees and Hartlepool NHS Foundation Trust in 2018-19 that were recruited during that period to participate in research approved by a research ethics committee was **1,834** (target 1,408). This is our highest ever number of patients recruited into NIHR portfolio Studies in any year.

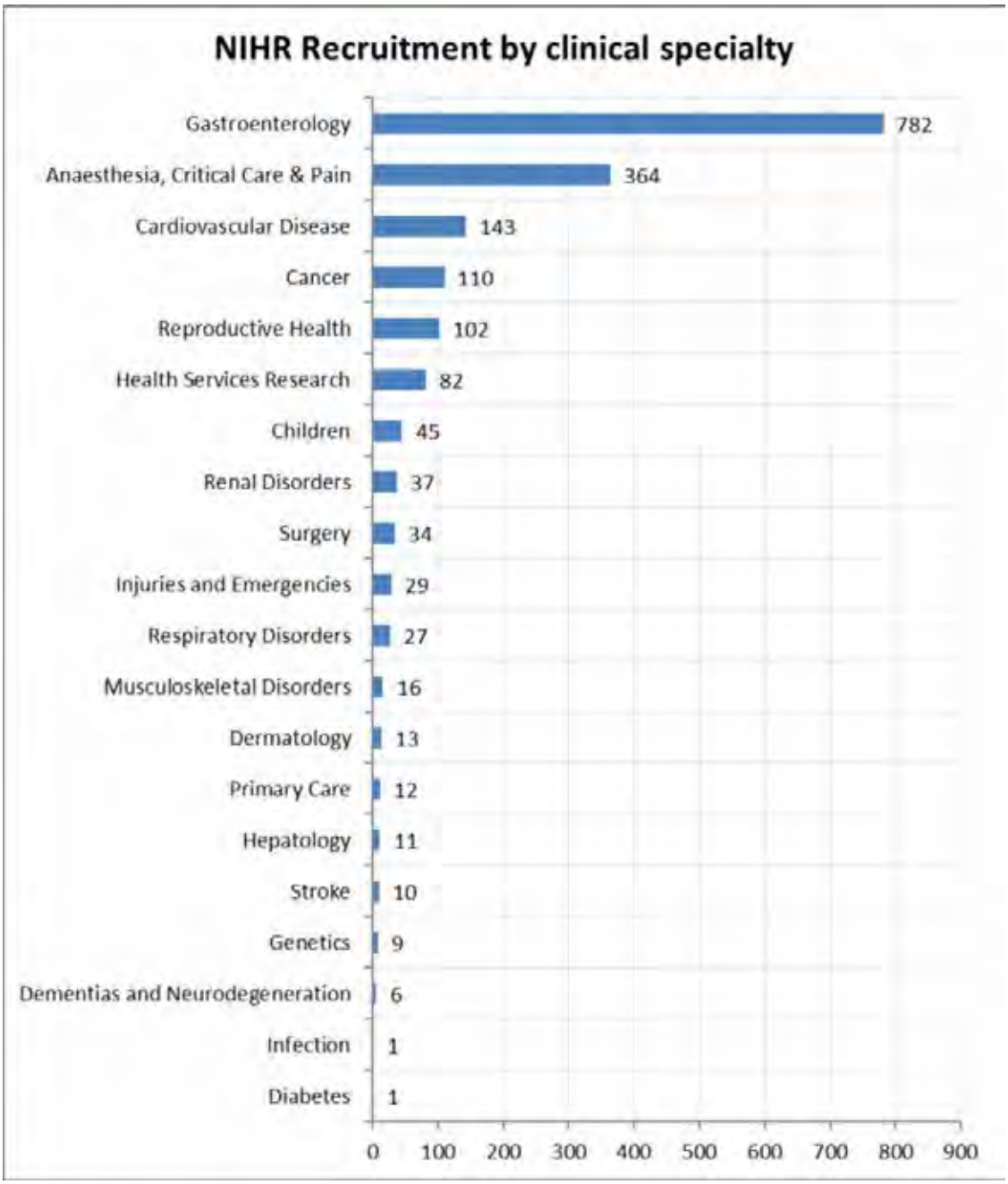
Total year on year recruitment into National Institute for Health Research (NIHR) portfolio research is shown below:



2018-19 Study Participation - number of studies

The NIHR CRN portfolio is a database of clinical research studies that are supported by the NIHR CRN in England. In 2018-19 the Trust was actively recruiting patients into **74 portfolio studies** (77 in 2017-18). **49%** of patients were recruited into the more complex interventional studies. This is a high figure of interventional trials compared with either the regional (32%) or national figures (24%). Interventional studies, also called experimental studies, are those where the researcher intervenes in routine clinical care as part of the study design through a new drug, new surgical procedure or device.

Participation in research is now beginning to be embedded within every clinical directorate as evidenced by the spread of our research activity by specialism in the chart below:



Quality Improvement (QI) Metrics

In addition to the above we are set annual "Quality Improvement" metrics by the Clinical Network for North East & N Cumbria. This year these related to the accuracy and completeness of information on our R&D Database called "LPMS". Data for our Trust is shown overleaf and resulted in us securing additional income from the Research network for both R&D (£10K) and the Pharmacy Department (£6K).

QI metric	Trust performance
100% data completeness in LPMS for High Level Objective (HLO) 2A and 2B	100%
100% data completeness in LPMS for HLO 4 Study set up data	100%
90% data completeness for Pharmacy set up data recording in LPMS	100%

Within the Trust there are **64 members of staff with valid Good Clinical Practice** (GCP) training. Most specialisms and all directorates are now participating in research with a few notable areas where research is embedded within the entire clinical team.

There are **107 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 8 studies in their research portfolio.

Commercially Sponsored Studies

There are **6 commercially sponsored studies actively recruiting patients** within the Trust this year and more where patients are in "follow-up". The studies are open within Cardiology, Cancer and Obs & Gynae. Additionally, we have one commercial study in neonates where we act as a Participant Identification Centre (PIC).

From 2013, government funding for research to the Trust became conditional on meeting national benchmarks. One of which relates to the Trust's performance in recruiting to time and target for commercially sponsored studies. The Trust reports quarterly to the Department of Health (DH) on the following performance measure.

Commercial studies: Recruitment to time and target stated in clinical trial agreement (studies closed within 2018/19)		
Time and target met	**Number of studies**	
Yes	3	100%
No	0	

In previous years we were obliged to report on meeting a 70-day target to open studies and recruit the first patient. This metric has now been discontinued.

Commissioning for quality and innovation (CQUIN)

A proportion of North Tees and Hartlepool NHS Foundation Trust income in 2018-19 was conditional upon 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.

2017-18 CQUIN

Approximate CQUIN money available in line with agreed contract values (across several contracts) was **£5.1m** – of this, approximately **£4.7m** was achieved (92%).

It should be noted that the final financial return is based upon an actual contract performance figure at year end rather than the indicative value at beginning of the contract. This final precise figure is not available at time of writing however would expect to be close to the figure previously quoted.

2018-19 CQUIN

The total income available for 2018-19 up to Q3 is £3,450,000. In Q1 to Q3 2018-19 **£3,450,000** from (100%) has been achieved across all indicators. This value was conditional upon achieving quality improvement and innovation goals monetary total for the associated payment (2017-18). Q4 data not available at the time of print

Further details of the agreed goals for 2018-19 and the following 12 month period are available electronically at: https://www.england.nhs.uk/nhs-standard-contract/cquin/

Care Quality Commission (CQC)

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

The Trust has taken part in three joint thematic inspections led by CQC and Ofsted; the focus of the thematic has been Special Educational Needs Disability for both Hartlepool and Durham, Neglect (children) for Stockton. The Trust supported the Hartlepool Local Authority appreciative review undertaken by CQC which considered the health and social care system within a local area, rather than being focused only on the Local Authority's role.

The Care Quality Commission (CQC) has not taken enforcement action against North Tees and Hartlepool NHS Foundation Trust during 2018-19. 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 Trust was inspected by the Care Quality Commission (CQC) under the new regime of inspection at the end of 2017. The new inspection includes an unannounced inspection which took place from 21 to the 23 November 2017 and a planned well-led inspection which took place from the 19 to the 21 December 2017.

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.

The overall CQC rating from the recent inspection improved to 'Good.'

CQC identified significant levels of good practice in all areas inspected which must be celebrated and built upon to sustain and continue improvements to patient care. This good practice included direct care provision, responding to individual needs of women, access and flow across the trust, improved Referral to Treatment time and improvements in discharge and length of stay lower than the England average for elective and non-elective medical patients.

The CQC inspection and subsequent report identified a number of areas for improvement including 11 'should do's' split across the three areas of Emergency Care, In hospital care and Maternity.

The well-led element of inspection was also rated as good noting that there was a clear statement of vision, driven by quality and sustainability and those leaders at every level were visible and approachable. However sustainable delivery of quality care was at risk by the financial challenge we face.

2017-18 Overall ratings for the Trust

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

The full inspection report can be found on the CQC website: http://www.cqc.org.uk/provider/RVW

Rating for Acute Services/Acute Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Good > < Mar-18	Good ^ Mar-18	Good > < Mar-18	Good > < Mar-18	Requires Improvement > < Mar-18	Good ^ Mar-18
Community	Good Feb 16	Good Feb 16	Good Feb 16	Good Feb 16	Good Feb 16	Good Feb 16
Overall Trust	Good > <	Good ^	Good > <	Good > <	Good ^	Good ^

The Trust are now working towards achieving an `Outstanding` rating and there is a strong focus on continuous learning and quality improvement at all levels throughout the organisation. The trust proactively supports a culture of innovation and improvement with a number of initiatives being driven from the frontline staff. The Trust continues to build upon good, visible and approachable leaders which fosters strong teamwork throughout the organisation. Our focus is to stay in touch with front line services, communicate effectively and promote accountability within all teams across the Trust. Staff engagement is key and is driven by leadership, engaging managers, employee voice and an organisation which lives it values.

It is important to highlight the Trust has recently launched the Quality Improvement Strategy which is aligned to several key sub-strategies and the Trusts Vision, mission and values. It underpins continuous improvement in patient care and services by developing effective leaders, engaging support and participation by all relevant staff with an emphasis on team work, innovation and sustainability. Fundamentally `Putting Patients First` is the Trust`s main objective and it is important as a Trust we create a person-centred approach across the organisation, embedding a culture which engages and enables staff to add value to patient experience and that can be demonstrated through patient safety, high quality and effective delivery of care.

The full inspection reports for the Trust are available to the public on the CQC website:
www.cqc.org.uk/provider/RVW

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/

Seven Day Hospital Services

In response to the publication of the clinical standards (2013, updated 2017) by the 'NHS Services, Seven Days a Week Forum' and as directed by NHS Improvement within the Single Oversight Framework and Delivering the Forward View NHS planning guidance 2016/17-2020/21, the Trust is committed to delivering the four priority standards: 2 – time to first consultant review; 5 – time to diagnostics; 6 – consultant directed interventions; and 8 – on-going review by 2020.

The Trust has participated in three national benchmarked surveys which provided a positive position on the four priority standards and identified areas on which to focus improvement work. The survey was repeated in April 2018 with similar results. The Trust is currently completing the Board Assurance Framework for sign off and submission in February 2019.

By 2020 the Trust will also demonstrate that progress has been made on the other six clinical standards: 1 – patient experience; 3 – multi-disciplinary team review; 4 – shift handovers; 7 – mental health; 9 – transfer to community, primary and social care; and quality improvement.

The above clinical standards are being progressed and monitored by a working group with robust clinical leadership and significant work is on-going to address any gaps in service provision. The Trust is also participating in a peer support group organised by NHS England.

Duty of Candour

Duty of Candour is the process of being open and transparent with people who use the Trust's 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.

