NHS
North Tees and Hartlepool
NHS Foundation Trust

Quality Accounts 2020-21

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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 2020-21, which highlights the excellent work we are doing to ensure we provide the very best safe, quality care for our patients.

The Trust has experienced a challenging and pressured 2020-21 as with many other organisations across the country who have been impacted by the COVID-19 pandemic.
I am proud to lead an organisation with such committed and passionate staff through these challenging times. The strength, resolve and commitment shown by all of our colleagues across the organisation has not surprised me or the Board and we are all humbled by their unwavering support to our patients.

Throughout the COVID-19 health pandemic, our Trust has evolved and responded to support the very best possible care for those impacted. Our Critical Care team has worked to reflect the challenges presented by the high numbers of patients needing treatment. This involved a physical infrastructure change, working with our estates team colleagues to ensure we could be ready for surge and an improvement in our approach to Infection Prevention and Control.

The pandemic also allowed us to contribute, and indeed lead with vaccine trials as part of the RECOVERY initiative and the NOVAVAX treatment that contributed to successful recovery and speedier discharge for our patients.

The Trust continues to perform well. During 2020-21 in relation to the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) mortality values, we reported within the 'as expected' range and below the national average, which is exceptionally positive. We know that our ongoing focus on quality of care provision and being completely aligned with the health care needs of our patients, and indeed our wider population has contributed to this achievement.

Infection Prevention Control (IPC) has been a headline for the NHS this past year. Our teams have worked to support the challenges presented by the pandemic, ensuring critical oversight to manage nosocomial infection, but our ageing hospital landscape has presented, and continues to present some major challenges.

The Trust continually monitors infection rates and continues to strive for improvement implementing new initiatives and innovations, which are outlined within this report. The Trust reported 49 cases of Clostridium Difficile during 2020-21, 37 Hospital Acquired and 12 Community Acquired cases. This compares with 53 the previous reporting year. The forthcoming year will see further challenges in the work toward improving infection, prevention and control, and this remains a priority in line with our physical hospital infrastructure ambitions for 2021-22.

Our absolute obligation to engagement is of paramount importance. Our open and honest approach to how we work with all of our stakeholders' remains central. Our Quality Accounts are developed with our patients, carers, staff, governors, commissioners and other key contributors including health scrutiny committees, local involvement networks (Healthwatch) and Healthcare User Group (HUG). It is this level of positive engagement that must remain a high priority for the future. By working with those that are impacted by our services, we can develop pathways of care that truly reflect a more aspirant focus for the Tees Valley and surrounding areas.

Our work with neighbouring organisations is focused on developing networked services – aimed at raising quality even higher and ensuring our operating standards reflect both equity and ambition for all. The priority is to ensure that there is absolute local access for the populations we serve. Health and care for the people across our region continues to evolve, and we are proud of how we contribute to positive change

Population health remains a priority, as a region we face some of the biggest challenges regards our local demographic. Our focus is to raise aspiration, and we believe this is facilitated by collaboration across all of the impacting contributors that influence how we live – education, housing, the economy and the political landscape. We benefit from close working relationships with our local authority partners, and our hopes are to build on these as a foundation to help reduce inequalities in access, experience and clinical and care outcomes.

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

Julie Gillon
Chief Executive
Date: 31 May 2021

What is a 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.

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 2020-21 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.

Listening to Patients and Meeting their Needs - We recognise the importance of understanding patients' needs and reflecting these in our values and goals. Our patients want and deserve excellent clinical care delivered with dignity, compassion, and professionalism and these remain our key quality goals.

Over the last year we have spoken with over **20,000** patients 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.

CQC Rating - The most recent CQC visit took place 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 95.

Part 2a: 2019-20 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 2019-20. We are very pleased to report some significant achievements during the course of the year.

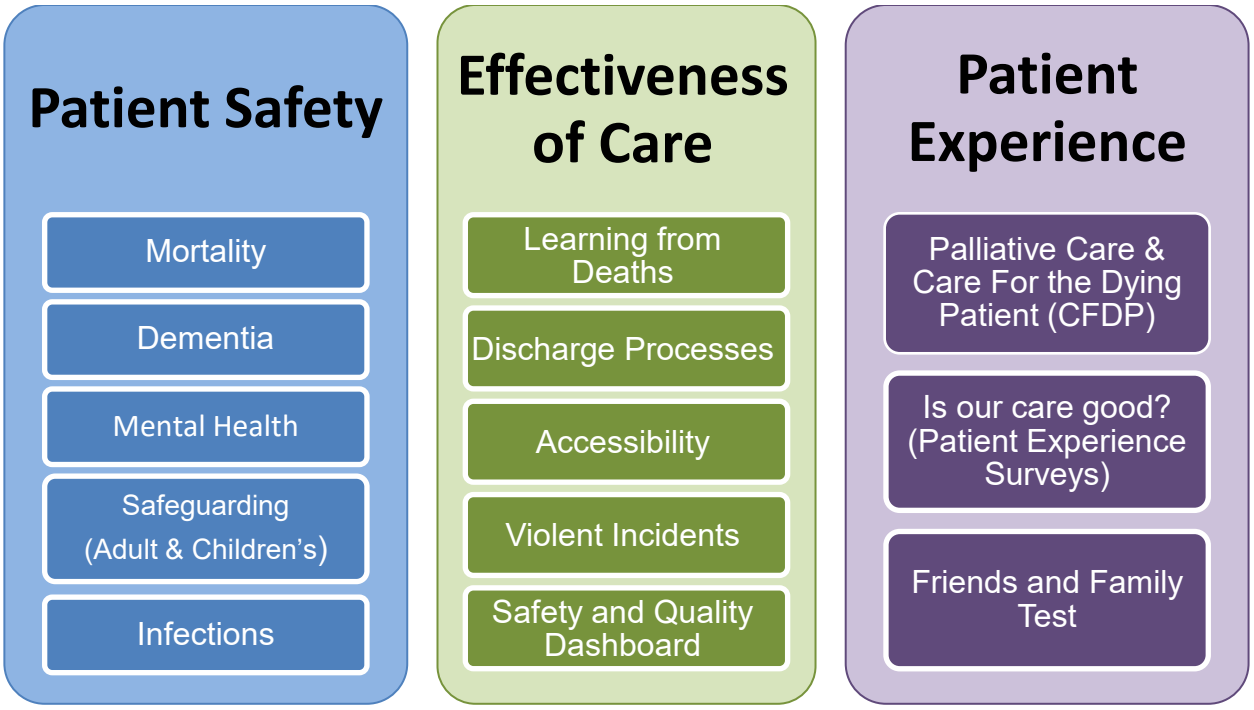
Consideration has also been given to feedback received from patients, staff, governors and the public.

Presentations have been undertaken to various staff groups, providing the opportunity for staff to comment on any feedback and views obtained from patients.

Progress is described in this section for each of the 2020-21 priorities.

Stakeholder priorities 2020-21

The quality indicators that our external stakeholders said they would like to see reported in the 2020-21 Quality Accounts were:



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

Priority 1: Patient Safety

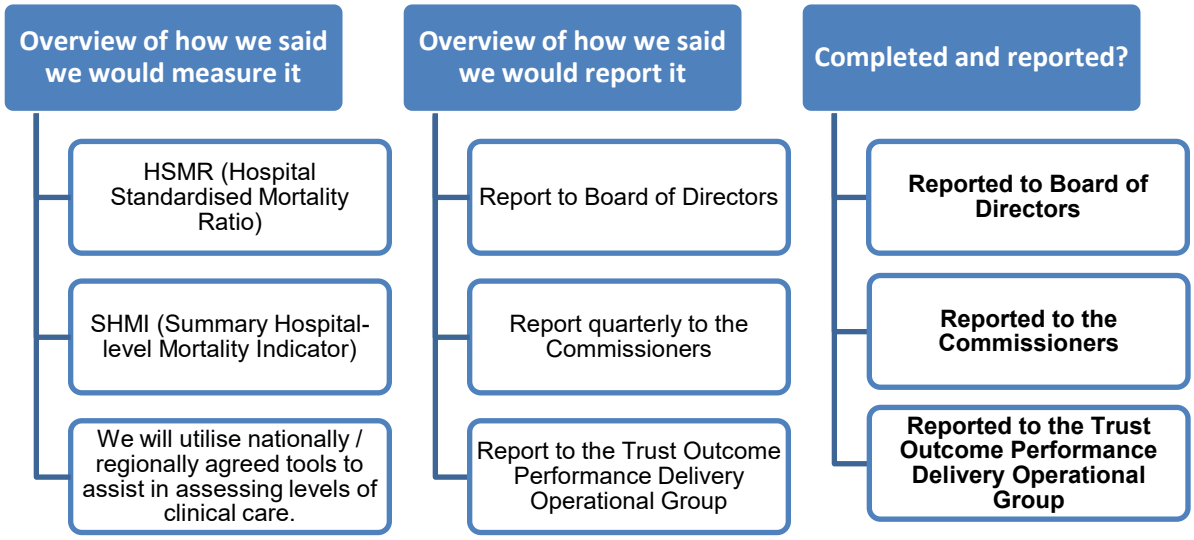
Mortality

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.



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 2020-21 continues to reap great rewards in respect of depth of coding. This increase in the number of co-morbidities being captured and documented per patient to over seven, from the lows of just over three, has had a profound effect on the HSMR and SHMI values, as well as giving a more accurate reflection of the patient's true level of sickness.

The following data is from the two nationally recognised mortality indicators of Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI).

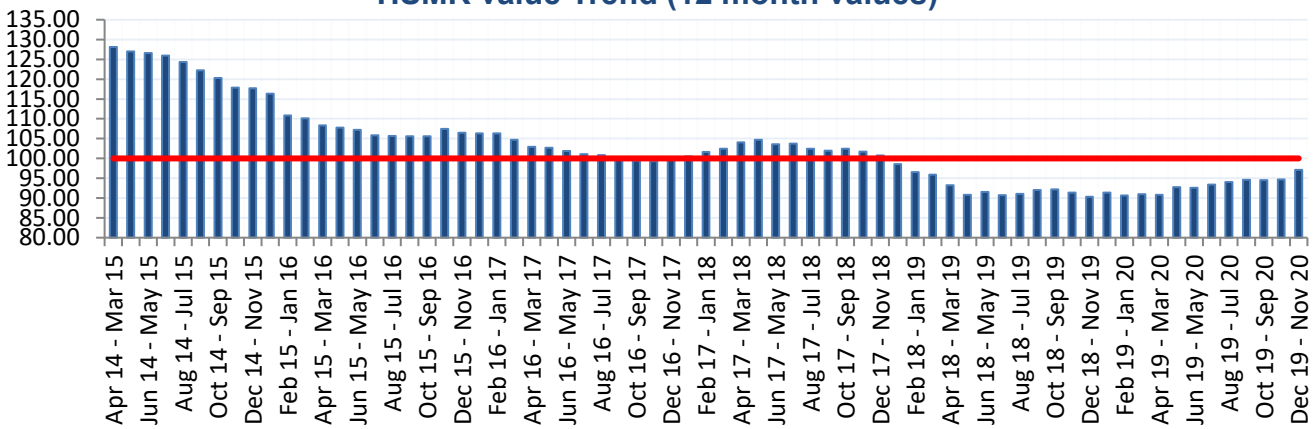
Hospital Standardised Mortality Ratio (HSMR)
December 2019 to November 2020

The Trust **HSMR** value is **97.12** for the reporting period from **December 2019 to November 2020**; 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.

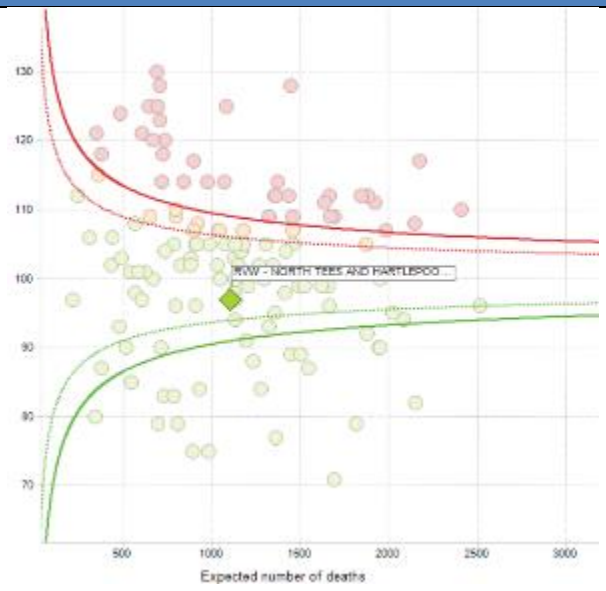
Reporting Period	*CMR	HSMR	National Mean
Dec 19 - Nov 20	**3.70%**	**97.12**	**100**
Nov 19 - Oct 20	3.61%	94.68	100
Oct 19 - Sep 20	3.63%	94.50	100
Sep 19 - Aug 20	3.63%	95.77	100

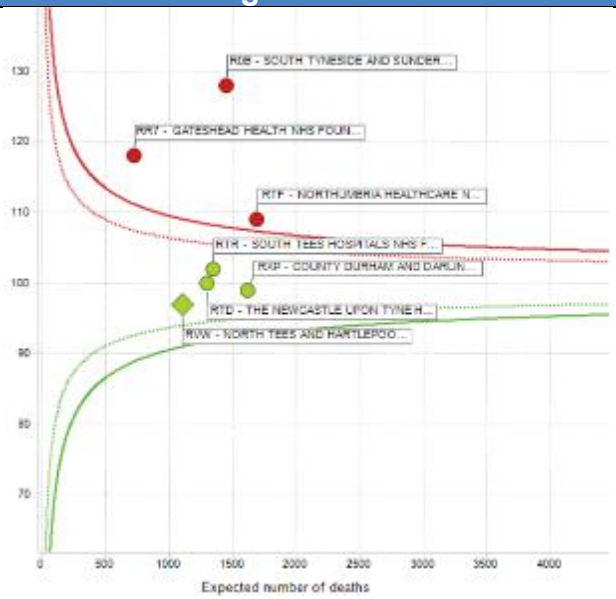
*Crude Mortality Rate (CMR)

HSMR value Trend (12 month values)



National View	Regional View





*Data obtained from the Healthcare Evaluation Data (HED)

Summary Hospital-level Mortality Indicator (SHMI)
October 2019 to Septembre 2020

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.

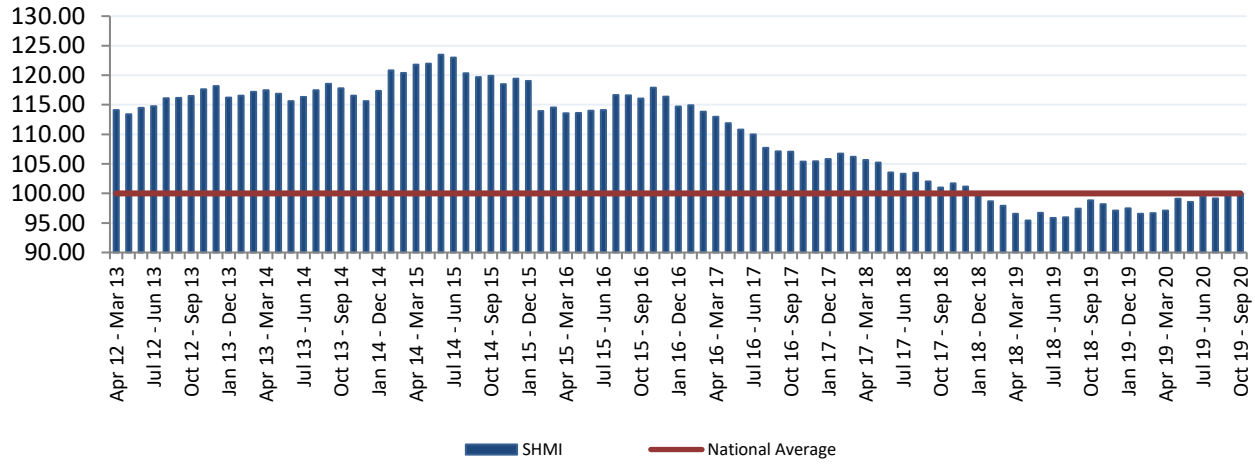
SHMI includes *deaths up to 30 days after discharge and does not take into consideration palliative care*.

The following graphic demonstrates the Trust (red) National position with a SHMI value of **99.94 (October 2019 to September 2020)**, this value continues to reside in the **'as expected'** range.

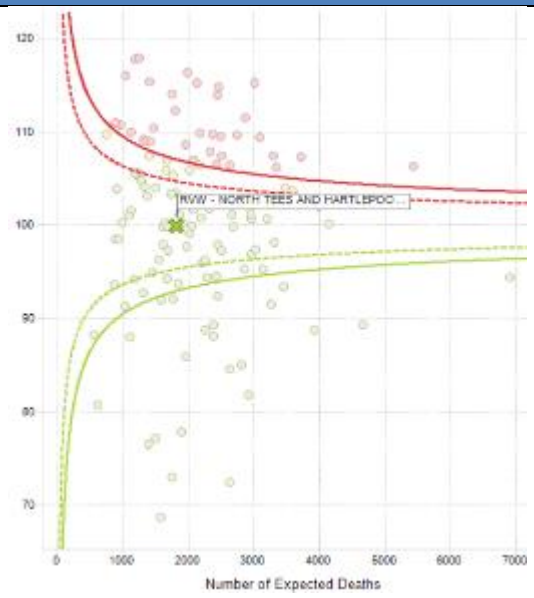
Reporting Period	*CMR	SHMI	National Mean
Oct 19 - Sep 20	**3.61%**	**99.94**	**100**
Sep 19 - Aug 20	3.60%	100.03	100
Aug 19 - Jul 20	3.56%	99.17	100
Jul 19 - Jun 20	3.54%	99.52	100

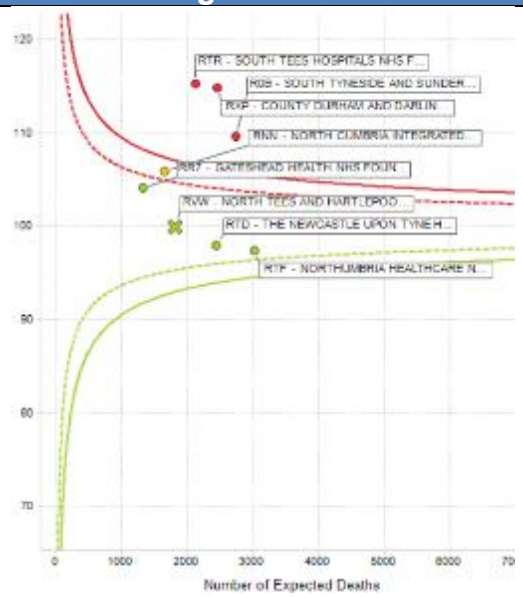
*Crude Mortality Rate (CMR)

SHMI Trend Values (12 Month Values)



National View	Regional View





*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 2016-17. For the latest financial year of 2020-21, the Trust experienced **1,547** mortalities, this is **62** more mortalities than experienced in 2019-20.

	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
2019-20	106	248	338	456	573	697	823	948	1105	1251	1367	1485
2020-21	**152**	**265**	**366**	**459**	**561**	**667**	**787**	**941**	**1147**	**1354**	**1464**	**1547**

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

- Introduce the 4at delirium assessment tool into the new falls pathway in nursing notes, to identify and delirium sooner after admission
- 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 the diagnosis of dementia is confirmed, then an alert will be added to Trakcare system. This alert will aid and assist a dementia champion that is available on every ward.

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 the 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 now has an agreement with Parking Eye regarding parking allowances for eligible families and carers.
- We now have John's campaign as an alert on Trakcare for staff awareness. We have also negotiated a discount at Costa and staff discount in the canteen. We have produced a card that the carers can produce to get this discount.
- PET team are doing follow ups questions for families and carers that have used John's campaign, so we can evaluate data and improve the service further.
- 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. University hospital of Hartlepool is part of Dementia friendly Hartlepool.

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

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

Financial Year	Patients admitted to the Trust with a diagnosis of Dementia/Delirium	Increase or Decrease from Previous Year
2016-17	3,298	+587
2017-18	3,614	+316
2018-19	4,218	+604
2019-20	3,784	-434
	3,253	-531

*Data from Information Management Department

Dementia Training Levels

Tier 1 - Dementia Awareness Raising

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

The team also provide a 1.5 hour face to face training session. 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.

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

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.

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

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

Training Figures 2020-21	
Dementia Tier 1	97%
Dementia Tier 2	87%
Dementia Tier 3	87%

*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
- Through Treat as One, develop a 1 day, tier 2 course to ensure that appropriate staff has a more in-depth understanding of how mental health and physical health are linked.

2021 Update

In April 2020, following the education work stream for Treat As One - we developed L1 training (mental health awareness) and this became mandatory for all staff.

Since April 2020 73.7% of staff have now completed this training which is a significant achievement and demonstrates the willingness of staff to engage with mind and body care for patients.

A 'Mind and Body' logo was developed and integrated within communications more generally across the trust.

An update around the work on **embedding 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 (one of the stated aims within the *Mental Health* priority).

The trust signed up the 'Time to Change' national initiative last autumn.

Two years ago the trust invested in Schwartz Rounds for staff – again to ensure that the psychological and emotional aspect of providing care was attended to for our staff and so they would in turn be compassionate in this way towards patients and others.

Schwartz Rounds are group reflective practice forums giving staff from all disciplines an opportunity to reflect on the emotional and social aspects of working in healthcare.

Further developments are in the pipeline to coordinate 'mind and body' care for patients and staff alike and support at the highest board level has recently been agreed to expand the remit of an existing workforce group in encompass patient and staff aspects of this agenda.

Professor Jane Metcalfe is the lead within the trust and regionally for implementing and reviewing the recommendations from the NCEPOD (2017) and is the regional chair for the same.

Priority 1: Patient safety

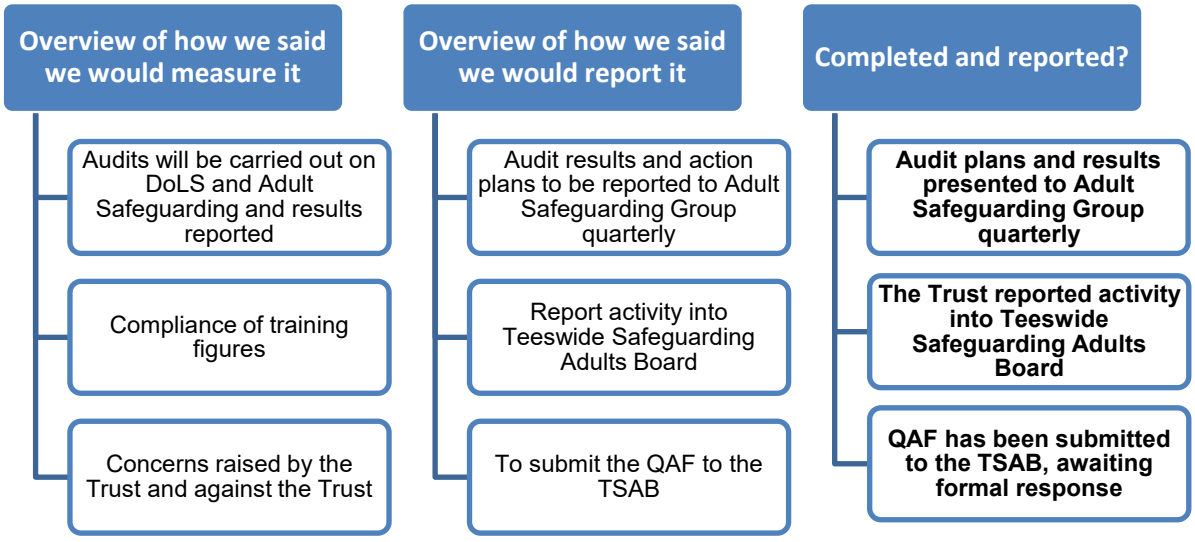
Safeguarding (Adults & Children's)

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)



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 Figures 2020-21	
Level 1	92%
Level 2	93%
Level 3	84%

*Date provided by the Safeguarding team

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 / Enquiries raised within the Trust

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).

There have been **536** concerns raised by the Trust. This trend demonstrates that there has been a increase in concerns in 2020-21.

2015-16	2016-17	2017-18	2018-19	2019-20	*2020-21
255	244	413	484	478	**536**

*Data as of 31 March 2021

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
Discriminatory	0	0	0	0	**0**
Domestic Abuse	16	15	14	18	**63**
Financial or Material	10	11	12	15	**48**
Modern Day Slavery	0	1	1	0	**2**
Neglect and Acts of Omission	58	81	71	46	**256**
Organisational	5	6	5	4	**20**
Physical	9	24	17	17	**67**
Psychological	7	6	10	10	**33**
Self-Neglect	45	40	46	43	**174**
Sexual Abuse	2	4	3	5	**14**
Sexual Exploitation	1	1	0	2	**4**
Total	**153**	**189**	**179**	**160**	**681**

*Data from the Trusts Adult Safeguarding database 31 March 2021

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 Care Group

Care Group	Q1	Q2	Q3	Q4	Total
Care Group 1 - Healthy Lives	40	56	32	22	**150**
Care Group 2 - Responsive Care	60	49	47	51	**207**
Care Group 3 - Collaborative Care	5	9	9	10	**33**
Corporate Group	1	5	4	5	**15**
North Tees & Hartlepool Solutions (Estates & Facilities)	0	0	0	0	**0**
Total	**106**	**119**	**92**	**88**	**405**

Number of concerns against the Trust

There have been **80** concerns against the Trust.

2015-16	2016-17	2017-18	2018-19	2019-20	*2020-21
514	50	79	79	**79**	**80**

*Data as of 31 March 2021

Themes of Alerts against the Trust

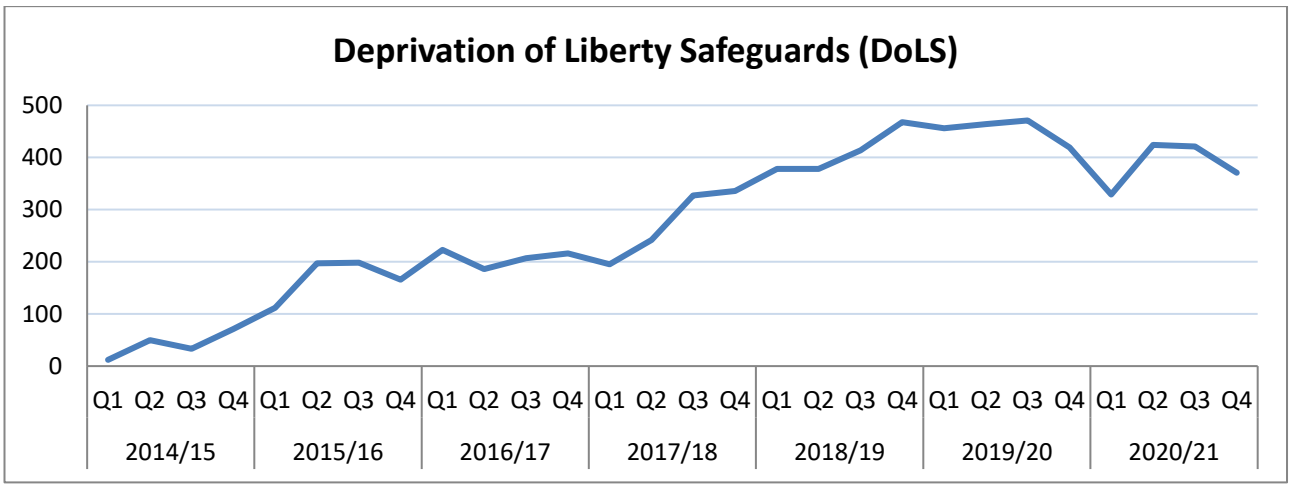
Themes of Alerts	Q1	Q2	Q3	Q4	Total
Assault	0	0	0	0	**0**
Communication	2	1	9	9	**21**
Dehydration	0	0	0	0	**0**
Discharge Issue	9	2	16	13	**40**
Documentation	0	0	3	0	**3**
Lack or Reasonable Adjustments	0	0	2	0	**2**
Malnourishment	0	0	0	0	**0**
Medication Error	3	3	4	5	**15**
Moving & Handling	0	1	0	0	**1**
Pressure Damage/Ulcer	3	2	3	3	**11**
Psychological	0	0	0	0	**0**
Sexual	0	0	0	0	**0**
SPA Referral	0	1	0	1	**2**
Theft	0	0	0	0	**0**
Unexplained Injury	0	1	0	0	**1**
Unkempt	0	1	0	0	**1**
Unwitnessed Fall	0	0	0	0	**0**
Total	**17**	**12**	**37**	**31**	**97**

*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 **1,545** applications during the first three quarters of 2020-21.

