NHS
North Tees and Hartlepool
NHS Foundation Trust

Quality Accounts 2021-22

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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 pleased to bring you this year's Quality Accounts report for North Tees and Hartlepool NHS Foundation Trust, which is about raising the spotlight on the outstanding work we are carrying out to ensure high quality, safe care for our patients.

We know that our ongoing focus on quality of care provision and being completely aligned with the health care needs of our patients.

We continue to develop and improve as an organisation, learning from the experience of patients, families and staff. To support this journey we updated our "Quality and Safety Strategy" for 2022 – 2025", which describes our focus and how we will develop as an organisation to continue to deliver clinically effective, high quality and safe patient care. We believe that our approach to empowering staff and patients will ensure our services to meet the needs of our staff and our community, our aims are to:

- Maximise the things that go right and minimising the things that go wrong,
- Promote quality through everything we do
- Support, encourage and enable improvement

I am delighted with how the organisation has continued to respond – and indeed recover – from COVID-19. In December, we facilitated a Getting It Right First Time follow-up visit specifically relating to our pandemic response. We were invited to share learning opportunities to be cascaded to other providers after being identified as one of the top performers during the pandemic.

The way we work has continued to change over the last 12 months – we have created a specialist respiratory unit to help treat patients and we are also intervening and treating patients long before they become so unwell that they need to be treated in our critical care unit. Healthcare never stands still, we have learned lessons about the virus and we now know significantly more about how to provide the best quality care to our patients.

We have also rolled out a full vaccine programme for staff and patients –something which has had a significant impact in helping to reduce staffing and bed pressures across the organisation. Our involvement in the national RECOVERY study into treatments for the virus has also been outstanding. We have discovered numerous effective treatments from this trial – treatments that we are using on a regular basis within our hospital settings. And our own research team has helped play a significant and exceptional role in this study.

We are pleased to have made significant progress with reducing the backlog created by the pandemic – particularly in the areas of non-urgent surgery and hospital outpatient appointments. We have been comparatively highlighted as one of the highest performing trusts in this area, an excellent achievement.

The Trust continues to perform well. During 2021-22 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. We recognise that death is the natural part of life, however we recognise of the impact of death on loved ones. We continue to improve the management and experience of patients and families at this very difficult time, this is underpinned by the role of the Medical Examiner who supports bereaved relatives

and learning from their experience, Infection Prevention Control (IPC) has continued to be in the headlines for the NHS this past year.

The Trust continually monitors infection rates and remains ambitious for improvement implementing new initiatives and innovations, which are outlined within this report. The Trust reported 50 cases of Clostridium Difficile against a target of 64 during 2021-22. The forthcoming year will see further challenges in the work toward improving infection, prevention and control, and this remains a firm priority for us as an organisation.

We remain open and transparent with all of our close partners and it is this level of positive engagement that must remain a high priority for the future. to develop pathways of care that truly reflect a more aspirant focus for the Tees Valley and the wider region.

This is why 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).

Closer collaborative working with our health partners is clearly a real focus of the organisation as we move forward. Ensuring we transform to deliver services fit for the future to the populations we serve is always our priority. The way that healthcare looks continues to evolve and we plan to continue to play a significant part in shaping the future of healthcare in the region so that our patients are always being provided with the very best quality of care. The appointment of a joint chair with South Tees Hospitals NHS Foundation Trust is further helping us realise this focus in wider population health and prevention and shaping services to the benefit of our patients.

There are so many ways we are already working with other stakeholders to help raise aspirations in our community – and there are so many significant plans afoot over the next 12 months and beyond around education, housing, the economy and in the political landscape.

We benefit from close working relationships with our local authority partners, and our hopes are to build on these placed based aspirations to meet the needs of our communities in the forthcoming year.

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 2022

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 2021-22 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: 2020-21 Quality Improvement

Part 2 of the Quality Account provides an opportunity for the Trust to report on progress against quality priorities that were agreed with external stakeholders in 2020-21. We are very pleased to report some significant achievements during the course of the year.

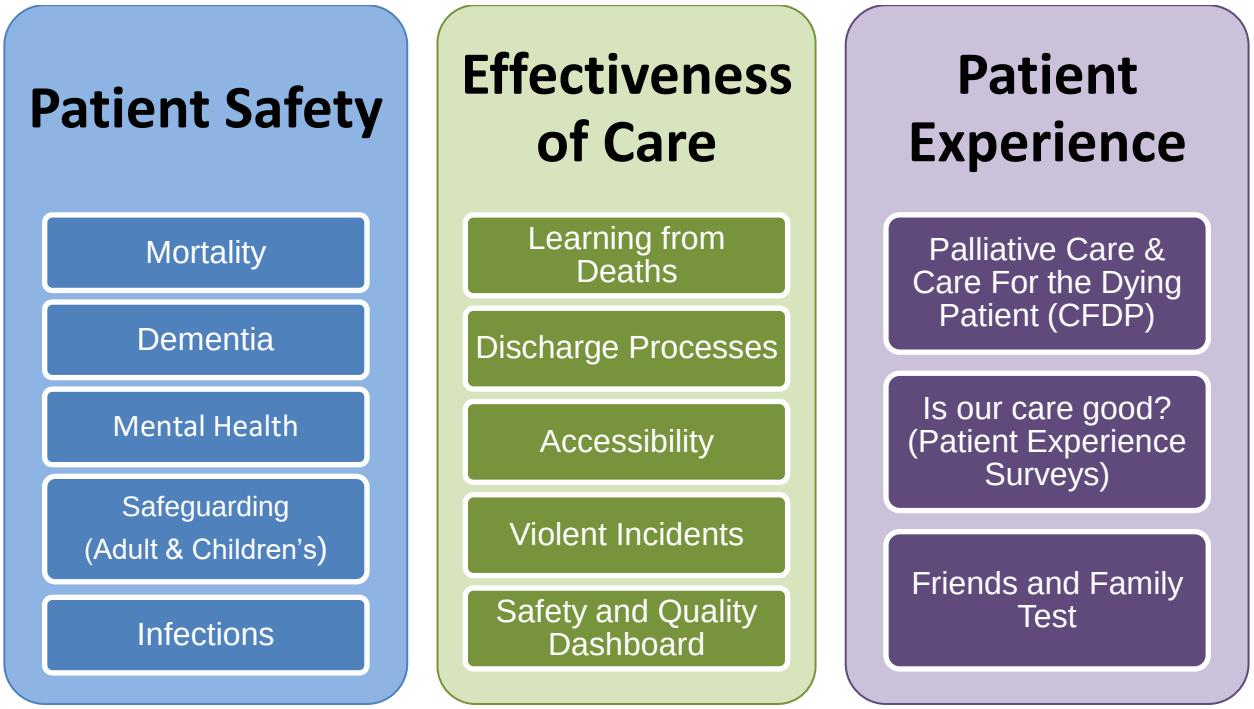
Consideration has also been given to feedback received from patients, staff, governors and the public.

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 2021-22 priorities.

Stakeholder priorities 2021-22

The quality indicators that our external stakeholders said they would like to see reported in the 2021-22 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

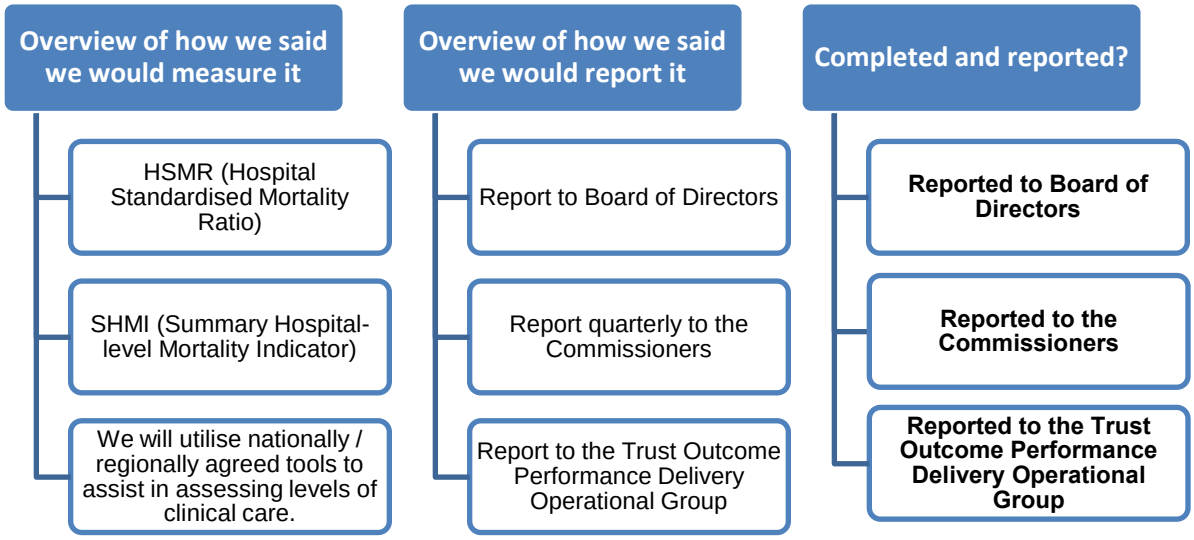
Mortality

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 2021-22 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.

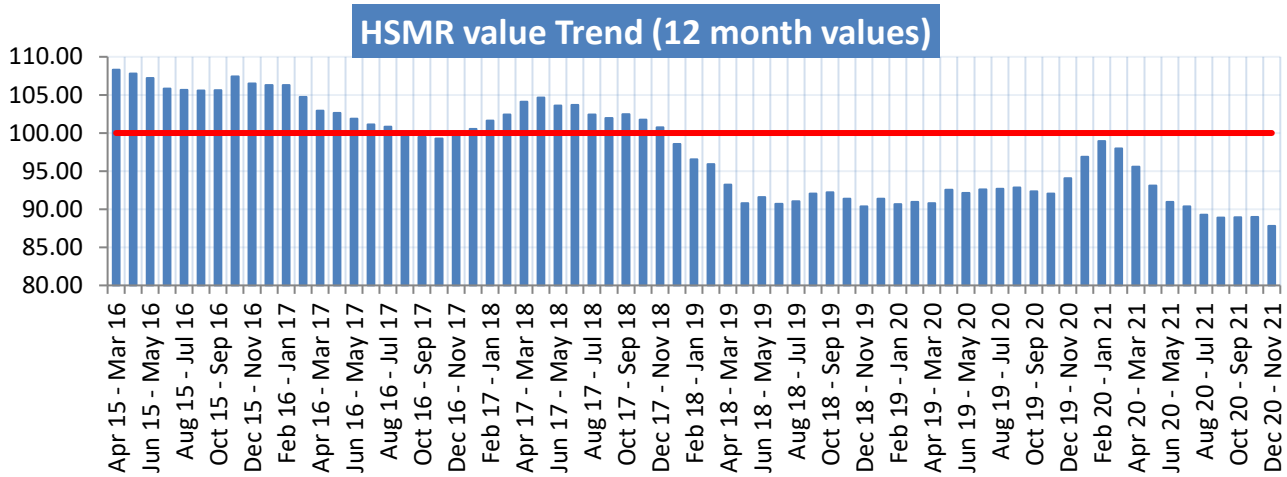
The following data is from the two nationally recognised mortality indicators of Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI).

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

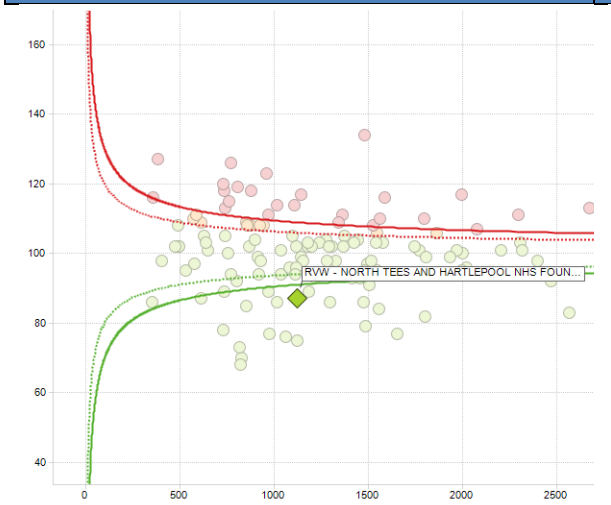
The Trust **HSMR** value is **87.81** for the reporting period from **December 2020 to November 2021**; this value continues to place the Trust in the **'as expected'** range. The National Mean is 100, which denotes the same number of people dying as expected by the calculations, any value higher means more people dying than expected.

Reporting Period	*CMR	HSMR	National Mean
Dec 20 - Nov 21	**3.16%**	**87.81**	**100**
Nov 20 - Oct 21	3.28%	88.99	100
Oct 20 - Sep 21	3.33%	88.94	100
Sep 20 - Aug 21	3.38%	88.9	100

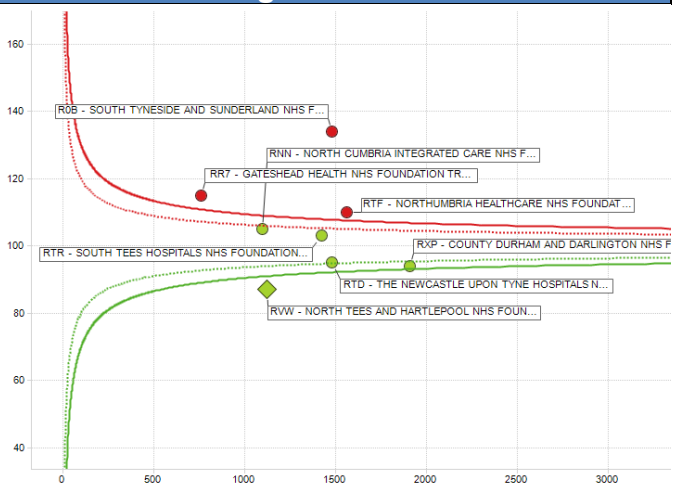
*Crude Mortality Rate (CMR)



National View



Regional View



*Latest 12 month position (December 2020 to November 2021) Data obtained from the Healthcare Evaluation Data (HED)

Summary Hospital-level Mortality Indicator (SHMI)

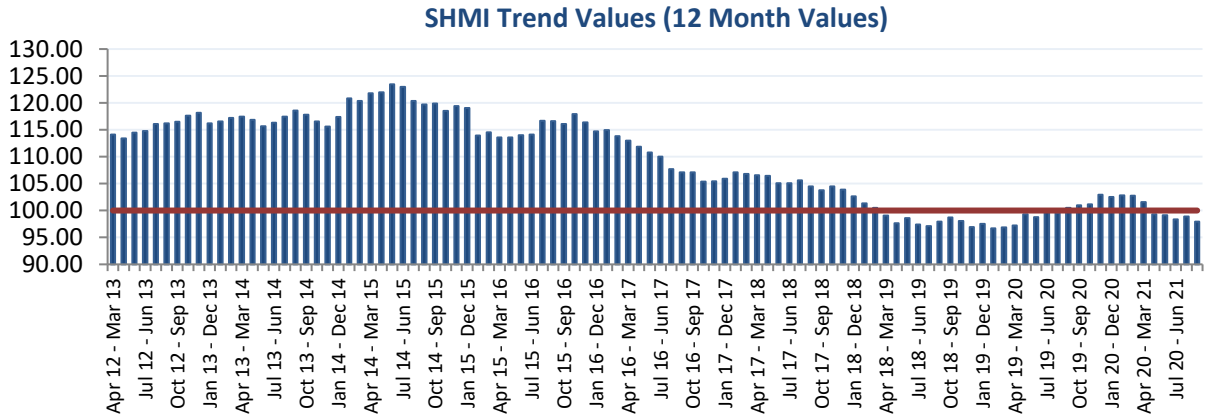
The **SHMI** indicator provides an indication on whether the mortality ratio of a provider is as expected, higher than expected or lower than expected when compared to the national baseline in England.