The Trust policy has been in place since the regulations were introduced. The policy details for staff how application of the regulations should be communicated to patients and their families/carers and then recorded. This is supported by the provision of a healthcare document to be completed and stored in the patients records, full completion of this records 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.

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 wider knowledge of the regulations. From April 2018 Duty of Candour training has been mandated for all staff grade 6 and above; the training is provided monthly on a face to face basis but also available as e-learning. Training levels are monitored monthly through the Trusts mandatory training reports.

Monitoring of compliance is reported to the Trust Board and also to the Trust's Commissioners.

Commissioners Assurance

The Trust has had two announced and one unannounced Commissioner Assurance visits during 2018-19. The ward or department to be visited is not known until the day of the visit.

These visits took place to Holdforth Unit in May 2018, Urgent Care/Accident and Emergency and Paediatric Ward in September 2018, Ward 25 in November 2018 and Ward 28 in March 2019.

An action plan has been developed for any issues identified at each of these visits and these have been shared with the commissioners.

Freedom to Speak Up (FTSU)

Guidance

In its response to the Gosport Independent Panel Report, the Government committed to legislation requiring all NHS trusts and NHS foundation trusts in England to report annually on staff who speak up (including whistleblowers). Ahead of such legislation, NHS trusts and NHS foundation trusts are asked to provide details of ways in which staff can speak up (including how feedback is given to those who speak up), and how they ensure staff who do speak up do not suffer detriment. This disclosure should explain the different ways in which staff can speak up if they have concerns over quality of care, patient safety or bullying and harassment within the trust.

Background to the Freedom to Speak Up Guardian

Following the public enquiry by Sir Robert Francis, into the failures in care in Mid Staffordshire Hospital in 2013, where staff were raising concerns around patient safety and were not being listened to or taken seriously, which led on to the avoidable deaths of patients and a sub standard quality of care.

The Francis Report raised 290 recommendations. One of the recommendations was to have a designated person who was impartial and independent working in every Trust, for staff to speak to in confidence, regarding any public interest disclosure. Staff would be listened to, taken seriously and would not suffer detriment for speaking up.

Philosophy

This role takes in the recommendations of Sir Robert Francis, following his review into whistleblowing in the NHS. It is intended that this will help normalise the raising of concerns for the benefit of all patients.

The Trust positively encourages all employees to speak up if they have a concern about risk, malpractice or wrongdoing, if they feel that this is harming the services that the Trust delivers. Examples may include (but are by no means restricted to):

- Unsafe patient care
- Unsafe working conditions
- Inadequate induction or training for staff
- Professional malpractice
- Lack of, or poor, response to a reported patient safety incident
- Suspicions of fraud (which can also be reported to our local counter-fraud team)
- A bullying culture (across a team or organisation rather than individual instances of bullying)
- A person has failed, is failing or is likely to fail to comply with any legal or professional/regulatory obligation to which he or she is subject
- Suspicion that a bribe has been either offered, promised, agreed, requested or accepted
- Conduct which is likely to damage the reputation of the Trust;
- Breach of the Trust's policies and procedures
- A criminal offence has been, or is being committed, or is likely to be committed
- Issues relating to the prevention of violent extremism
- Any misrepresentation of the true state of affairs of the Trust
- The environment has been, is being or is likely to be damaged
- The deliberate concealment of any of the above matters or information which has been or may be deliberately concealed.

Trust progress:

- The Trust has appointed and supports a Freedom To Speak Up Guardian (FTSUG) and six First Stop Contact officer (FSCO).
- The Trust gives the FTSUG access to all members of staff including immediate contact with the Chief

Executive if needed and all documents for the purpose of the disclosure.

- Receives challenges from the guardian openly and honestly.
- Provides telephone/Email/Face to face contact openly, confidentially or anonymously.
- Protects staff from suffering detriment by maintaining confidentially for the disclosee if this does not affect patient safety. Gives feedback to the disclosee.
- Trust investigates all disclosures, actions are taken and lessons learnt.
- Promotes a culture that encourages speaking up – particularly from minority and vulnerable groups, via the culture group, walk rounds by the Employee Relations team, meeting with staff.
- Posters on all wards/departments displayed in staff areas. Flyers handed out with contact details. Emails introducing the role to heads of service with contact details.
- Pens/keyrings/business cards with contact details on for staff.
- FTSUG attends inductions/student nurse inductions/junior doctors forums/culture group/community staff meetings, Our Voice, Heads of Service meetings. Training and education with staff through managers of departments. Walkabouts by the guardian.
- Communications advertise the role on the intranet, anthem and regular communication emails throughout the Trust and Facebook.
- Reports to the National Guardians Office quarterly on staff who speak up, reporting on themes and if staff have suffered detriment.
- Staff are able to speak up openly, in confidence or anonymously.
- Staff and guardian advise if staff member has suffered detriment from speaking up and this is fed back to the Trust board and National Guardians Office and investigation carried out.
- Awareness session for the workforce team.
- Develop sharepoint site with guidance for staff and managers.
- Support the FTSUG to work as the deputy regional chair for the North East.
- Support the guardian on development days and encourage learning for the guardian with peers and launch days.
- Keeps up to date and accurate, confidential data base for auditing themes or areas of culture.

NHS Number and general medical practice validity

North Tees and Hartlepool NHS Foundation Trust submitted records during 2018-19 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:

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**	**99.90**	Percentage for admitted patient care	**100**
Percentage for outpatient care	**100**	Percentage for outpatient care	**100**
Percentage for accident and emergency care	**99.50**	Percentage for accident and emergency care	**100**

*Data for April 2018 to December 2018
** NHS number low because of anonymised data sent to SUS for sensitive patients

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 Data Security Protection Toolkit (DSPT). The DSPT is an online self-assessment tool which allows orgianistions to assess themselves against the Data Security and Protection Standards for health and care set out in the National Data Guardian's (NDG) data security ten standards.

All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practicing good data security and that personal information is handled correctly. The DSPT sets out 100 mandatory evidence items in 40 assertions (32 Mandatory) which cover these 10 standards that the Trust must evidence compliance against in order to gain compliance.

The Trust for 2018-19 have self-assessed compliance with all 100 mandatory evidence items and are scored as 'Standards Met' for the 32 mandatory assertions shown below:

The Trust has also submitted compliance against five of the eight non-mandatory assertions.

The 2018-19 DSPT was also subject to external audit, a sample of 25 of the 100 mandatory evidence items were audited by AuditOne during March 2018 prior to the DSPT submission.

Staff training and awareness of Information Governance is a key indicator, in 2018-19 we again had to ensure that 95% of all of our staff had received data security training. The training compliance was achieved for the seventh year running.

Freedom of Information (FOI)

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. For the year 2018/19 the Trust received 630 requests with a compliance level as of the end of March 2019 of 94% with complete compliance data available after 30 April 2019 (a further 47 have a completion date between 1 April and 30 April 2019). This reflects improvements made to the internal FOI process, with a previous compliance figure of 91% for 2017-18.

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 the reporting period 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	2017-18	2018-19
Primary diagnoses correct	91.50%	91.00%	90.50%	**91.00%**
Secondary diagnoses correct	89.94%	87.65%	81.88%	**93.56%**
Primary procedures correct	91.43%	92.74%	93.65%	**93.75%**
Secondary procedures correct	83.41%	87.50%	86.21%	**88.33%**

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. Targeted internal 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 are available to attend mortality review meetings to ensure the correct coding of deceased patients.

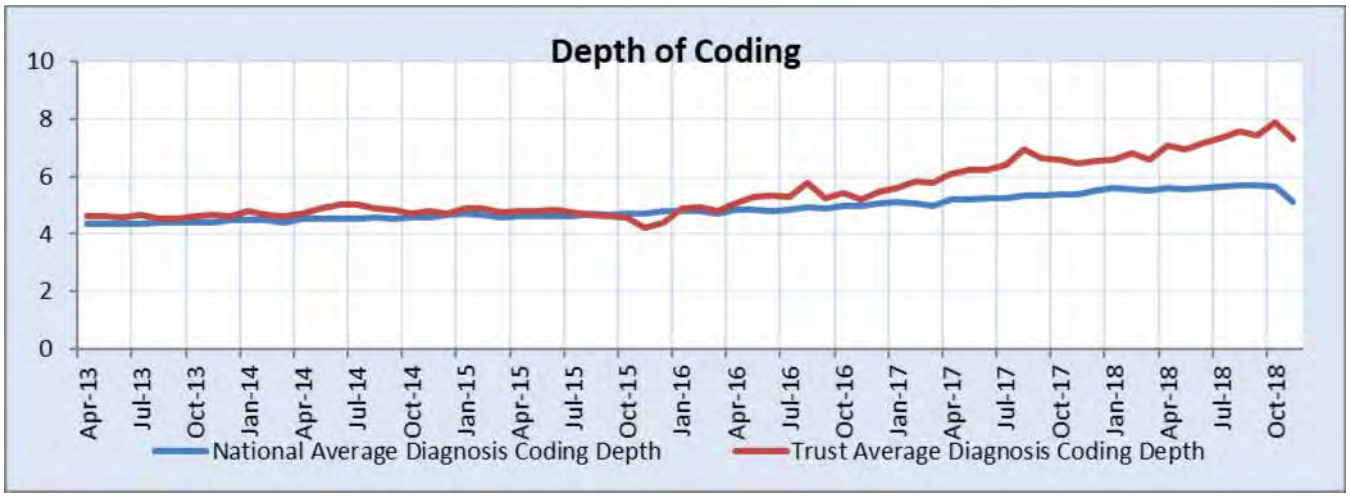
Our coders organise their work so that they are aligned to the clinical teams. This results in sustained improvements to clinical documentation. This supports accurate clinical coding and a reduction in the number of Healthcare Resource Group changes made. This is the methodology which establishes how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

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 coding department has undergone a re-structure in order to facilitate coding medical episodes from case notes.

A gradual roll out has taken place and the majority of medical wards are now coded from the case notes. It is hoped this will improve the capture of additional co-morbidities that are used to calculate HSMR and SHMI. The only wards currently outstanding are EAU, ward 37 and ward 38 but the resultant increase in daily workload coupled with the imbalance in the team dynamic means that maintaining coding accuracy while continuing to achieve 100% of coding within the mandatory time deadlines is increasingly challenging. Due to the current shortage of trained and experienced coders working within the team the remaining rollout of coding medical wards from case notes has been put on hold. In order to improve the flow of medical case notes being sent to the coding department a temporary red sticker has been piloted on the medical base wards. The sticker instructs whoever has the case notes at that time to send them to the coding department. If the pilot is deemed successful this system will be rolled out to all wards across the Trust.