2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
673	832	1,100	1,638	1,810	**1,545**

*Data as of 31 March 2021

Trust Adult Safeguarding Governance Arrangements

The Chief Nurse/Director of Patient Safety and Quality is the executive lead for safeguarding adults with the Deputy Chief Nurse 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 2020-21 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 training.

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

Training Figures 2020-21	
PREVENT	84%
WRAP	85%

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 Chief Nurse/Director of 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 commissioners and providers 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 from Durham, Darlington, Easington & Sedgefield.

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

The Trust has made active contributions at senior level to the **Hartlepool and Stockton Safeguarding Children Partnership (HSSCP) and the Durham Safeguarding Children Partnership (DSCP).**

The Trust has maintained representation on a number of Safeguarding Partnership subgroups including:

- Tees Procedures and Policy group
- HSSCP (Hartlepool and Stockton Children's Partnership) Strategic - Engine room
- DSCP (Durham Safeguarding Children's Partnership) Strategic Board
- VEMT (Vulnerable Exploited and Trafficked) Strategic and Operational Groups
- MARAC (Multi Agency Risk Assessment Conference)
- MATAC (Multi Agency T
- County Durham Neglect Sub Group
- County Durham Safeguarding Health Leads
- County Durham Child Exploitation Group (CEG)
- County Durham Missing Exploited group (MEG)

Representatives from across all directorates take a lead role to act as champions for the safeguarding of children and through the safeguarding operational professional group meets on a monthly basis. Key professionals for example from Emergency Department and Women's and Children's services are brought together to ensure momentum of the Safeguarding and Looked after Children's agenda and work programme remains paramount. Providing safeguarding assurance to the trust and its partners through a Safeguarding Strategic Steering Group.

Children's Safeguarding Work Program

The Children's Safeguarding Work Program sets out the work for the year including:

1. Action plans from Rapid Reviews / Children's Safeguarding Practice Reviews; learning lesson reviews, Domestic Homicide Reviews and any internal incidents.

2. The safeguarding children annual audit and assurance program

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

There have been five Local Safeguarding Children Practice Reviews (LSCPR) commissioned by Hartlepool and Stockton Children's Partnership and significant learning has been identified for the Trust within three of these reviews. The Named Nurse, Senior Nurse Children's safeguarding and Specialist midwifery colleagues have been active members of the reviews, leading on actions from the learning with ongoing progress on action plans monitored through the Steering Group. No reviews have progressed to a National Children's Practice Review.

Two of the above LSCPR reviews are now published in response to the conclusion of criminal proceedings and all Trust actions completed.

Another three Rapid Reviews facilitated by HSSCP have not progressed to LSCPR as agreed by the national panel. This is in response to the in-depth analysis within the Rapid Review has been sufficient in identifying agreed actions amongst agencies which continues to be actively monitored through partnership meetings.

There is one remaining active Serious Case Review with Durham Safeguarding Children's Partnership however all actions for the trust have now been completed.

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 understand when a child has not been brought to appointments may be an early indicator of neglect and requires an appropriate response. The Trust can now also identify children whose appointments frequently rescheduled by parents/carers alongside those that do not attend.

Safeguarding Children's Policy

The Safeguarding Children's Policy ensures that Trust staff supported in understanding 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. This policy was recently reviewed and agreed by members of the children's safeguarding Professionals and Steering group at the end of 2020.

Safeguarding Children Supervision

The local quality and performance indicators include safeguarding children supervision of Trust staff. Safeguarding supervision recognised as being fundamental to safe practice. The team supports this in the delivery of mandatory 1:1 supervision on a three monthly basis for every staff member who has contact with children and young people within their caseload. These include all Community Midwives and Specialist Paediatric Nurses. Group supervision facilitated by Safeguarding Senior Nurses is valued by and continues for our Speech and Language Therapists on a rolling program. This provision has been extended to include our allied health professionals from Children's Physiotherapy, Occupational Therapy, Nutritionists and Diabetes Transition Nurse.

North of Tees Children's 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) practitioners group 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.

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 and the Trust also contribute to Multi Agency Tasking and Coordination (MATAC).

A Domestic Abuse Policy is in place across the Trust to support staff in responding to indicators that are suggestive of Domestic Abuse, how to address these safely with the child or other vulnerable adult's paramount to the assessment of an appropriate response including what to do if a colleague discloses Domestic Abuse.

Local Authority Designated Officer (LADO)

Regular meetings established between the Named Nurse and staff within the Workforce department has improved communication and referrals to the LADO. Additional safeguarding training is delivered to Trust senior managers to increase their awareness of adult risky behaviors that may require safeguarding intervention when supporting staff are on sickness/absence or there are capability issues.

Voice of the Child

Actions in response to recommendations from the CQC report 'Not Seen, Not Heard' continue to be reinforced by the Trust and are embedded within the Safeguarding Children's Foundation, yearly update and e-learning training, to continue to promote the importance of listening to children and promote working in partnership with the child to understand their felt needs. The wishes and feeling of Children in our Care (LAC) continue to capture by the Children's Health in Care team within every Review Health Assessment or contact with a child or young person.

Electronic health care records for children receiving care within the Trust now incorporate prompts for practitioners to gain the voice of the child during contacts/assessments.

Bruising in Immobile Babies Policy

Bruising in non-mobile children is rare and therefore there is a significant risk that bruising may be indicative of 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 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 embedded 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

Children's Safeguarding trainer through increasing hours continues to support joint working across Vulnerability Unit in providing training for both children and adult safeguarding across the Trust including Female Genital Mutilation (FGM), Prevent, Forced Marriage and Modern Slavery and Trafficking. The Named Nurses for Adult and Children's safeguarding both contribute to the Safeguarding Children's Steering Group and the Adult Vulnerability Committee.

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 Medical Assessment Audit**
Section 11 Audit	**Safer Referral Audit**
NICE Guideline 89 Audit	**Looked After Children Review Health Assessment Audit**
Midwifery Quality Assurance Record Audit	**Immobile Baby Pathway Audit**
Paediatrics Quality Assurance Record Audit	**Children Not Brought for Appointments by Parents/Carers Policy Audit**

Key Achievements 2020/2021

1. Key children's safeguarding priorities of the Trust are aligned to the new working arrangements of HSSCP and DSCP partnerships.
2. Despite challenges of the pandemic the team has continued to work creatively to support and ensure ongoing compliance is met for all local safeguarding children quality requirements.
3. The Trust safeguarding children training program has continued to maintain safe face to face delivery of Foundation and Update training as per intercollegiate document. In addition an e-learning component for both has been developed and introduced as a temporary measure for those staff who have found it difficult to attend face to face in light of additional pressures on care delivery in response to the pandemic.

4. Awareness raising of the VEMT agenda continues within the Trust utilising agreed risk screening and assessment tools to identify and improve outcomes for children and young people who may be vulnerable, exploited, missing or trafficked, including the rising trends of criminal exploitation. Working closely with the partnerships to understand and incorporate new processes and frameworks around contextual safeguarding recognising the different responses required to protect children from extra-familial and peer abuse.
5. Development, completion and ongoing monitoring of action plans following recommendations from the Joint Targeted Area Inspections and local Safeguarding Children Practice Reviews continuing to challenge and improve safeguarding practice.

Key Priorities 2021/2022

1. Provision of bespoke training in response to lessons from a serious untoward incident investigation.
2. Increase practice clinics and bitesized briefings to Adult Wards to continue to improve 'Think Family' approach to safeguarding both children and adults.
3. Continue to sustain high compliance for safeguarding supervision.
4. Increase visibility again of Safeguarding Nurses in high demand areas such as A&E and UCC, introduce increasing level of support in Emergency Assessment Unit to improve understanding and response to 16 – 18 year olds.
5. Auditing of the Child Protection Information System (CP-IS).
6. Build on collaborative working relationships and shared learning with neighbouring acute trust safeguarding teams.
7. Continue to support and share information with universal services and partnership to support their risk assessment of children who have had contact with the trust and appropriate support and response is considered at all levels of concern.

Safeguarding Children Training Programme

Throughout 2020 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 (2019) 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 elements of effective referrals and information sharing.

Where appropriate staff are required and supported to attend multi-agency training provided by the Safeguarding partnerships and other external providers and this is strongly recommended 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, incident (Datix) themes, Learning Lessons Reviews, Serious Case Reviews, and new and changing national guidance and legislation.

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.

Training Figures 2020-21	
Level 1	88%
Level 2	84%
Level 3 - Foundation	92%
Level 3 - Update	80%
Level 3 +	89%
Level 4	86%

*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.

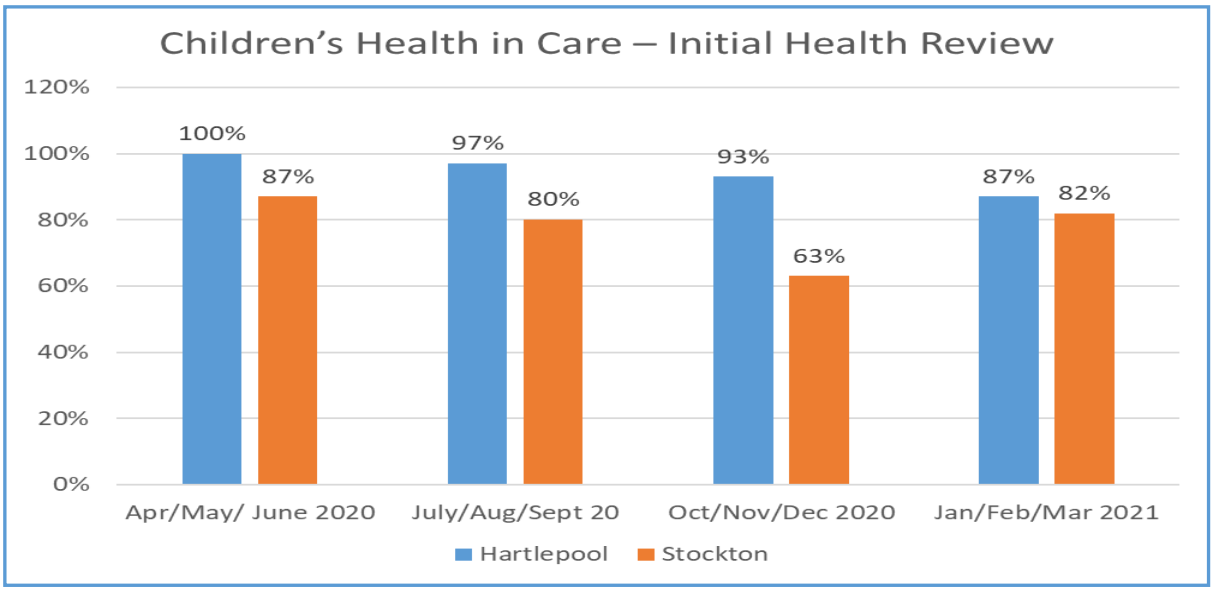
- LAC health provision is an integral part of the Trust Safeguarding and LAC Steering Group work programme which reports to the Trusts Children's Safeguarding Steering Group and Patient Safety Committee.

- 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:



Through appointment booking processes sufficient capacity to respond to any increase in IHA's requested by social care are fed back to Paediatric Clinical Lead by Looked After Team to address any resilience issues. Points to note in relation to reduced compliance include:

- Not receiving timely and appropriate consent for IHAs affects the overall compliance rate

- 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 six 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 dedicated 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 RHA's are undertaken by the Trust's Children's Health in Care (CHiC) team. To support this activity additional staff nurses have been recruited

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 and more recently an escalation pathway is sent out with every out-of-area request. This supports all agencies to be aware of expected timescales and actions the LAC team will take if the RHA cannot be completed within timescales.

Key Achievements 2020 - 2021

- 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 Trakcare enabling early identification of vulnerability

- CSE screening tool used on all LAC children over the age of 10

- The recruitment of additional staff nurses to support the improvements to quality and timeliness of RHA's in Hartlepool.

- The introduction of new review and initial assessment paperwork which enables practitioners completing the assessment to effectively capture the voice of the child.

Key Priorities 2021 – 2022

- To continue to work in partnership with all agencies to support changes required in order to respond and protect children appropriately against extra familial harm, peer on peer abuse, criminal and sexual exploitation. Additional focused training to support staff to understand the potential need for trauma informed care for children who have experienced these forms of abuse.

- To extend children's safeguarding supervision offer to include allied services from the Trust who provide an intensive, continuous level of health care delivery, to support complex case discussion and reinforce their role and responsibilities in assessing safeguarding needs.

- Continue to develop and monitor action plans following recommendations from both Local and National Children's Safeguarding Practice Reviews and Joint Targeted Area inspections to inform children's safeguarding training updates and facilitate dissemination of any targeted learning.

- As the impact of the pandemic on children's psychological, social and physical wellbeing is not fully understood, targeted work with the Trust's front of house staff need 's additional scaffolding by children's safeguarding team. This is to ensure robust screening tools that supports identification of risk and harm are utilised to respond to any unmet need in response to reduced visibility of children during lockdown.

- Support midwifery team in making the transition to electronic record keeping system to facilitate connection to integrated healthcare systems and improve information sharing and communication, a requirement identified in recent Local Safeguarding Practice Reviews.

- Safeguarding activity data to be captured effortlessly through recording system's which can then be analysed to inform targeted response to quality improvements.

- Earlier identification and case management and supervision is provided more proactively in cases with perplexing presentations.

- Auditing processes are strengthened around Child Protection Medicals in response to new standards set out by the Royal College of Paediatrics and Child Health.

- To continue to monitor and respond to challenges that may affect the achievement of 100% compliance of all local safeguarding quality requirements.

- Continue to provide Trust representation at operational and strategic Partnership meetings that ensures the Trust Key Priorities align with Teeswide Hartlepool and Stockton Safeguarding Children's Partnership (HSSCP) and Durham Safeguarding Children's Partnership (DSCP).

- To continue promote 'Think Family' approach to safeguarding of both vulnerable children and adults at risk.
- To strengthen and nurture safeguarding champion support to deliver bite sized safeguarding teaching and briefings, centred on key topics with direction from the Safeguarding Children's Trainer and Senior Nurse's linked to specialist areas.

LAC Key Priorities 2021 - 2022

- Any changes to Looked After Children's service in response to commissioning decisions are supported to ensure impact on children's health assessments is not affected and a smooth transition is enabled that informs partner agencies.
- To continue to achieve compliance of local quality requirements as agreed with Care Quality Commission on the delivery of Initial and Review Health assessments for children in our care.
- To ensure that families and carers are engaged and involved as appropriate to promote optimum health and development of all looked after children.
- To ensure that the young person's views, as appropriate are included in the health care plan.

- To work in conjunction with local authority and other partners to promote the health and well-being of looked after children.
- Ongoing updates and improvements to the Electronic Health Care Record to improve the identification of health trends in the LAC population.
- To identify and address barriers to accessing health services and make them accessible to Looked After Children and Young People.
- To provide training for foster carers and residential workers in agreement, or jointly, with social work and health colleagues.
- To provide expert health advice and training for partner agencies and carers in the needs of this specific client group.

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.

The trust has been actively involved in Sensory loss planning and provision with external stakeholders. Trust representation is visible within the Hartlepool sensory loss strategy group, a working partnership to improve sensory loss provision and knowledge across the Hartlepool area.

A trust Accessibility group has been established which meets monthly and core members from external stakeholder organisations are invited. The group action plans improvements ideas, receives input from experts in accessibility relating to improvement projects and outlines and agrees task to finish groups based on improvements.

The trust has been offered the opportunity to participate in free sensory loss training as part of the ongoing accessibility work, this is currently under review from Learning and Development.

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.

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

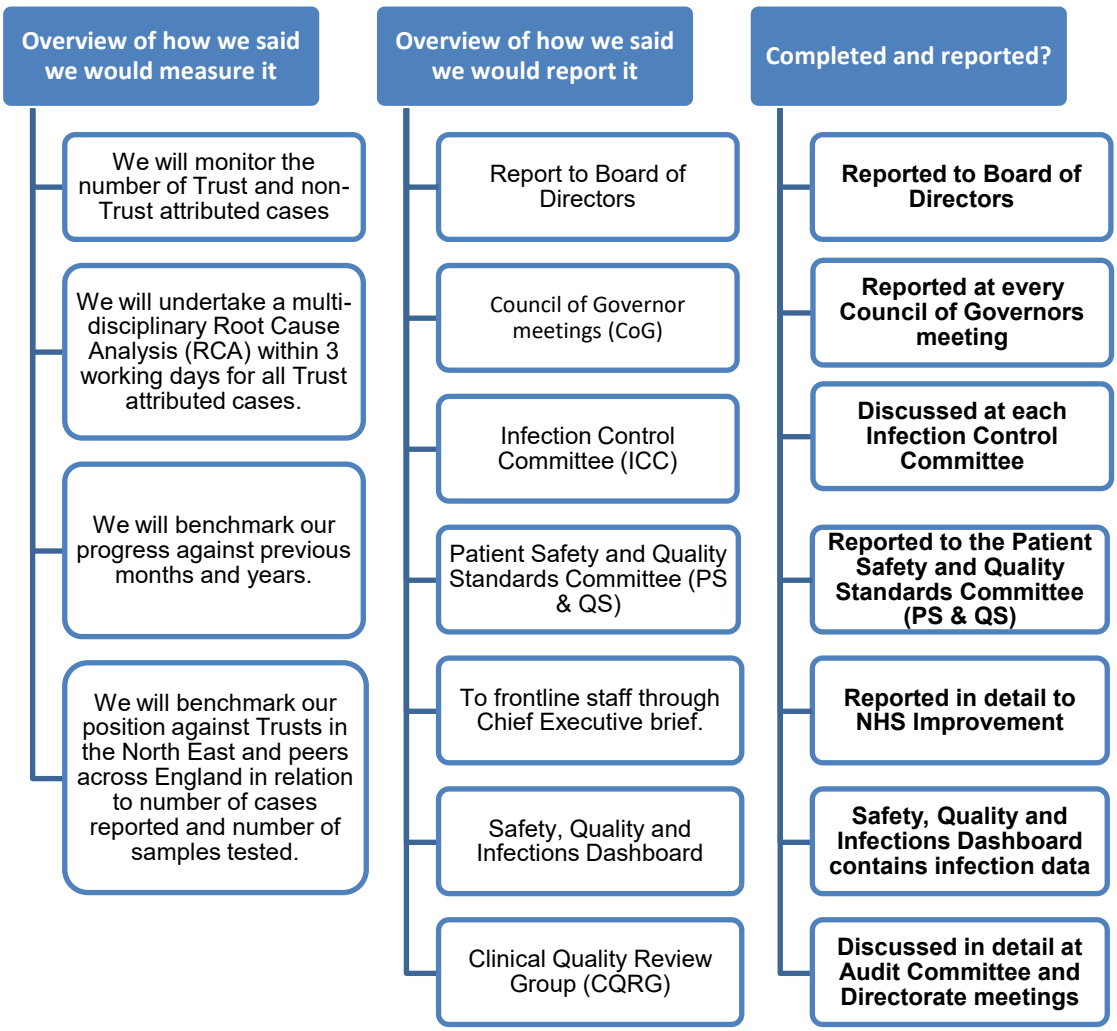
Infections

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.
- Catheter-associated urinary tract infection (CAUTI)
- COVID-19

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.



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 2020-21 the Trust experienced **49** Clostridium difficile cases. Due to COIVD-19 no trajectory was set in 2020-21.

Our staff continue their efforts to control and reduce opportunities 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, and the provision of a hygienist team to support additional cleaning. The focus on antimicrobial stewardship has continued and is led by a Consultant Microbiologist and Antimicrobial Pharmacist. The importance of adherence to high standards of hand hygiene has continued to be a core element of our strategy.

Actions to reduce C difficile are within an integrated HCAI improvement plan covering all infections and practices 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.

Data reporting using the new requirements

- Hospital onset healthcare associated (HOHA): cases that are detected in the hospital two or more days after admission
- Community onset healthcare associated (COHA): cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.
-

***Trust Cdiff bacteraemia cases 2016-21**

	2018-19	2019-20	2020-21
Cases allocated to the Trust	61	53	**49**
Cases allocated to commissioners	53	39	**44**

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

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 2020-21 our organisation reported **one** hospital onset cases of MRSA bloodstream infection, which is disappointing given the previous 2 years with no cases, and breaches with the national zero tolerance trajectory. Learning has been identified and shared across the Trust. Two community onset cases have been reported this year with no learning for the Trust identified from either case.

***Trust MRSA bacteraemia cases 2016-21**

	2016-17	2017-18	2018-19	2019-20	2020-21
Hospital Onset	1	4	0	0	**1**
Community Onset	2	2	0	3	**2**

*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 2020-21 we reported **25** cases of hospital onset MSSA bacteraemia. This is a deterioration from 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 high number of community onset cases has continued to be 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 promptly in the emergency department and emergency assessment unit.

***Trust MSSA bacteraemia cases 2016-21**

	2016-17	2017-18	2018-19	2019-20	2020-21
Hospital Onset	21	25	21	26	**25**
Community Onset	57	71	93	75	**63**

*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 by the Trust for the year are shown in the table below. As the majority of these cases are those that are identified within the first 48 hours of hospital admission, work is required across all healthcare settings to achieve improvements. A national objective to reduce gram negative blood stream infections (E coli, Klebsiella and Pseudomonas) by 50% by 2023 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.

***Trust E.coli bacteraemia cases 2016-21**

	2016-17	2017-18	2018-19	2019-20	2020-21
Trust Attributed	50	43	39	52	**25**
Non-Trust Attributed	267	304	317	279	**205**

*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.

***Trust Klep sp bacteraemia cases 2017-21**

	2017-18	2018-19	2019-20	2020-21
Hospital Onset	29	20	10	**10**
Community Onset	42	40	49	**39**

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

In 2020-21 the Trust reported **10** Klebsiella species bloodstream infections which remained the same from 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.

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.

***Trust Ps a bacteraemia cases 2017-21**

	2017-18	2018-19	2019-20	2020-21
Hospital Onset	5	9	3	**3**
Community Onset	19	20	17	**13**

In 2020-21 the Trust reported **3** Trust attributed cases of Pseudomonas aeruginosa bloodstream infections which has remained the same from the previous year. It is not possible to identify trends from such low numbers of cases. 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.

Catheter-associated urinary tract infection (CAUTI)

A catheter-associated urinary tract infection (CAUTI) is one of the most common infections a person can contract in the hospital, according to the American Association of Critical-Care Nurses. Indwelling catheters are the cause of this infection. An indwelling catheter is a tube inserted into your urethra.

	2019-20	2020-21
Hospital Onset	**360**	**211**

In 2020-21 the Trust reported **211** Trust attributed cases of catheter-associated urinary tract infection (CAUTI), it was not a mandated reporting requirement for the previous years. However, the Trust will be reporting CAUTIs to the Trust Board and Executive team each month in the Integrated Board Paper.

Coronavirus disease (COVID-19)

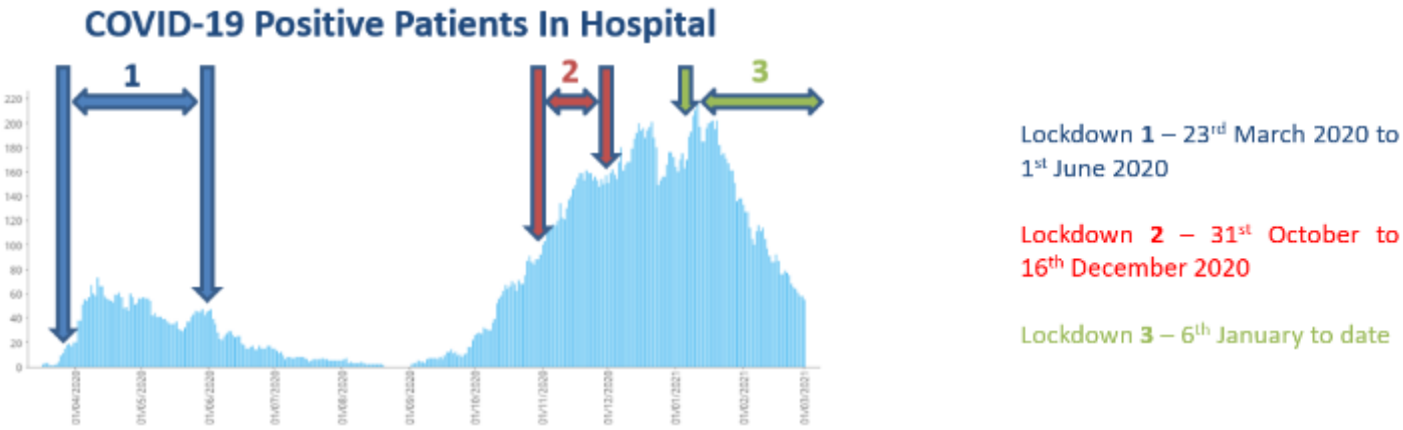
Coronavirus disease (COVID-19) is an infectious disease caused by a newly discovered coronavirus.

Most people infected with the COVID-19 virus will experience mild to moderate respiratory illness and recover without requiring special treatment. Older people, and those with underlying medical problems like cardiovascular disease, diabetes, chronic respiratory disease, and cancer are more likely to develop serious illness.

The COVID-19 virus spreads primarily through droplets of saliva or discharge from the nose when an infected person coughs or sneezes, so it's important that you also practice respiratory etiquette (for example, by coughing into a flexed elbow).

Between 17 March 2020 and 31 March 2021, there have been **2,528** number of COVID-19 positive patients in the Trust on Other Wards with **484** deaths.

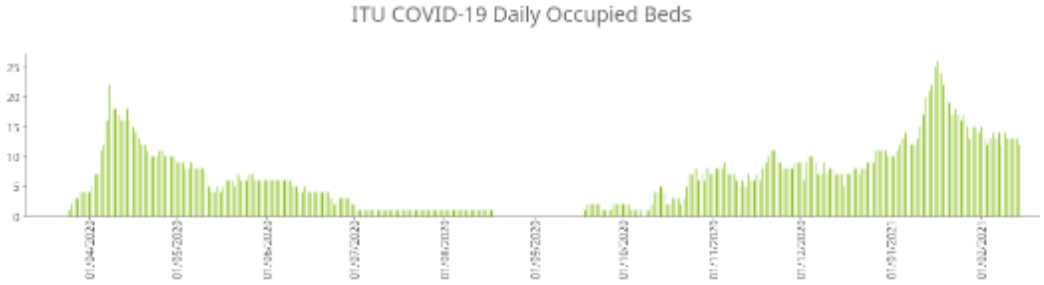
COVID-19 Positive Patients in the Trust



The peak of COVID-19 patients in the Trust was 216, this was on the 11th Januyary 2021 (during Lockdown 3).

The following chart demonstrates the nmber of patients that occupied our ITU during the pandemic.

Between 17 March 2020 and 31 March 2021, there have been **184** number of COVID-19 positive patients in the Trust in ITU with **48** deaths.



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 overview of how we said we would do it, see page 76.

During **April 2020 to March 2021**, **1,542** 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:

366 in the first quarter;
301 in the second quarter;
440 in the third quarter;
395 in the fourth quarter.

By **31st March 2021**, **171** case record reviews and **18** investigations have been carried out in relation to **189** of the deaths included above.

In **18** 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:
6 in the first quarter;
4 in the second quarter;
6 in the third quarter.
2 in the fourth quarter.

0 representing **0%** of the patient deaths during the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient. To date, 4 investigation remains ongoing, there are some cases from 2020-21 which are also awaiting information from Coronial review.

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.