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

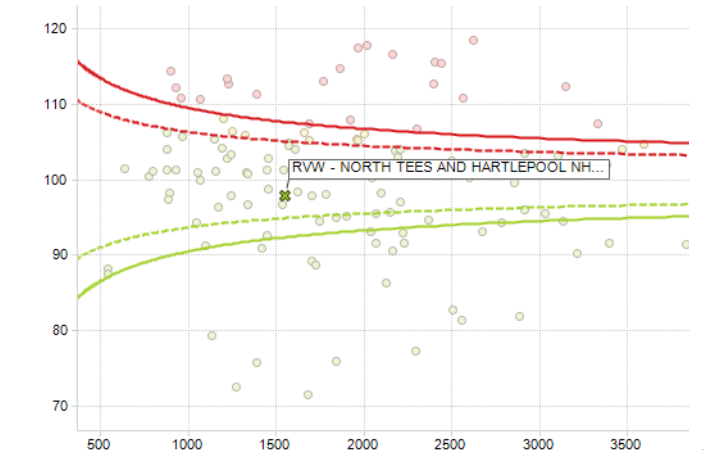
The latest SHMI value of **97.95 (September 2020 to August 2021)** continues to reside in the **'as expected'** range.

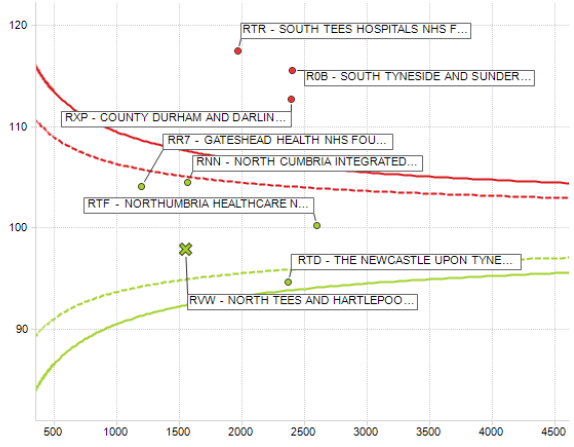
Reporting Period	*CMR	SHMI	National Mean
Sep 20 - Aug 21	**3.22%**	**97.95**	**100**
Aug 20 - Jul 21	3.27%	98.89	100
Jul 20 - Jun 21	3.26%	98.37	100
Jun 20 - May 21	3.27%	99.10	100

*Crude Mortality Rate (CMR)



National View	Regional View



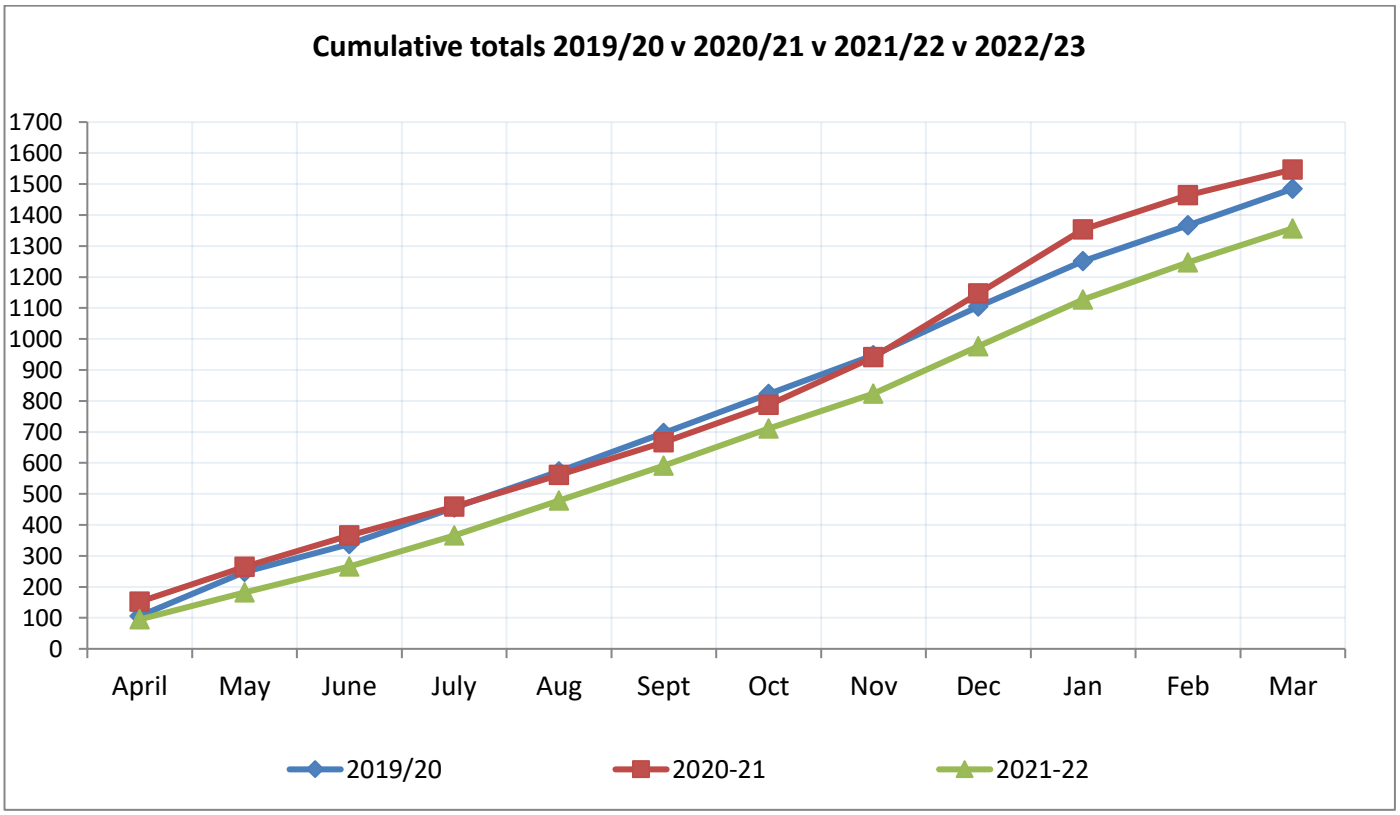


*Data obtained from the Healthcare Evaluation Data (HED)

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 2021-22, the Trust experienced **1,357** mortalities (April to March), this is **190** fewer mortalities than experienced in 2020-21.

	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
2021-22	**95**	**182**	**266**	**366**	**479**	**591**	**711**	**824**	**975**	**1127**	**1247**	**1357**



Priority 1: Patient safety

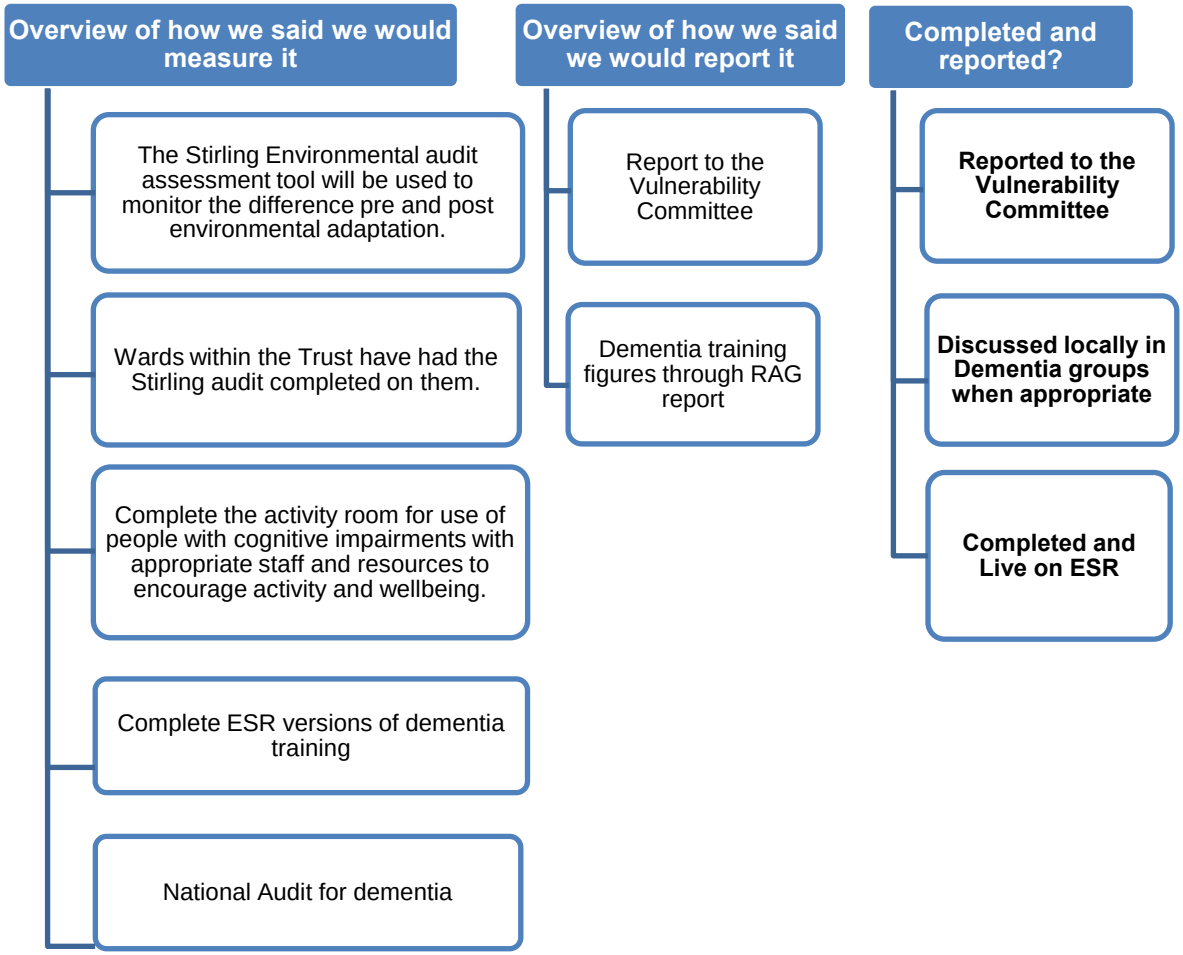
Dementia

Rationale: 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. The region has an 85.8% diagnostic rate. This is significantly higher than the 66.7% national benchmark; which shows the progress the region has made in relation to accurate and timely diagnosis.

The National audit of Dementia is due to commence the next round later in 2022 and the trust will be involved again. We are striving to further improve on the last rounds positive results.

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.
- Development of a new North Tees and Hartlepool Dementia Strategy to share and promote our vision for supporting people living with dementia that we serve.
- 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.
- Creation of a dementia friendly activity room for use to assess and provide therapeutic interventions for people with dementia in a safe, calm and appropriately equipped environment.
- 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.



Carers Support

- 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
- Community Dementia Liaison service run carers support sessions through The Bridge at Hartlepool, to support and educate carers of people living with a dementia.
- 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 and University Hospital of Hartlepool has also been given this accolade. The aim is to continue to develop close and consistent links with relevant local agencies.

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

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
2020-21	3,253	-531
*2021-22	3,624	+371

*Data from Information Management Department April 2021 to March 2022

Dementia Training Levels

Level 1 - Dementia Awareness Raising

This includes general awareness of what dementia is, different types of dementia and how it may effect the person. Basic skills and approaches are included in this training.

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. This is also available as e-learning.

There has been an identified training need for the Trust volunteers in relation to dementia. As a result, volunteer training in dementia and delirium is offered regularly and attendance is always good.

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

Level 2 includes all of the content of level 1, but in more detail. It includes treatment options, information on more complex behaviours as a result of cognitive impairment, and provides a variety of options for the staff try to provide the best care possible.

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.

Level 2 e-learning is now also available on ESR.

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

This is the level of 'Trust Dementia Champions'.

Level 3 provides staff with high level knowledge of dementia, assessment, diagnosis and treatments. It gives the learner opportunities to become confident enough to be a leader in their clinical area. Attendees of level 3 with also get information on carer support, national audits and techniques for managing behaviours that challenge in relation to people living with dementia.

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 5 times a year, excluding winter months when staffing pressure on the trust is expected to be higher.

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.

Training Figures 2021-22	
Dementia Level 1	97%
Dementia Level 2	82%
Dementia Level 3	89%

*Data obtained from the Trust dementia training for February 2022.

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.

As at February 2022, 90.76%% 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 and continuers to embed this within the Trust.

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.

Priority 1: Patient safety

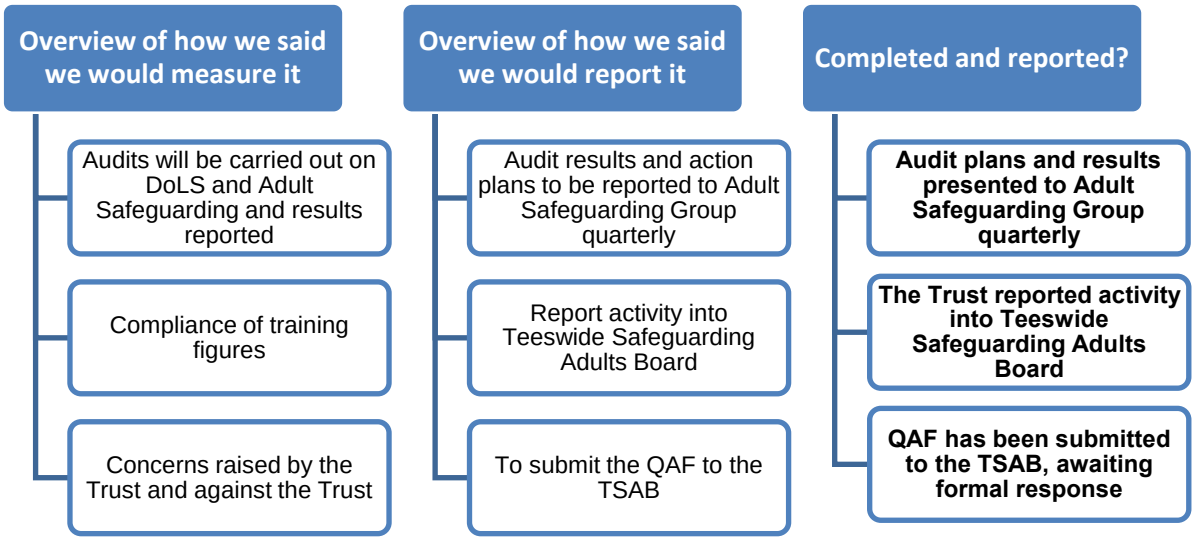
Safeguarding (Adults & Children's)

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 has been produced, RAG rated is currently been 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 2021-22	
Level 1	93%
Level 2	95%
Level 3	70%

*Data obtained from the Trust workforce for March 2022.