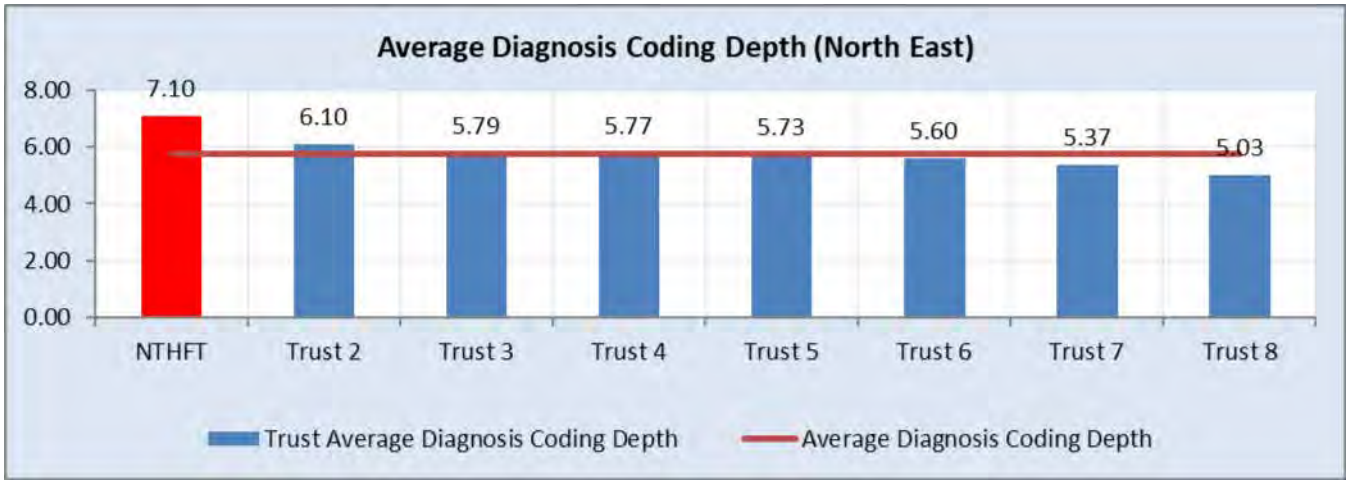
Diagnosis Coding Depth National and Trust Trend (April 2013 to November 2018)

The Trust has made great strides in improving the accuracy and depth of patient coding, the following chart demonstrates the increase (red) against the national average (blue). The Trust has Improved the quality of discharge documentation and actively engaged clinicians to work closely with Clinical Coding.



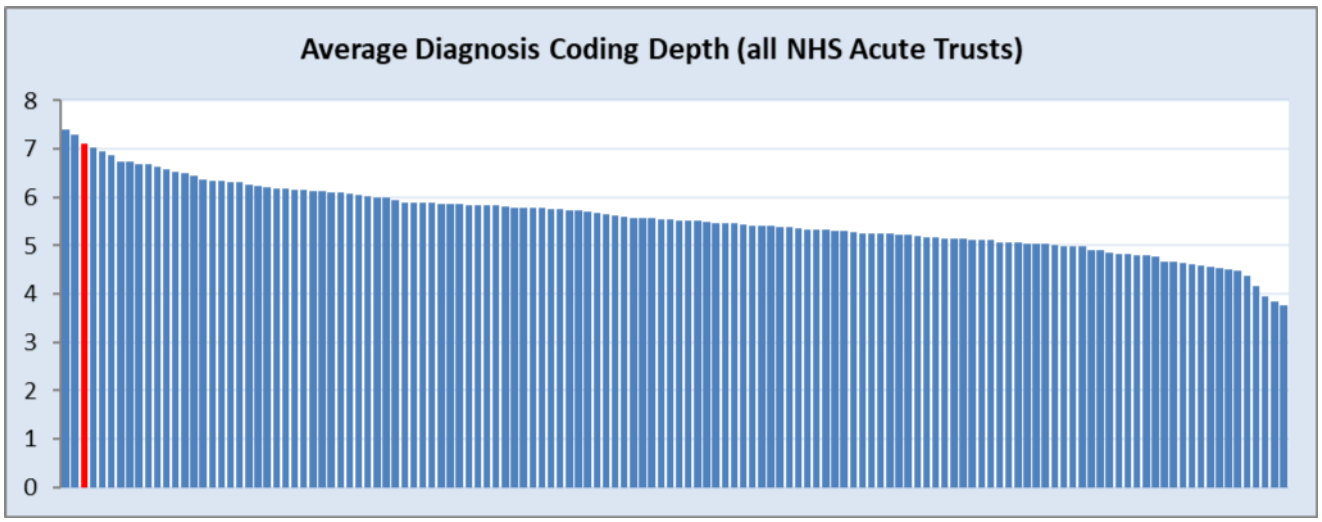
Diagnosis Coding Depth - North East Trusts (December 2017 to November 2018)

The following chart demonstrates the North East average depth of coding.



*Data taken from Data Quality Clinical Coding in HED and up to November 2018

The following chart details where the Trust **(red)** sits nationally with regards to depth of coding.




eros
coffee

Section 2D: Core set of Quality Indicators

Measure	Measure Description	Data Source
1a	The data made available to the trust by NHS Digital with regard to — the value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period **January 2018 – December 2018.**	NHS DIGITAL

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, **January 2018 – December 2018**

Time period	Over-dispersion banding	Trust Score	National Average	Highest – SHMI Trust Value in the country	Lowest – SHMI Trust Value in the country
Oct 2015 – Sep 2016	Band 2 (As Expected)	1.1195	1.00	1.1638	0.6897
Jan 2016 – Dec 2016	Band 2 (As Expected)	1.1029	1.00	1.1894	0.6907
Apr 2016 – May 2017	Band 2 (As Expected)	1.0942	1.00	1.2123	0.7075
Jul 2016 – Jun 2017	Band 2 (As Expected)	1.0801	1.00	1.2277	0.7261
Oct 2016 – Sep 2017	Band 2 (As Expected)	1.0591	1.00	1.2473	0.7270
Oct 2017 – Sep 2018	Band 2 (As Expected)	1.0072	1.00	1.2681	0.6917
Jan 2018 - Dec 2018	**Band 2 (As Expected)**	**1.0018**	**1.00**	**1.2264**	**0.6993**

SHMI Regional – January 2018 – December 2018

Trust	Trust Score	OD banding
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	1.0993	2
SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST	1.0759	2
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	1.0670	2
GATESHEAD HEALTH NHS FOUNDATION TRUST	1.0507	2
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	1.0152	2
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	**1.0018**	**2**
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	0.9867	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 and so the quality of its services. The Trust continues to undertake mortality reviews over two sessions each week, this is in line with the Secretary of State for Health requirements for all Trusts to undertake mortality reviews; this continues to be supported by the CQC. This has been supported by the inclusion of the mortality reviews in the quality work undertaken by all consultant staff as part of their annual appraisal. The information is input directly onto a dedicated database, this is then used to extract data for reporting.

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.

The multiple work streams that have been delivered during 2018-19 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 data made available to the trust by NHS Digital with regard to — The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust - **January 2018 – December 2018**	NHS DIGITAL

Percentage of deaths with palliative care coding, January 2018 – December 2018

Time period	Diagnosis Rate	Diagnosis Rate National Average	Highest – Diagnosis Rate	Lowest – Diagnosis Rate
Jul 2015 – Jun 2016	35.88	29.39	54.83	0.57
Oct 2015 – Sep 2016	36.42	29.60	56.27	0.39
Jul 2016 – Jun 2017	39.00	30.80	58.30	11.20
Oct 2016 – Sep 2017	36.70	31.20	59.50	11.50
Oct 2017 – Sep 2018	35.80	33.40	59.50	14.20
Jan 2018 – Dec 2018	**37.00**	**34.00**	**60.00**	**15.00**

Latest Time Period benchmarking position – January 2018 – December 2018

Provider	Diagnosis Rate
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	42.00
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	41.00
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	**37.00**
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	32.00
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	29.00
GATESHEAD HEALTH NHS FOUNDATION TRUST	29.00
SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST	24.00
National Average	**34.00**

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 within the Trust is now a fully embedded practice. The processes and procedures are continuously reviewed to ensure that the Specialist Palliative Care team are reviewing patients in a timely manner.

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

The **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 has continued 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 Trust's 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 also on-going with GPs to try and reduce inappropriate admissions to the Trust.

Measure	Measure Description	Data Source	Value
2	The data made available to the trust by NHS Digital with regard to the trust's patient reported outcome measures scores for— 1. Groin hernia surgery 2. Varicose vein surgery 3. Hip replacement surgery, and 4. Knee replacement surgery during the reporting period	NHS DIGITAL	Adjusted average health gain EQ-5D Index

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

April 16 to March 17	Groin hernia	Varicose vein	Hip replacement – Primary	Hip replacement – Revisions	Knee replacement – Primary	Knee replacement – Revisions
Trust Score	0.073	**No data**	0.432	**No data**	0.362	**No data**
National Average	0.087	0.092	0.444	0.292	0.323	0.266
Highest National	0.132	0.154	0.540	0.367	0.403	0.294
Lowest National	-0.009	0.015	0.305	0.235	0.245	0.233

April 17 to March 18	*Groin hernia	*Varicose vein	Hip replacement – Primary	Hip replacement – Revisions	Knee replacement – Primary	Knee replacement – Revisions
Trust Score	No data	**No data**	0.489	**No data**	0.362	**No data**
National Average	0.089	0.096	0.470	0.293	0.340	0.291
Highest National	0.140	0.134	0.581	0.353	0.418	0.338
Lowest National	0.000	0.000	0.398	0.191	0.217	0.304

*Groin Hernia and Varicose Vein data up to Sept 2017

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 Trust's position continues to demonstrate good results.

The **North Tees and Hartlepool NHS Foundation Trust** has taken the following actions to improve this score and so the quality of its service. 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 data made available to the trust by NHS Digital with regard to the percentage of patients aged— (i) 0 to 15; and (ii) 16 or over. 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.	NHS DIGITAL

Age Group	Value	Emergency readmissions within 28 days of discharge from hospital Apr 2017 to Mar 2018	Emergency readmissions within 28 days of discharge from hospital Apr 2016 to Mar 2017
0 to 15	Trust Score	**12.90**	11.40
	National Average	**11.90**	11.60
	Band	**Significantly higher than the national average at the 95% level but not at the**	National average lies within expected variation (95% confidence interval)
	Highest National	**32.90**	68.40
	Lowest National	**1.30**	1.60
16 or over	Trust Score	**13.80**	13.70
	National Average	**14.10**	13.60
	Band	**National average lies within expected variation (95% confidence interval)**	National average lies within expected variation (95% confidence interval)
	Highest National	**46.40**	121.50
	Lowest National	**1.80**	0.90

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 2018 position (latest available data) indicates the Trust has an overall readmission rate of 9.46% against the internal stretch target of 7.70%, indicating the Trust's readmission rates have slightly increased by 0.96% compared to the same period in 2017.

The **North Tees and Hartlepool NHS Foundation Trust** has taken the following actions to improve the rate and so the quality of its service. The Trust recognises further work is required to reduce potential avoidable readmissions and so a revised process has been agreed which has seen the development of a standardised template to capture data which will be clinically led. Results will be presented to the Learning and Improvement Committee and Business Team. Patient pathways continue to be redesigned to incorporate an integrated approach to collaboration with health and social care services. Initiatives continue including: a discharge liaison team of therapy staff to actively support timely discharge, social workers within the hospital teams to facilitate discharge with appropriate packages of care to prevent readmission; utilisation of ambulatory care and rapid assessment 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. These actions have seen a significant reduction in stranded patients and delayed transfers of care which have assisted in the successful management of winter pressures.

Measure	Measure Description	Data Source
4	The data made available to the trust by NHS Digital with regard to the trust's responsiveness to the personal needs of its patients during the reporting period.	NHS DIGITAL

Period of Coverage	National Average	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST (out of 100)
***2018-19**	**Not Available**	**Not Available**
2017-18	**68.60**	**68.70**
2016-17	68.10	67.20
2015-16	69.60	67.70
2014-15	68.90	68.10
2013-14	68.70	69.00
2012-13	68.10	68.70

*2018-19 data not available at the time of print – Available August 2019

Benchmarked against over North East Trusts for 2017-18;

Trust	Overall Score (out of 100)
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	74.90
Northumbria Healthcare NHS Foundation Trust The	74.40
Gateshead Health NHS Foundation Trust	73.80
South Tees Hospitals NHS Trust	72.00
South Tyneside NHS Foundation Trust	72.00
City Hospitals Sunderland NHS Foundation Trust	70.30
County Durham and Darlington NHS Foundation Trust	69.30
North Tees & Hartlepool NHS Foundation Trust	**68.70**

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 helps us to understand how well we are performing.