Medical Examiner

During 2020-21, the Trust has implemented national requirement for having Medical Examiners (MEs) in place. The Trusts team of Medical Examiners (ME) have been in place for 9 months; the team comprises if an ME lead and four consultants, covering 6 clinical sessions each week; the service has been in place for all deaths in the West Wing in-patient areas. The team are

implementing a plan with an aim to give clinical scrutiny to all adult in-patient hospital deaths by the end of 2021-22. The MEs are now supported by two Medical Examiners Officers (MEOs). All of the MEs and MEOs have now been accredited by the Royal College of Pathologists. The Trust ME office continues to have support from the Regional ME and MEO; this is reinforcing strong links with ME colleagues serving the hospitals south of the Tees.

The Trust works to national standards in the timeliness of issuing medical certificates of death and registering deaths. The mortuary and bereavement teams have reviewed their processes to maintain timeliness under recent pressures. The introduction of an appointment system has improved medical staff access to the Mortuary within the usual department working hours. A morning huddle held with the MEOs and Bereavement Support Officers coordinates the prompt provision of documents and interactions with families. Feedback from families is shared with clinical teams; any concerns are addressed with patient safety and patient experience team support.

Additional training sessions in relation to the MEs role and death certification, have been developed and held virtually; these are open to the doctors in training as well as final year medical students. These are extending to include Coronial interactions and Cremation legislation with training for junior doctors also being included in the education programme within Medicine. A session is planned for the Trust induction of new appointees. Updates on the ME role and the relevant service changes have been delivered in the Trust to the Community, Orthopaedic and Surgical group meetings. The MEOs are meeting with Ward Managers and Ward clerks to facilitate the roll out to all adult ward areas.

There have been difficulties recognised in relation to the implementation of the ME role; the medical staff providing this service have a wealth of clinical expertise and experience; this means they are required to support the increasing activity required during the Covid pandemic.

With assistance from IT, the electronic records and laboratory systems support teams, the Trust is aiming to be the first in the North East to be a fully digital ME service integrated within the electronic patient records (EPR) and wider patient safety systems. The Trust is including local partners in the Coroner's office, Registrars and Crematoria within this significant move towards a paper minimal approach. As a result of identifying delays when post mortems are required, the ME team have arranged for the Pathologists appointed by the Coroner to have access to and training in relation to the electronic records system Trakcare. Provision of these records electronically allows the Pathologists to review A&E and medical records in a timely fashion; nursing records continue to be provided currently as paper records.

Learning Disabilities Mortality Reviews (LeDeR)

The Trust has continued to undertake LeDeR reviews alongside the internal mortality review process. The LeDeR reviews are undertaken for all deaths of patients who have diagnosed learning disability from the age of 4; the reviews are not only undertaken by the trust but by all services who have been involved in the patients care during their lifetime. Deaths in patients with a learning disability (LD) in our care; are thankfully low with an average of less than one per month since 2019, however, this makes it even more important to take every opportunity to learn. Information from the reviews is shared with the Teeswide LeDeR team who then collate the information for shared learning across all health and social care services. If necessary for individual cases, this can lead to a full multiagency review meeting to assist in identifying any shared learning. Over 2020-21, the Trust has received good feedback from these multiprofessional reviews, in particular around the reasonable adjustments put into place and the involvement of the Trusts Nurse Advisor for LD alongside the Community LD staff.

As a result of the internal LeDeR reviews, however, it has been identified that the referral processes to the Nurse Advisor for LD, internally to the Trust, could be improved. A standard operating procedure (SOP) has now been developed to help guide staff when making a referral and to also outline what actions will be taken following a referral. As part of this an online referral system has

been developed to ensure there is a clear record of referrals and the information provided by the staff. This also allows the Nurse Advisor for learning disability to hold an audit trail of who has been referred to service as it is electronic; there are plans for this process to be audited to ensure it is working well.

The Trust is part of a regional network; the network has developed a training package for acute secondary care services to access. This training has been developed to ensure there is consistency within all of the education and pathways for patients with a learning disability across all North East Trusts. This supports the Trusts introduction of the learning disability diamond standards; these support a pathway of care promoting good practice. Once trust staff have accessed the training they can then become a learning disability diamond (champion) for their area of work. This has been rolled out in the Trust over 2020/2021.

The reviews undertaken this year have evidenced good team working and understanding of the Mental Capacity Act requirements. There is clear evidence of the use of best interest meetings to ensure an MDT approach to planning of care whilst in hospital; this has also supported communication with families. The reviews have highlighted how vital this is in all cases when discussing resuscitation requirements and palliative care.

Another opportunity for families and carers, of patients with learning disabilities, to be involved in the care of the patients whilst they are in hospital is by the use of “Johns Campaign”. This is a national campaign highlighting the role of informal carers in contributing to the provision of safe and responsive care to their relatives and friends. The Trusts has this year introduced its own local guidance for staff. By implementing the principles of John’s Campaign it is anticipated this will provide reasonable adjustments to ensure that vulnerable patients will suffer the least disruption to aspects of their everyday life during their stay in hospital. Additional benefits of this are that this group of patients will have their experience enhanced through greater involvement of their informal carers. The campaign itself is also covered in the mandatory training mentioned earlier, and the overall impact of implementation will be monitored through family feedback surveys. The Vulnerability team have developed a SOP around the use of Johns Campaign, there are plans being developed to audit the implementation of this to gain assurance that the SOP and the campaign are being used effectively to provide support.

Learning as described above, and from future LeDer reviews are collated into a work programme for the Trust. This also identifies improvements initiated and is monitored via the Trusts Vulnerability Group with actions being followed up to completion; where necessary additional support initiated for any barriers or challenges identified.

Bereavement surveys

The Trust has had a bereavement survey in place for several years; this survey is provided as a part of a pack of information given to families when they meet with the Trust bereavement team. The survey is provided with a self-addressed envelope and invites families to provide feedback on the care of their relative leading up to and also following their death; this also includes how the family were treated during this time and also offers them an opportunity to request a review of the care and management provided. Over 2020-21, 167 surveys have been returned; the majority of these provide some excellent feedback for the staff involved; where concerns are outlined these are forwarded by the Patient Experience Team to the relevant clinical teams to follow up with the families as needed. Over this year 43 families have taken up the offer for the records to be reviewed, this is around 26%; none of the reviews completed to date have been identified as avoidable deaths.

In order to get the maximum benefit from returned surveys all are reviewed and the overall information, positive and negative, is collated; and then shared with various committees and groups in the Trust to ensure learning is identified and actions implemented as needed. As the MEs team expand their service and scrutinise all in-hospital deaths, there are plans to review the content of the survey as reviews can be requested through the ME during family discussions as needed.

Leading Improvements in Clinical Activity Recording and Coding

There continues to be an ongoing focus on ensuring there is accurate documentation of the diagnosis and co-morbidities; this information is required to ensure there is clear clinical communication between healthcare professionals who are caring for the patients.

Education and Training

Multiprofessional regular training sessions:

a. Cross specialty including nurse practitioners, clinicians, doctors in training, ward and specialist nurses.
b. Prioritised by areas of highest need, based on gap analysis following clinical audits.
c. Reinforced with subsequent rolling audits and monitoring of outcomes to demonstrate and share learning.
d. Training to coders which is specialty specific.

Planned outcome: To have an improved understanding of the principles of accurate and optimal recording leading to better coding practices, demonstrated by depths of coding.

Digital alignment

Working in collaboration with Electronic Patient Record (EPR) team to improve digital processes to provide more clinical information to clinicians:

a. For example; the availability of primary care report helped to gain access to comorbidities at the time of admission and first clerking, leading to improved depth of coding and Charlson comorbidities, such as Chronic Kidney Disease (CKD) or previous heart attack.
b. Other examples include:
    - improved automation of comorbidities in discharge summaries.
    - Access to clinic letters for the coders on the electronic patient record (Trak), facilitating capture of comorbidities especially for elective cases.
    - Automated recording of CKD on the pathology system (ICE) to prompt clinicians to record CKD better.
c. The Clinical Coding team are now involved in Clinical Active Record development, to ensure processes embedded so far are retained and further opportunities to be identified to optimise recording, reduced inefficiencies and lead to better coding, due to improved retrieval of clinical information.

Improved coding practices

a. Increased coding from case notes, this has been rolled out in phased manner, starting with areas of highest priority, as directed by clinical audits led by senior clinical staff. This was temporarily withheld in March, as a result of Covid, but is gradually being re-established.
b. Senior clinical input is provided as a regular source of support to the clinical coders, this helps them to resolve uncertainties in relation to clinical information without undue delay.

The Trust has implemented the use of automated software to identify potential missed comorbidities followed by clinician validation, this is leading to improved depth of coding. There is ongoing benchmarking on a monthly basis in relation to the depth of coding and overall rate of Charlson comorbidities. Specific comorbidities are also being used to identify areas of variation and subsequent audit, targeted training and re-audit. Examples of this include recording of metastatic cancer in clinical oncology/chemotherapy day unit and CKD). Focused clinician and coding auditor led audits are being undertaken including pneumonia, stroke, senility. These will help determine if diagnoses are being recorded appropriately.

There has been an audit of random cases where sepsis is a main diagnosis; this is the highest diagnosis group coded for Trust deaths currently. The audit revealed that the cases are being correctly coded as sepsis but also highlighted some areas for improvement in clinical management and timescales. This is now being linked in to education sessions as described earlier. The results

of future audits linked to sepsis and acute or chronic kidney disease will be followed up with the Trusts, newly introduced Deteriorating Patient Group as part of their ongoing work programme.

The Trust recognises that patients at the end of their life benefit from improved clinical care as a result of the involvement of the Specialist Palliative Care team (SPCT), not only to support the patients and their families but also to assist clinical staff providing the required care. In order to accurately understand and monitor, how many patients, the SPCT provide support to, there has been an improved capture of palliative care input with SPCT coding being continuously updated via data from SystmOne.

Surgical Mortality Reviews

The Surgical department has for many years undertaken reviews of any cases linked to morbidity, where complications occur, and where patients have died in their care. The reviews are presented at the Morbidity and Mortality (M&M) meetings; this allows multidisciplinary (MDT) involvement in the reviews to share learning but also gives a wider range of professionals an opportunity to identify what actions need to be taken.

The Surgical team have identified the following areas where improvements and changes in practice have been initiated as a result of the M&M reviews:

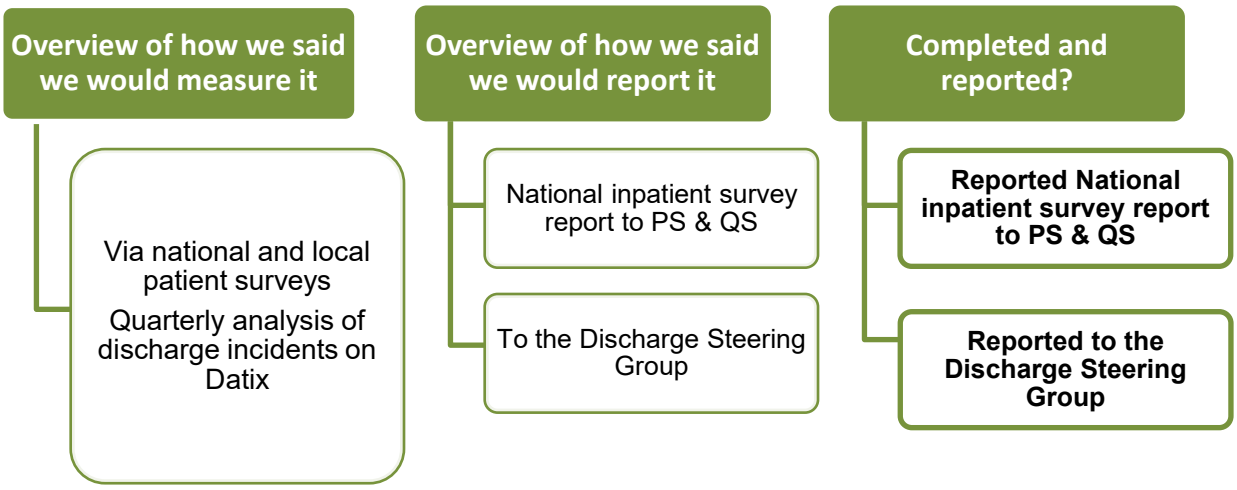
- In order to ensure consistency of review, any patients in the hospital that have been by the surgical team are now discussed at a daily meeting at 8am which are led by a consultant. This will ensure there all relevant patients have consultant input into their management, either by reviewing test results or attending the patient directly. The introduction of this daily session has evaluated well by supporting prompt and appropriate treatments for referrals.
- The team have arranged for a specific referral slot on the request system for emergency Computerised Tomography (CT) scans. This was identified from reviews of cases where patients required emergency laparotomy surgery; having this referral process for scans supports them being completed more promptly which can then support clinical decision making about undertaking emergency surgical procedures.
- Some surgical cases reviewed have identified the need for broader discussions across other specialist services to support shared learning and collaborative improvements. Recently there has been joint governance session with the anaesthetic, medicine and orthopaedic teams to do this.
- The team have also recognised through their M&M reviews, and following discussions in relation to other Trust wide serious incident investigations; that there are some complex conditions that need more specialist management and involvement to support current practices. In order to enhance the services awareness of these they have invited specialist teams Geriatric medicine, urologists, nephrologists, palliative care and gastroenterologists to the Clinical Governance sessions to provide updates.

A clinical audit has been undertaken by the surgical team to examine the use of DNACPR forms for surgical patients; this generated significant discussion and has helped raise awareness amongst clinicians. This has also supported the surgical team when considering management and escalation plans for critically ill patients; and where necessary escalation to, and the involvement of, the palliative care team.

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.



Introduction of Hospital Discharge service: policy and operating model August 2020.Trusted assessor pathways and Criteria to reside

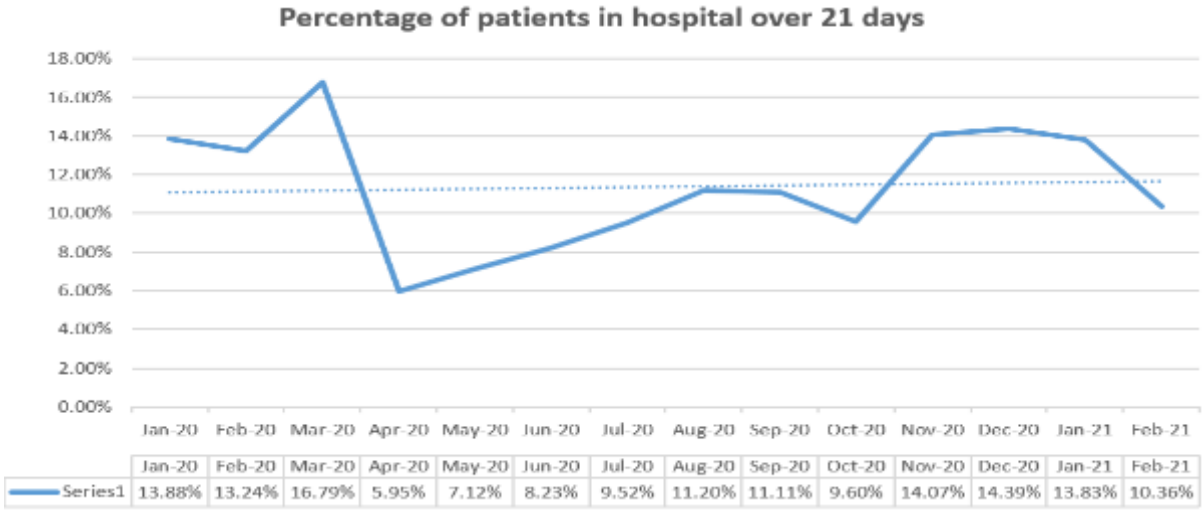
The Trust and our partners in social care have worked together to implement the discharge policy and continue to reduce delayed transfers of care.

The government has provided funding, to help cover the cost of post-discharge recovery and support services, rehabilitation and reablement care for up to 6 weeks following discharge from hospital. The Trust has developed further the trusted assessor pathways during 2020 to meet this requirement and ensure the processes are fully embedded for all people aged 18+. The trusted assessors work with patients, their families and staff on the wards to transfer patients in a safe and timely manner. The trusted assessor model has reduced the time it takes from referral to transfer. The model is fully supported by our Partners in Hartlepool & Stockton Borough Council.

Acute hospitals must discharge all persons who no longer meet the criteria to reside in hospital as developed with the Academy of Medical Royal Colleges, as soon as they are clinically safe to do so. Daily morning ward huddles to review every person take place and a decision, informed by the criteria to reside, are the foundation for avoiding delay and improving outcomes for individuals. As a trust the daily reviews have been integrated into the electronic patient information systems, this ensures a list is available for all agencies to work from and include those suitable for discharge. This list is shared daily with local partners and a daily review meeting has been embedded to ensure that patient discharge plans are in place and carried out in a timely manner. Reporting of the number and percentage of people on the list who have left the hospital, and reason of delay for those unable to be discharged in a timely way. This data forms part of national data performance reporting arrangements. This included the suspension of Delayed Transfer of Care (DTOC) data collection and submissions. NHS providers should no longer record or report DTOC data, which has been superseded by the data collections outlined above.

Reduction length of stay in hospital

The graph below shows the proportion of patients in hospital over 21 days. Prior to the first wave of the pandemic, we saw a continued reduction of patients that remained in hospital after 21 days. The organisation had worked hard to implement a weekly super stranded audit to understand why patients are in hospital for prolonged periods and to take actions to influence any themes that have been identified. Our approach was recognised by NHS Improvement.. During the first Wave of the pandemic, we saw a sharp drop in the numbers in hospital over 21 days this has since risen to its peak in December 2020. In January 2021 the weekly reviews were reintroduced to reduce the numbers along with other pieces of work to support its reduction.



	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Series1	13.88%	13.24%	16.79%	5.95%	7.12%	8.23%	9.52%	11.20%	11.11%	9.60%	14.07%	14.39%	13.83%	10.36%

Help Force – Home but not alone scheme

A volunteer led and delivered service to support patients through the discharge process. This programme was being piloted on 6 wards across the Trust. Those patients, who are aged over 65 years old, live on their own and would like someone to talk to are referred onto the programme. Volunteers meet them and discuss their needs upon discharge and post discharge. Our volunteers have access to local Foodbank's emergency food parcels and clothes for those in need. Our volunteer driver service can transport these patients home following a period of hospitalisation. Drivers can also deliver medication when appropriate.

Our volunteer team can travel home with those patients who need support, when doing this they help the patients to settle back at home, (checking that heating/TV works and they get a cup of tea). Volunteers follow up upon discharge for 28 days to encourage the patients to get involved in local befriending services, involvement in local community activities; also to take advice from support networks e.g. CAB, etc.

Since the first wave of the pandemic volunteers supporting this programme have stayed away from the Trust. The restrictions on footfall and access to wards have had a dramatic impact on the effectiveness of this provision and resulted in a suspension of activities. As of February 2021, the programme remains suspended and will remain so until we can safely allow volunteers open access to regular wards in a regular manner. We will resume activities and again support those aged over 65years old, who live on their own and would like someone to talk to and have some support. Volunteers meet them and discuss their needs upon discharge and post discharge.

7 day working – focus on weekend discharges

There have been a range of developments to support discharge over the weekend as well as out of hours.

There has been a change to the medical workforce on the Emergency Assessment Unit and medical base wards to address a number of issues; changes to post graduate medical training, the out of hour workload and associated increased admissions between 11-7pm. The change provides increased numbers of staff out of hours and at peak times to improve the resilience for more timely patient assessments and discharge planning. Alternative workforce models with Physician Associates and Advanced Practitioners have been used to support this. Different ways of working have been explored and capacity prioritised to ensure best use of resources, e.g. “Weekend working teams”, 'Home Safe Sooner' work streams and huddle/board rounds.

The Trust has a ‘Hospital at Night’ team to support appropriate allocation of tasks and triage to allow the appropriate staff to be available to ensure timely interventions. This also allows the appropriate use of the medical resource to be available for the more complex interventions. During the first Wave of the pandemic and through to now there has been little use of this service due to the availability of for example medical students. This service although never stopped will be reviewed/relaunched.

Seven-day pharmacy is available, providing extended hours. Seven-day physiotherapy, occupational therapy, district nurses and community matrons is provided and there is equipment provision for basic items.

Patient transport is available 7 days a week to support patient discharge supported by the use of redeployed staff and trust vehicles.

Integrated single point of access pilot (ISPA)

The integrated single point of access (ISPA) has been operational since April 2018 and has demonstrated to be effective in improving patient journeys across health and social care services, supporting people to remain in their own homes and providing an integrated approach to hospital discharge. This can be clearly evidenced within the latest better care fund performance figures, particularly those relating to the significant reduction in delayed discharges since the development of the iSPA.

The service manages a broad set of pathways and the work currently delivered in iSPA has a range of complexity, which is all delivered through a multi professional group of staff, which include nursing, therapy and social care. The ISPA has demonstrated effectiveness in the triage and clinical assessment of those patients requiring urgent response to remain in the community and avoid unnecessary acute admissions. The team within the ISPA have a broad knowledge of community health and social care services as well as the voluntary sector and are able to make decisions on appropriate pathways of care. Primary Care Networks are also key partners in the development of the iSPA through our System Design and Delivery Groups. In the past year the ISPA have increased the links with the PCN’s by completing weekly MDT meeting with each PCN across Stockton and Hartlepool as part of the Enhancing Health in Care Homes framework supporting care plans in care homes and with the aim to support residents in their own homes reducing non-elective admissions.

ISPA has also expanded to include a 24/7 clinical triage service which enhances the current out of hours offer and support to care homes to look at alternative options to admission. The Clinical triage team 24/7 is also creating an opportunities to support urgent care centres, out of hours nursing support, Home First overnight support and the NEAS paramedic pathfinder scheme.

District nursing in reach project

During 2020-21 we have been able to pilot an in reach district nursing service. The district nursing team are providing two Nursing Sisters, one from Stockton and one from Hartlepool and the staff are working alongside the Integrated Discharge Team. The nurses provide support to patients in the Hospital, providing an experienced voice to alleviate concerns that patients and their families might have when hospital discharge is approaching.

The team have been able to reduce delays by providing timely information and advice and coordinating complex discharges. This has added quality to our discharge pathways, specifically the fast track discharge pathway for patients who are reaching the last days of their lives. The Hospital staff have provided very positive feedback about this initiative and currently this service continues to be offered. There is a plan to introduce a rotational post into the discharge team from District nursing to further enhance this in reach.

Frailty Coordinators

The Frailty team has been in operation since 2017 and consists of experienced clinicians who coordinate the care of complex elderly frail patients through their acute admission. The service is operational 7 days a week and the team facilitate the management and complex care planning of frail patients supporting their timely discharge into the community. The team have recently increased their capacity to ensure the early facilitation and coordination of the elderly frail pathway is initiated as soon as the patient is admitted into acute care. This is happening through the integration of the frailty team with the 'Home First' team, which currently includes therapists within emergency care department to improve the transition into the community and avoid unnecessary admissions to base wards. In addition to this.

A pilot to enhance Huddles at front of house which includes the Emergency Department and Emergency assessment unit with more senior staff with the aim of identifying more patients on admission whom could be treated/ cared for on a pathways in the community is ongoing and the results of this are due for evaluation.

Home First Pilot

The Home First pilot supports individuals to receive their care in the right setting. The service supports patients to remain or return to their own home through provision of a 24/7 nurse led service, allowing individuals to be both care managed and have their needs assessed within their own home environment by an appropriate integrated community workforce.

The Home First team is a multidisciplinary team that can deliver effective nursing and rehabilitation interventions during an initial 72-hour period to promote independence. The service works in collaboration with the integrated single point of access (iSPA) to support a health and social care approach to the delivery of care. Following assessment a package of support is wrapped around the individual his can be 24 hour 1-1 care or a package of individual calls.

The model is being developed in collaboration with health and social care colleagues during the pilot and will be evaluated to inform future commissioning/ provision.

Priority 2: Effectiveness of Care

Accessibility

Rationale: The trust is committed to ensuring that the Accessible information standard is met and all of the services we provide are able to make reasonable adjustments for those in need as required.

Aim

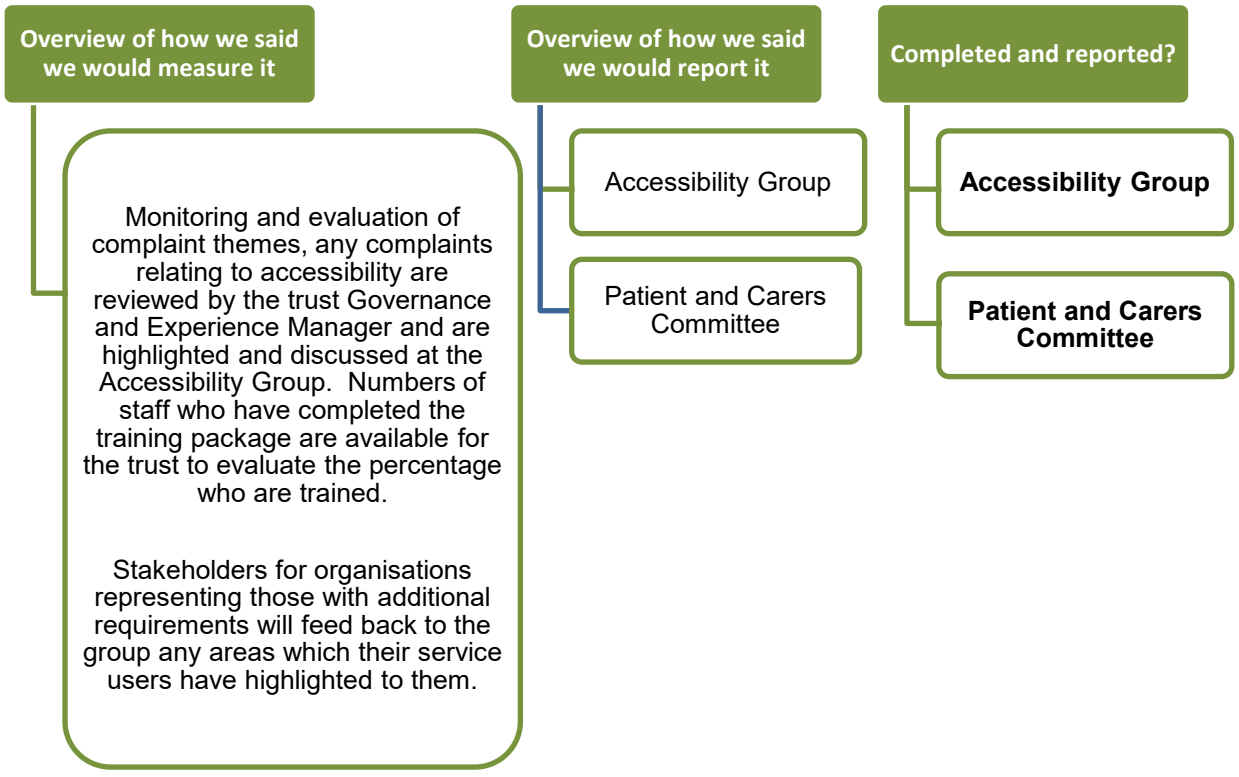
The aim is to develop a culture which learns from service user/stakeholder feedback. To provide a forum for service users/stakeholders to participate in accessibility projects and groups to ensure that their voices can be heard and that their views make a difference to the work in the trust. To ensure organisational compliance with accessibility standards, action plan on feedback received from service users and key stakeholders regarding accessibility in the trust and to receive expert guidance from external stakeholders.

Overview of how we will do it

The trust has set up an Accessibility group which includes representatives from stakeholder organisations, patient experience, dementia and learning disability specialist nurses, senior clinical staff, learning and development, estates, and governance.

An e-learning package to increase awareness of people with sensory loss developed by a stakeholder has been provided to the trust and adopted into the trust's dementia training. The trust is continuing to work closely with the stakeholder to promote the training within the trust.

A training package has been developed by a stakeholder organisation who have provided access for the trust with training for dual sensory impairment.