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 has moved to Datix to manage and record safeguarding concerns. This 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 **564** concerns the Trust has been involved with in 2021-22, the Trust raised **392** of these concerns. This trend demonstrates that there has been an increase in concerns in 2021-22.

2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
255	244	413	484	478	540	**564**

*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	1	1	1	**3**
Domestic Abuse	18	17	16	18	**69**
Financial or Material	14	12	10	18	**54**
Modern Day Slavery	0	1	0	0	**1**
Neglect and Acts of Omission	74	58	67	69	**268**
Organisational	3	4	5	7	**19**
Physical	22	9	15	28	**74**
Psychological	13	10	6	9	**38**
Self-Neglect	34	33	33	40	**140**
Sexual Abuse	4	2	4	3	**13**
Sexual Exploitation	1	0	0	0	**1**
Total	**183**	**147**	**157**	**193**	**680**

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	43	48	48	54	**193**
Care Group 2 - Responsive Care	57	28	36	37	**158**
Care Group 3 - Collaborative Care	6	7	9	13	**35**
Corporate Group	1	6	4	6	**17**
North Tees & Hartlepool Solutions (Estates & Facilities)	0	0	0	0	**0**
Total	**107**	**89**	**97**	**110**	**403**

Number of concerns against the Trust

There have been **93** concerns against the Trust.

2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
50	79	79	79	80	**93**

Themes of Alerts against the Trust

Themes of Alerts	Q1	Q2	Q3	Q4	Total
Assault	1	0	1	0	**2**
Communication	10	8	10	10	**38**
Dehydration	0	0	0	0	**0**
Discharge Issue	15	8	13	8	**44**
Documentation	4	2	3	5	**14**
Lack or Reasonable Adjustments	1	0	0	1	**2**
Malnourishment	0	0	0	0	**0**
Medication Error	4	3	5	6	**18**
Moving & Handling	1	2	2	2	**7**
Pressure Damage/Ulcer	4	1	2	7	**14**
Psychological	0	1	0	1	**2**
Sexual	0	0	0	0	**0**
SPA Referral	1	0	1	0	**2**
Theft	0	0	0	0	**0**
Unexplained Injury	1	1	0	1	**3**
Unkempt	1	1	1	1	**4**
Unwitnessed Fall	0	0	1	0	**1**
Total	**43**	**27**	**39**	**42**	**151**

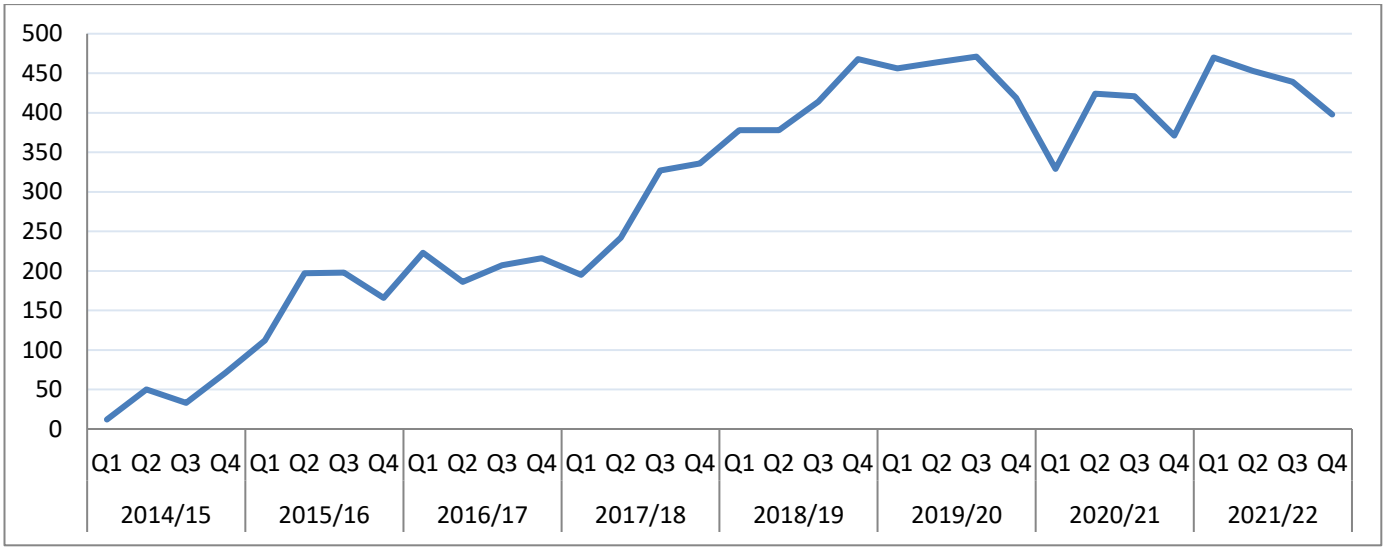
*To note: one concern can cover multiple themes

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 code of practice for Liberty Protection Safeguards (LPS) was released in March 2022, a 16 week consultation period is in place. Following the formal consultation, new guidelines that replace DoLS will be produced



The Trust has seen **1,760** applications during the first three quarters of 2021-22.

2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
673	832	1,100	1,638	1,810	1,545	**1,760**

*Data as of 31 March 2021

Trust Adult Safeguarding Governance Arrangements

The Associate Director of Nursing –Patient Safety, Risk & Governance is the executive lead for safeguarding adults with the Named Nurse Adult Safeguarding 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 combined with Childrens so that there is a joint strategic safeguarding Committee, this reports to Patient Safety and Quality Standards Committee (PS & QS), including representatives from key Trust clinical and non-clinical directorates and partners from Local Authority and Harbour who are experts in domestic abuse.

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 2021-22 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. During this year **1** Prevent concern has been raised.

Training Figures 2021-22	
PREVENT	92%
WRAP	90%

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 Children in Our Care (formerly LAC) led by the Chief Nurse/Director of Patient Safety and Quality. A monthly Adult and Childrens Safeguarding Committee, chaired by a Non-Executive Director maintains responsibility for the performance monitoring of the Children's Safeguarding work program. The Committee also brings together commissioners and providers with representation from Tees Valley CCG (Designated Doctor and Designated Nurse for 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 Associate Director of Risk and Governance 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 Group and MACE Board
- MARAC (Multi Agency Risk Assessment Conference)
- MATAC (Multi Agency Tasking and Co-ordination)
- County Durham Safeguarding Health Leads
- County Durham Child Exploitation Group (CEG)

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 bi-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 Children's Health in Care agenda and work program remains paramount. This governance framework provides safeguarding assurance to the trust and its partners through a Safeguarding Strategic Committee.

Children's Safeguarding Work Program

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

- Action plans from Rapid Reviews / Children's Safeguarding Practice Reviews; learning lesson reviews, Domestic Homicide Reviews and any internal incidents.
- The safeguarding children annual audit and assurance program.

Part 1 – Learning Lessons from Children's Safeguarding Practice Reviews

There have been four Local Safeguarding Children Practice Reviews (LSCPR) commissioned by Hartlepool and Stockton Children's Partnership over the last year 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 Safeguarding Committee. No reviews have progressed to a National Children's Practice Review.

All of the above LSCPR reviews are now published in response to the conclusion of criminal proceedings and all Trust actions completed. The Trust remain actively involved in dissemination of the wider partnership learning as per the reviews final recommendations.

Two 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 was found to be sufficient in identifying agreed actions amongst agencies which continues to be actively monitored through partnership meetings.

There remains actions which are presently being progressed in response to one Rapid Review conducted with our Durham Safeguarding Children's Partnership.

Part 2 - Development Work

Children Not Brought for Appointments by Parents/Carers' Policy

The policy and assurance process embedded across the Trust is in response to a local serious case and learning lessons review. The policy enables practitioners to understand that when a child has not been brought to appointments this may be an early indicator of neglect and requires an appropriate response. The Trust can now also identify children where appointments are frequently rescheduled by parents/carers alongside those that do not attend and improvements are monitored through auditing as to how practitioners respond.

Safeguarding Children's Policy

The Safeguarding Children's Policy ensures that Trust staff understand 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 has been recently reviewed and agreed by members of the Children's Safeguarding Professionals and Steering group at the end of 2020 now the Safeguarding Committee.

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 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.

Safeguarding Children's Supervision Policy provides guidance to practitioners regarding expectations around supervision and support available. This is due to be reviewed April 2022.

Supervision compliance reported via the quarterly dashboard is demonstrated in the table below. Staff sickness is *not included* in compliance figures.

Supervision Figures 2021-22	
Q1	94%
Q2	96%
Q3	96%
Q4	96%

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) and Child Criminal Exploitation (CCE)

CSE and CCE continue to be a growing concern. The Stockton and Hartlepool VEMT (Vulnerable, Exploited, Missing Trafficked) practitioners group and the Child Exploited group (CEG) 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 10 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) where response to high risk perpetrators are managed.

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. The policy is presently under review to ensure it reflects guidance to staff on recent changes in response to the Domestic Abuse Bill (2021). Safeguarding training updates include updated advice.

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 feelings of Children in our Care (LAC) continue to be captured 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, bruising is not always responded to appropriately by health practitioners both nationally and locally. As a result, a significant number of abusive events have been missed nationally resulting in children being placed at risk, serious incidents and are continued to be identified through Safeguarding Children's Practice 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 trainers continue to support joint working across the 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 Adult Vulnerability Committee and Children's Steering Group have been brought together into the Safeguarding Committee to facilitate the 'Think Family' approach at a Strategic level.

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	**Medical Audits:** • **Child Protection Medical Assessment** • **Haematological investigations in Non Accidental Injuries (Initial and re audit)** • **Impact of Pandemic on Abusive Head Trauma** • **Fabricated or Induced Illnesses**
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 Child Protection Medical Quality Assurance Record Audit	**Children Not Brought for Appointments by Parents/Carers Policy Audit**

Children's Safeguarding Key Achievements 2021/2022

- Increased visibility on wards by Safeguarding Senior Nurses through their liaison role to improve 'Think Family' approach promoting safeguarding of both children and adults throughout the trust
- Daily tracking of Children admitted on adult wards by children's safeguarding team to ensure safeguarding is considered by staff in areas where staff are only trained to level 2 children's safeguarding.
- High compliance for safeguarding supervision sustained for professionals who hold children on their caseload despite challenges of staffing around COVID.
- High visibility of Children's Safeguarding Nurses in high demand areas such as A&E and UCC, and an increasing level of support in Emergency Assessment Unit (EAU) to improve understanding and response to 16 – 18 year olds they have admitted.
- Tracking by Senior Nurses Safeguarding Children of all children admitted to the hospital who are nursed on adult wards to ensure safeguarding is considered.
- The Trust is now compliant to all standards set out by Royal College in October 2020 for child protection medicals through the development of New Trust Guidelines, review and update of Child Protection Medical Proforma's for Consultant Paediatricians and chaperoning with completion for staff of relevant training. Prospective Auditing of Child Protection Medical Standards is in progress and is part of the Safeguarding Committee work plan.
- Children's safeguarding group supervision is now provided to allied services from the Trust who although do not caseload manage children do provide an intensive, continuous level of health care delivery. This is to support complex case discussion and reinforce their role and responsibilities in assessing safeguarding needs.
- Earlier identification and case management and supervision is provided more proactively in cases with perplexing presentations in line with FII guidance published March 2020, and ensure these align with Trust policies and procedures.
- E-learning packages developed for Level 3 Foundation and Update Training.
- Successful introduction to annual safeguarding Schwartz round.

Children's Safeguarding Key Priorities 2022/2023

- A Child Protection Medical Suite is under development through support from the Trust in recognition of the stress for children and their families and professionals in having to undergo and support Child Protection Medicals. Providing an increased level of confidentiality for families and promoting information sharing.
- Continue to strengthen partnership working through expanding the Interface Group between front of house services from all agencies. This now includes the Trusts Emergency Department, Urgent Care and CYPED with Social Care's Emergency Duty Team, Social Care Children's Hub, CAMHS and Police representatives with Named Safeguarding Professionals for the Trust. This group has proved to be successful through improving collaboration and understanding of each other challenges, embedding any learning and breaking down barriers to sharing of information in a timely way.
- Continue to collaborate with agencies in the development of the MACE contextual safeguarding hub to support how all agencies including the Trust understand how to respond and protect children appropriately against extra familial harm, peer on peer abuse, who are criminally and sexually exploitation.
- Continue to explore challenges to capturing Safeguarding activity data through recording systems for analysis, to inform targeted response to quality improvements.
- Build on collaborative working relationships and shared learning with neighbouring acute trust safeguarding teams.
- Continue to support and share information with appropriate consents to universal services and partners to support risk assessment of children who have had contact with the trust and appropriate support and response is considered at all levels of concern.
- The development of communication and engagement process to support sharing of key safeguarding messages to all trust members to promote increasing awareness of adverse childhood experiences and the need to adopt a trauma informed care approach throughout the trust in response to recent lessons learned.
- Development of new pathway in response to lessons learned through incidents; Fracture review pathway and Genital Injuries Pathway.
- Dental Neglect Pathway development to support access and feedback to practitioners for our vulnerable children (following child protection medical and our Children in Care)
- Review of non-mobile baby pathway to ensure alignment with neighbouring trust and Tees procedures.
- Paediatricians offered mini pupillage and group supervision under discussion in addition to Peer Review.

Safeguarding Children Training Programme

Throughout 2021 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.