The **North Tees and Hartlepool NHS Foundation Trust** has taken the following actions to improve this score and the quality of its services, by delivering accredited programmes that focus on responsiveness of patient and carers for both registered and unregistered nurses. We use human factors training to raise awareness of the impact and 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 data made available to the trust by NHS Digital with regard to the percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	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

	Survey Year	
Trust Name	**2017**	**2018**
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	77	83
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	58	59
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	**67**	**71**
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	89	90
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	69	71
GATESHEAD HEALTH NHS FOUNDATION TRUST	81	81
SOUTH TYNESIDE NHS FOUNDATION TRUST	62	65
CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST	71	72
North East	72	74
England	70	70
National High	**86**	**95**
National Low	**47**	**41**

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	92.70%	93.90%	71.00%	97.30%
Percentage Not Recommended – Care	1.70%	2.00%	6.00%	0.00%

*Q1, Q2 and Q4 data obtain 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	84.70%	86.90%	67.10%	91.67%
Percentage Not Recommended – Work	6.20%	3.00%	12.00%	0.00%

*Q1, Q2 data obtain 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 2017-18, 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. It is important that the results of these surveys are communicated to our staff and we utilise a 'you said, we did' approach to facilitate this. A new approach to action planning has been identified for 2019, with a specific focus on improving staff engagement. We are also incorporating staff survey action plans into the directorate performance reviews, which will improve accountability for action plans and ensure that actions are monitored going forward.

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 the Workforce directorate is carrying out projects to understand the culture of the organisation. We have now commenced Phase 2 of the Culture and Leadership programme, which involves developing a collective leadership strategy for high quality, continuously improving, and compassionate care. The Culture Dashboard reports on a number of key staff survey metrics which can then be shared with the directorates for consideration and action where required.

National Staff Survey

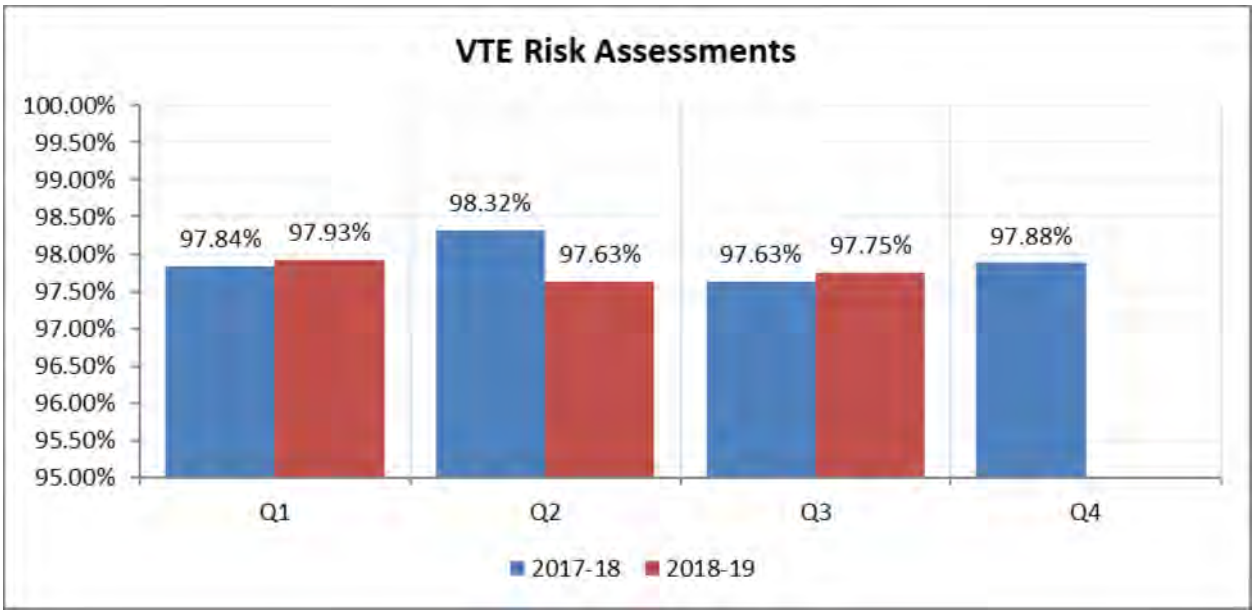
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months:

2014	2015	2016	2017	2018	2018 National Average
21%	26%	20%	24%	20%	**24%**

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

2014	2015	2016	2017	2018	2018 National Average
90%	90%	91%	93%	91%	**83%**

Measure	Measure Description	Data Source
6	The data made available to the trust by NHS Digital with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	NHS DIGITAL



Two year reporting trend

Measure	Reporting Year	2017-18				2018-19			
	Quarter	Q1	Q2	Q3	Q4	Q1	Q2	Q3	*Q4
Venous Thromboembolism	Value	97.84%	98.32%	97.63%	97.88%	97.96%	97.63%	97.75%	
	National Average	95.20%	95.25%	95.36%	95.21%	95.63%	95.49%	95.65%	
	Highest National	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	
	Lowest National	51.38%	71.88%	76.08%	67.04%	75.84%	68.67%	54.86%	

*Q4 data not available at time of print

North East Trust benchmarking 2018-19

	2018-19			
Trust	Q1	Q2	Q3	*Q4
City Hospitals Sunderland NHS Foundation Trust	98.73%	98.61%	98.79%	
County Durham and Darlington NHS Foundation Trust	96.97%	96.23%	95.65%	
Gateshead Health NHS Foundation Trust	99.52%	99.24%	99.10%	
North Tees & Hartlepool NHS Foundation Trust	**97.96%**	**97.64%**	**97.75%**	**97.53%**
Northumbria Healthcare NHS Foundation Trust	96.11%	96.62%	98.39%	
South Tees Hospitals NHS Trust	95.58%	95.16%	95.14%	
South Tyneside NHS Foundation Trust	96.37%	98.73%	96.41%	
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	96.49%	95.72%	97.23%	

*Q4 data not 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 VTE 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 lead is responsible for monitoring and audit of compliance of NICE VTE guidelines and this is presented yearly to the Audit and Clinical Effectiveness (ACE) CVommittee.

The following value demonstrates the venous thromboembolism (VTE) mandatory training for the whole Trust:

***VTE Training (Compliance)**
90%

*Data obtained from the Trust training department
*Data for 2018-19

Measure	Measure Description	Data Source
7	The data made available to the trust by NHS Digital with regard to the rate per 100,000 bed days of cases of C difficile infection reported 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
Apr 2018 – Mar 2019	**31**	**Not Available**	**Not Available**	**Not Available**	**Not Available**
Apr 2017 – Mar 2018	35	17.80	13.70	91.00	0.00
Apr 2016 – Mar 2017	39	18.40	13.20	82.70	0.00
Apr 2015 – Mar 2016	36	17.40	14.90	67.20	0.00
Apr 2014 – Mar 2015	20	10.20	15.00	62.60	0.00

* 2018-19 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.
- Exploration of new patient products such as commodes to ensure they are easy to clean and fit for purpose.
- 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 again participated in European Antibiotic Awareness day with displays for staff around prudent prescribing. Awareness has also been raised via the CQUIN scheme to reduce overall antibiotic consumption and ensure that prompt review of antibiotics takes place.
- Continued emphasis on high standards of hand hygiene for staff and patients, utilising hand hygiene champions and a monthly RAG report.
- Monitoring of the management of affected patients to support ward staff and ensure guidance is being adhered to.
- The continuation of annual update training in infection prevention and control for all clinical staff.
- Review of all hospital onset cases by an independent panel to ascertain whether the infection was avoidable and the ensure all learning has been identified.
- Collaborative working with partner organisations to standardise guidance and promote seamless care for patients who move between care providers.

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

Measure	Measure Description	Data Source
8	The data made available to the trust by NHS Digital with regard to the number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and 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 2017 – March 2018**

	Based on occurring dataset (Degree of Harm – All)		National			Our Trust	
			Degree of harm Severe or Death			Degree of harm Severe or Death	
Report period	**Number of incidents occurring**	**Rate per 1000 Bed Days**	**Average %**	**Highest %**	**Lowest %**	**Number of incidents**	**%**
Oct 17 – Mar 18	**4,582**	**44.80**	**0.15**	**0.55**	**0.00**	**18**	**0.18**
Oct 16 – Mar 17	3,087	29.80	0.15	0.53	0.01	5	0.05

Regional Benchmarking

	October 2017 – March 2018	
Trust	**Degree of Harm (All) – Rate per 1000 bed days**	**Degree of Harm (Severe or Death) Rate per 1000 bed days**
City Hospitals Sunderland NHS Foundation Trust	44.80	0.03
North Tees & Hartlepool NHS Foundation Trust	**44.80**	**0.15**
Northumbria Healthcare NHS Foundation Trust	42.70	0.06
Gateshead Health NHS Foundation Trust	37.80	0.35
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	36.50	0.09
County Durham and Darlington NHS Foundation Trust	35.60	0.07
South Tees Hospitals NHS Trust	29.60	0.06
South Tyneside NHS Foundation Trust	24.20	0.00

*Data for Oct 17 – Mar 18

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 the 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 and pressure damage, the Trust have developed templates within the incident reporting system to identify contributory factors of incidents, identify trends, develop improvements and evaluate the impact of these.

All reported incidents are reviewed internally within the local departments for accuracy in regards 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 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 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 fundamental 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.


NHS

PART 3

Section 3A: Additional Quality Performance measures during 2018-19

This section is an overview of the quality of care based on performance in 2018-19. 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 2018-19 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 2018-19. 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

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 upon.

Whenever a "fall" occurs this is recorded per the Datix System. A fall is defined as an unexpected event in which the participant comes to rest on the ground, floor or lower level.

A post falls checklist is completed and is used to help categorise the fall into one of the following:

- Fracture
- Injury, no fracture
- No injury

Falls with Fracture

During **2018-19** the Trust has experienced **32** falls resulting in fracture; this has increased from **25** in the 2017-18 reporting period.

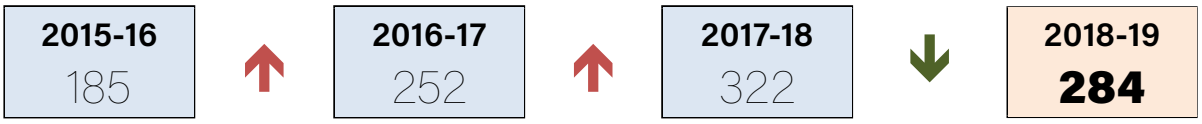
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2015-16	4	3	11	1	4	1	1	0	2	0	2	3	**32**
2016-17	3	1	1	1	3	1	0	0	3	1	3	3	**20**
2017-18	1	2	5	5	2	2	3	0	0	2	1	2	**25**
2018-19	**3**	**1**	**2**	**4**	**3**	**2**	**3**	**2**	**4**	**2**	**2**	**4**	**32**

*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 **2018-19** the Trust has experienced **284** falls resulting in an injury and no fracture; this has decreased from **322** in the 2017-18 reporting period.