Developments and improvements 2020/2021:

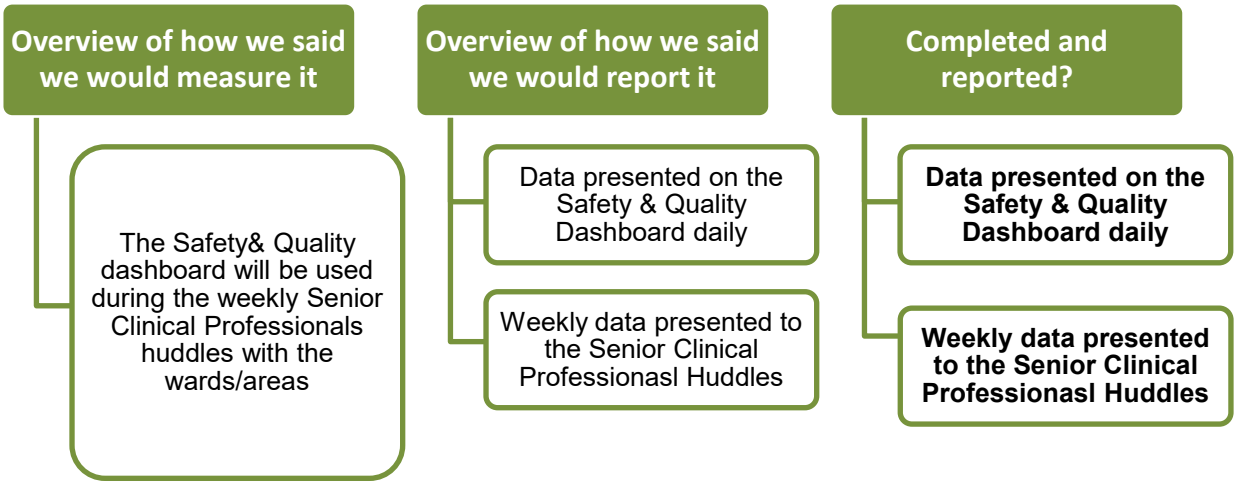
- E-learning sensory loss training package – included in the trust's dementia training
- 2 additional Task to Finish Groups have been set up and are in the initial stages groups to outline actions with deliverable aims – Guidance for staff - my colleague has autism and the second group Guidance for staff for patients with autism (paediatric and adult).
- Working with the Communication Team regarding the Trust's external website and accessibility. Ensuring patient information leaflets are available in an accessible format for our service users.
- Currently implementing a process to ensure virtual translation including BSL is available in inpatient areas.
- Reviewing the feasibility of Resource Boxes in inpatient areas to provide tools/resources for service users with sensory loss, autism, dementia etc to enhance their experience with the trust.
- Report on complaints and compliments which include an accessibility element and ensure any concerns are investigated and responded to.
- Joint working with Tees, Esk and Wear Valley and James Cook via a Patient and Carer Participation Group – to share learning and gain expert guidance around accessibility, mental health etc.
- To receive feedback and provide input into the trust's accessibility audits.

Priority 2: Effectiveness of Care

Violent Incidents

Rationale: With the ever increasing number of violent incidents occurring to members of staff from patients and other persons, the Trust will monitor the numbers of violent incidents that are occurring across which areas.

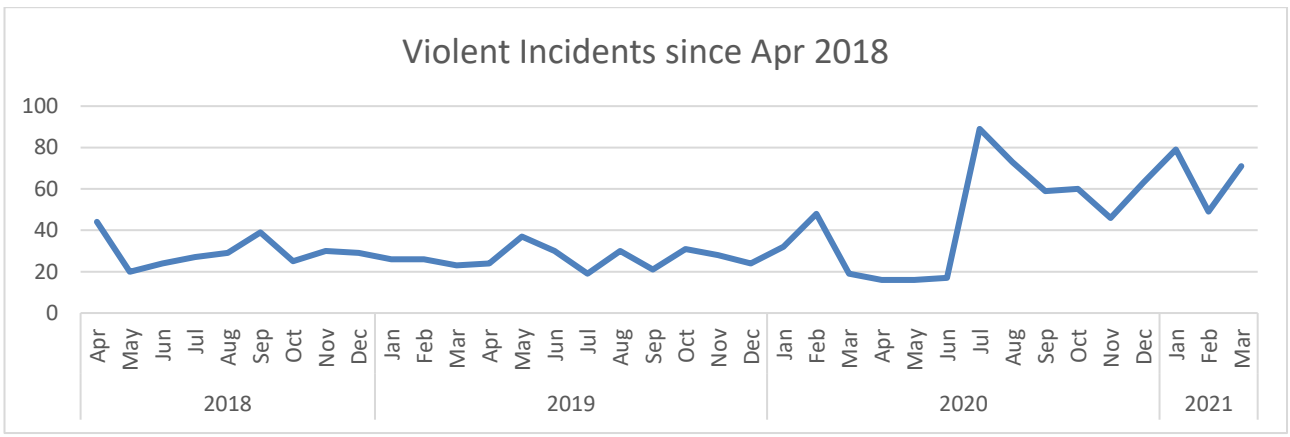
Overview of how we will do it
Utilise the Violent Incidents data held within the Trusts incidents reporting software (Datix).



Year Comparison

There has been a change in the reporting process within the Trust for 2020-21. These changes have allowed for increased reporting that were previously not being logged.

	Total Violent Incidents
2020-21	638
2019-20	343



	2020-21				
Adverse Event	Qtr1	Qtr2	Qtr3	Qtr4	Grand Total
Abuse - other		1		1	2
Assault etc with a weapon			1	4	5
Attempted suicide, whether proven or suspected		4	1		5
Concerns to do with personal safety	1	2	10	15	28
Disruptive, aggressive behaviour - other	10	55	44	52	161
Inappropriate behaviour and/or personal comments	2	9	8	11	30
Need for use of control and restraint with patient		17	6	7	30
Physical abuse, assault or violence - Malicious	5	16	6	3	30
Physical Abuse, assault or violence - unintentional	11	44	20	31	106
Racial	4	1	4	3	12
Self Harm			1		1
Sexual		2		1	3
Suicidal thoughts			1		1
Verbal abuse or disruption	16	70	67	71	224
Grand Total	**49**	**221**	**169**	**199**	**638**

*Data up to 31 March 2021

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

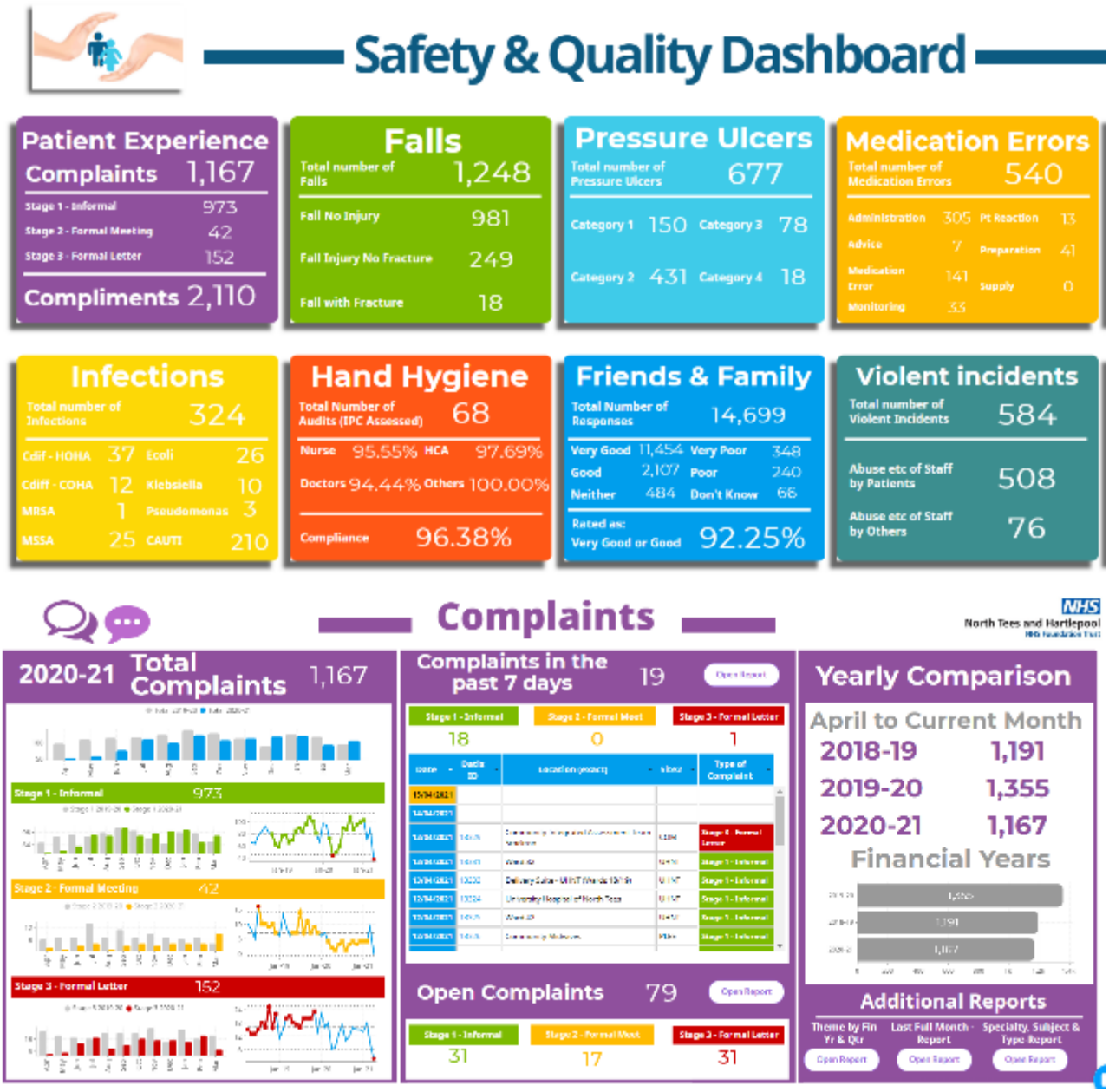
- Training will be completed and each department will evidence that their results have been disseminated and acted upon.
- Ward matrons will present their analysis on a public area of the ward for patients and staff to see. The results will be discussed and minutes taken.

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:

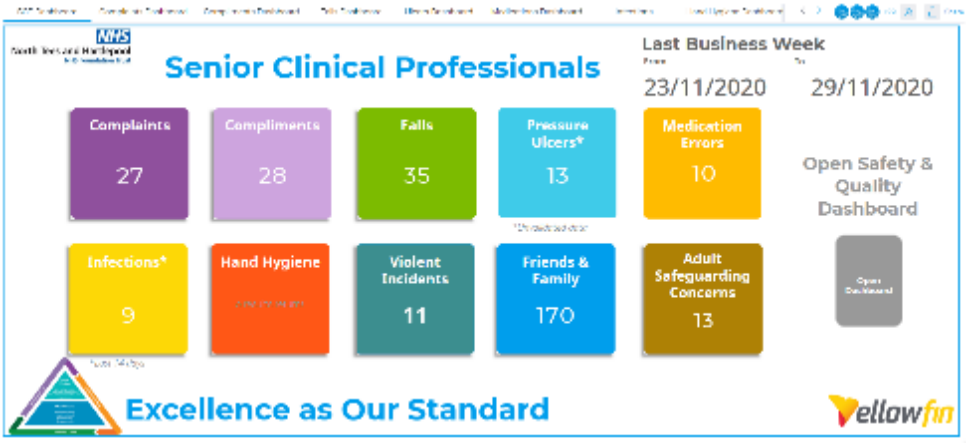
- Complaints, Stage 1 to 3
- Compliments
- Patient In-hopsital Falls
- Pressure Ulcers Grade 1 to 4
- Medication Errors
- Infection Control
- Hand Hygiene Audit
- Friends and Family Test
- Violent Incidents
- Adult Safeguarding

The following pictures are a visual dispay of how the Dashboards look.



Senior Clinical Professionals Weekly Huddle

The Trust also utlilises the Safety & Quality data on a weekly basis within the Senior Clinical Professionals (SCP) huddle. The huddle is a quick 20 minutes giving assurance of the previous weeks data is



Priority 3: Patient Experience

Palliative Care and Care For the Dying Patient

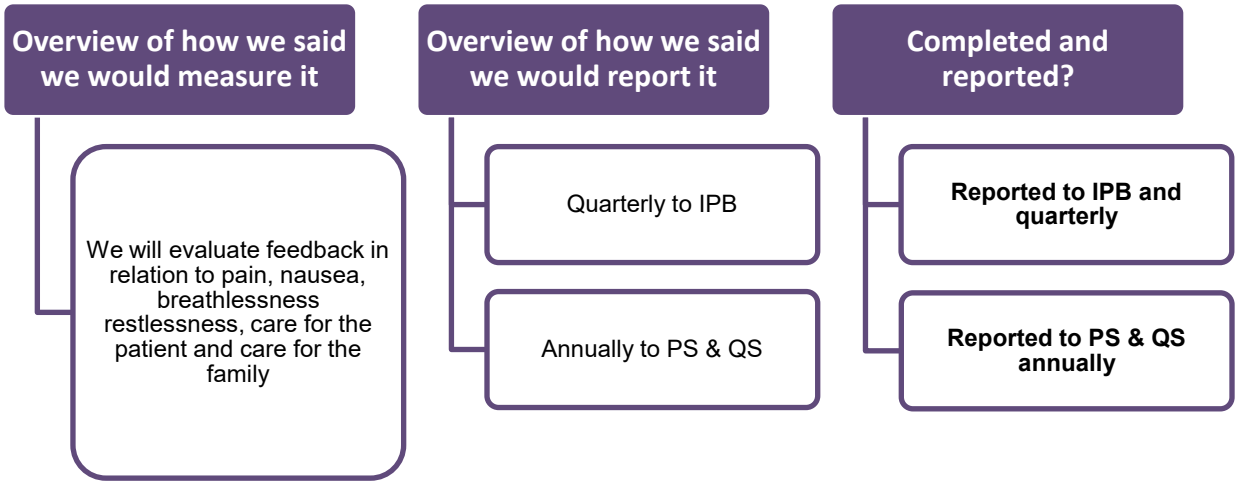
Rationale: The Trust used the Care For the Dying Patient (CFDP) and Family's Voice. Stakeholders and the Trust believe that this needs to remain a priority in 2019-20 both in hospital and in the community.

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



"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]

"End of life Pathway explained fully and sympathetically." [sic]

Specialist Palliative Care

The Trust instigated a number of changes to the palliative care process and team during **2020-21**, to improve patient experience, quality of care given and more accurate data collection.

The number of patients seen by the Specialist Palliative Care Team was **1,492** in 2020-21. There has been a big increase in referrals due to covid as well as the Trust moving to a 7 day service.

2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
1,040	1,436	1,108	1,072	**1,102**	**1,492**

*Data obtained from the Information Department

Band 5 & Band 3 Development

Throughout the last 12 months, we introduced the opportunity for band 3 and band 5 staff to join the Specialist Level Palliative Care Team to develop skills and knowledge to enhance their work in core teams. These development options have supported the enhanced delivery of Core Level Palliative Care (CLPC) and Specialist Level Palliative Care (SLPC) being delivered across the organisation and beyond. They provided some additional resilience as we introduced the 7-day provision of Specialist Level Palliative Care, implemented in response to the Covid-19 pandemic. Feedback has been excellent, with some staff developing and being recruited into substantive posts within Specialist Level Palliative Care and others returning to their areas and developing quality improvements.

7 Day Specialist Level Clinical Support

In response to the Covid-19 pandemic, Specialist Palliative Care were asked to be available to provide specialist clinical advice for clinical teams across the Trust and beyond to support patients and their families. This supported clinical teams across the North Tees & Hartlepool area, both in and out of hospital, to plan, deliver and support care for palliative patients in a safe, effective and timely manner. This specialist expertise has supported clinicians to care for patients with increasing complexity, and has been so well used and received, we have adopted it as core business for the organisation, enabling 24/7 specialist advice and support being available, from either Clinical Nurse Specialist or Consultant, supporting complex management and decision making across the locality.

End of Life Care Steering Group

The Trust continues to focus its strategic development of palliative and end of life care, through the ongoing work and development of the End of Life Steering Group. The group has continued to meet, plan and develop throughout the pandemic and are currently looking to focus some key work around Oasis Suites and formulating the Trust strategy for the coming 5 years.

Specialist Nurse Co-ordinator

With some staff having to shield during the pandemic, development of a Specialist Nurse Co-ordinator role rapidly proved a success. The aim was to offer a coordinated and responsive service, which supports patient care, enabling rapid response, by a thorough triage process which in turn provides a prompt contact point with a Clinical Nurse Specialist. With the provision of a dedicated triage nurse giving immediate access to specialist advice, prompting self-management and potentially preventing unnecessary GP reviews and admissions.

Over the past months the Covid pandemic has created a rapid and unprecedented shift in the way the Specialist Level Palliative Care Team have work. Clinicians have had to shift their visits from face to face and manage more reviews by either telephone or through video links. This posed the question 'how do we actively triage the most urgent visits while keeping vulnerable patients safe from the pandemic'. The centralised co-ordination and clinical advice and support afforded by this has released time to be responsive to clinical needs, signposting or referring to appropriate services across the Trust and beyond and promoting greater collaborative working ensuring the patients have the right person delivering their care at the right time.

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.

Staff support Creative writing research project – Covid19

The North Tees and Hartlepool Foundation Trust and The Open University joined forces on the Covid-19-Creative Writing with Health Care Workers Research Project to establish whether creative writing practice could reduce stress. This work was funded by the Open University rapid response Covid research funding scheme (see http://www.open.ac.uk/research/news/ou-funds-creative-writing-research-covid-19-frontline-healthcare-workers)
The project devised and facilitated eight workshops over three months, and this work developed a Creative Writing handbook for Health Care workers now set to be used in other Trusts. Facilitated by Dr Siobhan Campbell (OU), poet and social literary practitioner, with Mel McEvoy (Nurse Consultant in Cancer and Palliative Care) and Dr Donna Wakefield (Consultant in Palliative Medicine). Siobhan was Principal Investigator on a project in the use of creative writing in End of Life Care with Royal Trinity Hospice. Co-author of The Expressive Life Writing Handbook, her work in adapting writing pedagogies in communities led to projects with patients and clinicians as well as military veterans and rights activists. Mel worked on wards during Covid-19 and in providing psycho-social support to fellow staff. He is author of Listening to the family's voice: to improve symptom control and communication (2018), a project which used diaries as a method of supporting expression.
In questionnaires, all of the workshop participants noted that the workshops 'helped me to feel good about myself' and that the Creative Writing exercises 'helped me to express myself'. In an adapted Warwick-Edinburgh scale of psycho-social well-being, participants reported reductions in stress, and increased ability to cope. Participants were doctors, nurses, physiotherapists, occupational therapists and pharmacists who delivered care in C19. The writing shared powerful moments of personal experience:

Unwritten letter to my nan: Hi nan, it's been a while and we miss you. The world has gone a bit mad. I'd love you to still be around but you wouldn't like it here any more. No visitors, no hugs, no bingo -

hopefully one day these things will be here again. I'd hate you to be lonely again. It's not the world you came into or left, or where I'd want you to be.

And:
I only cry at night. That's when I allow myself to cry. So I can function in the day.
The workshops led to a Trust-wide writing competition, 'Working in a time of Covid-19', with winners announced at a reading showcase on April 14th 2021.The competition was judged by Siobhan Campbell, and novelist/academic Dr Jo Reardon. Winner Maria Nawaz' entry is 'This time too, shall pass'. Second place: Dr Louis Ttofa-Roberts with 'One More Day' and third: 'What lies beyond?' by Jane Easterby (Hospital Chaplain). Four entries received Highly Commended awards: '40 Steps to Freedom' by Tracy Foreman, 'A letter from the heart' by Karen Bradley, 'Ward 24' by Sophie Waterfield and Kate Campbell and 'For Staff' by Maria Lawson (Ward Matron).

The Family Voice Diary

The Family Voice Diary continues to be used in the Trust, where it was created by Mel McEvoy, Nurse Consultant in Palliative Care. It continues to support families and carers to be integral to the patients care and experience, enabling them to be key to the effective end of life care of their loved one. The diary has been highlighted as best practice nationally, with the diary being used by a number of organisations across the country.

End of Life Care Steering Group

In recognition of the priority palliative & end of life care issues often pose, it was recognised that to encourage greater collaboration around developments across the organisation, whilst acknowledging national and regional guidance and recommendations, the trust has developed an End of Life Steering Group, which will enable greater co-ordination of strategy, developments and quality assurance. This group reports to the executive care group and feeds into the locality group on progress, challenges and opportunities.

NHSE / I work

We have continued to support work at national level, with John Sheridan, Macmillan Lead Nurse for Palliative & End of Life Care supporting as a Clinical Advisor to the NHS England & Improvement End of Life Lead Nurse. This work is ongoing and will highlight the trust commitment to palliative and end of life care strategy and work plan development, as part of a team of supporting organisations nationally.

Care For the Dying Patient (CFDP)

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

Between April 2020 and March 2021, the Trust has had returned **19** diaries, currently the average score has decreased to **20.40** from the previous average of 20.51.

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:

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Number of Patients	167	171	147	134	139	**19**
Average Daily Score (Max 24.00)	20.80	20.40	20.60	20.51	20.11	**20.40**

*Data obtained from the Trusts Family's Voice database

Quotes from family members/carers for the dying patient

"Nurses were amazing and so kind, helpful and compassionate."

"Moved to ward 26 and staff are caring to both my mam and her family."

"Not sufficient staff on duty to be available when needed." [sic]

"I feel the care and support received from NTH Staff has been absolutly brilliant." [sic]

Spiritual and emotional 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:

The Trust has routinely referred patients on the end of life care pathway to the chaplaincy team. During 2020-21,**334** 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. **1** patient declined support during the reporting year. **176** 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.

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

	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Referrals	424	437	401	359	302	400	**334**
Received more than 1 visit	272	274	298	244	198	225	**176**
Declined Support	1	3	4	2	6	8	**1**

*data from the Trusts chaplain service (April 2020 to March 2021)

"Dad passed away peacefully this morning. Chaplain has been and given great comfort. Staff here were so kind and caring and supportive and we can not say thank 'You' enough to them. It is a comfort to us to know they were making him comfortable at the end of his journey.]"

"Mam slipping away. The chaplain said a prayer for her everyone has been kind and caring. .sic]"

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.

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

"The kindness and compassion and professionalism shown was second to none. Well done NHS. .sic]"

"Everything that was given the job of getting me better was so professional, as well as caring and understanding, and so genuine. [sic]"

"Poor care , lack of communication between staff on ward , other agency and family. [sic]"

Patient Experience Surveys

Below are a list of the national surveys that the Trust have started between April 2020 and March 2021. The 'current response rate' column shows the number of patients who have responded and the response rate. Please note that both the national maternity and the national cancer patient experience surveys were cancelled in 2020 because of the Covid 19 Pandemic. As well as this, the national patient survey programme was paused by a number of months until the autumn 2020.

National Surveys

Survey	Time frame for publication published	Current response rate
CQC National Inpatient Survey 2020	Autumn 2021	344 responses (29%) *
CQC National Emergency Survey 2020	Summer 2021	Type 1 – 261 responses (29%) Type 3 – 99 responses (24%)
CQC National Children and Young People's Survey 2020	Late autumn 2021	Fieldwork not commenced

*Please note that the CQC National Inpatient Survey 2020 has adopted a mixed methodology mode using a mixture of inviting patients to complete an electronic survey via a letter, followed by a SMS text. For those who do not complete an online survey a postal questionnaire is sent to the patient.

Local Surveys

Survey	Survey results compiled	Number of Patients Surveyed
Endoscopy Patient Survey 2020	June 2020	180 (38%)
Upper GI Cancer Survey 2020	September 2020	15 (38%)
Bereavement Survey 2020-21	March 2021	198 surveys
Family Health Counselling Survey	March 2021	33 surveys
Maternity survey 2020	March 2021	37 surveys

National Surveys

We take part in the national survey programme. This is a mandatory Care Quality Commission (CQC) requirement for all acute NHS trusts. Each question is nationally benchmarked so we can understand how we scored when compared with other trusts. The coloured bars below show how the trust scored. The calculation of expected range takes into account the number of respondents from each trust, as well as the scores for all other trusts, and allows us to identify which scores we can confidently say are "better" or "worse" than the majority of other trusts.

Better than other trusts	Scored about the same as other trusts	Scored worse than other trusts

Indicate where a question scored significantly better or worse than the previous year's score.

The Trust randomly selected adult inpatients discharged during July 2019. We had a 42% response rate with 493 surveys completed and results were published in the Summer 2020. ***All Scores out of 10***

Where we could do better	2018	2019
How would you rate the hospital food?	5.6	4.5 ↓
Were you involved as much as you wanted to be in decisions about your care and treatment?	7.1	6.6 ↓
If you needed attention, were you able to get a member of staff to help you within a reasonable time?	7.3	7.0

Areas of good practice	2018	2019
Were you given enough privacy when being examined or treated in the A&E Department?	8.9	9.0
Was your admission date changed by the hospital?	9.2	9.5
In your opinion, had the specialist you saw in hospital been given all of the necessary information a	8.5	9.1

When you had important questions to ask a doctor, did you get answers that you could understand?	**7.9**	**8.0**
When you had important questions to ask a nurse, did you get answers that you could understand?	**7.8**	**8.2**
Did you have confidence and trust in the nurses treating you?	**8.7**	**8.8**
Did nurses talk in front of you as if you weren't there?	**8.9**	**9.0**
Areas of good practice	**2018**	**2019**
How much information about your condition or treatment was given to you?	**8.4**	**8.6**
After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?	**7.8**	**8.4**
Did hospital staff discuss with you whether you would need any additional equipment in your home, or any adaptions made to your home, after leaving hospital?	**7.9**	**8.2**

"Doctors and nurses very helpful. Ward was clean and tidy. I was made to feel safe and looked after"

"I thought that all the medical and support staff in the A&E department, the CCU and the operating department (fitting of an ICD) were extremely professional, helpful and attentive. I was very impressed and am grateful to them"."

"Hardworking, very caring. They looked after me 100%"

"All staff were lovely and did their jobs well. Went above and beyond to make my stay as good as possible".

Action plans

When survey reports are published or locally compiled, the results are feedback to the clinical team via: senior clinical practitioner meetings, directorate and ward meetings, strategy groups, external committees where patient representatives are present such as the Cancer Patient and Carer group and the Patient and Carer Experience Committee. Results are also feedback via clinical governance and education sessions.

Action plans are developed after feedback, review and reflection. These include:

To improve:	Change ideas
Food quality	• Daily and monthly audits carried out by catering team leaders to check on quality. On average 78% of patients say that quality of food is either very good or good. The Essential Nutrition Group will receive updates from catering and will work in tandem with them to support quality, choice and service.
Food service	• All wards now have a ward hostess to help support the meal service.
Food temperature	• Temperature checks daily as meals leave the kitchen, arrive on the ward and final probe when the last ward bay is served.
Food choice	• The choice of menu has increased ensuring better variety of cultural menu, allergen and gluten free meals as well as a wider vegan choice.
Involvement in decisions	• Shared with clinical teams at management meetings, Clinical Governance sessions, Senior Nursing Meetings and at ward huddles.
Attentiveness of staff	• Shared with clinical teams at management meetings, Clinical Governance sessions, Senior Nursing Meetings and at ward huddles.

"The knowledge and experience of the staff. The professionalism of all the staff. The training give to the student nurses was very professional".

"Congratulations to every single member of staff within the trust. The care delivered and the environment could not have been better or cleaner".