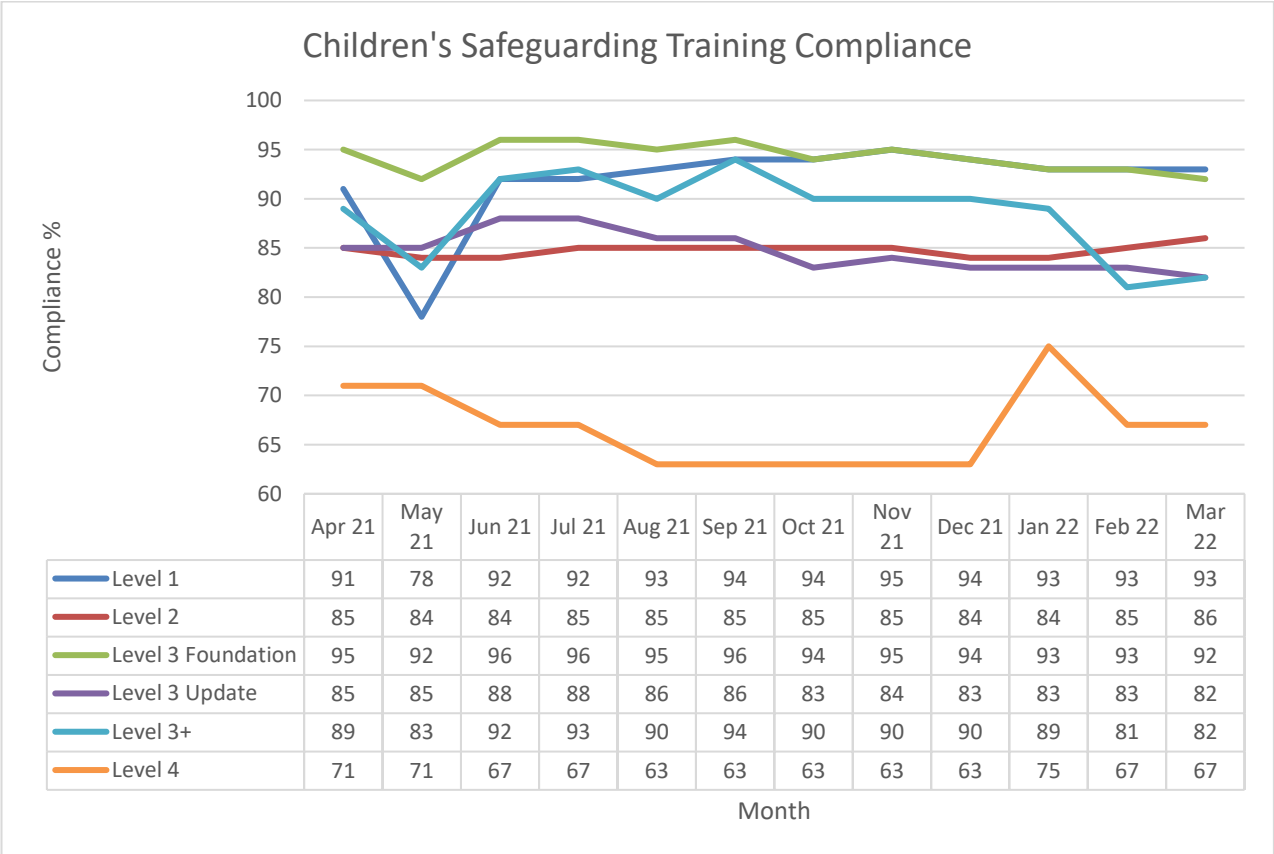
Where appropriate staff are required and supported to attend multi-agency training provided by the Safeguarding partnerships and other external providers and is strongly recommended for those staff groups identified as requiring Level 3 plus competencies.

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, LSCPR's, and new and changing national guidance and legislation.

In response to the challenges and pressures on staffing during COVID the Children's Safeguarding Trainers responded by developing e-learning packages for level 3 foundation and update training and increasing the number of face to face sessions to support reduced numbers allowed to attend.

Overall Trust Compliance for Safeguarding Children Training

Training compliance is monitored by the Safeguarding Committee and Care Groups are required to present a quarterly improvement plan to address the reduced compliance. ESR competency reporting covers compliance for 12 months.



	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Level 1	91	78	92	92	93	94	94	95	94	93	93	93
Level 2	85	84	84	85	85	85	85	85	84	84	85	86
Level 3 Foundation	95	92	96	96	95	96	94	95	94	93	93	92
Level 3 Update	85	85	88	88	86	86	83	84	83	83	83	82
Level 3+	89	83	92	93	90	94	90	90	90	89	81	82
Level 4	71	71	67	67	63	63	63	63	63	75	67	67

Looked After Children (LAC)

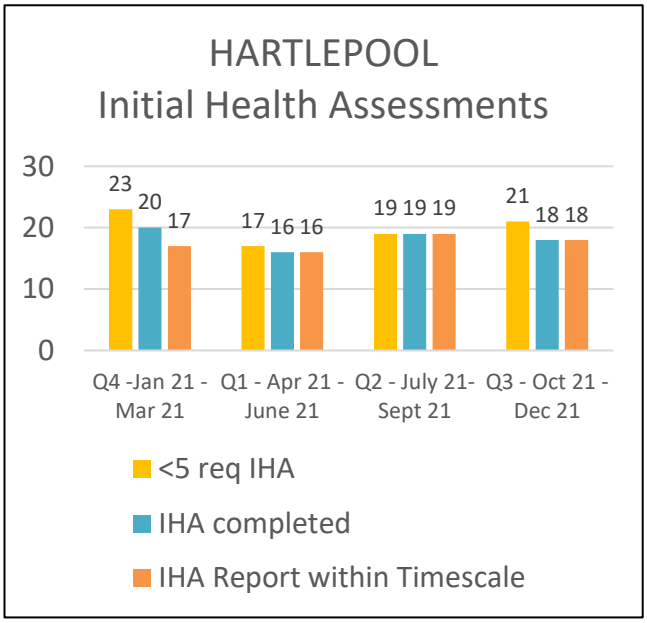
The services and responsibilities for LAC are underpinned by legislation, Statutory guidance and good practice guidance which include: *Statutory Guidance on Promoting the Health and Well-being of Looked After Children* (DH, 2015) and *Looked After Children and Young People* (NICE, Oct 2021). The importance 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.

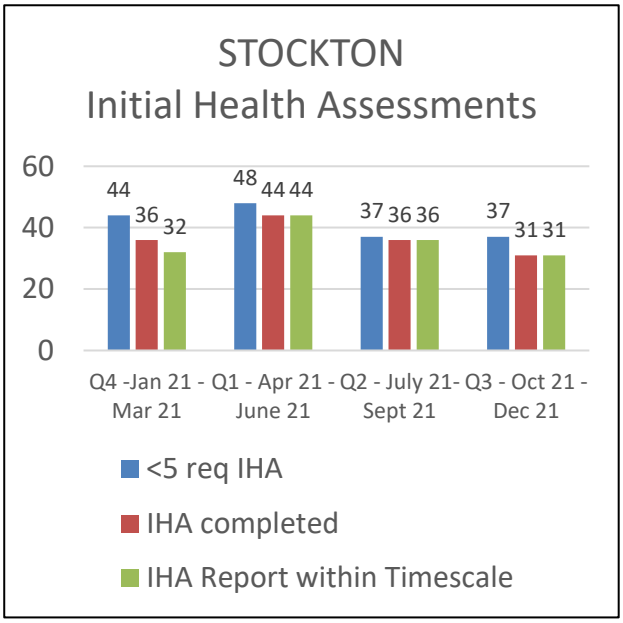
- LAC health provision over the last year has been an integral part of the Trust Safeguarding work programme which reports to the Trusts Safeguarding Committee and Patient Safety Committee.
- The Trust continues to be represented and is an active member of the Children in Our Care Council in Stockton 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's Health in Care service are notified by the Local Authority when children have come into 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:

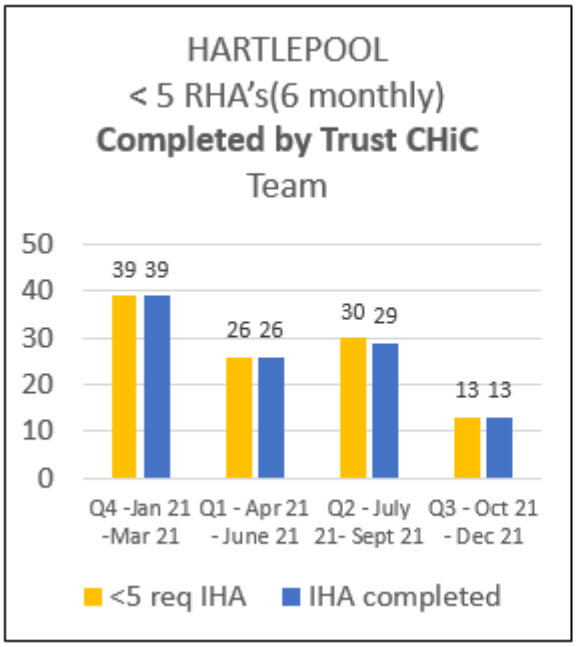
- Not receiving timely and appropriate consent for IHAs affects the overall compliance rate
- Cancellations by carers continue to affect the rates of compliance. These issues are addressed with partner agencies and carers at the time

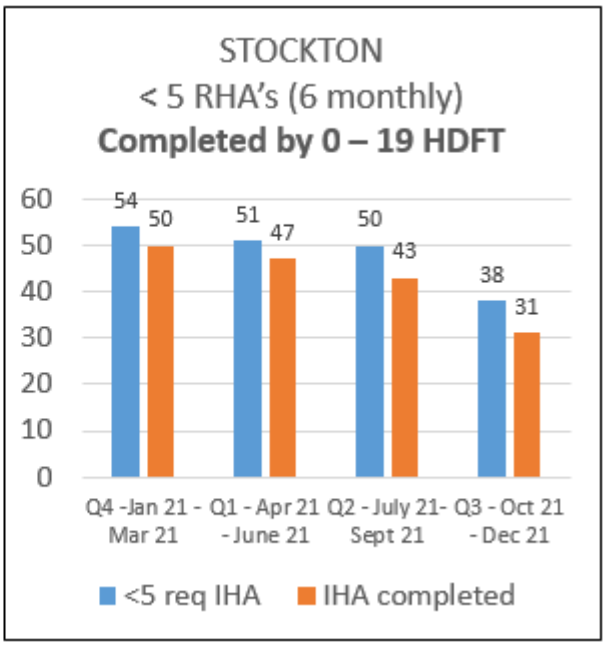
The completion of Initial Health Assessment will remain with the Trust however notification and coordination of Initial Health Assessments will now come from Harrogate and District NHS Foundation Trust as part of their commissioning responsibilities alongside completion of Review Health Assessments across the Tees Valley footprint, including Darlington, Hartlepool, Stockton, Middlesbrough and Redcar local authorities.

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.

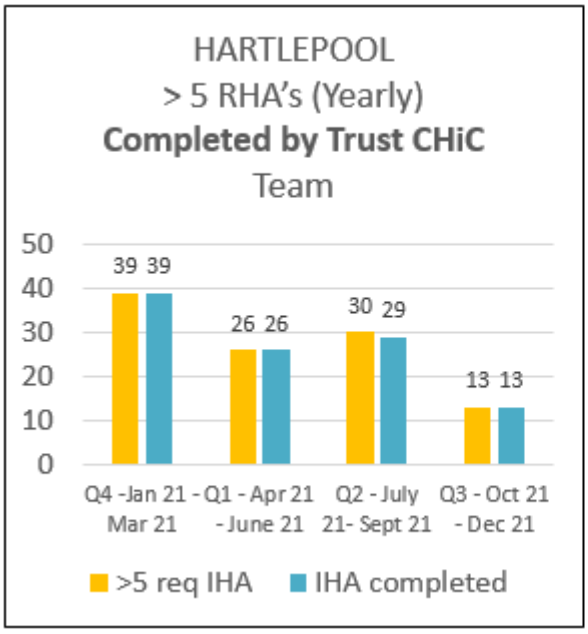
Reviews are designed to identify and monitor health needs of the looked after child and are a statutory obligation. In Stockton the service model includes Health Visitors and dedicated School Nurses who undertake the RHA for those LAC accessing universal services. Health Visiting and School Nursing are 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.

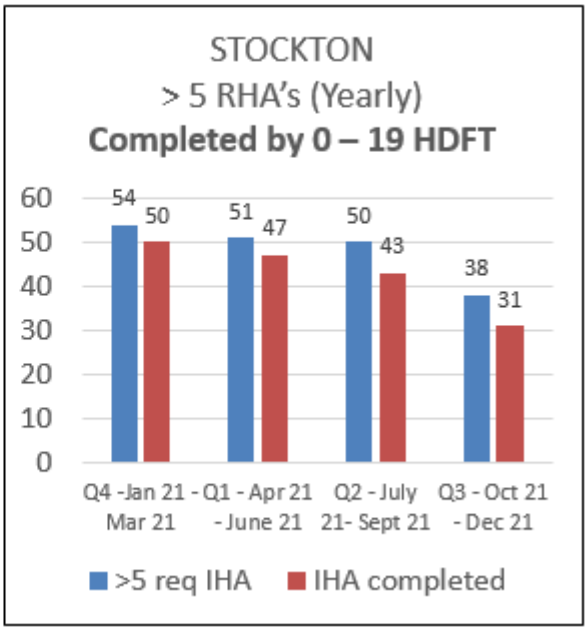




The tables above represent compliance to completion of Review Health Assessments for our under five year olds.

The tables above represent compliance to completion of Review Health Assessments for our over five year olds.





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

- Reduced capacity to undertake the RHA in services provided by out of area providers, particularly challenging during COVID has prompted a response by the Trust CHiC team by providing additional support to out of area providers when being able to complete RHA's virtually.
- Review assessments cancelled by carers due to COVID.
- Movement of placement without notification to the CHiC team.

An escalation pathway continues to be 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.

The Trust's key priority has been to support smooth transitioning of the Children Health in Care team to ensure response to the needs of children in care, staff and appropriate data is transferred seamlessly. The trust will no longer have any commissioning responsibilities for Review Health Assessments from 1st April 2022.

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's Accessibility Meeting will monitor compliance with the Trust's legal obligation in meeting the Standards. The Meeting will incorporate developments to ensure equal access and experience of service to patients and carers within the Trust's sphere of control.

The Trust continues to make improvements to the care provided to patients with a disability, impairment or sensory loss, these include – improved signage at the main entrance to the University Hospital of North Tees Hospital, the ability to record, flag and share a patient's preferred method of communication in the acute setting via Trakcare (patient administration system). In addition, as part of the process for development and update of patient information authors are asked to consider development of talking/video leaflets.

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 has also been undertaken to update current electronic systems used in the community settings to ensure inclusion of the requirements of the Accessibility Standards i.e. identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents where their needs relate to a disability, impairment or sensory loss.

Patient Experience

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

The Trust Accessibility monthly Meeting includes core members from external stakeholder organisations. The Terms of Reference for the Meeting has been reviewed to ensure good practice is regularly shared within the meeting by the Care Groups within the Trust.

The Trust has adopted sensory loss training as part of the ongoing accessibility work which has been devised and provided free of charge by one of the Accessibility Meeting core members. This training is available throughout the Trust and promoted via the Learning and Development Team.

Specialist Equipment

A previous audit of fixed hearing loop provision throughout the Trust highlighted the need to maintain and review the placement of the equipment to maximise its use. Since this audit there has been some focused 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.