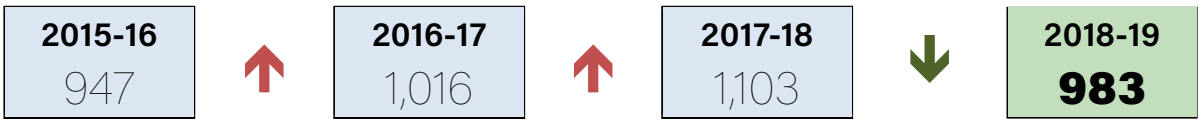


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2015-16	13	19	9	14	19	16	13	13	20	15	13	21	**185**
2016-17	15	17	19	24	26	24	23	10	26	26	22	20	**252**
2017-18	18	27	20	36	23	31	28	32	24	32	27	24	**322**
2018-19	**30**	**29**	**20**	**35**	**20**	**21**	**20**	**22**	**23**	**27**	**23**	**14**	**284**

*Data obtained via the Trust's Incident Reporting database (Datix)

Falls with No Injury

During **2018-19** the Trust has experienced **983** falls resulting in no injury; this has decreased from **1,103** in the 2017-18 reporting period.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
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**
2017-18	99	74	75	88	85	95	79	99	106	90	107	106	**1,103**
2018-19	**112**	**90**	**70**	**72**	**70**	**83**	**83**	**81**	**83**	**86**	**74**	**79**	**983**

*Data obtained via the Trust's Incident Reporting database (Datix)

Reporting to date for 2018-19 would indicate that a similar numbers of falls will be reported for this financial year as the previous financial year. The proportion of falls with no harm, low harm and moderate harm remains similar, with incidents of moderate harm accounting for just 2% of all patient falls. The number of patients sustaining a fractured neck of femur remains similar to last year, however, the Trust was proud to achieve 140 days without an inpatient fractured neck of femur during Q3.

The post falls checklist has been introduced and embedded this year, the checklist prompts staff to immediately document relevant factors about the circumstances of the fall which allows the investigator to complete a review within 24 hours and ensure relevant improvements are taken to reduce further falls. The form is now completed electronically via Datix which will allow audit of the results and trend analysis.

Never Events

The Trust continues to work hard to improve patient safety therefore stakeholders and the Board wanted to reflect the low numbers of Never Events in the organisation.

Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event.

Since 2014 the Trust has had 5 Never Events and they are broken down as follows:

2014-15	2015-16	2016-17	2017-18	2018-19
1	2	1	0	**1**

The NHS England report can be accessed via:
https://improvement.nhs.uk/resources/never-events-data/

There has been one Never Event reported in the period of 2018-19, this occurred in October 2018 . The never event was for a wrong implant prosthesis and was linked to a patient safety alert. (currently under review)

Additional Patient Safety indicators are in Part 2 of these accounts, pages 113 to 146.

Effectiveness of Care

Patient and Staff Experience

Patient and staff experiences are what drive the Trust in ensuring that the standard of care being provided is of a high standard. The following data for Patient and Staff Experience Audits is an internal reporting tool used when visits have taken place. This process for 2018-19 has been developed to make use of existing audits to avoid duplication and to provide a robust review.

This audit is led by the Deputy Director of Nursing, Patient Safety and Quality and/or the Head of Nursing Quality. The audit is undertaken by various members ranging from Senior Clinical Matrons, members of the Board, Assistant Directors and Governors.

The following table provides data relating to the **249** visits undertaken during the 2018-19 visits:

*Data obtained from the Trusts Patient and Staff Experience Audits

Medication Errors

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.

In **2017-18** there were 670 medicines incident reports via Datix. In **2018-19** there has been **775** incident reports. A small number of these incidents originate from external organisations such as GPs and care homes.

Type of incidents	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
Prescribing	124	147	224	138	141	**172**
Administration	256	314	321	413	386	**468**
Dispensing	41	43	48	72	78	**61**
Other	56	50	16	62	65	**74**
Total	**477**	**554**	**609**	**685**	**670**	**775**

*Data from the Trusts Datix system

2018-19 Trust Medication Error Categories

Trust Medication Error Category	Q1	Q2	Q3	Q4	Total
Administration or supply of a medicine from a clinical area	133	104	112	119	**468**
Medication error during the prescription process	37	43	36	56	**172**
Preparation of medicines / dispensing in pharmacy	16	13	17	15	**61**
Monitoring or follow up of medicine use	5	15	13	13	**46**
Patient's reaction to Medication	1	1	0	4	**6**
Advice	2	2	3	2	**9**
Supply or use of Over the Counter medicines	0	0	1	1	**2**
Other	5	1	5	0	**11**
Total	**199**	**179**	**187**	**69**	**775**

*Data from the Trusts Datix system

Safe Medication Practices Group (SMPG)

Medicines incident data is reviewed bi-monthly by the Safe Medication Practices Group (SMPG). The aim is to:

- Analyse and theme incidents;
- Introduce system changes to reduce errors; and
- Engage with users.

The use of the Management and Investigation of Medication Incidents guideline is being encouraged. It was updated to provide a framework to support managers through the process of medication incident management and investigation and to encourage shared learning.

Electronic prescribing and medicines administration continues to be rolled out in the Trust and is now live on all in-patient areas and two out-patient areas. This system has the potential to reduce medicines errors through:

- Greater legibility of prescription which should result in less reader error
- Increased access to prescription means that a medicine chart no longer needs to be sent to pharmacy for clinical checking, resulting in fewer delays in administration
- No more missing medicine administration chart
- Includes some prescriber support
- Clear identification of due dose with less risk of missed doses
- Clear audit trail of who did what, for both prescribing and administration
- Reduction in transcription errors
- We are awaiting safety metrics being produced to measure the above factors

Pharmacy are currently working with Rosedale Rehabilitation and Assessment Centre to support the transition of patient medicines from hospital discharge to admission to Rosedale. The aim is to improve the discharge process and increase medicines safety post discharge.

Pharmacy staff are now utilising a 'good catch log' to highlight near miss errors before the medication has been released to wards and patients. The aim of this is to encourage a 'no blame' reporting culture thereby promoting thorough checking of dispensed items to reduce the potential risk of patients receiving incorrect medication therefore improving patient safety. This work has been published on the Specialist Pharmacy Services website and can be accessed via link: https://www.sps.nhs.uk/repositories/good-catch-encouraging-a-no-blame-reporting-culture-for-near-misses-in-our-dispensing-areas/

A business case submitted for the expansion of ward based pharmacy services has been approved and jobs have gone to advertisement for employment of staff to fill the new posts. This expansion will provide more wards with a designated pharmacist and supporting technicians to improve the safe supply of medications for patients and increase accurate and speedier supply of medication at the point of discharge.

"Very friendly explained the procedure kept me informed throughout. Made me feel relaxed and calm. Fully explained after care and medication... " [sic]

"Nurses were late changing the infusion medication. I noticed that there were only two not three medications included so asked another nurse later. This was an error and needed to be replaced. Nan is also in pain today after eating (trying to eat possibly because she has not been given her regular medication for stomach ulcers." [sic]

Clinical Effectiveness Indicators

These indicators for Clinical Effectiveness are covered under the section of Effectiveness of Care. 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 Monitor Compliance Framework.

For this report the Trust has chosen high risk Transient Ischemic Attack (TIA) and Stroke indicators.

The following table demonstrates the quarter on quarter performance with a benchmark position against 2017-18 data and against the 2018-19 performance target.

	2017-18 Performance	2018-19 Target	Q1	Q2	Q3	*Q4	2018-19 Performance
Stroke – 80% of people with stroke to spend at least 90% of their time on a stroke unit	93.90%	**80%**	89.81%	91.72%	93.44%	94.79%	**92.44%**
Percentage high risk TIA cases treated within 24 hours	96.98%	**75%**	91.43%	95.24%	92.31%	88.24%	**91.81%**

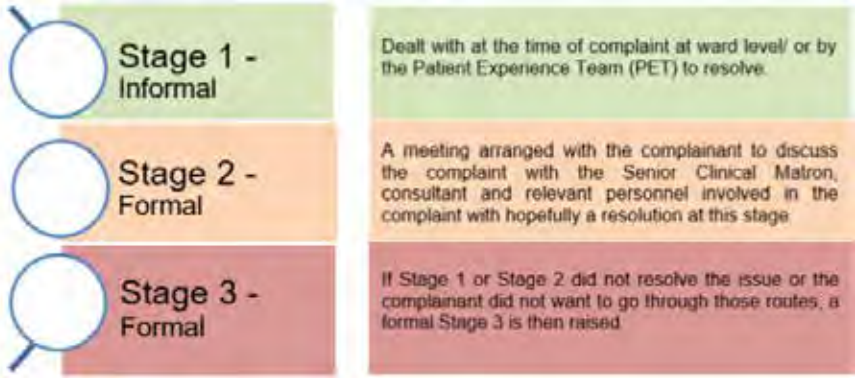
*Data from Trust Clinical Effectiveness Team and upto and including February 2019

Patient Experience

Complaints

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.



Number of Complaints - 2018-19

The Trust received **1,017** complaints in 2018-19; the following demonstrates how many were concluded during stage 1, stage 2 and stage 3.

*Data for 2018-19 obtained from Datix

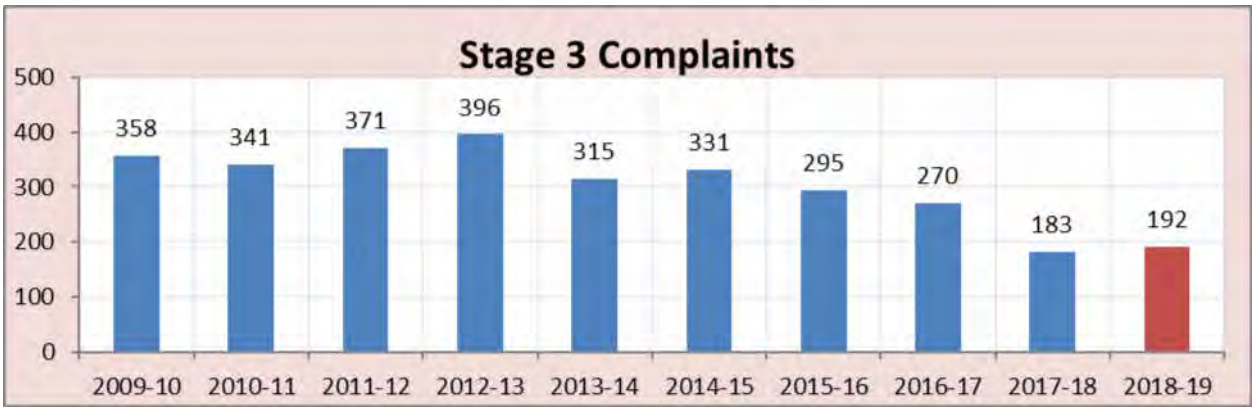
2018-19 Complaints by complaint type:
From the **1,017** complaints received in 2018-19 there are **995** with a sub-subject description.
Please see the following breakdown of the **top 10 complaint types.**

Complaint Subject	Total
Communication - verbal/non verbal	259
Attitude of staff	109
Treatment and procedure delays	88
Outpatient delay	82
Delay to diagnosis	68
Competence of staff member	52
Discharge arrangements	36
Outpatient cancellation	32
Car Parking	29
Length of time to be given appointment	27

*Data obtained from Trust complaints dept.

Since April 2018, the Trust has received **1,017** complaints of which **192** have gone onto the formal complaint process, this only equates to **18.88%** of the complaints.

The number of formal complaints received over the last 10-years is shown in the following table:



*Data obtained from Trust complaints dept. up to 28 February 2019

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.

The Trust continually monitors the percentage of formal complaints that the Trust responds to in an agreed timeframe with the complainant.

Month	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Compliance Rate	93%	93%	85%	80%	83%	100%	84%	100%	91%	82%	93%	82%

*Data obtained from Trust complaints dept.