Priority 3: Effectiveness of Care

Friends and Family Test

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 2020-21 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	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**

> “The district nurses who visit daily are excellent and very professional and caring in their care” [sic]

> “wouldn't want to recommend a hospital stay. if I had to id say not bad . nice staff.” [sic]

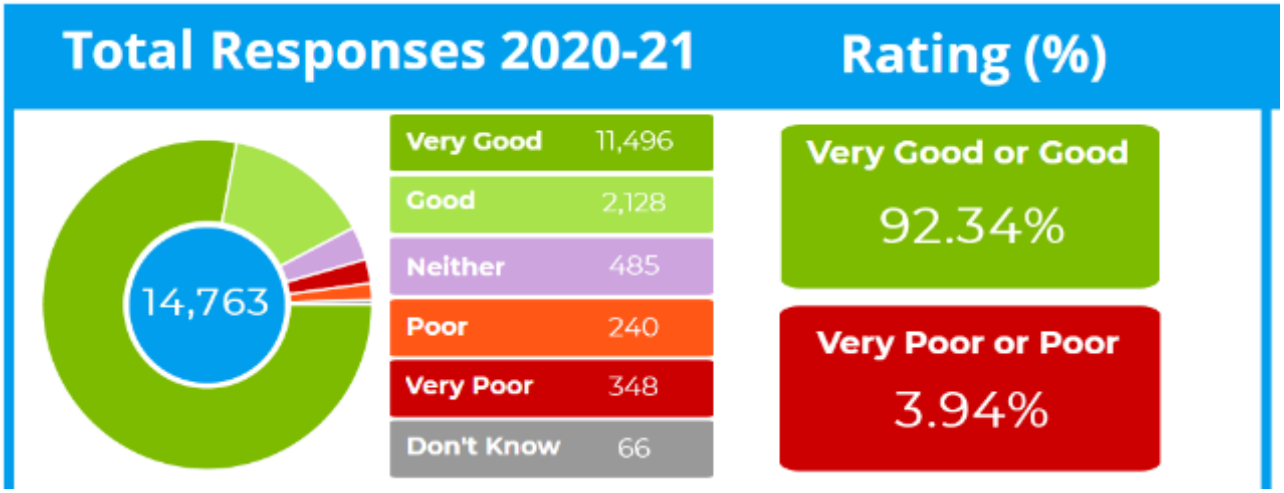
The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.

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 2020 to 31 March 2021

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.



Total Responses	Month												
FFT Response	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Total
Very Good	644	753	980	1,172	1,113	1,179	1,016	1,097	933	541	884	1,184	11,496
Good	90	142	171	271	191	237	191	187	163	90	159	236	2,128
Neither Good nor Poor	25	24	42	49	60	48	50	52	37	17	31	50	485
Poor	7	14	18	27	25	35	29	16	24	5	16	24	240
Very Poor	14	22	39	39	36	36	41	29	28	9	24	31	348
Don't know	6	1	9	10	2	13	3	9	5	1	3	4	66
Total	786	956	1,259	1,568	1,427	1,548	1,330	1,390	1,190	663	1,117	1,529	14,763

*Data from Trusts Friends and Family database and Inhealthcare

"Always extremely helpful very efficient even though overloaded with patients." [ ]

"Very friendly staff. Explained everything well. Made you feel at ease. Very clean and tidy." [ ]

"Seen quite quick by very professional staff with patients." [ ]

"Far too long to wait beyond appt time. We were about to leave [sic]

"I arrived 5 mins before my appointment at 11.40 and I wasnt seen until 2.10pm. No one informed me of the delay or spoke to me during my wait to inform me of how long the delay or an apology I would of made another appointment if I was aware as I had come out of work for my appointment." [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, the following data refers to the full 2020-21 financial year.

Breakdown of Responses – Care

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

Due to COVID-19 NHS Improvements suspended this data collection for April 2020. Therefore there is no data to report.

The Trust will be re-instating the data in some form from April 2021.

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'**.

Due to COVID-19 NHS Improvements suspended this data collection for April 2020. Therefore there is no data to report.

The Trust will be re-instating the data in some form from April 2021.

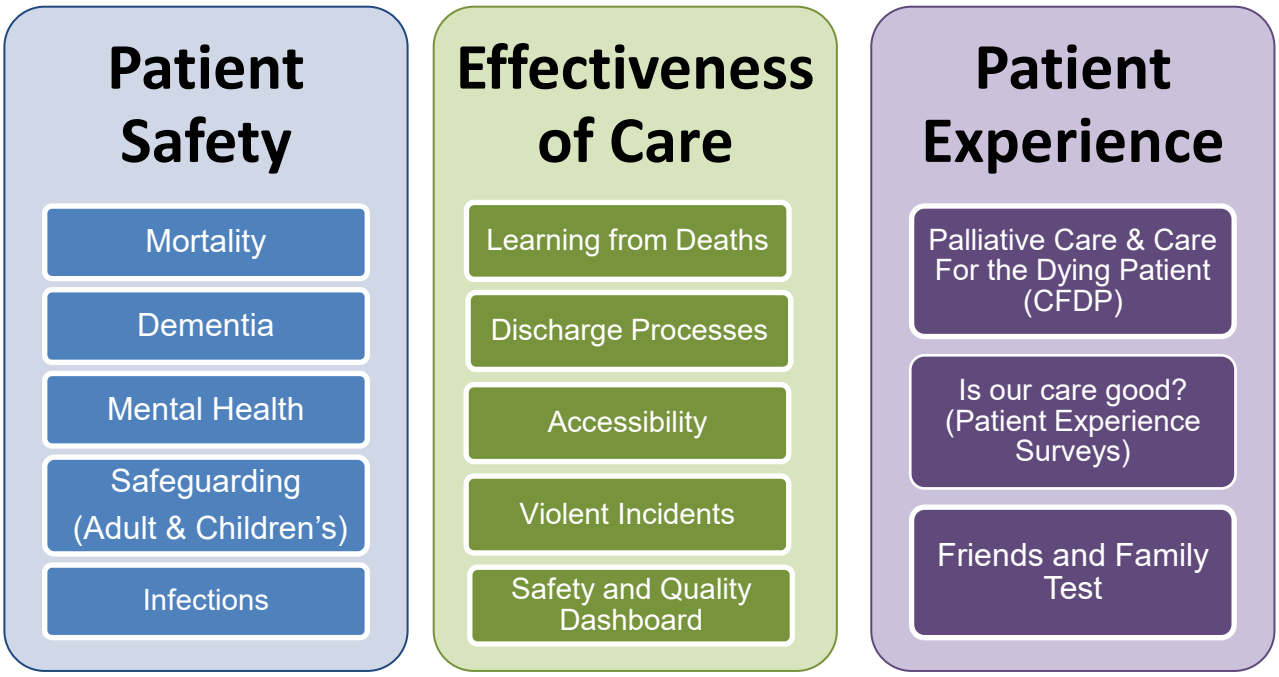
Part 2b: 2021-22 Quality Improvement Priorities

Introduction to 2021-22 Priorities

Due to COVID-19, the key priorities for improvement for 2021-22 have been rolled over from 2020-21. This has been discussed and agreed with governors, Healthwatch colleagues, commissioners, local health scrutiny committees, healthcare user group and the Board of Directors.

Stakeholder Priorities for 2021-22

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



Rationale for the selection of priorities for 2021-22

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 2021-22 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 Mortality 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

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 Information 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 undertake 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 Patient Safety and & 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 Chief Nurse/Director of 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 2020-21 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 – 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

Priority 7 – Discharge Processes

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

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 – Accessibility

The trust is committed to ensuring that the Accessible information standard is met and all of the services we provide are able to make reasonable adjustments for those in need as required.

Aim

The aim is to develop a culture which learns from service user/stakeholder feedback. To provide a forum for service users/stakeholders to participate in accessibility projects and groups

to ensure that their voices can be heard and that their views make a difference to the work in the trust. To ensure organisational compliance with accessibility standards, action plan on feedback received from service users and key stakeholders regarding accessibility in the trust and to receive expert guidance from external stakeholders.

Overview of how we will do it

The trust has set up an Accessibility group which includes representatives from stakeholder organisations, patient experience, dementia and learning disability specialist nurses, senior clinical staff, learning and development, estates, and governance.

An e-learning package to increase awareness of people with sensory loss developed by a stakeholder has been provided to the trust and adopted into the trust's dementia training. The trust is continuing to work closely with the stakeholder to promote the training within the trust.

A training package has been developed by a stakeholder organisation who have provided access for the trust with training for dual sensory impairment.

Overview of how we will measure it

Monitoring and evaluation of complaint themes, any complaints relating to accessibility are reviewed by the trust Governance and Experience Manager and are highlighted and discussed at the Accessibility Group. Numbers of staff who have completed the training package are available for the trust to evaluate the percentage who are trained.

Stakeholders for organisations representing those with additional requirements will feed back to the group any areas which their service users have highlighted to them.

Overview how we will monitor it

Analysis of complaints trends to the Chief Nurse/Director of Patient Safety and Quality.

Overview of how we will report it

Accessibility Group
Patient and Carers Committee

Priority 9 – Violent Incidents

With the ever increasing number of violent incidents occurring to members of staff from patients and other persons, the Trust will monitor the numbers of violent incidents that are occurring across which areas.

Overview of how we will do it
Utilise the Violent Incidents data held within the Trusts incidents reporting software (Datix).

Overview of how we will measure it
The Safety& Quality dashboard will be used during the weekly Senior Clinical Professionals huddles with the wards/areas.

Overview how we will monitor it
Data presented on the Safety & Quality Dashboard daily
Weekly data presented from the dashboard to the Senior Clinical Professionals Huddles

Overview of how we will report it
Data presented on the Safety & Quality Dashboard daily
Weekly data presented from the dashboard to the Senior Clinical Professionals Huddles

Priority 10 – Safety and Quality Dashboard – Business Intelligence

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 Chief Nurse/Director of 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

Patient Experience

Priority 9 – 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 2020-21.

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 10 – 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

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, Urgent Care 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.

Part 2c: Statements of Assurance from the Board

Review of Services

During 2020-21 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 2020-21 represents **100%** of the total income generated from the provision of relevant health services by the North Tees and Hartlepool NHS Foundation Trust for 2020-21.

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 2020-21 and this can be found on the following link:

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

During 2020-21, **44** national clinical audits and **3** national confidential enquiries covered the relevant health services that North Tees and Hartlepool NHS Foundation Trust provides.

During 2020-21, North Tees and Hartlepool NHS Foundation Trust participated in **82%** 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 2020-21 are as follows:

Mandatory National Clinical Audits	
Project name	**Provider organisation**
BAUS Urology Audit: Radical Nephrectomy	British Association of Urological Surgeons (BAUS)
BAUS Urology Audit: Renal Colic	British Association of Urological Surgeons (BAUS)
British Spine Registry	Amplitude Clinical Services Ltd
Case Mix Programme (CMP)	Intensive Care National Audit & Research Centre (ICNARC)
Elective Surgery (National PROMs Programme)	NHS Digital
Emergency Medicine QIP: Fractured Neck of Femur	Royal College of Emergency Medicine
Emergency Medicine QIP: Pain in Children	Royal College of Emergency Medicine
Emergency Medicine QIP: Infection Control	Royal College of Emergency Medicine
Falls and Fragility Fracture Audit Programme (FFFAP)	Royal College of Physicians (RCP)
Inflammatory Bowel Disease (IBD) Audit	IBD Registry

Learning Disabilities Mortality Review Programme (LeDeR)	University of Bristol / Norah Fry Centre for Disability Studies
Mandatory Surveillance of HCAI	Public Health England
Maternal and Newborn Infant Clinical Outcome Review Programme	University of Oxford / MBRRACE-UK collaborative
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Adult COPD Audit	Royal College of Physicians (RCP)
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Adult Asthma Audit	Royal College of Physicians (RCP)
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Adult Pulmonary Rehabilitation Audit	Royal College of Physicians (RCP)
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Paediatric Asthma Audit	Royal College of Physicians (RCP)
National Audit of Breast Cancer in Older Patients (NABCOP)	Royal College of Surgeons (RCS)
National Audit of Cardiac Rehabilitation	University of York
National Audit of Care at the End of Life (NACEL)	NHS Benchmarking Network
National Audit of Dementia (NAD)	Royal College of Psychiatrists (RCPsych)
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Royal College of Paediatrics and Child Health (RCPCH)
National Bariatric Surgery Register	British Obesity and Metabolic Surgery Society
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre (ICNARC) / Resuscitation Council UK
National Cardiac Audit Programme (NCAP): Myocardial Ischaemia National Audit Project (MINAP)	Barts Health NHS Trust / National Institute for Cardiovascular Outcomes Research (NICOR)
National Cardiac Audit Programme (NCAP): Heart Failure Audit	Barts Health NHS Trust / National Institute for Cardiovascular Outcomes Research (NICOR)
National Diabetes Audit – Adults	NHS Digital
National Early Inflammatory Arthritis Audit (NEIAA)	British Society of Rheumatology (BSR)
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists (RCoA)
National Gastro-intestinal Cancer Programme	NHS Digital
National Joint Registry	Healthcare Quality improvement Partnership
National Lung Cancer Audit (NLCA)	Royal College of Physicians (RCP)
National Maternity and Perinatal Audit	Royal College of Obstetrics and Gynaecology (RCOG)
National Neonatal Audit Programme (NNAP)	Royal College of Paediatrics and Child Health (RCPCH)
National Paediatric Diabetes Audit (NPDA)	Royal College of Paediatrics and Child Health (RCPCH)
National Prostate Cancer Audit (NPCA)	Royal College of Surgeons (RCS)
Perioperative Quality Improvement Programme (PQIP)	Royal College of Anaesthetists

Sentinel Stroke National Audit Programme (SSNAP)	King's College London (KCL)
Serious Hazards of Transfusion Scheme (SHOT)	Serious Hazards of Transfusion (SHOT)
Society for Acute Medicine Benchmarking Audit	Society for Acute Medicine
Surgical Site Infection Surveillance	Public Health England
The Trauma Audit & Research Network (TARN)	The Trauma Audit & Research Network (TARN)
UK Registry of Endocrine and Thyroid Surgery	British Association of Endocrine and Thyroid Surgery (BAETS)

National Confidential Enquiries (NCEPOD)
Out of Hospital Cardiac Arrest Study
Dysphagia in Parkinson's Disease Study
Physical Health in Mental Health Hospitals Study

The national clinical audits and national confidential enquiries that North Tees and Hartlepool NHS Foundation Trust participated in during 2020-21 are as follows:

Mandatory National Clinical Audits	
Project name	**Provider organisation**
British Spine Registry	Amplitude Clinical Services Ltd
Case Mix Programme (CMP)	Intensive Care National Audit & Research Centre (ICNARC)
Elective Surgery (National PROMs Programme)	NHS Digital
Emergency Medicine QIP: Fractured Neck of Femur	Royal College of Emergency Medicine
Emergency Medicine QIP: Pain in Children	Royal College of Emergency Medicine
Emergency Medicine QIP: Infection Control	Royal College of Emergency Medicine
Falls and Fragility Fracture Audit Programme (FFFAP)	Royal College of Physicians (RCP)
Learning Disabilities Mortality Review Programme (LeDeR)	University of Bristol / Norah Fry Centre for Disability Studies
Mandatory Surveillance of HCAI	Public Health England
Maternal and Newborn Infant Clinical Outcome Review Programme	University of Oxford / MBRRACE-UK collaborative
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Adult COPD Audit	Royal College of Physicians (RCP)
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Adult Asthma Audit	Royal College of Physicians (RCP)
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Adult Pulmonary Rehabilitation Audit	Royal College of Physicians (RCP)
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit	Royal College of Physicians (RCP)

Programme (NACAP): Paediatric Asthma Audit	
National Audit of Breast Cancer in Older Patients (NABCOP)	Royal College of Surgeons (RCS)
National Audit of Cardiac Rehabilitation	University of York
National Audit of Care at the End of Life (NACEL)	NHS Benchmarking Network
National Audit of Dementia (NAD)	Royal College of Psychiatrists (RCPsych)
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Royal College of Paediatrics and Child Health (RCPCH)
National Bariatric Surgery Register	British Obesity and Metabolic Surgery Society
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre (ICNARC) / Resuscitation Council UK
National Cardiac Audit Programme (NCAP): Myocardial Ischaemia National Audit Project (MINAP)	Barts Health NHS Trust / National Institute for Cardiovascular Outcomes Research (NICOR)
National Cardiac Audit Programme (NCAP): Heart Failure Audit	Barts Health NHS Trust / National Institute for Cardiovascular Outcomes Research (NICOR)
National Diabetes Audit – Adults	NHS Digital
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists (RCoA)
National Gastro-intestinal Cancer Programme	NHS Digital
National Joint Registry	Healthcare Quality improvement Partnership
National Lung Cancer Audit (NLCA)	Royal College of Physicians (RCP)
National Maternity and Perinatal Audit	Royal College of Obstetrics and Gynaecology (RCOG)
National Neonatal Audit Programme (NNAP)	Royal College of Paediatrics and Child Health (RCPCH)
National Paediatric Diabetes Audit (NPDA)	Royal College of Paediatrics and Child Health (RCPCH)
National Prostate Cancer Audit (NPCA)	Royal College of Surgeons (RCS)
Sentinel Stroke National Audit Programme (SSNAP)	King's College London (KCL)
Serious Hazards of Transfusion Scheme (SHOT)	Serious Hazards of Transfusion (SHOT)
Surgical Site Infection Surveillance	Public Health England
The Trauma Audit & Research Network (TARN)	The Trauma Audit & Research Network (TARN)

National Confidential Enquiries (NCEPOD)
Out of Hospital Cardiac Arrest Study
Dysphagia in Parkinson's Disease Study
Physical Health in Mental Health Hospitals 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 2019-20, 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
British Spine Registry	Yes	100%
Case Mix Programme (CMP)	Yes	100%
Elective Surgery (National PROMs Programme)	Yes	100%
Emergency Medicine QIP: Fractured Neck of Femur	Yes	100%
Emergency Medicine QIP: Pain in Children	Yes	100%
Emergency Medicine QIP: Infection Control	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP)	Yes	100%
Learning Disabilities Mortality Review Programme (LeDeR)	Yes	100%
Mandatory Surveillance of HCAI	Yes	100%
Maternal and Newborn Infant Clinical Outcome Review Programme	Yes	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Adult COPD Audit	Yes	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Adult Asthma Audit	Yes	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Adult Pulmonary Rehabilitation Audit	Yes	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Paediatric Asthma Audit	Yes	100%
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	100%
National Audit of Cardiac Rehabilitation	Yes	100%
National Audit of Care at the End of Life (NACEL)	Yes	100%
National Audit of Dementia (NAD)	Yes	100%
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Yes	100%
National Bariatric Surgery Register	Yes	100%
National Cardiac Arrest Audit (NCAA)	Yes	100%

National Cardiac Audit Programme (NCAP): Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%
National Cardiac Audit Programme (NCAP): Heart Failure Audit	Yes	100%
National Diabetes Audit – Adults	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	100%
National Gastro-intestinal Cancer Programme	Yes	100%
National Joint Registry	Yes	100%
National Lung Cancer Audit (NLCA)	Yes	100%
National Maternity and Perinatal Audit	Yes	100%
National Neonatal Audit Programme (NNAP)	Yes	100%
National Paediatric Diabetes Audit (NPDA)	Yes	100%
National Prostate Cancer Audit (NPCA)	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Serious Hazards of Transfusion Scheme (SHOT)	Yes	100%
Surgical Site Infection Surveillance	Yes	100%
The Trauma Audit & Research Network (TARN)	Yes	100%

National Clinical Audits

The reports of **29** national clinical audits were reviewed by the provider in 2020-21 and North Tees and Hartlepool NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Audit title	Actions taken/in progress
National Neonatal Audit Programme: Very good results reported, favourable with national averages.	
National Hip Fracture Database: Best Practice Tariff achieved in 72% cases.	A review of the cases that did not meet the target has been undertaken and a working group established to identify improvements required.
Patient Reported Outcome Measures: Local improvements were evident, resulting in the trust being within the expected tolerance levels for both hip and knee replacements. We are amongst the better trusts in terms of completeness of the audit data.	
National Lung Cancer Audit: Overall, results were very good across the entire patient pathway.	

National Audit of Care at End of Life:	Promoting improved use of the Care of the Dying document and further rollout of the Amber Care Bundle.
National Fracture Liaison Service audit: Performance above the national average.	
National Parkinson's Disease Audit: Overall, clinical results were good.	The trust does not have a Parkinson's Disease Specialist Nurse, or dedicated Physiotherapy sessions. To be actioned.
NCEPOD Acute Bowel Obstruction:	Actions being taken to improve speed of CT scanning on admission, education re suspecting bowel obstruction on presentation and documentation of pre-operative risk scores.
National Major Haemorrhage Audit:	Tranexamic acid needs to be incorporated into local protocol.
National Prostate Cancer Audit: Results very good, and compared favourably with national averages.	
National Emergency Laparotomy Audit: Improvements made in achieving Best Practice Tariff. The trust scores highly in terms of data completeness.	A local MDT has been established.
National Oesophago-Gastric Cancer audit: Good results in reducing rate of emergency presentation.	Improving the use of CT staging.
National Inpatient Falls Audit: Areas of good performance included: documentation of multi-factorial risk assessment, medication reviews and bedrail prescription.	
National Dementia Audit: Results were above the national average for assessments for continence, mobility, BMI, nutritional status and pressure ulcers. There was also evidence of positive feedback from carers. There are now 182 'Dementia Champions' in the Trust.	There was a decline in results from the previous cycle regarding information about the person with dementia but it was noted that the primary tool used to evidence this information is the 'All About Me document, which stays with the patient on discharge so would not be filed in the patients notes.

	There was an overall decrease in compliance relating to cognitive impairment being summarised and recorded as part of discharge process, a lot of work has been done to promote this.
National Audit of Breast Cancer in Older People 2019 & 2020 reports: The report showed that the trust is performing above the national average for most results and above the national average for data completeness. Majority of women are assigned a named breast clinical nurse specialist.	It was noted some patients opted for mastectomy rather than more conservative surgery when not high risk, which could be because some patients don't wish to risk re-excision or have radiotherapy. The clinical team will be taking forward some patient survey work in order to gain a better understanding into this issue. They have also been asked to undertake an audit of chemotherapy provision to ensure this is a consistent provision.
Learning Disabilities Mortality Review: Best practice identified that 56% of patients had received care that met or exceeded expectations compared with deaths reviewed in 2018 which was 46%. Overall good practice was shown in Palliative Care and a good understanding and application of the MCA especially around DoLs.	Areas requiring improvement included the DNACPR and the process of LeDeR requests. Plan for the year ahead is to keep engaging with regional groups. Completing reviews as they are coming into the team, including COVID deaths and sharing learning from LeDeR Trust wide.
Sentinel Stroke National Audit Programme: Previously, there had been significant shortfall in intervention from Occupational Therapy, Physiotherapy and Speech & Language Therapy.	It was pleasing to report measurable improvement in all these areas, however it was noted that additional resource had been given in order to achieve this, and that this would need to remain in order to sustain current levels of performance.
NACAP National COPD Audit report: The majority of performance indicators were comparable to national average.	Areas that fell short included: availability of spirometry and access to smoking cessation services. The ACE Committee is awaiting presentation of the National Smoking Cessation Audit report in order to seek assurance of access to smoking cessation.
National Paediatric Diabetes Audit 2018/19 report: The trust performed excellent in completion of all seven health checks (HbA1c, BMI,	Areas requiring local improvement included: the need to reduce median HbA1c, ensure ethnicity is recorded for

Thyroid function, BP, Albuminuria, Eye screening and Foot examination) and was a positive outlier for the proportion of patients receiving all seven.	all patients, and improve outcomes for patients on insulin pumps.
NCEPOD Chronic Neurodisability Action Plan Update: A project assurance framework has been adopted in order to monitor progress against all recommendations over time. There are fortnightly update meetings held with the clinical lead in order to ensure timely progress.	A number of achievements have been made to date, including: development of a cerebral palsy admission document, virtual poster on SharePoint, development of a neurodisability clinical pathway, utilisation of a pain scoring tool and plan for implementing SystmOne within Community Paediatrics.
NACAP Pulmonary Rehabilitation National Audit Report: There are significantly more referrals within the Teesside area than any other. It has significant COPD density, hospital admissions and significant morbidity and mortality.	The waiting list for pulmonary rehab during the COVID pandemic has increased and the team are exploring ways of dealing with the volume of patients waiting. Home based and virtual rehab are being looked into as the currently feasible models. The team will provide telephone assessments and use the British Lung Foundation paper-based rehab where possible. Group-based sessions are being looked into and risk assessed for next year, depending on how much COVID is under control at the time.
Intensive Care National Audit & Research Centre Annual Report 2018/19: All results were good and well within the expected range, demonstrating excellent performance. One of the limitations for this audit was that the software has a defined set of diagnosis criteria which are occasionally restrictive and don't allow for specific information.	Actions included maintaining the accuracy of data entry and to maintain a robust and transparent mortality review process.
National Audit of Dementia: Psychotropic drugs spotlight audit: • 100% of new prescriptions had reasons for the prescriptions recorded. • 100% of new prescriptions during the admission were reviewed at discharge. • 100% of new prescriptions and 97% of prescriptions continued on admission had target symptoms recorded (compared with 57% nationally). Overall results were excellent, with no areas shown to be requiring improvement.	

NACAP Adult Asthma Audit: Respiratory review within 24 hours had improved slightly and patients in receipt of inhaled steroids had also improved.	Improvement required for peak flow measurements and administration of steroids within 4 hours of arrival, possibly due to COVID – reasons to be investigated. There was also a decline in current smokers with tobacco dependency addressed. Clinical Lead agreed to work with Smoking Cessation team to improve this. Progress report scheduled to June 2021 ACE committee.
BTS Non Invasive Ventilation Audit: 84% of patients have escalation plans and 90% of NIV patients were reviewed by an NIV specialist.	Compulsory NIV SIM training for IM-SpRs & A&E SpRs to be implemented. NIV guidance to be reviewed and updated in light of the recent COVID experience. Paper-based observation chart to be replaced by electronic version.
National Diabetes Inpatient Audit: Results showed we have an excess of Type 2 diabetes on insulin. Majority of admissions come in as emergency cases, in line with national results. Trust identified as an outlier for the number of foot patients admitted compared to the national average.	Discussion to be undertaken around future resourcing of the service to ensure effectiveness. A re-audit of the diabetes foot data will be undertaken. Recording charts for insulin infusion will be reviewed and updated.
Public Health England Surgical Site Infection National Audit: Excellent performance – Trust Surgical Site Infection rates across all specialties are below the national average.	Increased use of the Surgical Site Infection Preventions Bundle will be promoted.
BTS Smoking Cessation Audit: Inadequate smoking cessation services in the Hartlepool community.	Action plan to be drafted by key Trust leads in order to raise concerns about lack of service in the Hartlepool area.
RCEM Care of Children Audit: Good results were shown in infants at high safeguarding risk seen by a senior clinician.	Regarding psychosocial screening in older children, it was noted that Mental Health notes were kept on a different system that cannot be accessed by the emergency department. An action plan had been drafted, which included development of an easy and robust way to identify the target group.

	A standard operating procedure will be written to outline what needs to be done and documented. A paediatric mental health adolescent group will be established. There will also be a review of HEADS-ED or another tool for use in the department followed by a pilot.

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.

National Confidential Enquiries (NCEPOD):

The Trust participated in all **3** national confidential enquiries (100%) that it was eligible to participate in, namely:

NCEPOD study	Participation	% cases submitted
Out of Hospital Cardiac Arrest Study	Yes	100%
Dysphagia in Parkinson's Disease Study	Yes	100%
Physical Health in Mental Health Hospitals Study	Yes	100%

Local Clinical Audits

The reports of **47** local clinical audits were reviewed by the provider in 2020-21 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
Falls Audit	Improved documentation noted. Mobility assessment to continue to be undertaken for all patients.
Risky Behaviours Audit	Screening for alcohol and tobacco use to continue. Staff encouraged to become 'Smokefree Champions.'
Scaphoid fracture referral audit	Patients with 'query scaphoid fracture' were treated appropriately but increased compliance with the referral guidelines required.
Enhanced Recovery Audit of Lower Limb Arthroplasty	Guidelines for the management of a deteriorating patient continue to be embedded within Elective care. Good communication with registrars at UHNT was evident in the healthcare records and will continue to be supported.
Regional Coeliac Disease Audit	Continued good practice required for referral to dietitian for dietary advice and initial recording of weight. Continued recording of dietary compliance needed.

Community Consent Audits - Hand & Wrist Surgery	Excellent compliance. Clinical staff to be reminded to avoid abbreviations and document their GMC number.
Small Bowel Obstruction Audit	Some delays in the pathway of care were identified and a specific acute bowel obstruction pathway to be used.
Decompensated Chronic Liver Disease	Good documentation of escalating status of patient. There is a need to increase referral to the Liver Disease Specialist Nurse where appropriate.
Diabetes inpatient foot assessment audit	The average time to get vascular team input to be monitored and improved. The average length of stay in hospital to be decreased with increased use of Outpatient Parenteral Antibiotic Therapy (OPAT) services where required.
Botulinum in Patients with Detrussor Overactivity	New procedure to the trust - good response to the treatment in 68.5% of patients. No complications seen in follow up.