Priority 1: Patient safety

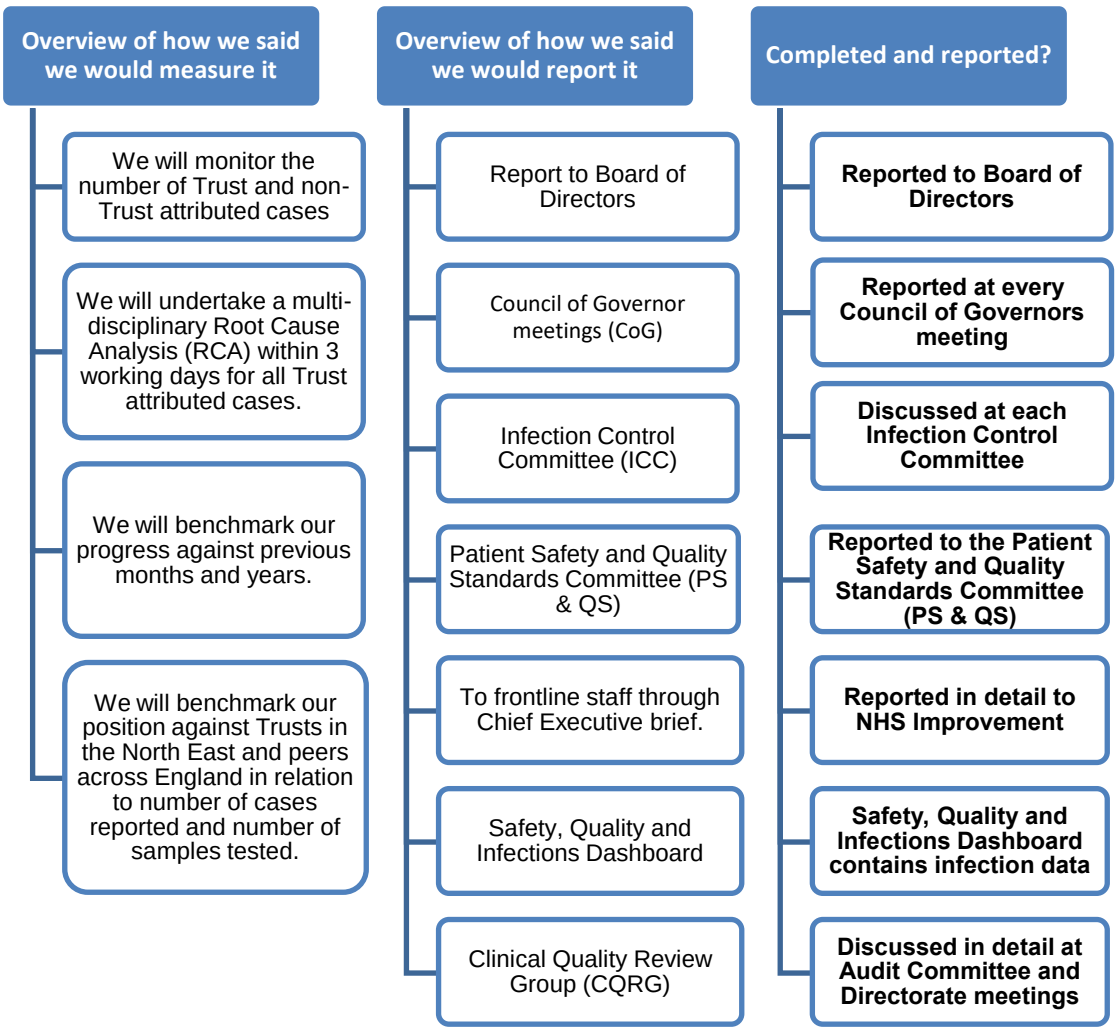
Infections

Rationale: The Trust continues to report on infections of:

- Clostridioides 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.



Due to COVID-19, no trajectory was set in 2020-21 for any of the reportable infections. In 2021-2022 trajectories were renewed for all trusts. However, the reporting criteria has changed and we currently report all **healthcare-associated** cases whether their onset was in hospital or in the community. This is in line with the criteria that is used for Clostridioides difficile, which means that comparing data from previous years not possible. The report will contain the healthcare-associated cases, and below the previous reporting data for reference.

Clostridioides difficile (C.difficile)

Clostridioides 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 Clostridioides difficile can then multiply and produce toxins which cause symptoms such as diarrhoea.

Due to the COVID-19 there was no trajectory set for 2020-21 for Clostridioides difficile. In 2021-22 a new trajectory was set of 64 cases. The trust is reporting **50** trust-attributable cases.

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 cases 2019-22**

	2019-20	2020-21	2021-22
Healthcare-associated	53	49	**50**
Community-associated	39	44	**55**

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

Methicillin-Resistant Staphylococcus

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 2021-22 the Trust has reported **zero** hospital-associated cases of MRSA bloodstream infection, which is a decrease on the one trust attributable case in 2020-21.

	2021-22
Healthcare-associated	0
Community-associated	1

***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 2021-22 we currently report **38** cases of healthcare-associated MSSA bacteraemia to date. This is an increase from 2020-21 where we reported 25 hospital-onset cases. 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 reduction in the number of community-associated cases is noted and this is likely due to the new reporting criteria. An increase in healthcare-associated cases is due to an increase in activity, compared to 2020-21 and increased length of stay.

	2021-22
Healthcare-associated	29
Community-associated	9

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

	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
Hospital Onset	21	25	21	26	25	38
Community Onset	57	71	93	75	63	54

*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 previous years are shown in the table below. The reported healthcare-associated cases to date are 67, against a trajectory of 117. As the majority of these cases remain 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. The recent publication of the Commissioning for Quality and Innovation (CQUIN) in January 2022 for 2022-23 also addresses the need for appropriate antibiotic prescribing for urinary tract infections, which remains the leading cause for gram –negative bloodstream infections.

Root cause analysis is completed for cases deemed to have been hospital-onset and healthcare-associated 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.

	2021-22
Healthcare-associated	35
Community-associated	43

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

	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
Trust Attributed	50	43	39	52	25	78
Non-Trust Attributed	267	304	317	279	205	184

*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.

	2021-22
Healthcare-associated	9
Community-associated	6

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

	2017-18	2018-19	2019-20	2020-21	2021-22
Hospital Onset	29	20	10	10	15
Community Onset	42	40	49	39	44

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

In 2021-22 the Trust reported **15** Klebsiella species bloodstream infections as healthcare-associated, against a trajectory of 24 cases. 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.

	2021-22
Healthcare-associated	9
Community-associated	5

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

	2017-18	2018-19	2019-20	2020-21
Hospital Onset	5	9	3	14
Community Onset	19	20	17	12

In 2020-21 the Trust reported **14** healthcare-associated cases of Pseudomonas aeruginosa bloodstream infections against a target of 11 cases. Many of these cases are considered 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	2021-22
Hospital Onset	**360**	**211**	**265**

In 2021-22 the Trust reported **265** Trust attributed cases of catheter-associated urinary tract infection (CAUTI) to date. The trust continues to report CAUTI cases at the safety huddles and to the trust board. There are currently no set targets for trusts but it is recognised that a reduction in CAUTI will have a positive impact on the gram-negative bacteraemia cases.

Coronavirus disease (COVID-19)

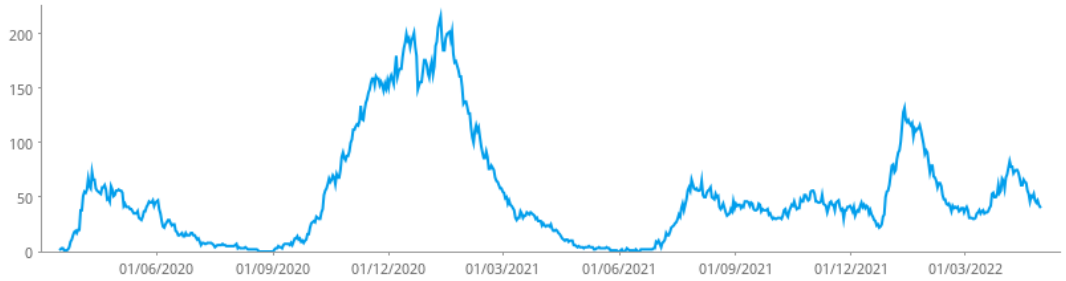
Coronavirus disease (COVID-19) is an infectious disease caused by a newly discovered coronavirus.

Most people infected with the COVID-19 virus will experience mild to moderate respiratory illness and recover without requiring special treatment. Older people, unvaccinated people and those with underlying medical problems like cardiovascular disease, diabetes, chronic respiratory disease, and cancer remain at a higher risk.

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, and the recommended 'Catch it, bin it kill it').

Between 17 March 2020 and 13 April 2022, there have been **4,875** number of COVID-19 positive patients in the Trust with **716** deaths.

COVID-19 Positive Patients in the Trust



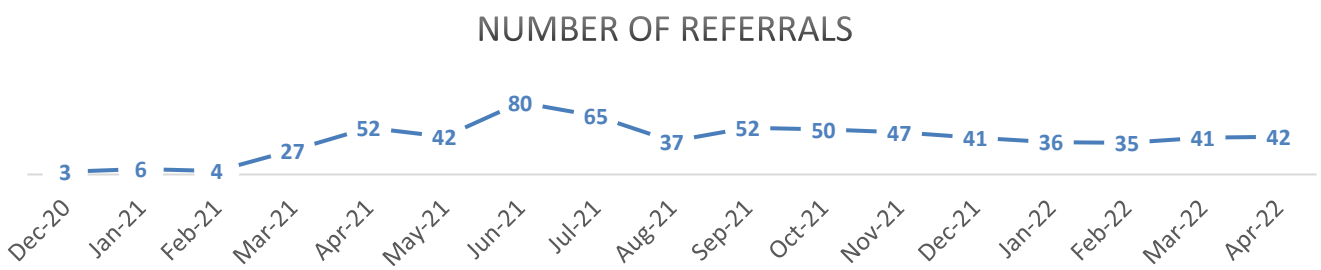
The peak of COVID-19 patients in the Trust was 216, this was in January 2021 (during Lockdown 3). Omicron has put further pressure on the NHS with high case numbers seen from December 2021, although it is noted that ITU admissions and deaths have decreased. Staff cases remain high, with January 2022 seeing the highest number of staff absences throughout the pandemic, placing significant pressures on the trust to increase capacity in response to demand.

Outbreaks remain high with a mixture of staff only and staff and patient outbreaks in clinical areas. High community prevalence and the limited number of single rooms within the footprint of our clinical areas contributes towards the challenges of managing COVID-19.

As we continue to manage the pandemic and the recovery plan within the NHS, the challenge continues reduce hospital transmission and ensure the safety of our patients. The trust continues to learn from the findings of our own experiences and others, both regionally and nationally implementing best practice wherever possible.

Long Covid Clinic

Since December 2020 there have been **660** patients reffered into the Long Covid Clinic.



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 2021 to March 2022**, **1,357** 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:

266 in the first quarter;
325 in the second quarter;
385 in the third quarter;
381 in the fourth quarter.

By **31st March 2022**, **98** case record reviews and **4** investigations have been carried out in relation to **161** of the deaths included above.

In **4** 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:
1 in the first quarter;
2 in the second quarter;
0 in the third quarter.
1 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, one investigation remains ongoing, there are some cases from 2021-22 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;

The Trust has during 2021-22 adopted a mortality review tool developed as part of NHS England's "Better Tomorrow Programme: learning from deaths, learning for lives". This is very similar to the previous "Prism 2" Hogan methodology used in the Trust. The tool provides a structured review of a case record, carried out by clinicians, to determine whether there were any problems in care. The findings identified from the reviews can be used to identify trends that require quality improvement; this learning is also linked with that from other forms of case review such as cardiac arrest reviews and clinical audits. Where a case has also been reported as a Serious Incident, a comprehensive

investigation is completed to identify any contributing factors and also identify service and care delivery problems where quality improvements may be required.

- **Medical Examiner**

During 2021-22, the Trust has continued compliance with the national requirement for having Medical Examiners (MEs) in place, the team have achieved their implementation goal to give clinical scrutiny to all adult in-patient hospital deaths by the end of 2021-22. 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. During 2022-23 there is a national requirement to roll out this process to review deaths in the community, as a result the Trust has recently appointed some new MEs, including some local General Practitioners. There are currently plans being developed with the local GP network to progress this requirement collaboratively.

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.

- **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 rare, 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 2021-22, the Trust has received some positive 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. Positive feedback has also been received from families, an example relates to experiences from patient and families who have been through a screening programme in the Trust. The Trust had previously identified areas of learning from mortality reviews which resulted in some quality improvement activity; the recent positive feedback provides supportive evaluation for the screening team involved and also the Trust.

Supporting patients and families at the end of life can be more complex for patients with learning disabilities; following case reviews and also feedback from families the Trust is undertaking some focused improvement work around involvement of families in planning care, decisions about resuscitation and in the use of the hospital passport to help record their decisions and choices clearly to ensure they are effectively communicated.

There have been some excellent examples of care planning and communication with patients and families; good practice, such as this, is shared as part of training and also at the Trusts Safeguarding Committee so that other areas can learn and make improvements themselves if necessary. Also, as there are often cases where some ward staff have given excellent care and made a significant difference to a patient and their family, the team have introduced the use of a letter summarising the key learning areas and identifying areas of good practice. This approach has been welcomed by staff and, is felt to be good practice as it also fulfils one of the recommendations within the Learning Disability Standards for NHS Trusts in which it was highlighted that nationally, staff had reported not receiving feedback from LeDeR cases.

As a result of previous mortality reviews, the Trust made Learning Disability awareness training mandatory for all staff from 2019. Learning from reviews, local or national, is integrated within face-to-face safeguard training across all types, including safeguarding, dementia and learning disabilities. This has received good feedback from staff as this information brings issues to "life" and details real situations where reasonable adjustments were used, or should have been used. Current compliance across the Trust for this training is 92%, having been maintained during the pandemic following an early decision by the Trust not to reduce any safeguarding training requirements or provision for any staff.

The Trust is an active member of the North East and Cumbria Learning Disabilities Network; the network has developed a package for acute secondary care services to access, this is the Learning Disability Acute Diamond Pathway. This has been implemented within the Trust and provides standards to help the Trust deliver high quality, reasonably adjusted care to people with learning disability. The training has been designed to be delivered face to face or via an e-learning package. By adopting the 'Diamond Standards' Trusts will be able to meet the NHS Improvement Learning Disability Standards for NHS Trusts.

The aim of the pathway is to:

- To improve communication for people with learning disability across settings
- To improve experiences of health care for people with learning disability
- Improve quality of life for people with learning disability
- Promote seamless care and disparity of service
- To reduce premature mortality.

- **Deteriorating Patient Group**

Recognition and management of the deteriorating patient has been identified as one of the most important areas of learning from all types of case reviews, not only for patients who have died but also those who have survived. The Trust recognises it is important to look at both to ensure all learning opportunities are taken to identify what is being done well, as well as where improvements can be made. The Deteriorating Patient Group has been established to provide oversight in relation to this area of learning. The group is led by senior clinical staff and is multidisciplinary, with all speciality groups are represented, acute and community, this is to ensure good communication and sharing of information. This Trust group is also working in collaboration with the Regional Deteriorating Patient Group, with information being shared at both groups for wider learning.

Following recognition of sepsis, or a deterioration in a patients National Early Warning Score (NEWS), the key focus is escalation to ensure that senior staff are involved in the management and

decision making for these patients. To support monitoring of appropriate escalation, the Deteriorating Patient Group have designed a tool within the electronic record providing key information that can be reviewed prospectively to help identify, escalate and manage deteriorating patients, but also retrospectively to allow cases to be reviewed in order to gain assurance.

Handover of information has been identified as an area where improvements can be made in order to ensure there is effective, consistent communication between staff providing clinical care in the hospital. The handover process is being reviewed in order to implement a supportive digital solution; the proposed clinical handover system is being trialled in three key areas of the Trust, once the trial has been evaluated, plans will be implemented to expand this across all areas.