Compliments

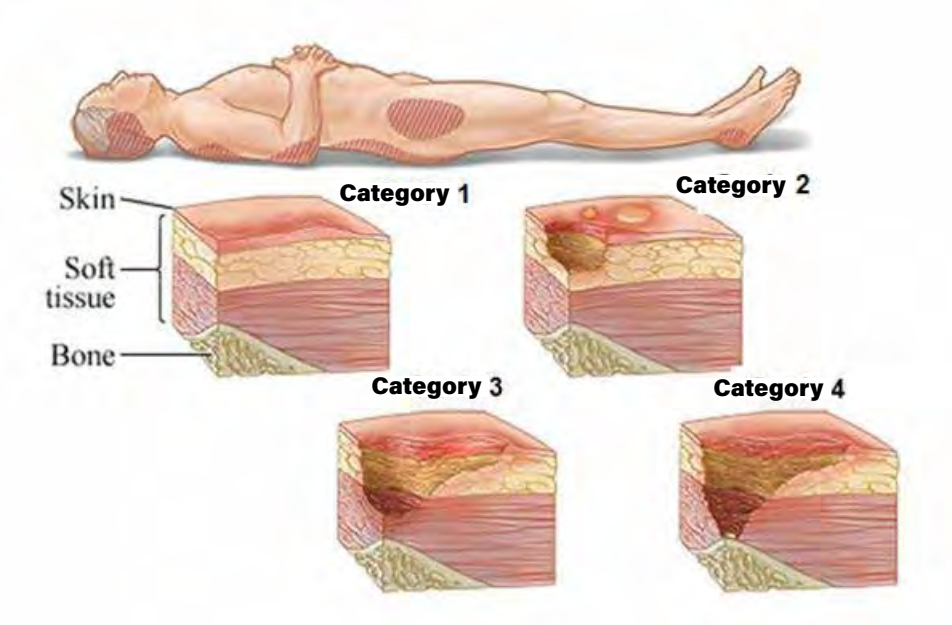
The Trust records the number of **compliments** received within each area. The trends in the number of compliments received can be seen in the following table and chart.

2009-2010	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019
2,212	3,786	5,097	5,414	9,296	11,357	11,367	11,818	11,732	**11,849**

*Data obtained from Trust dashboard database

Pressure Ulcers

Pressure ulcers, also known as **pressure sores, bedsores** and **decubitus ulcers**, are localised damage to the skin and/or underlying tissue that usually occur over a bony prominence as a result of **pressure**, or **pressure** in combination with shear and/or friction.



Year on Year Comparison – In-Hospital Acquired

Reporting Period	2014-15	2015-16	2016-17	2017-18	2018-19
Category 1	114	78	39	38	54
Category 2	326	258	128	189	198
Category 3	18	12	9	20	35
Category 4	2	1	1	2	2
Total	**460**	**349**	**177**	**249**	**289**

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

Year on Year Comparison – Out of Hospital Acquired

Reporting Period	2014-15	2015-16	2016-17	2017-18	2018-19
Category 1	118	83	68	159	55
Category 2	667	337	253	359	173
Category 3	74	21	36	85	69
Category 4	25	8	5	21	9
Total	**884**	**449**	**362**	**624**	**306**

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

Actions taken by the Trust:

Pressure damage is one of the top 5 reported incidents within the Trust; with risk assessment, prevention and management being guided through the application of NICE guidelines and quality standards. The incidents are reported via datix and the Trust has developed a checklist within the system to capture the overall data in relation to pressure ulcer incident reporting. The checklist also supports colleagues reviewing such incidents by providing

a consistent approach towards decision making in relation to the level of investigation required. The numbers of pressure ulcer incidents are discussed at the Senior Clinical Professionals Huddle each week and monitored through the monthly Tissue Viability Operational Group, Quality Reference Group which informs the integrated professional Board meeting.

The Tissue Viability Group has the remit of reviewing the Trust Tissue Viability improvement plan, Trust policies and guidelines. Following the review of our audit process within the Trust, quarterly audits by the directorates are undertaken. Following the moderation of results an improvement plan is negotiated with the Directorate Leads to provide assurance that there is evidence of continuous improvement and performance. The Trust continues with "Our Journey to Outstanding" and the Quality Improvement Strategy aims to place quality improvement at the heart of everything the Trust does, with a focus on the needs of our patients, families and carers. Therefore, as part of this journey the Trust is taking part in an In-House Pressure Ulcer Collaborative which will support education, learning and sharing best practice across directorates. This will empower the staff and reduce unwarranted variation providing the very best care to every patient, every day. The collaborative will be underpinned by evidence, research and best practice with measurable outcomes ensuring we do the right thing at the right time.

Education remains a key focus for the Tissue Viability Team so working with the departmental staff and managers is critical in the maintenance of a network of Tissue Viability Champions who 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 meeting are chosen by the Champions themselves and delivered by either the Tissue Viability team or colleagues from the wound industry. The annual "Stop the Pressure" event was again very successful in November 2018 and this will be repeated in 2019.

There is Information and resources for staff which are available on the Trust intranet site which provides resources and advice to staff when a tissue viability nurse is not available. The referral criteria for the tissue viability service have now been reviewed and available on ICE.

Communication between services continues to be promoted in order to provide seamless holistic care for our patients moving between hospital and community. A key element of this is ensuring wound care information is passed onto the next care provider. There is also work in progress regionally to streamline policies and reduce unwarranted variation across local providers. This forms part of the Alliance work with the care homes and education within the GP practices in support of improving integration across pathways both in and out of hospital.

Section 3B: Performance from key national priorities from the Department of Health Operating Framework, Appendix B of the Compliance Framework

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

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

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

Single Oversight Framework Indicators	Standard/ Trajectory	2018-19 Performance	2017-18 Performance	Achieved (cumulative)
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/ discharge	95%	A 97.18%	97.24%	✓
Cancer 31 day wait for second or subsequent treatment – surgery	94%	98.84%	98.29%	✓
Cancer 31 day wait for second or subsequent treatment – anti cancer drug treatments	98%	100.00%	99.87%	✓
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)	85%	A 84.83%	85.83%	✗
Cancer 62 Day Waits for first treatment (from NHS cancer screening service referral)	90%	96.25%	97.02%	✓
Cancer 31 day wait from diagnosis to first treatment	96%	99.38%	98.55%	✓
Cancer 2 week wait from referral to date first seen, all urgent referrals (cancer suspected)	93%	94.11%	93.82%	✓
Cancer 2 week wait from referral to date first seen, symptomatic breast patients (cancer not initially suspected)	93%	96.16%	96.64%	✓
Maximum time of 18 weeks from point of referral to treatment in aggregate, patients on incomplete pathways	92%	94.21%	93.63%	✓
Referral to Treatment 52 Week Waits	0	0	0	✓
Number of Diagnostic waiters over 6 weeks	99%	98.69%	99.56%	✗
Community care data completeness – referral to treatment information completeness	50%	96.11%	96.81%	✓
Community care data completeness – referral information completeness	50%	96.66%	96.47%	✓
Community care data completeness – activity information completeness	50%	96.84%	95.70%	✓
Community care data completeness – patient identifier information completeness (Shadow Monitoring)	50%	96.84%	95.70%	✓
Community care data completeness – End of life patients deaths at home information completeness (Shadow Monitoring)	50%	83.65%	85.70%	✓
Compliance with access to healthcare for patients with learning disabilities	100%	Full compliance	Full compliance	✓

Other National and Contract Indicators	2018-19 Target	2018-19 Performance	2017 18 Performance	Achieved
Cancelled Procedures for non-medical reasons on the day of op	0.80%	0.41%	0.72%	✓
Cancelled Procedures reappointed within 28 days	100%	99.41%	94.84%	✗
Eliminating Mixed Sex Accommodation	Zero cases	0	0	✓
A&E Trolley waits > 12 hours	Zero cases	0	1	✓
Stroke – 90% of time on dedicated Stroke unit	80%	91.73%	93.49%	✓
Stroke – TIA assessment within 24 hours	75%	91.67%	96.59%	✓
Delayed transfers of care	<3.5%	2.99%	3.42%	✓
VTE Risk Assessment	95%	97.72%	97.89%	✓
Sickness Absence Rate (2018/19)	3.5%	4.39%	4.53%	✗
Mandatory Training Compliance	80%	89.00%	84.00%	✓
Turnover Rate	10.0%	8.70%	14.80%	✓
Operational Efficiency Indicators	**2018-19 Target**	**2018-19 Performance**	**2017 18 Performance**	**Achieved**
New to Review Ratio	1.45	1.30	1.18	✓
Outpatient DNA (new)	5.40%	7.98%	8.67%	✗
Outpatient DNA (review)	9.00%	9.76%	10.61%	✗
Length of Stay Elective (Feb 18 – Jan 19)	3.23	1.67	1.86	✓
Length of Stay Emergency (Feb 18 – Jan 19)	4.14	3.48	3.76	✓
Readmission Elective (Apr 18 to Feb 19)	0.00%	4.58%	4.17%	✗
Readmission Emergency (Apr 18 to Feb 19)	9.37%	14.79%	14.60%	✗
Occupancy (Trust) (2018-19)	85%	90.06%	90.97%	✗
Quality Indicators	**Standard/ Trajectory**	**2018-19 Performance**	**2017 18 Performance**	**Achieved**
Clostridium Difficile – meeting the C.Diff objective	12	31	35	✗
Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia	0	0	4	✓
Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia	21	21	25	✓
Escherichia coli (E.coli)	50	39	43	✓
Klebsiella species (Kleb sp) bacteraemia	N/A	20	29	N/A
Pseudomonas aeruginosa (Ps a) bacteraemia	N/A	9	5	N/A
Trust Complaints - Formal CE Letter (Stage 3)	<270	192	183	✓
Trust Complaints Compliance within 25days	95%	89.45%	96.00%	✗
Trust Falls with Fracture	<20	32	26	✗
In Hospital Pressure Ulcers Grade 4	2	2	2	✓
Medication Error	<685	775	670	✗
Friends and Family Test - Would Recommend	95%	96.00%	95.10%	✓
Never Events	0	1	0	✗
Hand Hygiene	95%	97.00%	97.00%	✓
HSMR	100 102	95.80	101.32	✓
SHMI	100 106	100.72	105.91	✓
SPEQS	90%	93.91%	92.23%	✓

Additional Assurance:

The following indicators have been subject to assurance by the independent auditors Pricewaterhouse-Coopers:

Further assurance indicators	Criteria Identified
Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.	We confirmed the Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report: ▪ 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/wpcontent/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/wpcontent/uploads/sites/2/2013/
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	The Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report: the indicator is expressed as a percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer; an urgent GP referral is one which has a two week wait from date that the referral is received to first being seen by a consultant; the indicator only includes GP referrals for suspected cancer (i.e. excludes consultant upgrades and screening referrals and where the priority type of the referral is National Code 3 – Two week wait); the clock start date is defined as the date that the referral is received by the Trust; and the clock stop date is the date of first definitive cancer treatment as defined in the NHS Dataset Set Change Notice. In summary, this is the date of the first definitive cancer treatment given to a patient who is receiving care for a cancer condition or it is the date that cancer was discounted when the patient was first seen or it is the date that the patient made the decision to decline all treatment.

Annex A: Third Party Declarations

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

Collaborative statement from NHS Hartlepool and Stockton-On-Tees Clinical Commissioning Group (HAST), Durham Dales, Easington and Sedgefield (DDES) Clinical Commissioning Group, and Darlington Clinical Commissioning Group for NHS North Tees and Hartlepool Hospital Foundation Trust (NTHFT) Quality Account 2018/19, 21 May 2019.

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 and Darlington Clinical Commissioning Group (CCG) for its respective population. The CCGs welcome the opportunity to submit a statement on the Annual Quality Account for North Tees and Hartlepool NHS Foundation Trust (NTHFT).