NB: *Many of our clinical audits during 2020-21 were directly affected by the COVID-19 pandemic, therefore numbers of completed audits and their clinical outcomes are not directly comparable to previous years.*

Commissioning for quality and innovation (CQUIN)

A proportion of North Tees and Hartlepool NHS Foundation Trust income in 2020-21 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.

In 2020-21 our contract with our main commissioners has been an "Aligned Incentive Contract". This means that our level of income was set at the outset, reducing the risk and uncertainty faced by the Trust, in return for increased flexibility in delivering positive patient outcomes, both internally and as part of a wider "system". As part of this, full CQUIN attainment was assumed, but with continued, albeit light touch, review by the Commissioners of achievement.

The total figure for 2019-20 was **£3,230,000**. However for 2020-21 there was no CQUIN in line with national arrangements re COVID.

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 2020-21. 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 > < Mar-18	Good ^ Mar-18	Good > < Mar-18	Good > < Mar-18	Good ^ Mar-18	Good ^ Mar-18

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.

In 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 of Directors and also to the Trust's Commissioners.

Commissioners Assurance

There have been no visits due to Covid-19, CQRG has continued and regular Teams contacts.

Freedom to Speak Up (FTSU)

Background to the Freedom to Speak Up Guardian

The role of Freedom to Speak Up Guardians and the National Guardian were established in 2016 following the events at Mid-Staffordshire NHS Foundation Trust and recommendations from Sir Robert Francis' Freedom to Speak Up Inquiry.

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. Speaking up protects patient safety and improves the lives of workers. Freedom to Speak Up is about encouraging a positive culture where people feel they can speak up and their voices will be heard, and their suggestions acted upon.

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)
- 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
- 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:

- FTSUG provision reviewed and resource increased. Recruitment to commence.
- FTSU Champions continue to support staff and signpost as appropriate
- Awareness of FTSU at staff and volunteer inductions and training programmes
- Development of easy read versions of leaflets
- Review of policy to include monitoring requirements and report production

Between 1 April 2020 and 31 March 2021 there were 12 new cases commenced and eight carried forward from 2019-20. During the year 14 cases were resolved and six will carry forward into 20121-22.

Themes from the 12 new cases are:

- Bullying and harassment including disclosures around workload, management in departments, culture and discrimination.
- Patient safety including confidentiality, culture, discrimination, patient safety procedures and fraud.

NHS number and general medical practice validity

North Tees and Hartlepool NHS Foundation Trust submitted records during 2020-21 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**	**99.93%**	Percentage for admitted patient care	**100%**
Percentage for outpatient care	**99.97%**	Percentage for outpatient care	**100%**
Percentage for accident and emergency care	**99.61%**	Percentage for accident and emergency care	**100%**

** NHS number low because of anonymised data sent to SUS for sensitive patients

Information governance (IG)

The confidentiality and security of information regarding patients and staff is monitored and maintained though the implementation of the Trust Governance Framework which encompasses the elements of law and policy from which applicable information governance (IG) standards are derived.

Personal information is increasingly held electronically within secure IT systems. It is inevitable that in complex NHS organisations especially where there is a continued reliance upon manual paper records during a transitional phase to paperless or a paper-light environment, that a level of data security incidents can occur.

Any incident involving loss or damage to personal data is comprehensively investigated by the Trust in line with its Data and Cyber Breach Management Policy and graded in line with the NHS Digital 'Guide to the Notification of Data Security and Protection Incidents'.

All incidents are graded using the NHS Digital breach assessment criteria and the Trust risk assessment tool according to the significance of the breach and the likelihood of those serious consequences occurring. The incidents are also graded according to the impact on the individual or groups of individuals rather than the on the Trust. Those incidents deemed to be of a high risk are reportable to the Information Commissioners Office (ICO) via the Data Security Protection Toolkit within 72 hours of being reported to the Trust.

The Trust has seen improvements in its incident levels with the number of serious/high risk incidents falling over the past five-year period, the Trust reported three incidents to the ICO during 2020-21 two if which related to 'inappropriate access by staff' and one instance of 'disclosure in error'.

The ICO were satisfied that the actions taken by the Trust for two of these incidents were appropriate (one currently under review); the incidents have since been closed by the ICO with no pending actions. However, in order to further strengthen existing Trust policy and to prevent repeat incidents in areas where incidents have occurred during 2020-21 the following key actions were undertaken:

- Review of IG policies and standard operating procedures to ensure they reflect the specific needs and practicalities of each internal department and they reflect the changing needs of legislation in light of the updated Data Protection Act 2018 and the General Data Protection Regulations (GDPR).
- Increased the programme of comprehensive quality assurance and spot checks to ensure all departments are complying with Trust polices relating to the protection of personal data.
- Continue to provide annual Data Security Training inclusive of Cyber Security and the provision of targeted training in areas of non-compliance.
- Robust monitoring of departmental action plans following incidents to ensure appropriate actions have been implemented via the Information Management and Information Governance Committee.
- Full annual review of information assets and information flows thought the Trust within a redesigned framework to comply with GDPR requirements.
- HR processes followed where repeated non-compliance has been found.

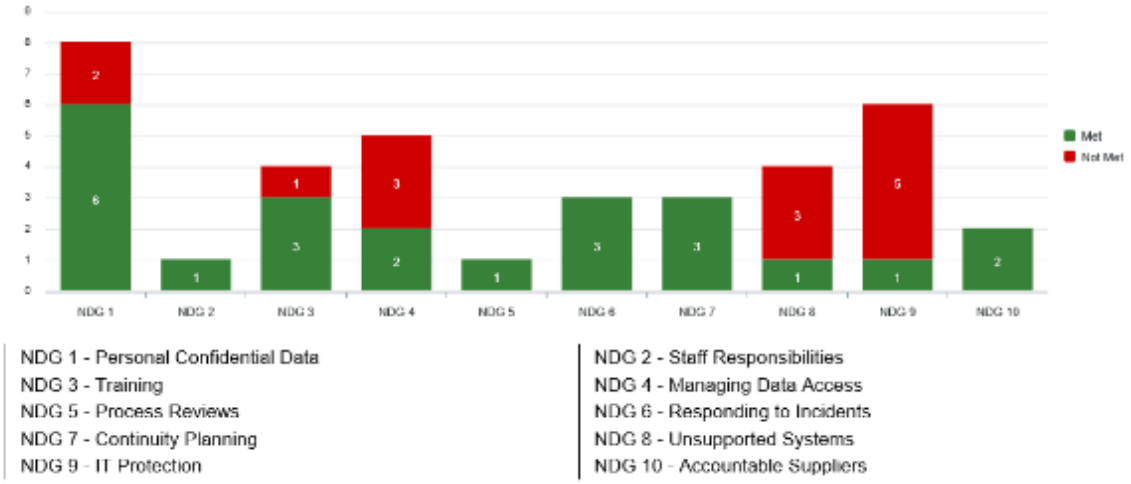
Assurance continues to be provided to the Board of Directors that systems and processes are being constantly assessed and improved to ensure that information is safe. The Data Security and Protection Standards for health and care are set out in the National Data Guardian's (NDG) ten standards and are measured though the completion of the Data Security Protection Toolkit (DSPT). 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 111 mandatory evidence items in 42 assertions (37 Mandatory) which cover these 10 standards that the Trust must evidence compliance against in order to gain compliance.

For 2020-21 the deadline for submission of the DSPT has been moved from 31st March 2021 to 30 June 2021 due to the advent of Covid-19. At the time of writing the Trust was in compliance with 79 of the 111 evidence items and have confirmed compliance with 21 of the 44 assertions. The Trust remains on plan to submit the remaining evidence items by the new June 2021 deadline.

The current position is reflected in the chart below:



The 2020-21 DSPT was also subject to an external audit which was being undertaken at the time of writing this report. The external audit for 2020 – 21 is a more in-depth audit as they focused not only on the evidence submitted in the DSPT but the controls and processes the Trust has in place for Data protection and Information Security.

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 2020-21 the Trust received 371 requests with a compliance level, as of 31 March 2021, of 96% with complete compliance data available after 30 April 2021. This was achieved despite Trust services experiencing significant pressure during the Covid-19.

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.

	2017-18	2018-19	2019-20	2020-21
Primary diagnoses correct	90.50%	91.00%	90.50%	**90.50%**
Secondary diagnoses correct	81.88%	93.56%	93.72%	**85.98%**
Primary procedures correct	93.65%	93.75%	90.82%	**97.66%**
Secondary procedures correct	86.21%	88.33%	91.49%	**82.35%**

The services reviewed within the sample were 200 finished consultant episodes (FCEs) taken from the specialties of obstetrics and gynaecology. 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.

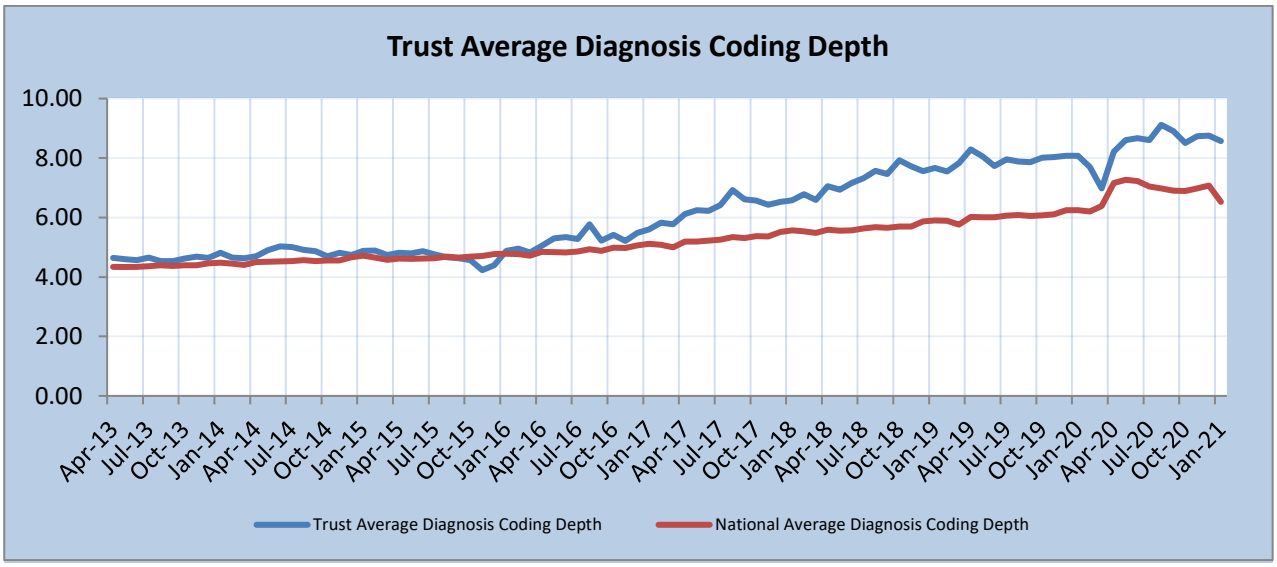
Specific issues highlighted within the audit have been fed back to individual coders and appropriate training planned where required. **North Tees and Hartlepool NHS Foundation Trust** will be taking the following actions to improve data quality. The coding department has undergone a re-structure in 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 and ambulatory 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. 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. The pilot was deemed a success, and the system was rolled out to all wards across the Trust.

In July 2020 the Trust went live with Active Clinical Notes (ACN). Active Clinical Notes allows traditional paper-processes and pathways to be made available digitally. This means the clinical details of patient's diagnoses and treatments are now added directly to the patient's Electronic Patient Record (EPR). Nursing pathways are currently not available electronically and are still manually completed and filed within the patient's case notes. As a result of this change it has allowed the coding department to introduce an opportunity for some of the coders to work from home. In May 2021 the Coding Department will start a twelve week homeworking trial period. A number of volunteer coders will be able to access clinical records remotely and securely via laptops using the same digital applications they access in the office to deliver high quality clinical coded data. If this trial is successful, we hope to continue this new way of working on a long term basis.

Diagnosis Coding Depth National and Trust Trend (April 2013 to November 2019)

The Trust has continued to make great strides in improving the accuracy and depth of patient coding, the following chart demonstrates the increase (blue) against the national average (red). The Trust has Improved the quality of discharge documentation and actively engaged clinicians to work closely with Clinical Coding. The latest depth of coding shows the Trust having an Average Diagnosis Depth of **8.57** (January 2021) compared with the National average of **6.52.**



*Data taken from Data Quality Clinical Coding in Healthcare Evalution Data (HED).

Part 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 **September 2019 – August 2020**.	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, **November 2019 – October 2020**

Time period	Over-dispersion banding	Trust Score	National Average	Highest – SHMI Trust Value in the country	Lowest – SHMI Trust Value in the country
Sep 2019 – Aug 2020	**Band 2 (As Expected)**	**0.9965**	**1.00**	**1.1816**	**0.6946**
Oct 2019 – Sep 2020	**Band 2 (As Expected)**	**0.9994**	**1.00**	**1.1795**	**0.6869**
Nov 2019 – Oct 2020	**Band 2 (As Expected)**	**0.9940**	**1.00**	**1.1775**	**0.6782**

SHMI Regional – November 2019 – October 2020

Trust	Trust Score
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	1.1573
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	1.1504
SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST	1.1195
GATESHEAD HEALTH NHS FOUNDATION TRUST	1.0255
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	**0.994**
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	0.9768
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	0.9757

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 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 awareness, work and engagement has been delivered during 2019-20, this continues 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 the values have maintained an excellent position over a number of months, 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 - **Nov 2019 – Oct 2020**	NHS DIGITAL

Percentage of deaths with palliative care coding, November 2019 – October 2020

Time period	Diagnosis Rate	Diagnosis Rate National Average	Highest – Diagnosis Rate	Lowest – Diagnosis Rate
Sep 2019 – Aug 2020	39.00	36.00	61.00	9.00
Oct 2019 – Sep 2020	39.00	36.00	60.00	8.00
Nov 2019 – Oct 2020	38.00	36.00	59.00	8.00

Latest Time Period benchmarking position – November 2019 – October 2020

Trust	Diagnosis Rate
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	51.00
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	48.00
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	**38.00**
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	37.00
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	36.00
GATESHEAD HEALTH NHS FOUNDATION TRUST	36.00
SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST	30.00

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 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

April 19 to March 20	*Groin hernia	*Varicose vein	Hip replacement – Primary	Hip replacement – Revisions	Knee replacement – Primary	Knee replacement – Revisions
Trust Score	No data	No data	0.468	No data	0.394	No data
National Average	No data	No data	0.459	0.307	0.335	0.295
Highest National	No data	No data	0.529	0.380	0.419	0.394
Lowest National	No data	No data	0.344	0.238	0.215	0.168

Apr 19 to Mar 20, Data from NHS Digital

April 18 to March 19	*Groin hernia	*Varicose vein	Hip replacement – Primary	Hip replacement – Revisions	Knee replacement – Primary	Knee replacement – Revisions
Trust Score	No data	No data	0.584	No data	0.456	No data
National Average	No data	No data	0.465	0.287	0.338	0.288
Highest National	No data	No data	0.550	0.398	0.411	0.296
Lowest National	No data	No data	0.333	0.231	0.254	0.380

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 2018 to Mar 2019	Emergency readmissions within 28 days of discharge from hospital Apr 2017 to Mar 2018
0 to 15	Trust Score	**13.50**	**12.90**
	National Average	12.50	11.90
	Band	Significantly higher than the national average at the 95% level but not at the 99.8% level	Significantly higher than the national average at the 95% level but not at the 99.8% level
	Highest National	69.20	32.90
	Lowest National	1.80	1.30
16 or over	Trust Score	**13.50**	**13.80**
	National Average	14.60	14.10
	Band	National average lies within expected variation (95% confidence interval)	National average lies within expected variation (95% confidence interval)
	Highest National	57.50	46.40
	Lowest National	2.10	1.80

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 December 2019 position (latest available data) indicates the Trust has an overall readmission rate of 10.01% against the internal stretch target of 7.70%, indicating the Trust's readmission rates have slightly decreased by 0.95% from the same period in the previous year (10.96% - December 2018).

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)
2020-21	Not Available	Not Available
2019-20	67.10	62.60
2018-19	67.20	65.20
2017-18	68.60	68.70
2016-17	68.10	67.20
2015-16	69.60	67.70
2014-15	68.90	68.10

*2019-20 data not available at the time of print – Available August 2020

Benchmarked against over North East Trusts for 2019-20;

Trust	Overall Score
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	74.80
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	72.60
GATESHEAD HEALTH NHS FOUNDATION TRUST	71.00
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	70.00
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	68.40
SOUTH TYNESIDE NHS FOUNDATION TRUST	68.00
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	**62.60**

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**	**2019**	**2020**
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	77	83	88	87
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	58	59	61	66
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	**67**	**71**	**72**	**74**
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	89	90	91	91
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	69	71	64	76
GATESHEAD HEALTH NHS FOUNDATION TRUST	81	81	82	80
SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST			70	71
North East	72	74	75	78
England	70	70	71	74
National High	**86**	**95**	**-**	**92**
National Low	**47**	**41**	**-**	**48**

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	N/A	N/A	74%	N/A

*Q1, Q2 and Q4 – Due to COVID-19 NHS Imprrovements stopped the data collection
**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	N/A	N/A	69%	N/A

*Q1, Q2 and Q4 – Due to COVID-19 NHS Imprrovements stopped the data collection
**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 2020-21, 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

In the last 12 months have you experienced harassment, bullying or abuse at work from other colleagues? (Q13c – National Staff Survey)

2015	2016	2017	2018	2019	*2020	2020 National Average
19.90%	16.10%	18.90%	16.60%	15.90%	**15.70%**	**19.80%**

*2020 released In March 2021

Does your organisation act fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age? (Q14 – National Staff Survey)

2015	2016	2017	2018	2019	*2020	2020 National Average
90.50%	90.60%	93.2%	91.10%	88.90%	**88.10%**	**84.90%**

*2020 released In March 2021

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	2018-19				2019-20			
VTE	Quarter	Q1	Q2	Q3	Q4	Q1	Q2	Q3	*Q4
	Value	97.96%	97.63%	97.75%	97.58%	97.45%	96.97%	97.10%	
	National Average	95.63%	95.49%	95.65%	95.74%	95.63%	95.47%	95.33%	
	Highest National	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	
	Lowest National	75.84%	68.67%	54.86%	74.03%	69.76%	71.72%	71.59%	

*2019-20 Q4 data not available at time of print

North East Trust benchmarking 2019-20

Trust	Q1	Q2	Q3	*Q4
County Durham and Darlington NHS Foundation Trust	96.37%	96.08%	96.09%	
Gateshead Health NHS Foundation Trust	98.26%	98.59%	98.95%	
North Tees & Hartlepool NHS Foundation Trust	97.45%	96.97%	**97.10%**	
Northumbria Healthcare NHS Foundation Trust	98.19%	98.16%	98.21%	
South Tees Hospitals NHS Trust	94.95%	95.02%	95.33%	
South Tyneside and Sunderland NHS Foundation Trust	98.51%	98.26%	96.98%	
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	97.65%	96.80%	97.21%	

*2019-20 Q4 data no available at time of print

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

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

The **North Tees and Hartlepool NHS Foundation Trust** has taken the following actions to continue to improve this percentage, and so the quality of its services, by updating the training booklets to keep them relevant, ensuring that 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) Committee.

Venous thromboembolism (VTE) mandatory training 2020-21	92%

*Data obtained from the Trust training department

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 2020 – Mar 2021	43	Not Available	Not Available	Not Available	Not Available
Apr 2019 – Mar 2020	53	13.20	Not Available	Not Available	Not Available
Apr 2018 – Mar 2019	31	16.40	12.20	79.97	0.00
Apr 2017 – Mar 2018	35	17.90	13.70	91.00	0.00
Apr 2016 – Mar 2017	39	18.80	13.20	82.70	0.00

* 2020-21 numbers as of 30 March 2021, additional detail 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 to 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 2019 – March 2020**

	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 19 – Mar 20	**3,820**	**41.60**	**0.16**	**0.49**	**0.01**	**26**	**0.30**
Oct 18 – Mar 19	1,580	16.90	0.16	0.49	0.01	15	0.16
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 2019 – March 2020	
Trust	Degree of Harm (All) – Rate per 1,000 bed days	Degree of Harm (Severe or Death) Rate per 1,000 bed days
City Hospitals Sunderland NHS Foundation Trust	45.10	0.07
North Tees & Hartlepool NHS Foundation Trust	**41.60**	**0.30**
Northumbria Healthcare NHS Foundation Trust	47.30	0.09
Gateshead Health NHS Foundation Trust	38.80	0.47
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	39.80	0.13
County Durham and Darlington NHS Foundation Trust	49.60	0.10
South Tees Hospitals NHS Trust	35.00	0.09
South Tyneside NHS Foundation Trust	44.50	0.12

*Data for Oct 18 – Mar 19

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 Chief Nurse/Director of Patient Safety and Quality for a decision. Incidents of significant harm are managed within the National Framework for Serious Incidents and the current requirements for both the national NHS contract and the local Clinical Commissioning Groups (CCGs).

On conclusion of a Serious Incident investigation, the weekly Safety Panel reviews and approves the Comprehensive Investigation report 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.

Part 3a:

Additional Quality Performance measures during 2020-21

This section is an overview of the quality of care based on performance in 2020-21. 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 2020-21 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 2020-21. 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

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 the classification of Fracture, Fall No Injury or Fall Injury No Fracture.

Falls with Fracture

During **2020-21** the Trust has experienced **5** falls resulting in fracture; this has *decreased* from **18** in the 2019-20 reporting period.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2017-18	1	2	5	5	2	2	3	0	0	2	1	2	**25**
2018-19	1	1	1	1	1	1	1	3	4	2	3	4	**23**
2019-20	1	3	0	2	1	2	0	0	0	0	9	0	**18**
2020-21	**0**	**0**	**0**	**1**	**0**	**2**	**1**	**0**	**0**	**0**	**1**	**0**	**5**

*Data obtained via the Trust's Incident Reporting database (Datix) – Mar 21

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 **2020-21** the Trust has experienced **208** falls resulting in an injury and no fracture; this has *decreased* from **223** in the 2019-20 reporting period.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2017-18	20	29	20	36	23	31	28	32	24	32	27	25	**327**
2018-19	13	11	8	15	10	9	18	21	23	28	20	16	**192**
2019-20	19	22	21	21	20	17	12	22	21	15	20	13	**223**
2020-21	**15**	**8**	**13**	**14**	**16**	**22**	**14**	**20**	**37**	**18**	**17**	**14**	**208**

*Data obtained via the Trust's Incident Reporting database (Datix) – Mar 21

Falls with No Injury

During **2020-21** the Trust has experienced **924** falls resulting in no injury; this has *increased* from **862** in the 2019-20 reporting period.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2017-18	97	72	75	88	85	95	79	99	106	90	106	105	**1,097**
2018-19	119	98	79	82	82	87	81	79	79	84	72	80	**1,022**
2019-20	74	90	76	67	87	77	82	67	69	57	64	52	**862**
2020-21	**59**	**55**	**61**	**74**	**74**	**74**	**91**	**85**	**100**	**91**	**78**	**82**	**924**

*Data obtained via the Trust's Incident Reporting database (Datix) – Mar 21

Reporting for 2020-21 indicates that there has been a slight increase of of 34 falls in the number of falls over the same period in 2019-20.

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 2015 the Trust has had **6** Never Events and they are broken down as follows:

2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
2	1	0	1	**1**	**1**

The NHS England report can be accessed via:

https://improvement.nhs.uk/resources/never-events-data/

There has been **1** Never Events reported in the period of 2020-21. The never event took place in July 2020.

Additional Patient Safety indicators are in Part 2 of these accounts, pages 5 to 42.

Effectiveness of Care

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 **2019-20** there were **713** medicines incident reports via Datix. In **2020-21** there has been **540** incident reports. A small number of these incidents originate from external organisations such as GPs and care homes.

Type of incidents	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Prescribing	147	224	138	141	172	162	**141**
Administration	314	321	413	386	468	376	**305**
Dispensing	43	48	72	78	61	83	**42**
Other	50	16	62	65	74	57	**52**
Total	**554**	**609**	**685**	**670**	**775**	**713**	**540**

* 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.

Pharmacy have rolled out monthly one minute medicines optimisation and safety briefings included in ward MDT huddles. This has recently included antibiotics awareness, insulin safety and medicines shortages.

Electronic prescribing and medicines administration continues to be developed further and rolled out in the Trust. 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

The recent employment of an Informatics Lead Pharmacist will assist in the further development of prescriber support and safety metrics to measure the above factors.

Pharmacy have successfully secured funding to support the Pharmacy Automation Project that is currently underway. This involves the installation of a state of the art robot to reduce picking errors in the dispensing process and encourage closed loop stock management for clinical areas utilising Omincell technology. It will also enable seamless compliance with the Falsified Medicines Directive, providing assurance of medicines authenticity in the supply chain.'

'Work-streams around self-checking and developing a safety conscious culture in the Pharmacy department are ongoing.'

Ward based pharmacy services have now been rolled out to two further wards. This service provides 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.

A trial of a Saturday morning roaming pharmacist is presently being undertaken to support weekend ward based discharges.

"I have memory problems and the nurses remind me to take my medication.Very happy with them. [sic]

"Waiting times unfair, general care disappointing and available medication poor. Triage Nurse had lack of understanding no empathy or care very disappointed. [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 2019-20 data and against the 2020-21 performance target.

	2019-20 Performance	2020-21 Target	2020-21 Performance
Stroke – 80% of people with stroke to spend at least 90% of their time on a stroke unit	92.81%	**80.00%**	**93.80%**
Percentage high risk TIA cases treated within 24 hours	85.45 %	**75.00%**	**93.10%**

*Data from Trust Clinical Effectiveness Team

"I was seen within 15 minutes of my appointment and a comprehensive explanation of what had occurred during my stroke and subsequent treatment, what follow-up would happen, so it was clear to I should expect in the future. [sic]

"3 members of staff, whom attended to my mam who could not speak due to having strokes, treat her with dignity, care and compassion. I could not thank them enough for taking the time needed to care for her, to communicate in a way my mam could answer for herself and be understood. Yes i told them what to do but they listened to me snd my mam felt included in her own care and wishes.. [sic]

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.

Stage 1 - Informal	Dealt with at the time of complaint at ward level/ or by the Patient Experience Team (PET) to resolve.
Stage 2 - Formal	A meeting arranged with the complainant to discuss the complaint with the Senior Clinical Matron, consultant and relevant personnel involved in the complaint with hopefully a resolution at this stage.
Stage 3 - Formal	If Stage 1 or Stage 2 did not resolve the issue or the complainant did not want to go through those routes, a formal Stage 3 is then raised.

Number of Complaints – 2020-21

The Trust received **1,146** complaints in 2020-21; the following demonstrates how many were concluded during stage 1, stage 2 and stage 3.