The Deteriorating Patient Group have commissioned the development of a "dashboard" which displays data to reflect compliance with the key areas of work linked to the group. The dashboard continues to be established and as well as displaying all KPIs in relation to the deteriorating patient and includes compliance with mandatory training such as NEWS, Basic Life Support (BLS), Immediate life Support (ILS), Acute Illness Management (AIMs), sepsis, acute kidney injury (AKI) prevention and other specialist training modules linked to its work.

The Deteriorating Patient Dashboard not only supports the group monitoring details available from KPIs and training; it supports the analysis of incidents reported related to the identification, management and escalation linked to the deteriorating patient. This allows the group to examine and consider any trends identified through incident reporting and then to generate any necessary actions to reduce the impact and the chances of these recurring.

- **Maternity Stillbirth update**

The Trust's maternity department helps deliver around 2,300 babies each year. In the majority of cases, outcomes for both the mother and baby are favourable. However unfortunately there are some tragic circumstances where a baby dies before birth, and are "silently born" being classed as stillbirths. Equally, there are cases where babies are born and subsequently die in the first 28 days if their life, and are classified as neonatal deaths. There has been a significant amount of work undertaken nationally as part of a quality improvement initiative led by the Royal College of Obstetricians and Gynaecologists, called "Each Baby Counts". This initiative developed a Perinatal Mortality Review Tool (PMRT), which facilitates a comprehensive, robust and standardised review of all perinatal deaths.

The information obtained through use of the PMRT is collated by *Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries* across the UK (MBRRACE-UK) with an overarching aim to reduce the number of babies who sadly die from preventable factors. It is important that for all parents that have lost a baby that maternity services actively learn and improve to prevent another parent experiencing such a tragic loss.

NHS England produced a document known as the "Saving Babies Lives Care Bundle" that has now had two versions. The second version dated March 2019 consists of 5 elements:

- Element 1: *smoking cessation*,
- Element 2: *fetal growth restriction*,
- Element 3: *reduced fetal movements*,
- Element 4: *fetal monitoring*,
- Element 5: *prevention of preterm birth*.

This document dovetails in to the 'Each Baby Counts' initiative to focus on areas of importance in improving outcomes and prevention of stillbirth an neonatal death. Our maternity service has embraced these documents and continues to work tirelessly to improve outcomes for mothers and babies within the Trust's catchment area.

- **Perinatal Mortality Review Tool (PMRT)**

The Perinatal Mortality Review Tool (PMRT) is a nationally developed and agreed tool that facilitates a comprehensive, robust and standardised review of all perinatal deaths, including stillbirths, but excluding terminations, from 22 weeks (+ 0 days) gestation to 28 days after birth; as well as babies who die after 28 days following receipt of neonatal care.

The information is used to identify local and national learning with action plans being generated, implemented and monitored. The learning obtained from the reviews is shared nationally, but also allows the Trust to identify and understand any factors that may have had an impact on the overall tragic outcome.

The web-based tool presents a series of questions about care from pre-conception to bereavement and follow-up care. Factual information about a case is entered in advance of a review by a multidisciplinary panel of internal and external peers; having external reviewers supports an independent 'fresh eyes' perspective when examining cases. This allows an unbiased and objective element to the case review. The tool is used to identify learning and improvement opportunities leading to the development of actions to be implemented, monitored and then evaluated, to assess the impact of changes in practice.

Parents are encouraged to be part of the review and are invited to a pre-meeting by the patient safety team. They are asked to provide any specific questions to be addressed during the PMRT meeting.

The Trust has been using the PMRT tool from December 2018 and has been fully compliant with reporting and reviewing all appropriate cases since that time. The Trust is part of the Local Maternity and Neonatal System (LMNS) that promotes shared learning across all regional maternity services; the independent reviewers are identified from all regional maternity services dependent on availability.

As a result of the trends identified within the PMRT reviews, the service has prioritised the following areas for action and improvement:

- **Risk assessment**

In order to ensure that women are on the correct care pathway during pregnancy and for their birth, a risk assessment is completed when the woman first sees her community midwife to "book" her place of birth. This risk assessment uses a wide range of personal and health details to ensure there is a personalised care and support plan in place from as early in a pregnancy as possible; this can then provide a support structure around each pregnant women if she should have concerns or develop complications.

It is important to promote with women that they "book" as early as possible in their pregnancy, ideally by 10 weeks into their pregnancy. This supports the care of mothers with complex co-morbidities or

significant risk factors to be directed to consultant-led care at an early stage. To promote this early contact with the midwives in the Trust have developed an on-line booking form, which has been gradually enhanced to include information in relation to ethnicity and BMI. Having this form completed by women supports the early allocation of the named midwife and following completion of the risk assessment, referral for Consultant involvement to ensure appropriate management plans are instigated as soon as possible to optimise maternal and fetal outcomes.
Antenatal risk assessment is undertaken at each encounter during the pregnancy as risks can change – the maternity teams record any changes in risk in the hand held records.

The maternity service has also developed a risk assessment for pre-term birth, which is also completed at booking. Audits have shown that this risk assessment is now embedded into practice and women with a history of early pregnancy losses are now being seen at an earlier stage in their subsequent pregnancies. The impact of this difference will be monitored locally and nationally to understand if it is having an overall impact on pregnancy outcomes. The maternity service has established preterm prevention consultant clinics across Hartlepool and Stockton to ensure there is early senior clinical oversight to establish a clear pregnancy management plan with the women. The preterm prevention team are also actively engaged in the regional clinical network within the Local Maternity and Neonatal System (LMNS) to develop standardised pathways for women at high risk of preterm birth.

The team are currently exploring how the digital maternity system can be used to support and strengthen the antenatal risk assessment processes.

- **Smoking**

Smoking is a known contributory factor to poor obstetric outcomes and it was apparent following the reviews, that smoking was a potential factor in half of the cases. The Trust has put a significant focus on reduction of smoking during pregnancy over recent years and despite some reduction, the service is clear that this focus needs to be maintained in order to continue to make an impact and reduce the risks linked to smoking during pregnancy and also by parents with young families.

The Trust continues to support the development of the North East England LMNS Tobacco Dependency in pregnancy pathway and as part of this promotes the use of the “Smoke free” APP from the National Centre for Smoking Cessation and training. During the Covid-19 pandemic Carbon Monoxide (CO) monitoring was suspended, but was re-established in April 2021. Throughout the pandemic, the midwifery team has continued to provide women with smoking cessation information and referrals, and support has been offered as needed. The Trust has established a Tobacco Dependency Treatment Service, which is expected to go live during quarter 1, 2022-23; this service will further support and strengthen the current provision offered to women, and families, in our care.

The Trust is also currently engaged with the “Mat-Neo-Sip” project; this has an aim to reduce the national rate of stillbirths, neonatal deaths and brain injury occurring during or soon after birth by 50% by 2025. One of the main factors for this is to improve the proportion of smoke free pregnancies; as a result, the service will be working during 2022/23 to:

- Ensure Carbon Monoxide monitoring is offered to all pregnant women
- Ensure “Brief intervention” training is given to all maternity and neonatal staff
- Monitor the referral and access to the Smoking Cessation Services.
- Continue to develop system wide pathways to achieve a smoke free pregnancy.

- **Reduced fetal movements**

A history of reduced fetal movements is a recurrent feature of stillbirths, especially over the last 2 years. This is known to be a national risk factor for poor outcomes in maternity. This is recognised in the Saving Babies Lives Bundle (version 2). The Trust has undertaken quality improvement work to ensure that women are aware of reduced fetal movements being a risk factor and the maternity service now sees many women with such concerns in all areas of the service. Risk assessments are undertaken where women present with reduced fetal movements and guidelines are in place to enable optimal management of these cases. In line with the Saving Babies Lives Bundle (version 2), women experiencing recurrent reduced fetal movements are offered induction of labour at 39 weeks' gestation.

In summary, the Trust maternity service continues to be fully vigilant over any publications that are issued nationally on the subject of stillbirth and neonatal death. The Trusts Maternity service work hard to ensure that national initiatives become an established part of the service. Quality improvement as a result of learning is embedded in the service to ensure that the maternity service provides effective, safe and quality care to pregnant women and their families.

- **Paediatric reviews**

The Trust has, thankfully, very few deaths in children; all are reviewed in depth to provide learning internally and dependant on the circumstances they may also be investigated through the incident processes. To also ensure any learning is shared with the Teeswide Child Death Overview Panel (CDOP); this panel comprises of a multidisciplinary group of professionals with a key function to review the information in relation to all child deaths, from birth to their 18th birthday; excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law. This multiprofessional review supports the consideration of actions to be taken if the death was possibly preventable with modifiable factors, which may have contributed to the death.

As part of the Trusts Deteriorating Patient work, in order to identify any potential areas for improvement the Paediatric service have a system in place to review all babies, children and young people who have required transfer to another unit. The team look at all cases for learning, regardless of why they were transferred; however, a key focus is on children whose condition has deteriorated requiring transfer as an escalation in their clinical care. This work has resulted in closer working relationships with the specialist services, but has also supported the development of joint simulation training with the Paediatric, Anaesthetics and A&E teams. The Paediatric team have recently employed a Clinical Educator who will focus on Paediatric specific training opportunities and work with other local and regional services, to assist in standardising training where possible.

- **Community Services**

Although the Trusts Community Services are not directly linked to in-patient deaths, the service takes an active role in using the information from various reviews to identify pertinent areas of learning and to generate actions. The actions identified have supported improvements in care for patients who need further support in their home, those who may need hospital admission, but also for those reaching the end of their life, providing appropriate palliative care and support around decision making about place of death, and to help provide any relevant care requirements or equipment to support this.

The Community Matrons facilitate weekly MDT discussions as part of “Enhanced Health in Care Homes” (EHiCH). These meetings aim to bring all professionals together, including a GP or agreed representative from the Primary Care Network (PCN), such as a care coordinator, to review the overall care and management of patients. The Community Matrons are also introducing peer support groups within the care homes; these will give an opportunity for reflection on the care provided to a dying patient, to consider what was managed well, what can be learned and how can this be used to support improvements for future patients at the end of life.

The community nursing and specialist palliative care teams have recently introduced “Palcall”; this aims to provide advice and guidance to patients their families and carers who are in the last 12 months of life, or who are on a PCN Gold Standard framework (GSF) register. The dedicated telephone line supports calls made at any time of day to enable access information and obtain relevant support.

The Community Team have also recently commenced a programme of e-learning training developed by the Nurse Consultant for Specialist Palliative Care on the following topics:

- Amber Care Bundle
- Care of the Dying Patient
- Introducing the family Voice

There are many patients being cared for in the community who require regular and frequent intravenous treatments such as chemotherapy; a number of the patients have Hickman lines in place. Hickman lines are designed to be left in place for longer periods of time and to reduce the number of injections a patient may need. As a result of learning from case reviews, the Community services have implemented a fully refreshed staff e-learning training package in relation to the ongoing management of Hickman lines and the all relevant staff involved in Hickman line care are completing this at the moment. To support this further the Trust patient information leaflet covering Hickman lines has also been updated to provide more detailed information to patients and families.

The Specialist Palliative Care Team (SPCT) Lead attends the weekly Trust Safety Panel to support learning from deaths, not only to identify areas for improvement but also to impart specialist knowledge as required. The role spans Trust across both community and acute services, it is an excellent opportunity to identify learning or missed opportunities and to build on these to make a difference for future patients. The SPCT also explore any complaints received by the Trust relating to end of life care; this provides another opportunity to understand, learn from and improve end of life experiences.

In order to help the Trust assess its overall approach to end of life care, the SPCT have devised an ‘Advance Care Planning’ audit to be undertaken during 2022-23. This will focus on recent deaths and examine whether there were missed opportunities around early identification and recognition of a dying patient and also ensuring if appropriate planning was in place, for example having an agreed “Do Not Attempt Cardio Pulmonary Resuscitation” (DNACPR) or Emergency Healthcare plan (EHCP).

The Trust has also recently received its results from the National Audit of Care at the End of Life (NACEL) 2020/2021; these are currently being reviewed and will be shared across the Trust in the coming months in order to develop an inclusive improvement plan covering any issues identified.

The fourth cycle of data collection for this national audit is planned later in 2022-23 which will allow the Trust to continue to measure its improvements.

- **Surgical Mortality Reviews**

The Surgical department has continued to undertake reviews of all in-hospital mortalities at their monthly Mortality and Morbidity (M&M) meetings. These reviews focus on cases where complications have occurred, and where patients may have died under their care, which are thankfully rare. The monthly M&M meetings encourage Multidisciplinary Team (MDT) involvement in the case reviews to promote shared analysis and learning. The reviews also give a wider range of professionals an opportunity to have frank discussions, and identify any actions that may need to be taken for future learning.

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

- The team recognised that there needed to be clearer information relating to the provision of senior input into clinical decision-making. As a result, they have focused on enhancing the daily Consultant led meetings where the team discuss all in-patients who have been admitted under the surgical team. This holistic MDT approach ensures that all relevant patients receive consultant input into their management, either by reviewing test results or attending the patient directly, and ensuring decisions made are entered in the healthcare records.

- The Surgical team recognise the importance of using Computerised Tomography (CT) scans to help support their clinical decision making, especially, about undertaking emergency surgical procedures which may involve frail, elderly patients. Discussions take place with radiologists so that CT scans are requested, undertaken promptly and that the National Emergency Laparotomy Audit (NELA) standards on reporting are followed.

  The surgical team collate data for NELA as part of an ongoing process, during 2021, they arranged for the national lead, from Freeman Hospital, to attend their Clinical Governance meeting to discuss the national, regional and local results and any learning from the audit. Although the Trust is not an outlier in relation to this data, emergency laparotomies represent a significant part of the Trusts emergency surgical activity and the team felt the wider picture was pertinent to maintain good outcomes.

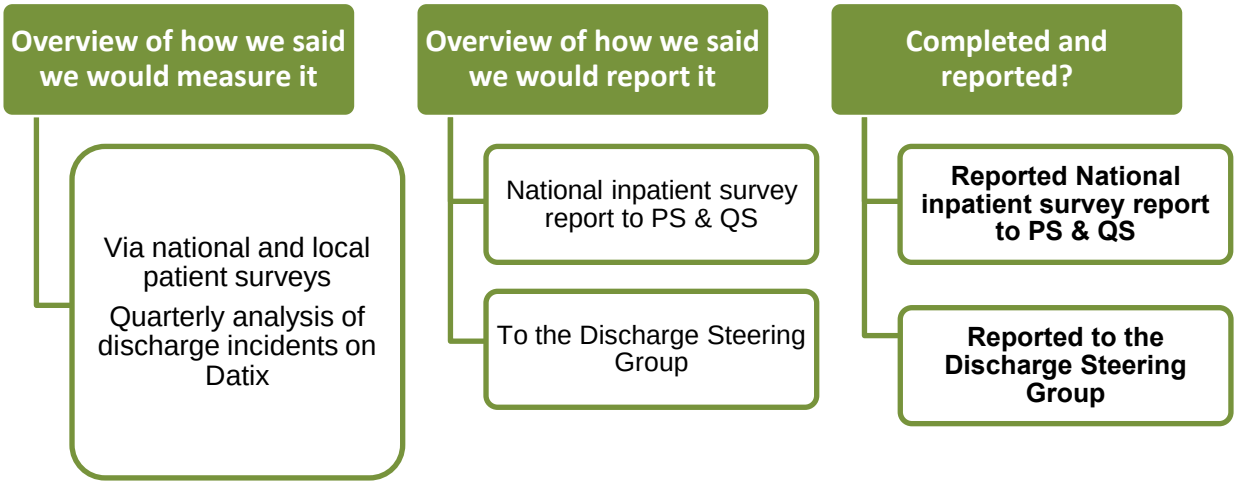
- A number of the surgical mortality cases reviewed continue to identify the need for broader discussions across other specialist services to support shared learning and collaborative improvements. In 2021, the Vascular Lead from South Tees virtually attended the surgical Clinical Governance meeting to discuss the management of mesenteric ischaemia. Although this diagnosis was only linked to a small number of mortalities, the current pathway was reiterated to promote awareness.