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 both CCGs and the Trust to gain assurance that there are effective systems and processes in place to promote the delivery of safe, effective and high quality care. The CCGs welcome that Quality remains the Trust's number one priority for 2019/20 and it is positive to see that the priority areas include mental health, safeguarding and infections.
We are pleased that the Chief Executive's overview to the Quality Account confirms the commitment to continuously improve the Trust's CQC rating, and already improvement initiatives are under way to strive for the 'Outstanding' rating. The Chief Executive's Overview recognises the importance of the dedicated and hardworking Trust staff that contributes to the delivery of safe and effective NHS care.

The CCGs acknowledge that mortality performance is demonstrating signs of improvement and the achievement made in 2018/19 reducing both metrics to 'as expected' range. We also acknowledge the positive steps taken in terms of establishing a clinical link between consultants and the Trust's Coding Department and the rewards seen throughout 2018/19 in terms of the improvement in the depth of clinical coding. The CCGs will continue to provide robust scrutiny and challenge in relation to mortality during 2019/20 and will continue working with the Trust to identify opportunities for shared learning across the health economy.

The CCGs recognise the challenges the health economy faces in terms of the dementia agenda and are very pleased to see the Trust's commitment to improving care for patients with dementia. This work undertaken in raising awareness and developing skills and roles is fully supported by the CCG's. We acknowledge developing the knowledge and skills of the workforce is very important and the Trust has been working hard to ensure the whole workforce in health and care completes the 'Essential Dementia Workbooks' as part of mandatory training and continues to support the Dementia Champaign Programme.

The CCGs welcome the safeguarding adult's team continued efforts to raise the profile and visibility within the Trust; noting that this has been in the form of walkabouts, increased teaching and attendance at staff meetings. Also level 2 training has been developed to give key staff more intensive training and understanding of adult safeguarding. The CCGs acknowledge the positive mandatory training compliance in 2018/19.

The CCGs would like to offer support to understand the rise in concerns around physical abuse, in particular the large increase around neglect across the localities.

Further to discussions at the Clinical Quality Review Group (CQRG) the CCGs acknowledges the increase in the number of Deprivation of Liberty (DoLs) applications and the ongoing commitment from the Trust to manage this increase. The CCGs would like to continue to monitor the number of applications and work with the Trust to ensure this service does not become a risk.

The CCGs support the amalgamation of the Trust's strategy group for adult safeguarding, learning disability and dementia and is pleased to see this supports sharing of information and lessons learnt for work streams in future. The CCGs are pleased to see the development work that has been undertaken for children 'not brought' for appointments in terms of the embedding of the policy and assurance process. It is very positive to see the Trust take action from a local serious review case and lessons learnt review to recognise possible early indicators of neglect when a child is not brought to appointments. This process will also identify those children whose appointments are frequently rescheduled by parents/carers.

The CCGs acknowledge the implementation of the revised immobile baby pathway, and will be keen to understand the impact this has on non-mobile children with bruising and how we can reduce the number of abusive events that are missed.

It is pleasing to see a key priority for 2019/20 is to achieve 100% compliance for all local safeguarding children quality requirements.

The CCG's would like to congratulate the Trust on the improved LAC performance and the close working relationships that have been developed with current providers of the Stockton IHAs.

The focus on Health Care Associated Infection (HCAI) in the Quality Account is welcome and we acknowledge the challenging target for Clostridium Difficile infections. The overall number of Clostridium Difficile Infections for 2018/19 is disappointing and above trajectory and so the CCGs support this priority and will continue to work collaboratively with the Trust in order to manage the number of infections. The CCGs acknowledge the improved performance for Methicillin-Resistant Staphylococcus Aureus infections in 2018/19 with a positive outcome of zero cases.

It is very positive to see the good work that has been undertaken throughout 2018/19 on the NHS Improvement project to reduce urinary tract infections (UTI) and the CCGs are pleased to see the Trust has been successful in achieving an 80% reduction on UTIs for residents of a pilot care home. We look forward to seeing the outcome from rolling this pilot out further to involve more care homes.

The CCGs would like to commend the Trust for the significant improvement shown in the number of patients experiencing a delayed transfer of care from the hospital. Collaborative working with partners in social care and commissioning has significantly reduced the number of delays. The CCGs are delighted to hear the weekly super stranded audit has been successful and the recognition the Trust has received from NHS Improvement.

In 2018/19 it is encouraging to see the Trust continued to engage in the LeDeR programme and work has commenced to deliver the improvement actions that have been identified from these reviews. It is also good to see the collaborative work the Trust has been involved in as part of the North Tees and Hartlepool Education Alliance.
It is encouraging to see the commitment and dedication shown by the Trust throughout 2018/19 to improve Specialist Palliative Care. The CCGs support all the initiatives the Trust have implemented, in particular the innovative approach taken to develop a Specialist Palliative Care Nursing Bank. We are delighted to hear the AMBER Care Bundle pilot was a success and the Trust are looking at developing this Trust wide.

The CCGs would like to congratulate the Trust on their Duty of Candour process and their success in being an open and transparent organisation. In 2018/19 there has been a significant increase in the number of incidents reported per 1000 bed days, which is a result of promoting a culture of openness and honesty. It has been positive to see the learning that has been identified and action taken to improve quality of care.

In 2018/19 the Trust has reported one never event in relation to a surgical/invasive procedure, the incident is currently being managed through the Serious Incident process and the CCGs will continue to work with the Trust to identify learning and appropriate action.

The CCGs can confirm to their best knowledge that, the information provided within the Annual Quality Account is an accurate and fair reflection of the Trust's performance for 2018/19. It is clearly presented in the format required and the information it contains accurately represents the Trust's Quality profile.

The CCGs would like to congratulate the Trust on the hard work and dedication shown throughout 2018/19 and the CCGs look forward to continuing to work in partnership with the Trust to assure the quality of services commissioned in 2019/20.

Yours sincerely

Dr N O'Brien
Chief Clinical Officer
NHS Hartlepool and Stockton-on-Tees, Darlington and South Tees CCG

Hartlepool Healthwatch - 09 May 2019

Thursday 9th May 2019

HealthWatch Hartlepool third party narrative - Annual Quality Account of North Tees and Hartlepool NHS Foundation Trust

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 the draft account provided to Healthwatch Hartlepool, referrals received into Healthwatch Hartlepool as part of our Enter & View activity and actual patient experience of Healthwatch Hartlepool members.

Our view of future priorities would be the addressing of concerns raised in our previous statements in relation to Mortality albeit we are encouraged by the overall trajectory of performance over the last year. A concern from our engagement with the wider public continues to highlight transport to hospital as a problem particularly around the Trust's adherence to the key principles within the Equality Act 2010. Many patients are still excluded from access to services due to no transport being available or transport that is not compliant with the Act. In previous years assurances were given that ALL patients would also be made aware of the Healthcare Travel Costs Scheme (HTCS) at the time of notification of appointments, which once again has not happened.
Hartlepool H

Other areas of concern Healthwatch Hartlepool would wish to highlight are in respect of the huge increase in DOL's cases and the interventions required when SEPSIS is diagnosed. It is imperative greater work needs to be undertaken to understand why this has happened.

Overall, HealthWatch Hartlepool welcomes the opportunity to respond to the Draft Quality Account and we must praise the Trust on the work they have undertaken in ensuring no cases of MRSA as well as the welcome our Enter & View teams have been given throughout the year.

Yours Sincerely,

Christopher Akers-Belcher – Healthwatch Manager

Stockton Healthwatch - 26 April 2019

healthwatch Stockton-on-Tees

North Tees and Hartlepool NHS Foundation Trust Quality Accounts

Healthwatch Stockton 3rd Party Declaration

Healthwatch Stockton-on-Tees are pleased to see lots of useful data explaining how North Tees and Hartlepool NHS Foundation Trust is performing against other Trusts in the region and nationally. The Quality Accounts is generally well written and provides good overview of how the Trust is performing and how it manages quality services.

It is evident that the Trust has made a number improvements over the last year with regards to the quality of care for patients with dementia. We are pleased to see that the Trust has recruited and trained over 170 staff to become Dementia Champions with further training for additional staff planned in the future. A number of actions have been taken and processes implemented to ensure that patients with dementia, their families and carers have a good experience and their needs are met during their stay. Some of the positive changes made include a number of elderly care wards being adapted to be more dementia friendly and adding an alert to Trakcare to ensure staff are aware of patients who have a diagnosis of dementia. It is encouraging to see that dementia is also a priority for 2019/20 with a number of further actions planned including continuing to undertake the National Audit for dementia.

Some of the Trust's key priorities identified for 2019/20 reflect similar priorities for Healthwatch Stockton-on-Tees in particular, Mental Health. As a stakeholder, Healthwatch Stockton-on-Tees are keen to support the work of the Trust in this area over the next year supporting the review of the 'Treat as One' guidance and feeding in local intelligence to support a gap analysis and conducting investigations as necessary.

Healthwatch Stockton-on-Tees have conducted a number of Enter and View visits and investigations within the Trust over the last year therefore we would like to recommend a short section in future Quality Accounts about the Trust's engagement with local Healthwatch covering role, responsibilities and Enter & View in a similar way as the CQC Contact and Communication section of the report.

Healthwatch Stockton-on-Tees has built a strong working relationship with the Trust over the last year and will continue to work with and support the Trust with the aim of further improving the quality of services provided and maximising patient experience.

Statement from Adult Services and Health Select Committee, Stockton-on-Tees BC – 01 May 2019

Adult Social Care and Health Select Committee
Third Party Declaration 2018-19

The Committee welcomes the opportunity to again consider and comment on the quality of services at the Trust.

Members have once again engaged with the Trust in a positive manner during 2018-19. The Committee has met once with Trust representatives to consider the quality priorities and overall performance.

The Committee continues to monitor the mortality data and is pleased to see the continued improvement in these figures which now stand well within the expected range.

Members have been impressed by the scale of the work that has been undertaken to tackle this issue. This has included work across several themes and diagnosis groups. It was reassuring to note that the Trust's own internal processes and 'heat mapping' appeared to be operating well, and had recently identified concerns prior to the national alerts on the same topics being issued.

The Committee is pleased to see the ongoing commitment to working with peers and regional groups in order to benchmark the Trust's position, and supports the continued inclusion of Mortality as a priority for 2019-20.

A relatively new development for NHS Trusts is the requirement to have processes in place to learn from deaths, including improved support for carers and families. The CQC reviews the implementation of this national guidance as part of the 'well-led' element of its inspections.

The CQC has found that nationally, some organisations need to do more to on this agenda. The Quality Account therefore represents a good opportunity to review the Trust's approach, and the inclusion of Learning from Deaths as a specific priority is supported.

The summary of progress for 2018-19 confirms that a review process is in place, and this complements the wider work on mortality outlined above. It is reassuring that of those cases investigated to date, no patient deaths had – more likely than not – been due to problems with care. It is however not clear within the Account what criteria was used to select which deaths should be subject to a case record review or investigation. It may be of benefit to clarify this in future Accounts.

The care of people with learning disabilities continues to be of interest to the Committee, and it was positive to see reference to the LeDeR programme within this priority. A specific example of local improvement work is the recognition of the need to include a specialist dietician within the Learning Disability Community Team, and to improve easy read promotional material for bowel screening. The Committee has been closely monitoring the provision of primary care to people with learning disabilities and would encourage this work wherever possible.

Also within this theme, the work to improve care for frail elderly patients in local care homes, through the North Tees and Hartlepool Education Alliance, is welcomed. Improving the quality of local commissioned care services has been a high priority for the Committee and is due to form a major part of its work programme during 2019-20.
Dementia awareness and identification continues to be a priority for both the Trust and Council; increasing detection rates requires the Trust to continually adapt its approach to care for patients with dementia and delirium, including ongoing staff training and 'dementia passports'. It remains key to take a whole system approach, and the Committee was reassured to hear that the Trust was receiving responsive and timely support from the Tees, Esk and Wear Valleys NHS Foundation Trust Psychiatric Liaison Service.