Stage 1 - Informal	982
Stage 2 - Formal	29
Stage 3 - Formal	135

Total

1,146

*Data for 2020-21 obtained from Datix

2020-21 Complaints by complaint type:

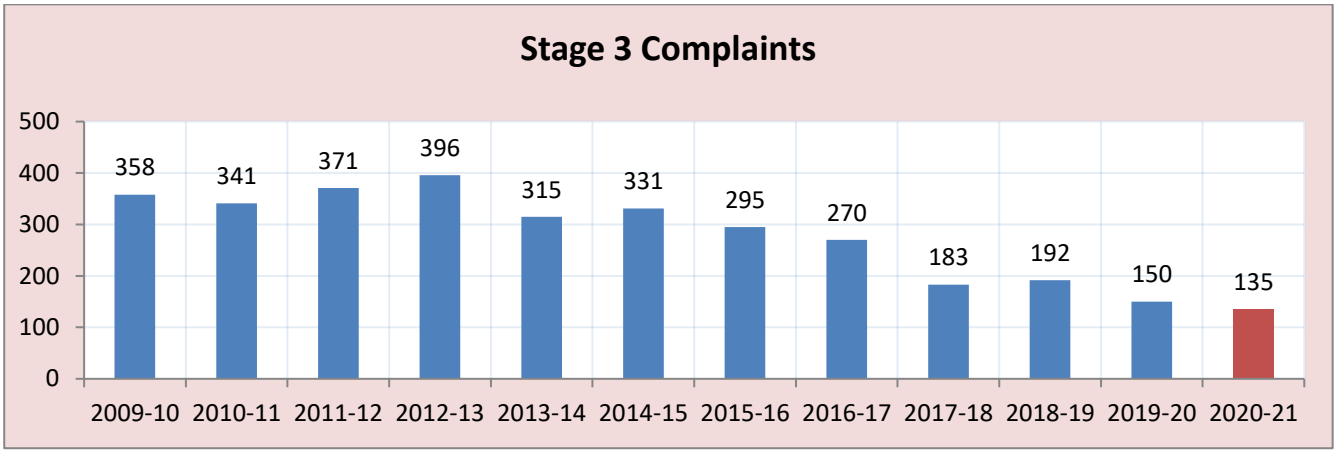
Please see the following breakdown for the Top 10 complaints from the **135 Stage 3** complaints in 2020-21

Number of Complaints	Month												
Sub-subject (primary)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Communication - verbal / non verbal	3	3	2	2	2	0	6	4	6	6	4		38
Delay to diagnosis	2	1	3	1	1	1	2	1	2	0	1		15
Treatment and procedure delays	0	1	0	2	1	2	1	1	0	4	2		14
Competence of staff member	0	0	5	0	2	1	0	2	1	2	0		13
Care and compassion	1	0	1	2	1	1	1	2	0	0	1		10
Attitude of staff	0	0	0	4	1	0	2	0	2	0	1		10
Discharge arrangements	0	1	2	1	0	2	0	0	0	1	0		7
Incorrect diagnosis	0	0	0	0	0	1	2	1	0	0	1		5
Visiting arrangements	0	0	0	1	0	1	0	1	0	0	0		3
Outpatient cancellation	0	0	0	2	0	0	0	1	0	0	0		3
End of life concerns incl DNAR	0	0	0	0	0	1	1	0	0	0	1		3
Infection Control	0	1	0	0	0	0	0	0	1	0	0		2
Mismatch of Patient Information	0	0	0	1	0	0	0	1	0	0	0		2
Lost property	0	0	0	0	0	0	0	0	0	2	0		2
Non Medical	0	0	0	1	0	0	0	0	0	0	0		1
Outpatient delay	0	0	0	0	1	0	0	0	0	0	0		1
Dignity & respect	0	0	0	0	1	0	0	0	0	0	0		1
Prescription issues, incl delays / unavailable	0	0	0	0	0	1	0	0	0	0	0		1
Maladministration	0	0	0	0	0	1	0	0	0	0	0		1
Social Distancing	0	0	0	0	0	0	1	0	0	0	0		1
Medical	0	0	0	0	0	0	0	1	0	0	0		1
Security incl attitude and communication	0	0	0	0	0	0	0	0	1	0	0		1
Length of time to be given apt	0	0	0	0	0	0	0	0	1	0	0		1
Disability	0	0	0	0	0	0	0	0	0	0	1		1
Admission delays and communication	0	0	0	0	0	0	0	0	0	0	1		1
Total	**6**	**7**	**13**	**17**	**10**	**12**	**16**	**15**	**14**	**15**	**13**	**0**	**138**

*Data obtained from Trust complaints dept. as of Mar 21

Since April 2020, the Trust has received **1,146** complaints of which **135** have gone onto the formal complaint process, this only equates to **11.78%** 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 Feb 2021

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-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Compliance Rate	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	N/A

*Data obtained from Trust complaints dept

Additional Info: Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009

Number of complaints

The number of complaints received into the Trust has risen for 2020-21 with an increase from the previous year. The number of stage 3 concerns has reduced for the year from 150 for 2019-20 down to 135 for 2020-21 representing more complaints managed locally with faster resolution for complainants.

Referred to PHSO

The Trust does not refer cases to the PHSO. If the complaint is unresolved after a Stage 3 written response, the Trust offers a further contact response, within this letter a paragraph is included advising the complainant, that they may come back to the Trust for further information or if they feel all attempts to resolve have been exhausted they can go to the PHSO. But this decision/contact with the PHSO is via the complainant.

Complaints upheld

During 2020-21 there were no cases upheld during this financial year.

Action taken to improve services

The trust takes all complaints raised seriously and actions are taken to improve service issues identified. The most common theme identified for 2019-20 was communication, customer service training is available to all staff in order to improve the communication they provide to patients and carers.

Trust policies and procedures have been reviewed following feedback from service users to improve the experience, maternity services procedures following miscarriage have been reviewed to limit emotional distress for patients.

Patients families informed the trust that they felt that they had difficulty in discussing their relatives care whilst they were an inpatient in hospital. An appointment system has been developed whereby patient's relatives and carers are able to make an appointment with the staff (medical, nursing, therapy) who are looking after the patient and be informed of their care, only if appropriate consent is received from the patient. Posters are displayed on wards detailing the appointment systems in place.

A Trust Accessibility group has been established, following feedback from a complaint, which meets monthly and includes trust staff, external stakeholders and representatives of expert patients.

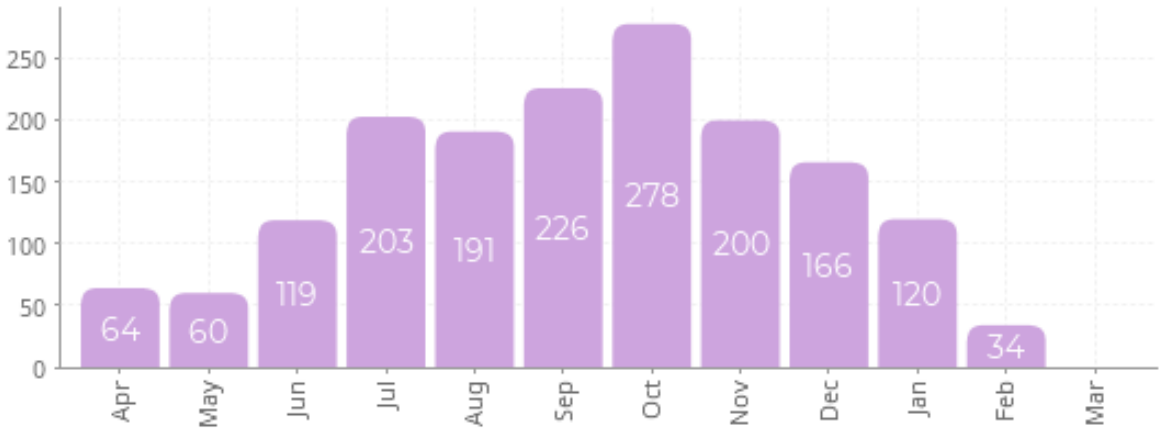
Workshops have been completed with staff to encourage local resolution of complaints, identifying and dealing with complaints locally is beneficially for both patients and staff as it allows for fast resolution of issues and appropriate escalation at the time of any issues.

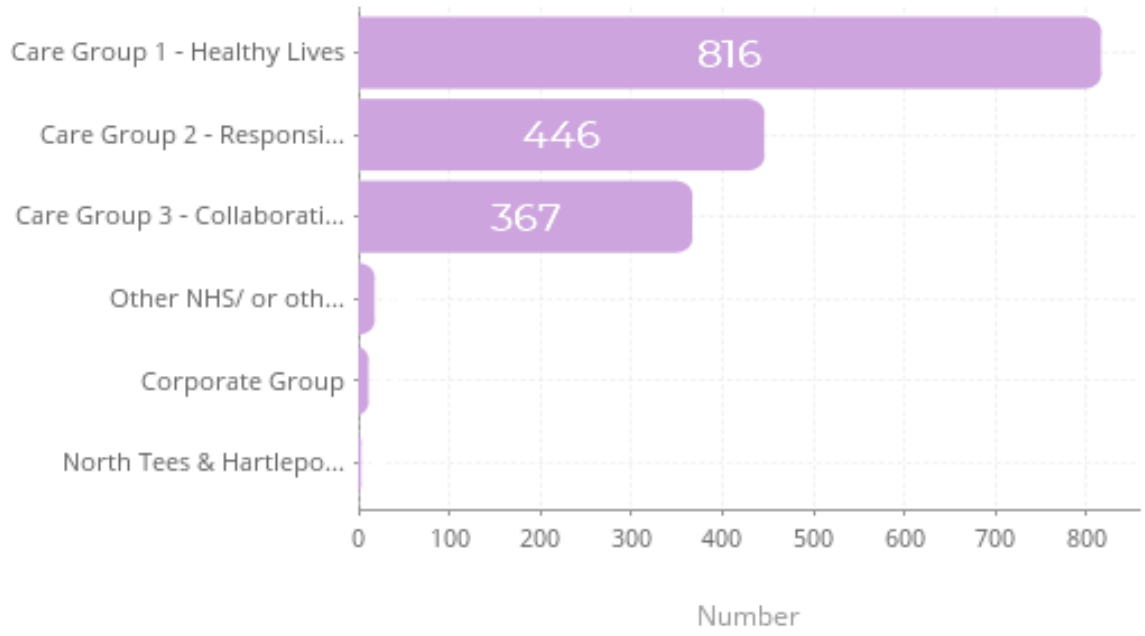
All staff involved in complaints are informed so they are able to reflect on their practice.

Compliments

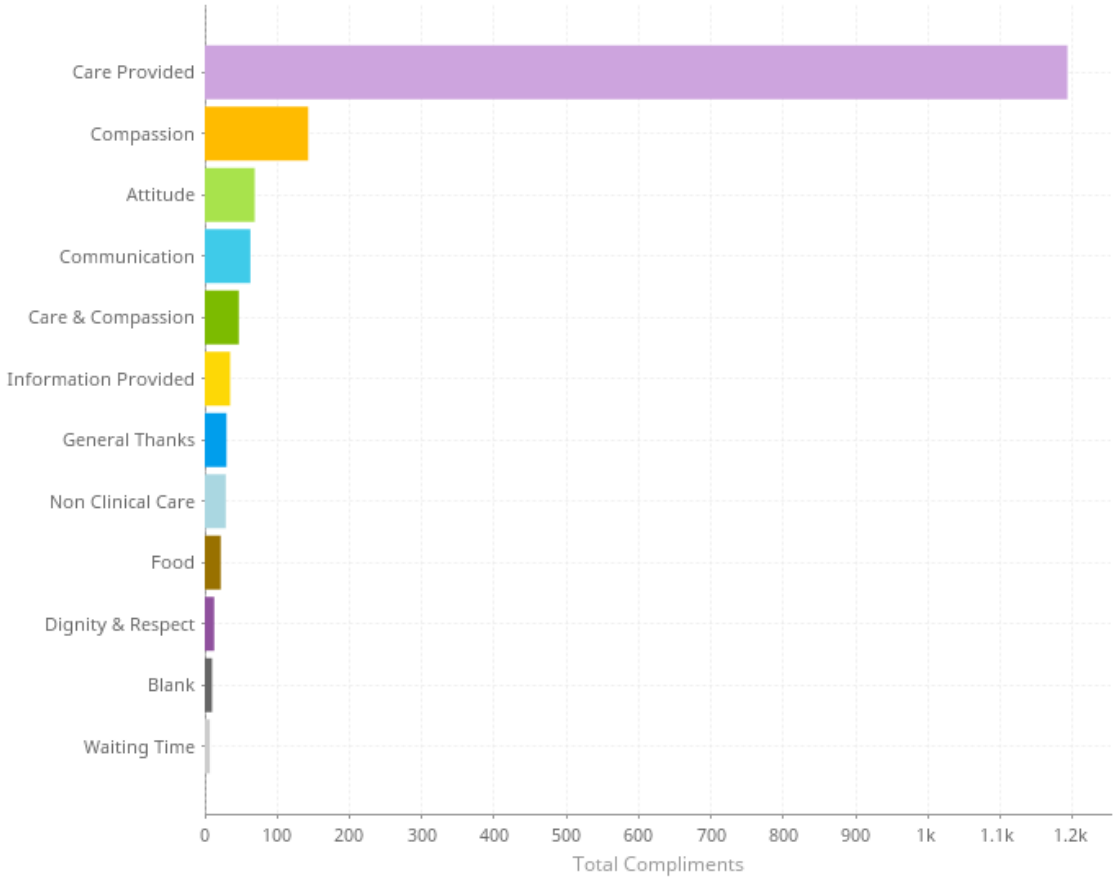
The Trust records the number of **compliments** received within each area. The trends in the number of compliments received can be seen in the following table and chart.

Total Compliments 2020-21 1,661





*Data obtained via the Trusts Compliments (PALS) module within Datix.



To improve the numbers and qualitative data around compliments, the Trust has established a Greatix system within the existing incidents platform to capture the relevant data.

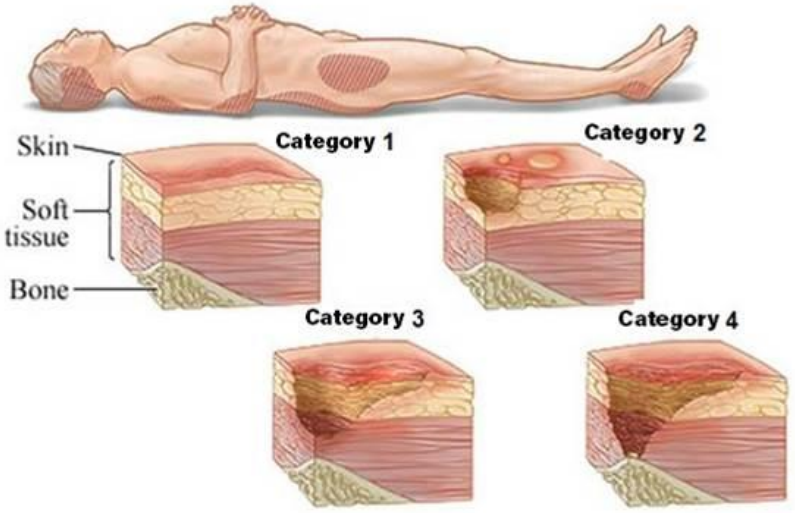
> “Quick , friendly & efficient. [sic]”

> “Made to feel relaxed. [sic]”

> “very helpful staff. [sic]”

Pressure Ulcers

Pressure ulcers, also known as **pressure sores**, **bedsores** and **decubitus ulcers**, are localized 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	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Category 1	78	39	38	54	92	64
Category 2	258	128	189	198	299	233
Category 3	12	9	20	35	34	14
Category 4	1	1	2	2	3	3
Total	**349**	**177**	**249**	**289**	**428**	**314**

*Data obtained via the Trusts Incident Reporting database (Datix) – Feb 21

Year on Year Comparison – Out of Hospital *Acquired*

Reporting Period	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Category 1	83	68	159	55	59	50
Category 2	337	253	359	173	152	128
Category 3	21	36	85	69	75	46
Category 4	8	5	21	9	19	12
Total	**449**	**362**	**624**	**306**	**305**	**236**

*Data obtained via the Trusts Incident Reporting database (Datix) – Feb 21

Actions taken by the Trust:

Pressure damage is one of the top five 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. All incidents are quality checked, after reporting, by the Tissue Viability Nurses. The numbers of pressure ulcer incidents are discussed at the Senior Clinical Professionals Huddle each week and monitored through the Tissue Viability Operational Group, Quality Reference Group which informs the integrated professional Board meeting.

The Tissue Viability Operational Group has the remit of reviewing the Trust's functioning programs of improvement, Trust policies and guidelines. Quarterly quality audits by the directorates are undertaken. An annual pressure ulcer prevalence audit is also undertaken for patients on the community nurse caseload and patients in hospital in-patient beds. 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 has developed a Pressure Ulcer Assurance Framework which aims to give assertion of progression of excellent practice within pressure ulcer prevention as well as identifying any areas of improvement needed. During the COVID-19 pandemic staff have continued to be educated and empowered through ongoing support to reduce unwarranted variation and provide the very best care to every patients, every day. The agenda for pressure ulcer prevention is underpinned by evidence, research and best practice with measurable outcomes ensuring we do the right thing at the right time. A successful and inclusive collaborative pilot is planned to be widened across clinical areas with a focus on improving risk assessments and reducing potential for patient harm.

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 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 care industry. The annual Tissue Viability champions day is a full day of study and is planned for July 2021. Last year's event went ahead despite the problems with the pandemic and was well evaluated. The annual "Stop the Pressure" event was again very successful in November 2020 with a well circulated social media campaign. The "Stop the Pressure" event will be repeated in 2021.

The Trust is an active participant in the regional pressure ulcer collaborative where neighbouring Trusts attend to discuss how best to achieve regional consensus on issues including pressure ulcer reporting and pressure ulcer policy. These meetings have been delayed due to the COVID-19 pandemic though they are planned to recommence in 2021.

There are information and resources for staff available on the Trust intranet site which provides advice to staff when a tissue viability nurse is not available. Referral to triage times and referral to treatment times are audited and are within the times given in the service specification of the Tissue Viability Team.

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. The Tissue Viability service have developed their SystmOne functionality to allow those that are able to access the patients health care record to see the input of the TVN team regardless of which clinical

area the patient is in when they are seen by the TVN team. This has already helped with continuity of care for these patients that move between services.

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	2020-21 Performance	2019-20 Performance	Achieved (cumulative)
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge	95%	N/A	N/A	N/A
Cancer 31 day wait for second or subsequent treatment – surgery (Apr 20 to Feb 21 provisional)	94%	91.39%	95.00%	X
Cancer 31 day wait for second or subsequent treatment – anti cancer drug treatments (Apr 20 to Feb 21 provisional)	98%	99.06%	99.22%	✔
Cancer 31 day wait for second or subsequent treatment – radiotherapy	94%	N/A	N/A	N/A
Cancer 62 Day Waits for first treatment (urgent GP referral for suspected cancer) (Apr 20 to Feb 21 provisional)	85%	77.74%	82.79%	X
Cancer 62 Day Waits for first treatment (from NHS cancer screening service referral) (Apr 20 to Feb 21 provisional)	90%	87.01%	94.53%	X
Cancer 31 day wait from diagnosis to first treatment (Apr 20 to Feb 21 provisional)	96%	91.39%	98.69%	X
Cancer 2 week wait from referral to date first seen, all urgent referrals (cancer suspected) (Apr 20 to Feb 21 provisional)	93%	92.19%	92.73%	X
Cancer 2 week wait from referral to date first seen, symptomatic breast patients (cancer not initially suspected) (Apr 20 to Feb 21 provisional)	93%	90.30%	94.70%	X
Maximum time of 18 weeks from point of referral to treatment in aggregate, patients on incomplete pathways (Apr 20 to Feb 21)	92%	85.14%	93.42%	X

Referral to Treatment 52 Week Waits (Apr 20 to Feb 21)	0	371	0	X
Number of Diagnostic waiters over 6 weeks (Apr 20 to Feb 21)	99%	76.16%	93.82%	X
Community care data completeness – referral to treatment information completeness (Apr 20 to Feb 21)	50%	98.30%	96.20%	✔
Community care data completeness – referral information completeness (Apr 20 to Feb 21)	50%	98.82%	95.62%	✔
Community care data completeness – activity information completeness (Apr 20 to Feb 21)	50%	98.58%	95.20%	✔
Community care data completeness – patient identifier information completeness (Shadow Monitoring) (Apr 20 to Feb 21)	50%	98.58%	95.20%	✔
Community care data completeness – End of life patients deaths at home information completeness (Shadow Monitoring) (Apr 20 to Feb 21)	50%	84.20%	83.72%	✔
Compliance with access to healthcare for patients with learning disabilities (Apr 20 to Feb 21)	100%	Full compliance	Full compliance	✔
Other National and Contract Indicators	**2020-21 Target**	**2020-21 Performance**	**2019-20 Performance**	**Achieved**
Cancelled Procedures for non-medical reasons on the day of op (Apr 20 to Feb 21)	0.80%	0.32%	0.51%	✔
Cancelled Procedures reappointed within 28 days (Apr 20 to Feb 21)	100%	74.32%	95.57%	X
Eliminating Mixed Sex Accommodation	Zero cases	0	0	✔
A&E Trolley waits > 12 hours (2020-21)	Zero cases	0	0	✔
Choose and Book slot issues (Apr 19 – Feb 20)	<4%		4.60%	X
Stroke – 90% of time on dedicated Stroke unit (Apr 20 to Feb 21)	80%	93.80%	92.81%	✔
Stroke – TIA assessment within 24 hours (Apr 20 to Feb 21)	75%	93.10%	85.45%	✔
Delayed transfers of care (Apr 20 to Feb 21)	<3.5%	N/A	2.09%	N/A
VTE Risk Assessment (2020-21)	95%	95.39%	97.21%	✔
Sickness Absence Rate (Feb 21)	4.0%	5.59%	4.52%	X
Mandatory Training Compliance (Feb 21)	80%	87.12%	90.00%	✔
Turnover Rate (Feb 21)	10.0%	7.66%	9.42%	✔
Operational Efficiency Indicators	**2020-21 Target**	**2020-21 Performance**	**2019-20 Performance**	**Achieved**
New to Review Ratio (Apr 19 – Feb 20)	1.45	1.31	1.33	✔
Outpatient DNA (new) (2019-20)	5.40%	6.82%	7.86%	X

Outpatient DNA (review) (2019-20)	9.00%	7.23%	10.02%	✔
Length of Stay Elective (Apr 19 – Feb 20)	3.33	1.64	2.16	✔
Length of Stay Emergency (Apr 19 – Feb 20)	4.26	3.47	3.43	✔
Readmission Elective (Apr 20 to Jan 21)	0.00%	4.05%	4.29%	X
Readmission Emergency (Apr 20 to Jan 21)	9.37%	15.30%	14.49%	X
Occupancy (Trust) (2019-20)	85%	79.69%	89.43%	X
Quality Indicators	**Standard/ Trajectory**	**2020-21 Performance**	**2019-20 Performance**	**Achieved**
Clostridium Difficile – variance from plan (objective) (Apr 20 – Mar 21)	53	49	53	✔
Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia (Apr 20 – Mar 21)	0	1	0	X
Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia (Apr 20 – Mar 21)	26	25	26	✔
Escherichia coli (E.coli) (Apr 20 – Mar 21)	52	26	52	✔
Klebsiella species (Kleb sp) bacteraemia (Apr 20 – Mar 21)	10	10	10	-
Pseudomonas aeruginosa (Ps a) bacteraemia (Apr 20 – Mar 21)	3	3	3	-
Trust Complaints - Formal CE Letter (Stage 3) (Apr 20 – Mar 21)	<270	135	150	✔
Trust Complaints Compliance within agreed timescalse (Apr 20 – Mar 21)	95%	100.00%	97.60%	✔
Trust Falls with Fracture *NOF (Apr 20 – Mar 21)	<20	5	18	✔
In Hospital Pressure Ulcers Grade 4 (Apr 20 – Feb 21)	1	3	3	X
Medication Error (Apr 20 – Mar 21)	<685	540	713	✔
Friends and Family Test - Very Good/Good (Apr 20 – Mar 21)	95%	92.25%	95.00%	X
Never Events (Apr 20 – Mar 21)	0	1	1	X
Hand Hygiene (Apr 20 – Mar 21)	95%	96.38%	98.00%	✔

Hospital Standardised Mortality Ratio (HSMR) (Feb 20 – Jan 21)	< 102	101.19	91.3	✔
Summary Hospital-level Mortality Indicator (SHMI) (Nov 11 – Oct 20)	< 106	97.87	98.53	✔

Additional Assurance:

The following indicators have been subject to assurance by the independent auditors PricewaterhouseCoopers:

Further assurance indicators	Criteria Identified
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period ("incomplete pathways indicator"	Not applicable due to COVID-19
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	Not applicable due to COVID-19

Annex A: Third party declarations

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

Statement from NHS Tees Valley Clinical Commissioning Group (CCG) and on behalf of NHS County Durham Clinical Commissioning Group for North Tees and Hartlepool NHS Foundation Trust (NTHFT) Quality Account 2020/21 – 22 June 2021

NHS Tees Valley CCG commissions healthcare services for the population of Darlington, Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton-On-Tees. The CCG take seriously their responsibility to ensure that the needs of patients are met by the provision of safe, high quality services and therefore 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. The meetings are well attended and provide an opportunity to gain assurance that there are robust systems in place to support the delivery of safe, effective and high-quality care.

Like many organisations across the country NTHFT faced a challenging 2020/21 as a result of the COVID-19 pandemic. The CCG's would like to commend the Trust on the commitment and dedication demonstrated during this difficult time.

The CCG are pleased to note from the 2020/21 Quality Account that the Trust continues to be a strong performer in relation to the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) mortality values.

The values continue to report within the 'as expected' range and below the national average. CCG colleagues would like to thank all staff who continue to contribute towards maintaining this position in challenging times. The CCG will continue to provide robust scrutiny and challenge in relation to mortality outcomes during 2021/22 and will continue working with the Trust to identify opportunities for shared learning across the health economy.

The CCG recognise the Trust's initiatives to improve infection, prevention and control and is pleased to note from the Chief Executive Statement a reduction in the number of cases of Clostridium Difficile; the Trust have reported 49 cases during 2020/21 compared to 53 in 2019/20. The CCG would like to congratulate the Trust on this achievement, acknowledging the concerted and coordinated work to achieve this, and note that this remains a priority for 2021/22.

The Trust's continued focus on Health Care Associated Infection (HCAI) has resulted in an overall reduction in the number of HCAIs reported. The CCG congratulates the Trust for achieving reductions in the number of Clostridium difficile, Methicillin-Sensitive Staphylococcus Aureus, Escherichia coli, Klebsiella, Pseudomonas aeruginosa and catheter-associated urinary tract infections.

The CCG recognises that there was a slight increase in the number of cases of Methicillin-Resistant Staphylococcus Aureus in 2020/21 with one case reported, and supports the Trust's continued efforts to improve clinical practices.

Commissioners appreciate the challenges that the health economy faces in terms of the dementia agenda, and acknowledge the extensive work undertaken by the Trust to improve the care provided to patients who are, or may be, diagnosed with this condition. The Trust has provided training for staff and volunteers, improved carer support facilities and introduced Dementia Champions. The CCG fully supports the Trust's intention to further improve care for patients with dementia throughout 2021/22, in particular, the introduction of named nurses and individualised plans of care.

The CCG notes the Trust's progress towards the "Treat as One" initiative in 2020/21 including the establishment of a "Treat as One" group and a mandatory mental health awareness training programme for all staff. The Trust's intention to continue this work throughout 2021/22 is noted and commissioners look forward to seeing the impact of this work over the coming year.

Throughout 2020/21 the Trust has made sizeable strides in its safeguarding adults agenda by continuing efforts to raise the profile and visibility of adult safeguarding, amalgamating strategy groups for safeguarding, learning disability and dementia care and revising the Adult Safeguarding Committee to include representatives from Local Authority partners. These improvements allow for enhanced sharing of information and lessons learnt and the CCG would like to congratulate the Trust on this achievement.

The CCG notes that the number of concerns relating to physical abuse and neglect experienced by patients continues to rise across the localities and is part of the effort to better understand this increase.

Commissioners welcome the opportunity to be involved in the Trust's review of the Safeguarding Children Policy which was agreed at the end of 2020.

The CCG acknowledges the amount of work that has been undertaken to embed the '*was not brought*' policy. The policy now includes guidance for staff on children whose parents/carers do not bring them to hospital appointments and children whose appointments are frequently rescheduled by parents/carers. The improvements implemented provide evidence of learning from local safeguarding child practice reviews to support early recognition of indicators of neglect in children.

The Trust is congratulated on the sustained improvement in relation to Initial Health Assessments and Review Health Assessments for Looked After Children and it is pleasing to see that actions have been taken to maintain these improvements going forward.

The CCG welcomes the Trust's safeguarding priorities for 2021/22, particularly the focus on the "Think Family" approach and the building of collaborative working relationships with neighbouring acute Trust safeguarding teams.

In 2020/21 the COVID-19 pandemic placed additional pressure on all NHS organisations and between 17th March 2020 and 31st March 2021 NTHFT cared for 2,528 COVID-19 positive patients with 184 requiring ITU care. The CCG commissioners would like to thank all of the staff of NTHFT for their tremendous hard work and dedication during this time.