Following on from some case reviews, the surgical team have undertaken an audit in relation to their use of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms. Following this, the team have introduced the review of DNACPR forms during the M&M presentations for any surgical cases reviewed. This has led to enhanced support to members of the surgical team when they are considering management and escalation plans for critically ill patients to the Intensive Care Unit, or where necessary escalation to, and the involvement of, the Specialist 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.



Continued consolidation of Hospital Discharge service: policy and operating model updated October 2021.Trusted assessor pathways and Criteria to reside

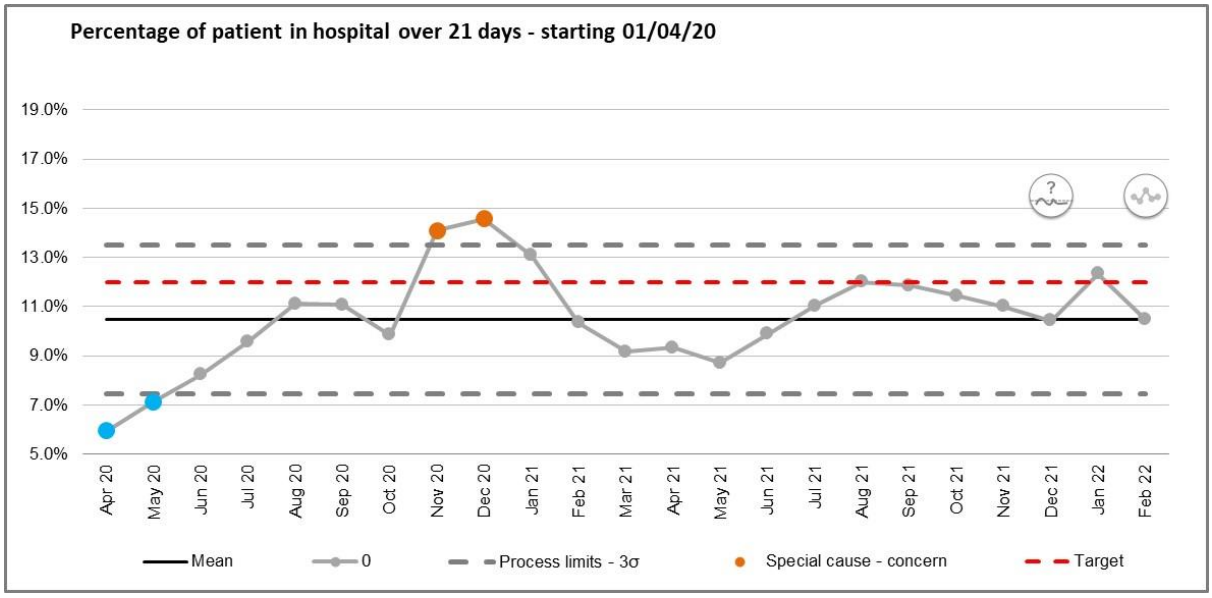
The Trust and our partners in social care have worked together to implement the discharge policy and continue to reduce delayed transfers of care. The Trust interagency discharge policy is to be reviewed for implementation May 2022.

The government provided funding until the end of March 2022, to help cover the cost of post-discharge recovery and support services, rehabilitation and reablement care following discharge from hospital through the discharge to assess funding. The Trust has established 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 and will be reviewed once new policy and guidance is published.

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 that tracking list is available for all agencies to work from and includes those patients suitable for discharge. We have progressed to a web based tool that enables all agencies to view the discharge patient tracking list to ensure that patient discharge plans are in place and carried out in a timely manner. We continue to produce data of the numbers of patients that no longer meet the criteria to reside and those that are discharged by 5pm by the national sitrep report. We have developed a new Discharge Flow Facilitator role within the Trust who provide operational support across the discharge team and the Trust patient flow teams to ensure information is continually available to the bed managers to support discharge activity and manage bed capacity.

Reduction length of stay in hospital

The graph below shows the proportion of patients in hospital over 21 days. During the pandemic, the organisation worked hard to establish an understanding as to why these patients sometimes remain in hospital for prolonged periods and to take actions to influence any themes that have been identified. We continue to see a reduction in the number of patients in hospital over 21 days. Despite a subtle increase in the numbers Aug 21, Sep 21 and Jan 22 we have performed well and maintained a position below the national target.



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 live on their own or would like someone to talk to are referred onto the programme. Volunteers meet them, whilst they are inpatients or at the point of discharge to 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 where appropriate and can also provide transport to outpatient appointments post discharge if they are on the scheme.

The 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.

The scheme was suspended during the height of the pandemic however re commenced in June 2021. The scope of the program has been expanded to include those aged under 65 years where appropriate. We continue to support the original pilot areas, and have ambitions to offer the service to other areas of the trust. We have developed good working relationships with local social prescribers and other befriending initiatives.

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. Many services provide a level of service at weekends such as pharmacy, physiotherapy, occupational therapy, district nurses and community matrons and there is equipment provision for basic items. There is availability of diagnostics required for discharge or to make decisions 7 days a week.

Patient transport is available 7 days a week to support patient discharge and this is further complimented by the use of a trust vehicle, if staffing is available.

Changes in medical training impact on the available hours for doctors in training working clinically on medical wards. Therefore, the out of hour workload and associated increased admissions between 11-7pm has led to some rota amendments to support increasing 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 also 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 First' principles and huddle/board rounds. There is also 8 medical consultants on site over the weekend to ensure timely decision making supporting management of care and discharging.

Working with an Integrated Coordination Centre approach supports the timely sharing of information between discharging/therapy teams and the site management/flow team. This happens 7 days per week with formal updates provided through the daily OPEL meetings with any escalations, if required.

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 and will include mental health services form May 2022. 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, ensuring patients receive the right care in the right place at the right time by the right professional. Primary Care Networks are also key partners in the development of the iSPA through our System Design and Delivery Groups. Since 2020 ISPA has developed integrated pathways of care with PCN’s to support delivery of the Enhanced Health in Care Homes framework. Each PCN, iSPA and other professionals meet weekly to collaborate and deliver on appropriate individual care plans to ensure system based support to manage frail elderly patients within a community setting and reduce non-elective admissions.

During 2021, ISPA has expanded to include a 24/7 clinical triage service. This 24/7 provision supports a standardized offer to care homes and NEAS linked to community based support as an alternative option to hospital admission or A&E attendance. The Out of Hours provision of iSPA has strong links to Out of hours District Nursing Service, HomeFirst and also the local authorities TeleCare service. The iSPA through the night is collocated within the Urgent Care Centre at Hartlepool to work alongside Out of hours GPs and Clinical Practitioners ensuring that all overnight services within the community are working together to provide the best options for patients to remain in their own home through the night.

District nursing in reach project

During 2020-21 we have been able to pilot an in-reach district nursing service to support with patient discharge. The district nursing service provide two District Nursing Sisters, one from the Stockton and one from Hartlepool locality The district Nursing Sisters work alongside the Integrated Discharge Team. The nurses provide support to patients in the Hospital, by providing an experienced voice to alleviate concerns that patients and their families might have regards returning home when hospital discharge is approaching and they also bring an extensive knowledge and understanding of community services to the inpatient setting.

The provision of this service by the team has 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 development.

Frailty Coordinators

The Frailty Team has been in operation since January 2018 and consists of experienced clinicians who coordinate the care of patients, from the point of admission, who are living with frailty and who also frequently have complex needs. The service is operational 7 days a week 08:00 - 20:00. The team facilitate the management of complex care planning of patients living with frailty by supporting their timely discharge into the community, focusing on the NHS Long Term Plan Ageing Well principles. The team work closely within the MDT with both the acute teams and community services, including, for example, the Integrated Single Point of Access (ISPA), liaison psychiatry and community nursing and therapy teams. The team have recently increased their capacity, in turn expanding the number of individuals that can be assessed/supported, as well as ensuring the early facilitation and coordination of care within the elderly frail pathway. The aim is to initiate an assessment as soon as the patient is admitted into acute care. This increase in capacity has also been supported through the integration of the Frailty Team with the 'Home First' team, which currently includes therapists within the Emergency Care Department, to improve the transition back into the community, and avoid unnecessary admissions to base wards. In addition, the Frailty Team have developed a framework that will allow the team to commence a Comprehensive Geriatric Assessment (CGA) on those patients who would benefit from a CGA. The Frailty Team have recently commenced an improvement programme with The Acute Frailty Network in order to further develop the service and improve patient outcomes.

A pilot to enhance Huddles and Board Rounds at front of house with more staff that are senior, including the Emergency Department and the Emergency Assessment Unit, has been introduced. The objective of these are to employ an MDT approach with the medical teams, the Frailty Team and community services, to identify more patients on admission who could be treated/cared for on pathways in the community. This work is ongoing and 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, rehabilitation interventions and social care 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 agreed with patients and their families and wrapped around the individual. This support that can be delivered can be individual calls over a 24 hour period or if required 24 hour 1-1 care.

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

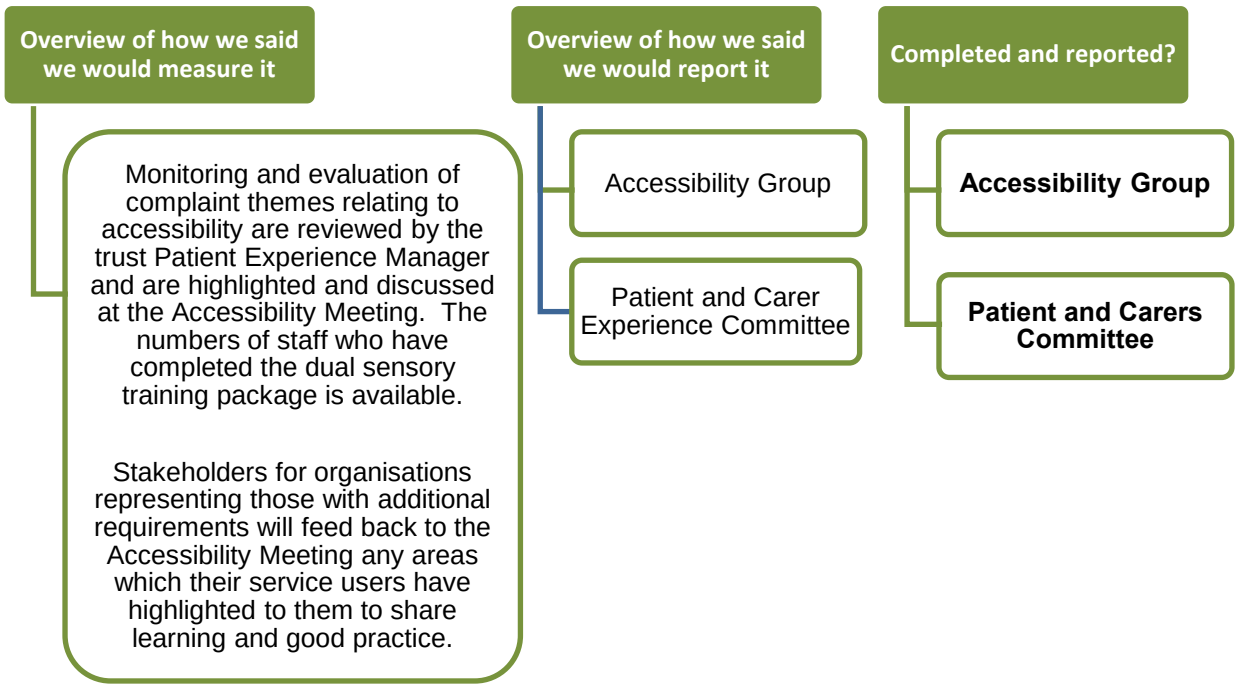
The aim is to develop a culture which learns from service user/stakeholder feedback. To provide a forum for service users/stakeholders to participate in accessibility projects and groups to ensure that their voices can be heard and that their views make a difference to the work in the trust. To ensure 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 and estates.

An e-learning package to increase staff awareness when caring for patients with dual sensory impairment has been developed by a stakeholder has been made available to all staff in the trust. This is referenced within the trust's dementia training and promoted via the Training Bulletin.

There are a number of ongoing projects to ensure our services are more accessible including on-line booking of interpreting services, virtual interpreting on in patient areas and introduction of an accessibility webpage to provide information for patients and guidance for staff.



Developments and improvements 2021/2022:

- E-learning sensory loss training package is in place and promoted within the Training Bulletin and within mandatory dementia training.
- The Trust continue to work with the Trust's web developer to review and update the external website to ensure compliance with the Accessible Information Standard. The Accessibility Meeting is working with the Communication Team to develop an Accessibility webpage. This will provide additional information and support for staff, patients and carers who may require adjustments to our services because they have a sensory loss or learning or physical disability.
- Patient information leaflets are available in an accessible format for our service users. Leaflet authors are also asked to consider a digitally recorded version of the leaflet.
- QR codes have been introduced within the Emergency Department to allow patients to download an electronic version of a patient information leaflet. Discussions are underway to roll this out to the Women & Children's services.
- Implementation of virtual visiting to ensure patients are able to receive a virtual visit during restricted visiting periods due to the Covid pandemic is in place. Support is provided by the Trust's volunteers who facilitate the visit for our patients and can provide additional support and reasonable adjustments.
- Increased joint working with the Trust's translation and interpreter provider to implement a standardised online booking service for virtual translation and BSL in inpatient areas.
- The Accessibility Group has provided input into the trust's environmental/ access audits.
- The Terms of Reference for the Accessibility Group has been reviewed with the aim to increase awareness of the Accessibility Standards and develop enhanced collaborative working within the Trust to promote, share good practice and ensure compliance with the Standard.

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.