The Committee supported the inclusion of mental health in the priorities for 2018-19 as this recognised the need to treat all patients in a holistic way. In the draft Account there was however limited information on progress against this priority. The Trust proposes to continue to include this as a priority for 2019-20, and Members look forward to receiving updates on this work.

In relation to infection control the Committee was pleased to see the generally good performance, and noted the need to closely monitor the impact of emerging infections including Klebsiella and Pseudomonas. Again, a whole

system approach is necessary to tackle this issue. The Committee was pleased to see where the Trust was placed in comparison to other Trusts.
Members received assurance on how quickly both positive and negative feedback from the Friends and Family Test was reported to the relevant ward. Compared to the previous year it is possible to see improvements in the levels of positive feedback from staff in terms of both recommending the Trust as a place to receive treatment, and a place to receive care.

The Committee sought and received further data on complaints, and also the number of cases raised with the Trust by the Ombudsman. Information on Ombudsman referrals may be worth including in the published version of the Account. Members were pleased to note the continuing high numbers of compliments received.

During 2018-19, health and local authority services in Stockton-on-Tees were subject to a joint inspection by CQC and Ofsted in relation to the effectiveness of services for children and young people with Special Education Needs and Disabilities. Reference to relevant results of the inspection will be reviewed in future consideration of the Account. Given the overall pressures on the NHS and social care workforce, the Committee was very pleased to note that the Trust recorded the lowest level of clinical vacancies in the country. This was especially pleasing recognising the nature of working across two main sites, and other Trusts were seeking to learn from the Trust in terms of how it recruits.

During the period of the Committee's consideration of the Quality Account (March 2019) it was confirmed that the Trust had the best performance in England in relation to the 4-hour Accident and Emergency Target. The Committee would like to praise all staff involved in ongoing delivery of urgent and emergency care.

The Committee, through its partnership working with other Local Authorities, continues to monitor the reconfiguration of local NHS services, and will consider the impact on quality of any future proposals for service change.

The Trusts Council of Governors – 23 April 2019

Council of Governors
(third party declaration)

On behalf of the Council of Governors, members of the Quality Account Working Group are able to confirm Governors involvement regarding the preparation of the Trust's Annual Quality Account, and during 2018-19 have been briefed in respect of specific aspects of its content around the Trust's performance.

The role of the Governor Quality Account 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. Members of the Group also select an additional priority to be audited by the Trust's External Auditors to provide greater assurance around the Trust's performance in this area.

In order to ensure the Council of Governors are kept fully informed on priority areas and key issues particularly during such a period of significant change across the whole health and care sector development sessions have been facilitated throughout the course of the year. Topics covered in these sessions included: Integrated Care Systems; Clinical Services Strategy – Trust and System wide; Trust Estate's Strategy & Optimisation; Absence Management and Clinical Services Strategy – Tees Wide. Pre-Council of Governors meetings are now scheduled a week before the Council of Governors meeting, which although informal in structure provide valuable time for discussion and debate, replacing the previously arranged Governor Coffee Mornings. These sessions help to inform future agenda items for key Committees and Meetings to ensure assurance is provided on any given subject.

A Schedule of Reports is refreshed annually, which sets out the range of reports to be presented to the Council of Governors at each meeting to 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. Despite the past year being another challenging period for the health service within a national context of rising demand for services, increased performance standards and continued financial pressures; the Trust has performed well and despite facing financial challenges has ensured quality remains the top priority. The Council of Governor meetings provide a valuable

opportunity for the Governors to review performance and seek assurance on actions, raising any concerns with the Board of Directors present.

The Governor Sub-committees continued throughout 2018-19, which include: Nominations Committee; Membership Strategy Committee, Strategy and Service Development Committee, and the External Audit Working Group. This Committee is required to meet when the provision of external audit to the Trust is under review, and to fulfil this remit it met three times during 2018. The remaining Sub-Committees allow detailed debate and discussion around key topics, allowing the Governors to take an active part in shaping Trust strategies. This is particularly evident in the Strategy and Service Development Committee which facilitated presentations regarding: Integrated Performance Report; Quality Improvement Strategy; Clinical Services Strategy; Winter Planning; Stranded Patients; Delivering Productivity and Performance – Corporate Services; Well Led Review; Communication and Engagement Strategy; CQC Journey to Outstanding; Annual Plan and NHS Long Term Plan.

New opportunities across a wide range of service areas arise often for Governors to become involved with which include Healthcare User Group; Trust Patient Information Panel; Trust Research Awareness and Governance Group; Menu Review Group and Essential Nutrition Group. In addition, Governors and other stakeholders are invited to attend ad hoc events such as department openings, Trust member events and taking part in the Patient and Staff Experience surveys to showcase the work we do.

Overall, the Governors confirm that the report provides enough detail on progress against our quality objectives from last year, it identifies the areas where the trust still needs to improve, and is clear about what the quality objectives are for 2019-20 and how these will be measured.

Hartlepool Borough Council – Audit and Governance Committee – 03 May 2018

Audit and Governance Committee – Third Party Declaration

Following consideration of the North Tees and Hartlepool NHS Foundation Trust Quality Accounts in March 2019, Hartlepool Borough Council's Audit and Governance Committee would like the following comments to be included in this year's Quality Account:-

In relation to quality improvement priorities identified for 2018-19, the Committee commended the Trust on their success in:

- Improving the Hospital Standardised Mortality Ratio (HSMR) and Summary Level Hospital Mortality Indicator (SHMI);
- Increasing dementia / delirium diagnosis rates and appointing 200 Dementia Champions across the organisation; and
- Reducing nursing staff vacancy levels to their lowest for a number of years.

The Committee supported the quality improvement priorities identified for 2019-20, with accompanying actions, and welcomed the Trust ongoing focus on mortality and dementia.

Yours faithfully

COUNCILLOR BRENDA LOYNES

Third Party Statement from the Healthcare User Group (HUG) – 01 May 2019

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. This is achieved through independent visits to inpatient wards and outpatient clinics, talking to staff and patients. HUG is also represented on several Trust committees including the Audit & Clinical Effectiveness Group (ACE), Patient & Carer Experience Committee (PCEC), Discharge Steering Group, Infection Control Committee (ICC) and Patient Quality & Safety Standards Group (PS & QS). A HUG representative also attends the Trust Board.

HUG has reviewed the Quality Accounts and concludes that they represent a true and fair reflection on what we have seen during our visits to the Trust's wards and clinics.
The continued progress in improving mortality rates is pleasing and reflects the work within the Trust to improve processes to aid the reduction.

The Trust is very diligent in tackling infection against some very challenging targets. Whilst the Trust has not met all these targets, we know staff strive to improve infection rates.

Staff are aware of their requirements towards patients with dementia, hence the Dementia Champions programme and training. We have evidenced this from our impatient visits.

The Trust takes safeguarding (adults and children) and mental health very seriously. HUG is aware of the development of standards and reporting, and the raising of the profile of these issues.

The Chief Executive points out the valued work of staff, and our visits throughout the year have highlighted that patients highly value the care, compassion and dedication of all staff during their stay in hospital.

The key priorities for 2019/20 are relatively unchanged from the previous year, but HUG supports this and has had the opportunity to comment on these priorities.

Healthcare User Group
April 2019

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 2018-19 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 2018 to April 2019
  - Papers relating to Quality reported to the Board over the period April 2018 to April 2019
  - Feedback from commissioners dated 17 May 2018
  - Feedback from governors dated 23 April 2019
  - Feedback from local Healthwatch organisations dated 26 April 2019 & 9 May 2019
  - Feedback from the Adult Services and Health Select Committee and Audit and Governance Committee dated 1 May 2019 & 3 May 2018
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated Q3 2018-19
  - The latest national patient survey 2017
  - The latest national staff survey 2018
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated 16 May 2019
  - CQC Quality Report – Inspection Report 14 March 2018
  - 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

Chief Executive.....

Date: 29 May 2019

Chairman.....

Date: 29 May 2019

Annex C: Independent Auditors' Limited Assurance Report

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 Board of Governors of North Tees and Hartlepool NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Board 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 2019 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance (the "specified indicators") marked with the symbol Ⓐ in the Quality Report, consist of the following national priority indicators as mandated by Monitor (operating as NHS Improvement) ("NHSI"):

Specified Indicators	*Specified indicators criteria*
Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.	Criteria can be found on page 226 of the Annual Report and Accounts.
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.	Criteria can be found on page 226 of the Annual Report and Accounts.

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 NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the 'Detailed requirements for quality reports 2018/19' issued by NHSI. The Directors are also responsible for the conformity of the specified indicators criteria with the assessment criteria set out in the FT ARM and the 'Detailed requirements for external assurance for quality reports 2018/19' issued by NHSI and for reporting the specified indicators in accordance with those criteria, as referred to on the pages of the Quality Report listed above.

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 2018/19';
- 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 2018/19'.

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM and the 'Detailed requirements for quality reports 2018/19'; 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 consistent with the following documents:

- Board minutes for the financial year, April 2018 and up to the date of signing this limited assurance report ("the period");
- Papers relating to quality reported to the Board over the period April 2018 to the date of signing this limited assurance report;
- 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) dated 21st May 2019;
- Feedback from Governors dated 23rd April 2019;
- Feedback from local Healthwatch organisations: Healthwatch Hartlepool dated 9th May 2019 and Healthwatch Stockon-on-Tees dated 26th April 2019;
- Feedback from the Overview and Scrutiny Committee: the Adult Services and Health Select Committee Stockton on Tees BC dated 1st May 2019;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated Q3 2018-19;
- Care Quality Commission inspection, dated 14th March 2018;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 23rd May 2019; and
- Representation from Healthcare User Group (HUG).

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 complied with 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) 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 Board of Governors of North Tees and Hartlepool NHS Foundation Trust as a body, to assist the Board 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 2019, to enable the Board 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 Board 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 2018/19';

- 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 criteria set out in the FT ARM and 'Detailed requirements for quality reports 2018/19'.

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 Fou ndation Trust.

Basis for Adverse Conclusion – patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

In our sample testing of 55 Type 1 A&E records the patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge, we found two errors when comparing electronic records to manual clinical records. These related to the clock stop time being recorded earlier on the system than written evidence within the clinical notes, resulting in a non-breach being recorded when a breach should have been. In addition we noted a further case of one record where the Trust validation process had incorrectly recorded an item as non-breach when a breach should have been recorded.

Adverse Conclusion
In our opinion, because the significance of the matters as described in the Basis for adverse conclusion paragraph above, the percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge has not been prepared in all material respects in accordance with the criteria.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2019:

- 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 2018/19';
- The Quality Report is not consistent in all material respects with the documents specified above; and
- The specified indicator 'Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers' 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 2018/19'.

PricewaterhouseCoopers LLP
Newcastle upon Tyne
29 May 2019

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?

In your Opinion, how could we improve Our Quality Account?

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
AKI	Acute Kidney Injury
AMT	Abbreviated Mental Test
AquA	Advancing Quality Alliance
CABG	Coronary Artery Bypass Graft (or "heart bypass")
CFDP	Care For the Dying Patient
CCG	Clinical Commissioning Group
CCOT	Critical Care Outreach Team
CDI	Clostridium difficile Infection
CHKS	Comparative Health Knowledge System
CIAT	Community integrated assessment team (CIAT)
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
FSCO	First Stop Contact officer
FTSUG	Freedom To Speak Up Guardian
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 ardex)	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
LPS	Liberty Protection Systems
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
NQB	National Quality Board
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
PHE	Public Health England
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
SPCT	Specialist Palliative Care Team
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
VEMT	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

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