The Trust continue to engage in the Learning Disabilities (LD) Mortality Review Programme which has highlighted a number of areas of good practice including good team working, good understanding of the Mental Capacity Act requirements and clear evidence of the use of best interest meetings to ensure an MDT approach to planning of care. The reviews have also identified that the process for referring to the Trust LD Nurse Advisor could be improved and the CCG is pleased to note that as a result, the Trust have developed guidance for staff and introduced an electronic referral system which will be the subject of a comprehensive audit in the future.

The CCG acknowledges the impact that COVID-19 has had on discharge processes but are pleased to note that the Trust continue to work together with partners in social care to reduce delayed transfers of care. The positive impact of the District Nursing In-reach Pilot is particularly notable, and it is pleasing to see the Trust have plans to continue this provision.

Due to the COVID-19 pandemic a number of national surveys were suspended for a period during 2020/21. Despite this the Trust continued to participate in patient feedback programmes and develop action plans where appropriate. The CCG is pleased to note that 92.34% of patients rated the Trust as Very Good or Good during a difficult 2020/21 period.

Commissioners recognise the Trust's involvement in numerous clinical audits and National Confidential Enquiries and encourage these contributions in improving the quality of healthcare services at both a local and national level.

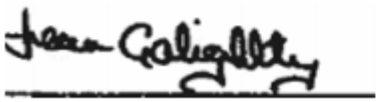
In 2020/21 the Trust reported one 'never event' in relation to wrong site surgery. All serious incidents are managed through the Serious Incident process and the CCG will continue to work with the Trust to identify and share learning and appropriate improvement actions.

The CCG are pleased to note that clinical quality will remain a priority for the Trust in 2021/22 with a focus on the three main areas: Patient Safety, Effectiveness of Care and Patient Experience.

The CCG can confirm that to their best knowledge the information provided within the NTHFT 2020/21 Annual Quality Account is an accurate and fair reflection of the Trust's performance. It is clearly presented in the format required and the information it contains accurately represents the Trust's Quality profile.

The CCGs look forward to continuing to work in partnership with the Trust to assure the quality of services commissioned in 2021/22.

Yours sincerely



Jean Golightly
Director of Nursing & Quality
NHS Tees Valley CCG

Anne Greenley
Director of Nursing & Quality (Interim)
NHS County Durham CCG

Hartlepool Healthwatch – 21 April 2021

Healthwatch Hartlepool – Response to Annual Quality Account of North Tees and Hartlepool NHS Foundation Trust

First, may I thank you for providing Healthwatch Hartlepool with a presentation in respect of the Trust's Quality Accounts 2020–21.

As agreed, please find below some information you may wish to consider when crafting the Trust's Quality Accounts Priorities 2020-2021.

Overall members felt that the information was quite light in detail albeit this may be due to the Covid19 environment we are currently working within. In respect of Patient Safety, Healthwatch members were not surprised at the latest mortality data given this has featured in our Third-Party narrative in recent years coupled with living through a pandemic. It is difficult for us to qualify this year's data given year on year comparisons are presently meaningless and members were not sure of the rationale or context of the data comparing NT & H NHS Foundation Trust with other regional Trusts given the extreme health inequalities endured within our own locality area.

In respect of Dementia this is real area of concern for us. It is quite alarming that there has been a reduction over the last year for diagnosis of dementia/delirium given the previous upward trend. The last year has brought into the public domain a greater need to address isolation as this can lead to the early onset of dementia and can only flag this at the present time and sincerely hope there is a collaboration of health & social care partners to increase diagnosis going forward but also provide the much needed support patients require. This like mental health needs to have the same priority as physical health and members would have liked to there being a reference to Alzheimer's disease.

Within effectiveness of care we note the new reporting process may have caused the increase around violent incidences. Members were keen to highlight that it is imperative at the current time for staff to be fully supported and protected. Pressure on staff must be enormous and retention of staff must be important especially for those supporting the end-of-life pathways. Perhaps there needs to be greater integration with social care too. Members were also keen to acknowledge effectiveness of care will have been very different given the lack of hospital visitors allowed for patients in your care.

Healthwatch Hartlepool would again hope a greater focus and examination can be made regarding Safeguarding, in particular DOLS, which we reported had a huge rise in cases within last year's Third Party narrative and any specific data on this element of the Quality Accounts would be appreciated throughout the year. Healthwatch Hartlepool would appreciate a future presentation from the Trust around patient safety.

Once again, we would hope you can include Transport, Accessibility, and adherence to the Equality Act 2010 within the priority of Patient Experience as we have received no feedback in this regard for the last year. We ask this for several reasons one of which is the failure of the Trust to implement their assurance to Healthwatch Hartlepool over a number of years to promote the Healthcare Travel Costs Scheme (HTCS) at the time the Trust notifies patients of their appointments. Transport is quite often a barrier to attendance at appointments and the high level of DNA's. We would therefore encourage a greater promotion of funded assistance to access hospital / promoting use of patient transport to those who qualify.

Other items that cut across greater accessibility and equality relates to better communication. Correspondence, where possible, should be sent in alternate formats ensuring patients can access and understand. Other considerations could be the provision of information leaflets etc. to patients in all accessible formats as well as ability for those with any kind of disability etc to have access of website. Patients with communication support needs should be able to independently contact relevant department to book appointments. There also needs to be a simple system for requesting appropriate communication from professionals in a timely manner (need flagged in patient records/not responsibility of the patient to identify).

In respect of the physical access - Access routes should be clearly identified and appropriate signage displayed / use of plain English and easy read where possible; accessible toilets/changing places conveniently located to promote dignity and independence. For discharge - Delayed discharge data should be collected for patients with communication/other support needs. Information at discharge should always be accessible (i.e. Deaf patients not given telephone number to call ward for advice post discharge). There should always be communication support at discharge to ensure patients understand the outcome of the treatment, future appointments as well as patients understanding what prescribed medication is for, how to take correctly and known side effects etc.

Finally, it would be helpful to include the returned Friends and Family Test as a proportion of those issued electronically or otherwise. I sincerely hope the above is helpful in the Trust formulating their draft quality account and please contact me should you require any further information.

Yours Sincerely,

Christopher Akers-Belcher

Chief Executive - Healthwatch Hartlepool

Stockton Healthwatch – 08 June 2021

Healthwatch Stockton 3rd Party Declaration

Healthwatch Stockton-on-Tees are pleased to report back on the 2020/21 Quality Accounts and note there is clear useful data explaining how North Tees and Hartlepool NHS Foundation Trust is performing against other Trusts in the region and nationally. The report is comprehensive and provides an excellent overview of how the Trust demonstrates quality of healthcare, its general performance and how it manages its services. It was pleasing to note that the Trust took up our recommendations where they were helpful.

It is noted that the Covid-19 pandemic has had a considerable impact on the management and staffing across the Trust and we share our sincere condolences with the families and friends of the 517 people across the Borough who have died in hospital in the last year due to Covid-19.

It is good to see the Trust has continued to improve in reducing infection rates for both hospital and community acquired infections and that this remains a priority for the next year. It is also noted that Healthwatch Stockton-on-Tees shares similar priorities to that of the Trust, in particular its work around improving services for people with mental health issues and note it has signed up to the 'Time to Change' national initiative.

We are pleased to see that the Trust report having a staff team who are committed and positively making progressive improvement. They have maintained their "Good" CQC inspection reported outcome by following through on recommendations and therefore deserve the acknowledgment of being one of the best performing Trusts in the country. It is good to see the Trust continue to recognise that people remain the centre of all they do.

We welcome the focus on listening to people, meeting their needs and providing excellent clinical care and delivering it with dignity, compassion and professionalism.

We also welcome the continued use of the Yellowfin business intelligence software as this helps improve the processing and quality of data and allow demonstration of useful information via automated dashboards.

It is good to note our own Healthwatch Stockton-on-Tees improvement priorities are also shared by the Trust in 2021/22 with some clear stretched targets to achieve improvements in services especially around dementia and mental health and we welcome the addition of the monitoring of accessibility and violent incidents.

Healthwatch Stockton-on-Tees has built a strong working relationship with the Trust in recent years and we will continue to work with and support the Trust with the aim of further improving the quality of services provided and maximising a positive person experience.

Stockton-on-Tees Borough Council – Adult Social Care and Health Select Committee – 04 June 2021

The Committee's closing comments in last year's third-party declaration referenced the emergence and likely impact of Coronavirus. As Members are given their annual opportunity to consider the Trust's latest Quality Account, the events that have unfolded since April 2020 have undoubtedly muddied the waters in terms of analysing performance in relation to anything previously seen as 'normal business'. Nevertheless, the Committee are grateful for the chance to reflect on what has been an extraordinary year for the Trust and the wider health and care sector in general.

Before the Quality Account content is addressed, the Committee would like to echo the sentiments of the Trust's Chief Executive and pay tribute to the incredible efforts of its staff during 2020-2021. As the country moves towards lifting the final COVID-enforced social restrictions, it is easy to lose sight of the uncertain and, at times, chaotic working environment faced by health professionals at the beginning of this municipal year. Back then, there were many unknowns surrounding COVID-19, yet the dedication and selfless attitude of staff in responding to this emergency was, and continues to be, outstanding.

Turning to the Quality Account document itself, Trust representatives presented an overview of the year's performance to the Committee in March 2021, allowing Members to digest and then comment on developments regarding the agreed quality improvement priorities.

The Trust rightly highlights its achievements around mortality measures which, despite increasing in comparison to the same period from the previous year, remain below the mean UK average. Much of the rise was attributable to the impact of the ongoing pandemic, though it is very positive that the Trust's performance in relation to these indicators continues to be strong when mapped against other regional / national Trusts.

As with a range of health issues, assessing the current situation around dementia has been clouded by the overwhelming need to respond to COVID-19 and the associated reduction in people being admitted with other health conditions. Whilst data on dementia / delirium patients has been skewed, the Committee welcomed developments regarding carers support and training uptake, particularly the flexible visiting arrangements for carers of those suffering from dementia, the Parking Eye agreement to support carers and offer of discounts in the canteen, and the drive to train volunteers on being dementia-aware. Members also fully support the promotion of the John's Campaign and were pleased to hear the Trust proactively following-up with families / carers who have used this.

Although perhaps understandable considering the pandemic, evidence of progress against the 'Mental Health' priority was again limited, though it was interesting to note investments in Schwartz rounds for staff – more detail on the take-up of, and feedback from, these sessions would be useful. As in previous years, the 'mind and body' approach is referenced, and the Committee would like to see a greater focus on developing this concept further as the Trust begins to concentrate more on non-COVID-related activity.

Data around infection control continues to be broadly positive, particularly the significant reduction in E.coli cases. Concern was raised last year around the high number of catheter-associated urinary tract infections, and whilst the Quality Account shows a significant reduction of cases in 2020-2021, ongoing surveillance of this issue is urged.

Regarding 'Effectiveness of Care', the Committee was again reassured that no patient deaths had (more likely than not) been due to problems with care, and welcomed developments (i.e. addition of Medical Examiners, identification of areas of improvement via surveys / audits) to strengthen the Trust's learning from deaths. Members became very familiar with work around the 'Discharge Processes' priority over the past year, with the Trust providing detailed submissions for the Committee's review of Hospital Discharge where positive progress was recognised in relation to supporting weekend discharges, the Integrated Single Point of Access (ISPA) and the excellent Home But Not Alone initiative. The Trust's willingness to engage in an open and transparent manner, as well as responding to subsequent recommendations / action points, remains a vital element in making services the best they can be.

The Trust rightly emphasises the need to seek patient experience feedback and demonstrates numerous ways in which this is collected and then used. Some excellent developments within Specialist Palliative Care were noted, not just for the benefit of patients themselves but also for staff (e.g. the innovative creative writing research project helping health professionals cope with some of the stresses they had endured in the last year).

Whilst a similar number of complaints were received by the Trust compared to the previous year, the Committee was pleased to see a significant rise in the amount being resolved at stage 1 (informal). For those progressing to the formal stage 3 level, it was positive that all 135 cases were responded to in an agreed timeframe with the complainant. Members did, however, express concern around the prevalence of complaints in relation to 'attitude of staff'. It was also encouraging to note the increase in staff 'Speaking Up' since 2018 – with only three of 24 concerns being raised anonymously, this suggests that the workforce has confidence that raising issues will not be held against them.

The Trust's performance regarding key national priorities from the Department of Health Operating Framework indicates a mixed picture, though the impact of COVID-19 on these measures is not underestimated. As referenced in last year's statement, the Committee remains keen on understanding plans for addressing cancer standards that have not been / are not being met, though was reassured that this will continue to be a Trust priority moving forward, particularly since future service pressures as a result of the pandemic are inevitable.

The Committee supports the roll-over of quality improvement priorities for 2021-2022 and agree with the Trust's Chief Executive that 'partnership and system-working is vital for the future of health and care services'. The impact of COVID-19 will continue to be felt well into the new municipal year, and all local health and care partners have a challenging job ahead to fully recover from the events of 2020-2021.

The Trusts Council of Governors – 03 June 2021

Council of Governors

(third party declaration)

One of the roles of the Council of Governors is to receive compliance and regulatory information throughout the year in respect of the Trust's performance, which provides oversight and the opportunity for constructive challenge. Key aspects of the information form part of the Trust's Annual Quality Account.

Governors also have the opportunity to review the draft Quality Account to provide general comments regarding its content and design, and to highlight any areas where it is felt further scrutiny or greater assurance is required. The Council of Governors are kept fully appraised in respect of the Trust's priority areas and future developments through a number of forums which include the formal Council of Governor meetings; development sessions; pre-Council of Governor meetings and the more informal sub-committee structure. During 2020/21, the impact of the COVID-19 pandemic meant the Trust had to undertake its key meetings on a virtual basis with reduced content in order to meet the extreme challenges placed on the organisation. Development sessions were facilitated for Governors around the Impact of COVID-19 and the developing Tees-wide Provider Collaborative, which continues to remain a focus.

The schedule of reports for the Council of Governor meetings and the Sub-Committees continue to be regularly reviewed to make sure that topical matters are shared in a timely manner. 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 and it is anticipated that these opportunities will resume fully during 2021/22.

Within the sub-committee structure the Strategy and Service Development Committee reviews new developments and monitors performance. At this Committee presentations were provided in respect of the impact of COVID-19; Climate Change and the Sustainability Agenda, and the Tees-wide Collaborative, in addition to being presented with the Integrated Performance Report at every meeting. These meetings provide the opportunity for detailed debate and interaction with the Governors to seek their views and knowledge. A decision was made during 2020/21 to extend the membership of the Strategy and Service Development Committee to include all Governors to provide the widest opportunity for Governors to be informed on new developments.

The other Sub-Committees include Nominations Committee; Membership Strategy Committee, and the External Audit Working Group, which met during 2020 to oversee the appointment of new external auditors for the Trust.

Although restricted activity due to COVID-19, the Trust ensured that Governors were kept up to date through regular briefings, including the Chairman's bulletin and the introduction of a weekly roundup. The Governors value the range and depth of information provided to them and this has been particularly evident during the COVID-19 pandemic.

Hartlepool Borough Council – Audit and Governance Committee – 26 May 2021

Audit and Governance Committee – Third Party Declaration

Following consideration of the North Tees and Hartlepool NHS Foundation Trust Quality Accounts on 18 March 2021, Hartlepool Borough Council's Audit and Governance Committee agreed the following:

In relation to quality improvement priorities identified for 2020/21, the Committee commended the Trust on their successes across the following areas:

Patient Safety;
Effectiveness of care; and
Patient Experience.

It was suggested by the Trust, that in view of Covid-19, the above key priorities be rolled forward for 2021/22 and the Committee were in support of this.

Yours faithfully

COUNCILLOR GERARD HALL

Healthcare User Group (HUG) – 24 May 2021

Third Party Statement from the Healthcare User Group (HUG)

The Healthcare User Group (HUG) a small group of volunteers made up of members of the general public with its main purpose being to assist the Trust with their Patient and Public Involvement (PPI) agenda. To do this, members make independent visits to inpatient wards and outpatient clinics as well as Accident and Emergency Department and the Integrated Urgent Care Clinics, talking to both staff and patients with the singular aim of hearing the patients' view of their care and experience during their care pathway.

The group also represents the public by attending several of the Trust committees including the Audit & Clinical Effectiveness Group (ACE), Clinical Governance Committee, Patient & Carer Experience Committee (PCEC), Discharge Steering Group, Infection Control Committee (ICC) and Patient Quality & Safety Standards Group (PS&QS), Organ Donation Committee, Research and any other groups created to improve patient treatments and choices.

2020 was a year "like no other" as reported in the national press. HUG representatives did their last ward visit on Ward 29 of UHNT. It was on this day the Trust wisely chose to suspend all volunteer activities within the Trust as the government stuttered towards announcing a national lock down. As many of the Trust's volunteers are elderly members of the public this was not a surprise as reports from China had already indicated that those people were most at risk, as were those with co-morbidities. So, 2020-21 was a year when there were no visits to inpatient wards or outpatient clinics, but those members of our group who were able to attend meetings remotely, using Microsoft Teams® or Cisco® video conferencing software continued to do so.

We have reviewed the Quality Accounts and conclude they are a true representation of the position the Trust finds itself at the end of this extraordinary year. We can only commend the fantastic work being done within the Trust to improve mortality rates, infection rates and the drive towards the delivery of excellence of care to patients both in hospital and in the community.

With the value of some of the data presented being questionable, as service provision has been stymied by the need for the entire NHS to concentrate on treating Covid-19 patients, what has been reported makes sense, in light of the necessity to cease patient's friends and family visiting. The "Friends and Family Test" results continue to provide a high level of appreciation by patients of the care they have received. However, it is also pleasing to see that the Trust takes patient and family complaints seriously and responds in a timely manner to any failing, perceived or otherwise, in treatment and care. It is pleasing to see that the majority (87%) of complaints can be resolved at the informal level.

The 86% rise in the number of violent incidents against staff/patients is a very worrying trend, although this could be due to a difference in reporting methodology which could account for some of the numbers. However, 638 incidents annually equates to almost 2 incidents per day, and with staff retention an issue nationally, the necessity to ensure staff (and patient) safety should remain at the forefront of the Trust's safety agenda.

The Chief Executive points out the valued work of staff, both in managing the changes forced upon them in 2020-21, with having to handle external pressures produced by the pandemic (PPE shortages) and the need to change how the entire Trust operated due to the infectious nature of this new pathogen. Having attended meetings via video conferencing, it is remarkable that the Trust staff have remained focused on patient care whilst enduring the uncomfortable situation of no longer being able to rely on input from patient family members.

The uncomfortable reading of the number of COVID-19 deaths within the Trust's catchment area is sobering, realising the difficult conversations each one of these deaths has had on both staff and families. We hope the Trust will support those staff adversely affected by their experiences during the pandemic, both with those who have manned the frontline services with the mental anguish that has had upon them, and those forced to shield, who may return with negative feelings of guilt at not being able to support their own colleagues.

The Trust continues to make increased use of ICT in order to achieve a paperless/paper light approach to healthcare. The use of hardware and integrated software to monitor and record patient data is becoming almost second nature to staff and with this come the ability to monitor performance in real-time, allowing senior ward staff the opportunity to use auditing tools and report to the ward staff of both the highs and lows of performance so changes can be made immediately. As the Trust moves forward towards this "Brave New World" it will be hopeful that medication errors and mistranslation of documentation will become a thing of the past with the electronic 'eye' ensuring the treatment of patients is safe and appropriate, as well as allowing GPs to access patient data very quickly. Also, as many people now have access to 'smart' technologies, such as Smartphones, iPads and other Tablet computers, the Trust are beginning to produce patient leaflets which can be accessed by scanning a QR code (in the ED, Outpatient Clinics, Wards) which can link to the Trust's website and other external sites for leaflets about particular treatments they will undergo within the Trust. It is hoped that moving forward the leaflets will be easier to read and always available as an online resource.

There is no doubt that the situation in the Tees region is one of inequality and there are a great number of potential patients living in areas of high deprivation, although it is to be hoped that the 'levelling up' promised will change this positively. However, no change will happen immediately and with an elderly and ageing population the demands on the healthcare and social care system will increase and those will inevitably impact on the local Hospital Trusts. The expected rising number of patients admitted into hospital with a diagnosis of Dementia in our area is already evident, and the Trust continues to deliver Dementia training to all staff who will have contact with patients suffering Dementia. This has been and will remain a priority for the Trust, and we look forward to our own Dementia training (planned for 2020 but that ship has sailed) in the near future.

The key priorities for 2021/22 are relatively unchanged from the previous years, but HUG supports this approach and will do all it can to help and support in any way possible. Our thanks go out to all those people working in the Trust, whether physicians or support staff, and applaud their commitment and dedication to the care of their patients.

Healthcare User Group
May 2021

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 2019-20* 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 2020 to April 2021
  - papers relating to Quality reported to the Board over the period April 2020 to April 2021
  - feedback from commissioners dated xx *June 2021*
  - feedback from governors dated 03 *June 2021*
  - feedback from local Healthwatch organisations dated 21 April *2021 & 08 June 2021*
  - feedback from the Adult Services and Health Select Committee and Audit and Governance Committee dated 26 May *2021 &* 04 *June 2021*
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated *Q4 2020-21*
  - the latest national patient survey *2019*
  - the latest national staff survey *2020*
  - 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

Date 31 May 2021

Chief Executive

Date 31 May 2021

Chairman

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

Due to COVID-19, there was no requirement for the Quality Accounts to be externally audited.

Annex D – We would like to hear your views on our Quality Accounts.

North Tees & Hartlepool NHS Foundation Trust value your feedback on the content of this year's Quality Account.

Please fill in the feedback form below, tear it off and return to us at the following address:

Patient Experience Team

North Tees & Hartlepool NHS Foundation Trust

Hardwick Road

Stockton-on-Tees

Cleveland

TS19 8PE

.....

Thank you for your time.

Feedback Form (please circle all answers that are applicable to you)

What best describes you: Patient Carer Member of public Staff Other

Did you find the Quality Account easy to read?	Yes	No	
Did you find the content easy to understand?	Yes all of it	Most of it	None of it
Did the content make sense to you?	Yes all of it	Most of it	None of it
Did you feel the content was relevant to you?	Yes all of it	Most of it	None of it
Would the content encourage you to use our hospital?	Yes all of it	Most of it	None of it
Did the content increase your confidence in the services we provide?	Yes all of it	Most of it	None of it

Are there any subjects/topics that you would like to see included in next year's Quality Account?

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

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Alternatively you can email us at: **Patientexperience@nth.nhs.uk** With the Subject **Quality Accounts**

Glossary

A&E	Accident and Emergency
ACE Committee	Audit and Clinical Effectiveness Committee – the committee that oversees both clinical audit (i.e. monitoring compliance with agreed standards of care) and clinical effectiveness (i.e. ensuring clinical services implement the most up-to-date clinical guidelines)
ACL	Anterior Cruciate Ligament – one of the four major ligaments of the knee
AKI	Acute Kidney Injury
AHP	Allied Health Professional
AMT	Abbreviated Mental Test
AquA	Advancing Quality Alliance
BI	Business Intelligence
CAB	Citizens Advice Bureau
CABG	Coronary Artery Bypass Graft (or “heart bypass”)
CAUTI	Catheter-associated urinary tract infection
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
CMR	Crude Mortality Rate
CNS	Clinical Nurse Specialist
COHA	Community onset Healthcare Associated
COPD	Chronic Obstructive Pulmonary Disease
CLIP	Complaints Litigation Incidents Performance
CPIS	Child Protection Information System
CPMS	Central Portfolio Management System
CSE	Child Sexual Exploitation
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
Datix	Datix is the Trust incident reporting system
DH	Department of Health
DLT	Discharge Liaison Team
DNA	Did Not Arrive
DNACPR	Do Not Attempt Cardio Pulmonary Resuscitation
DoLS	Deprivation of Liberty Safeguards
DSCP	Durham Safeguarding Children Partnership
DSPT	Data Security Protection Toolkit
DToC	Delayed Transfer of Care
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
ED	Emergency Department
EMSA	Eliminating mixed sex accommodation
EPMA	Electronic Prescribing and Medication Administration
EPR	Electronic Patient Record
EOL	End of Life
ESR	Electronic Staff Record
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

FTSU	Freedom To Speak Up
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
HENE	Health Education North East
HES	Hospital Episode Statistics
HLSCB	Hartlepool Local Safeguarding Children Board
HMB	Heavy Menstrual Bleeding
HOHA	Hospital Onset Healthcare Associated
HQIP	Healthcare Quality Improvement Partnership
HRG	Healthcare Resource Group – a group of clinically similar treatments and care that require similar levels of healthcare resource
HSCB	Hartlepool Safeguarding Children Boards
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
HSSCP	Hartlepool and Stockton Safeguarding Children Partnership
HUG	Healthcare User Group
IBD	Inflammatory Bowel Disease
ICC	Infection Control Committee
ICE	
ICNARC	Intensive Care National Audit and Research Centre
ICO	Information Commissioners Office
ICS	Intensive Care Society
IG	Information Governance
IHA	Initial Health Assessment
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
ICE	Integrated Clinical Environment
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
ISPA	Integrated Single Point of Access
Kardex (prescribing 145ardex)	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
Kleb sp	Klebsiella Species (type of infection)
KPI	Key Performance Indicator
LAC	Looked After Children
LADO	Local Authority Designated Officer
LAR	Looked After Review
LD	Learning disabilities
LeDeR	Learning Disabilities Mortality Review
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
LMS	Local Maternity System
LPMS	Local Portfolio Management Systems
LPS	Liberty Protection Systems
LQR	Local Quality Requirements
LSCB	Local Safeguarding Children's Board
MARAC	Multi Agency Risk Assessment Conferences
MATAC	Multi Agency Tasking and Co-ordination
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK
MCA	Mental Capacity Act
MDT	Multidisciplinary Team
ME	Medical Examiner
MEG	Missing Exploited Group
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
MSSA	Methicillin-Sensitive Staphylococcus Aureus
MUST	Malnutrition Universal Screening Tool
NCEPOD	The National Confidential Enquiry into Patient Outcome and Death
NCPES	National Cancer Patient Experience Survey
NCRN	National Cancer Research Network
NDG	National Data Guardian
NEAS	North East Ambulance Service
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
NRLS	National Learning and Reporting System
NTHFT	North Tees and Hartlepool Foundation Trust
OD Banding	Overdispersion (statistical indicators)
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
PET	Patient Experience Team
PHE	Public Health England
PIC	Patient Identification Centre
PICANet	Paediatric Intensive Care Audit Network
PMRT	Perinatal Mortality Review Tool
PREVENT	the government's counter-terrorism strategy
PROMs	Patient Reported Outcome Measures
Psa	Pseudomonas Aeruginosa (Type of Infection)
Pseudonymisation	A process where patient identifiable information is removed from data held by the Trust

QAF	Quality Assessment Framework
Quality Improvement	
R&D	Research and Development
RA	Recruitment Activity
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
RHA	Review Health Assessments
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
SCR	Serious Case Review
SEPSIS	Life-threatening reaction to an infection
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
SLSCB	Stockton Local Safeguarding Children Board
SMPG	Safety Medical Practices Group
SOF	Single Oversight Framework
SOP	Standard Operating Procedures
SPA	Single Point of Access
SPC	Specialist Palliative Care
SPCT	Specialist Palliative Care Team
SPEQS	Staff, Patient Experience and Quality Standards
SPICT	Supportive & Palliative Care Indicator Tools

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
SUS	Secondary User Service
TEWV	Tees, Esk and Wear Valleys NHS Foundation Trust
TIA	Transient Ischemic Attack
TNA	Training Needs Analysis
Tough-books	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
TRAKCARE	Electronic Patient Record System
TSAB	Tees-Wide Safeguarding Board
UCC	Urgent Care Centre
UHH	University Hospital of Hartlepool
UHNT	University Hospital of North Tees
UKST	UK Sepsis Trust
UNIFY	Unify2 is an online collection system used for collating, sharing and reporting NHS and social care data.
UTI	Urinary Tract Infection
UV	Ultra Violet
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
4at delirium assessment tool	Bedside medical scale used to help determine if a person has positive signs for delirium