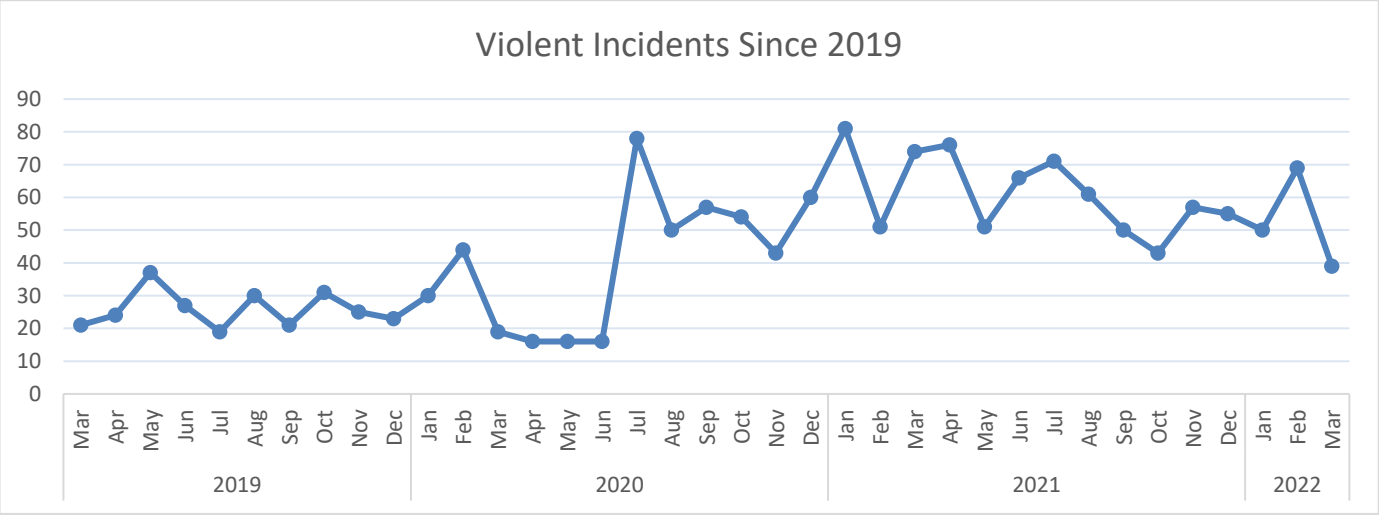
Overview of how we will do it
Utilise the Violent Incidents data held within the Trusts incidents reporting software (Datix).

Overview of how we said we would measure it	Overview of how we said we would report it	Completed and reported?
The Safety& Quality dashboard will be used during the weekly Senior Clinical Professionals huddles with the wards/areas	Data presented on the Safety & Quality Dashboard daily	**Data presented on the Safety & Quality Dashboard daily**
	Weekly data presented to the Senior Clinical Professionasl Huddles	**Weekly data presented to the Senior Clinical Professionasl Huddles**

Year Comparison

There has been a change in the reporting process within the Trust for 2021-22. These changes have allowed for increased reporting that were previously not being logged.

	Total Violent Incidents
2021-22	688
2020-21	596
2019-20	330



Adverse Event	2020-21	2021-22
Verbal abuse or disruption	213	256
Physical Abuse, assault or violence - unintentional	97	107
Concerns to do with personal safety	27	96
Disruptive, aggressive behaviour - other	155	92
Need for use of control and restraint with patient	28	56
Physical abuse, assault or violence - Malicious	31	30
Inappropriate behaviour and/or personal comments	28	27
Racial	11	14
Assault etc with a weapon	5	9
Sexual	1	1
Grand Total	**596**	**688**

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
- Venous Thromboem

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 2021-22 both in hospital and in the community.

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

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

Overview of how we said we would do it

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

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

"Excellent care. We were involved in every aspect of care. The Oasis suite is fabulous and all the staff today have been caring and compassionate. Mam died so peacefully." [sic]

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

Specialist Palliative Care

There have been ongoing significant changes and quality initiatives within the Specialist Palliative and End of Life Care Team during 2021-2022. A new Palliative and End of Life Care Lead was appointed in December 2021 who is committed to ensuring the continuation of the high quality patient and family experience already delivered by the team and previous lead.

PalCall, a 24/7 telephone advice line for patients anticipated to be in their last year of life, living in the Stockton and Hartlepool localities, was launched in December 2021. This service is expected to significantly improve the advice and support that patients and their carers need, in a timely way to ensure they are cared for in the right place at the right time.

The Caring for the Dying Patient Document remains in use across both Acute and Community settings. Alongside this the use of the Family Voice is actively encouraged and the team have recently been successful in obtaining funding for a research project to evaluate the Family Voice work further.

The established 7 day working service which brings great benefit to patients, relatives and staff continues

The End of Life Steering Group has been re-established, following a hiatus due to the Covid 19 pandemic and meets bi-monthly to provide strategic leadership and guidance for the organisation.
We took part in the third round of the National Audit of Care at the End of Life (NACEL) for 2021/2022 and are awaiting results. These will be cascaded throughout the organisation and themes to focus education delivery and quality initiatives will be drawn from the results.

One of our Palliative Medicine Consultants and Nurse Consultant in Palliative Care are presenting at the Palliative Care Congress. They are discussing the work that was undertaken in supporting staff through creative writing during the pandemic.

The EOL Companions initiative is ongoing and further volunteers have been recruited to help enhance the care of dying patients throughout the Trust.

The team is represented at regular meetings within the North East and North Cumbria working in partnership with other regional organisations to improve palliative and end of life care. We are an active member of the Tees wide Exemplar work on Palliative and End of Life Care.

The Trust continues to offer short and long term placements to students and qualified staff from a variety of professions to enhance their awareness and knowledge of palliative and end of life care. Furthermore we have continued to offer formal and informal education throughout the Trust on demand with a plan to increase our education delivery in 2022/2023, including working with identified role champions to promote palliative and end of life care.

Our specialist therapies team are working closely with Butterwick Hospice Bishop Auckland to support safe and meaningful group activities for patients' in day services. They are also working to introduce enhanced rehabilitation services to Butterwick Hospice Stockton –including establishing a rehabilitation gym.

The chaplaincy team came under the auspices of the Palliative care team in June 2021, further cementing the opportunities for close collaboration. Chaplaincy team representatives attend regular SPCT allocation meetings as well as the weekly MDT and follow up on patient referrals in the hospital and community.

Chaplaincy offer a range of sensitive support initiatives. Services of blessing surrounding baby loss, prayers and blessings for those nearing end-of-life, bespoke services which honour the love and relationships of those touched by end-of-life circumstances as well as general pastoral care are regularly offered to patients and their families. This past year has also seen increased opportunities to offer creative support to trust staff – from the informal offer of being a listening ear and sounding board during challenging times to responding to specific requests from teams that have undergone significant loss and fashioning reflective spaces for them to hold themselves and their grief gently.

Care For the Dying Patient (CFDP)

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

Between April 2021 and March 2022, the Trust has had returned **107** diaries, currently the average score has decreased to **20.30** from the previous average of 20.40. 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	2021-22
Number of Patients	167	171	147	134	139	48	**92**
Average Daily Score (Max 24.00)	20.80	20.40	20.60	20.51	20.11	20.40	**20.30**

*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 . [sic]"

"Not sufficient staff on duty to be available when needed. . [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 2021-22, **333** 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. **2** patients declined support during the reporting year. **168** patients welcomed and received multiple visits. This service offers added value to the quality of overall care provided to patients and their loved ones and has highlighted the importance of this aspect of support to the dying patient.

The Trust continues to address the spiritual and pastoral needs of patients in the community. Initially, this was for patients on or near the end of life, but practice has indicated that the service needs to be offered to patients earlier in the palliative care stage, in order to build up a relationship with the patient and offer a meaningful service.

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

Chaplain Referrals, Received more than 1 visit and Declined Support

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

	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
Referrals	424	437	401	359	302	400	334	**333**
Received more than 1 visit	272	274	298	244	198	225	176	**168**
Declined Support	1	3	4	2	6	8	1	**2**

*data from the Trusts chaplain service

"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

"Very pleased with treatment. Kind, efficient and considerate."

"Under current circumstances of COVID I felt safe and well looked after whilst I was in hospital. The doctors and nurses were great and reassured me what was going on with my care. Hats off to you all. You are dedicated angels."

"You would not think there was a pandemic because of the speed of treatment and quality of care was certainly not impacted upon".

"Staff in the hospital where amazing! It would have been nice to have more support postnatally at home or via the phone or even email".

"When attending a follow-up appointment not on the ward I asked for privacy to breastfeed my child. I was informed there wasn't anywhere and was kept waiting 40 minutes with a hungry baby. I was very disappointed I could not be offered some privacy".

Patient Experience Surveys

Below are a list of the national surveys that the Trust have started between April 2021 and March 2022. The 'current response rate' column shows the number of patients who have responded and the response rate.

National Surveys

Survey	Time frame for publication published	Current response rate
CQC National Inpatient Survey 2020	October 2021	46%
CQC National Emergency Survey 2020	August 2021	Type 1 – 29% Type 3 - 24%
CQC National Children and Young People's Survey 2020/21	November 2021	31%
CQC National Maternity Survey 2021	February 2022	43%

*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 2021	August 2021	163 patients
Colposcopy Survey 2021/22	March 2022	110 patients
Family Health Counselling Survey	December 2021	23 patients
Cancer Care Coordinator Survey (cycle 1)	April 2022	40 patients

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.

Better than expected	About the same	Worse than expected

CQC National Inpatient Data 2020 – Key results

The Trust randomly selected adult inpatients discharged during November 2020. We had a 46% response rate with 537 surveys completed. Results were published in the October 2021. ***All Scores out of 10***

Where we could do better	2020
During your hospital stay, were you ever asked to give your views on the quality of your care?	0.7
In your opinion, were there enough nurses on duty to care for you in hospital?	7.4
How would you rate the hospital food?	6.6
Were you ever prevented from sleeping at night by noise from staff?	7.8
Were you ever prevented from sleeping at night by noise from other patients?	5.9

Areas of good practice	2020
How did you feel about the length of time you were on the waiting list before your admission to hospital?	8.8 (Better)
Beforehand, how well did hospital staff answer your questions about the operations or procedures?	9.4 (Better)
To what extent did staff involve you in decisions about you leaving hospital?	7.6 (Somewhat better)

"Unfortunately my treatment had to be performed in a very full and very busy Hospital. This was done very well and efficiently. I only have thanks and praise for the excellent stay I had in North Tees. Thank you".

"I remain genuinely grateful for the level of care, attention and treatment I have received at the University Hospital of North Tees during my last two admissions I do appreciate the staff are working very hard in a difficult working environment within some cases limited resources".

"I had a very pleasing time in this hospital and was well looked after".

"Had a few health problems over last 12 months. Apart from delay due to COVID pandemic I was treated well. I am grateful for all the treatment and care I received from NHS. Thank you".

CQC National Emergency Survey – Key results

Where we could do better	2020
Did you have enough time to discuss your condition with the health professional whilst in **Urgent Care**?	9.2 (scored significantly worse than 2018)
While you were at the **Urgent Care**, how much information about your condition or treatment was given to you?	8.7 (scored significantly worse than 2018)
Were you involved as much as you wanted to be in decisions about your care and treatment in **Urgent Care**?	8.2 (scored significantly worse than 2018)
Overall, did you feel you were treated with respect and dignity while you were in the **Urgent Care**?	9.0 (scored significantly worse than 2018)

Areas of good practice	2020
After leaving **A&E**, was the care and support you expected available when you needed it?	8.7 (Better)
Sometimes in **Urgent Care**, people will first talk to a doctor or nurse and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?	7.3 (scored significantly better than 2018)
While you were in the **Urgent Care**, did you feel threatened by other patients or visitors	9.9 (Better)

"Very pleased with treatment. Kind, efficient, considerate".

"We felt that the staff at the A&E Department of University Hospital of North Tees went above and beyond to give the best care possible. It's a very worrying time for all concerned with this pandemic but at no time did we feel rushed or wasting the staff's valuable time. Mum was reassured throughout her time in A&E and we appreciate everything they did for us. Thank you NT Hospital and thank you NHS!"

"I have never been admitted to a hospital in my adult life before this date. I had a horrible dread of hospitals despite working in the NHS for 36 years as a SRN. However, my experience was 1st class. Couldn't have had better care, and attention. Most grateful!"

CQC National Childrens and Young People's Survey – Key results

Where we could do better	2020
Were there enough things for your child to do in hospital?	6.6
Were there enough things for you to do in hospital?	6.2
Were you able to prepare food in the hospital if you wanted to?	5.2
Were you involved in decisions about your care and treatment?	6.5

Areas of good practice	2020
	Much better
When you spoke to hospital staff, did they listen to what you had to say?	9.8
Before the operations or procedures, did hospital staff explain to you what would be done?	10
Afterwards, did staff explain to you how the operations or procedures had gone?	9.6
Do you feel that the people looking after you were friendly?	9.8
	Better/Somewhat better
Did you like the hospital food?	7.7
Was it quiet enough for you to sleep when needed in hospital?	7.9
Were you given enough privacy when you were receiving care and treatment?	9.7
Did staff play with your child at all while they were in hospital?	9.0
Did staff involve you in decisions about your child's care and treatment?	9.0
Were you able to ask staff any questions you had about your child's care?	9.4
Were members of staff available when your child needed attention?	9.0
Did the members of staff caring for your child work well together?	9.5
If you had been unhappy with your child's care and treatment, do you feel that you could have told hospital staff?	8.0
Before your child had any operations or procedures did a member of staff explain to you what would be done?	9.8
Before the operations or procedures, did a member of staff answer your questions in a way you could understand?	9.9
During any operations or procedures, did staff play with your child or do anything to distract them?	9.1
Did a member of staff tell you who to talk to if you were worried about anything when you got home?	8.8
Did a member of staff tell you who to talk to if you were worried about your child when you got home?	9.2

When you left hospital, did you know what was going to happen next with your child's care?	8.8
Do you feel that you (the parent/carer) were looked after by hospital staff?	9.1
Were you treated with dignity and respect by the people looking after your child?	9.8

"My child went to hospital due to episode of seizures. Child is a bit confused and a little scared. The staff are very kind to calm him down and make him feel safe and happy".

"All the staff and nurses were lovely, they reassured me when I was really worried about my son. Thankfully it wasn't anything major. Well done to all the staff".

"We were well looked after, the specialist that saw my daughter answered all my questions, he made my 5 year old daughter feel at ease. The atmosphere was jolly, he really understood how to talk to children, making jokes and made my daughter laugh. He also explained everything to her too, telling her not to worry so he was very child friendly. I can't fault anything".

CQC National Maternity Survey – Key results

Where we could do better	2021
Were you offered a choice about where to have your baby?	2.6 (Worse)
Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth	7.6 (Much worse)
On the day you left hospital, was your discharge delayed for any reason?	5.4 (Somewhat worse)
Were you given a choice about where your postnatal care would take place?	2.2 (Worse)
Did you feel that the midwife or midwifery team that you saw or spoke to always listened to you?	8.1 (Somewhat worse)

Areas of good practice	2020
	Better
During your antenatal check-ups, did your midwives ask you about your mental health?	9.1
Were you given enough support for your mental health during your pregnancy?	9.4
Thinking about your antenatal care, were you spoken to in a way you could understand?	9.7
During your pregnancy did midwives provide relevant information about feeding your baby?	7.8
Were your decisions about how you wanted to feed your baby respected by midwives?	9.4
	Better/Somewhat better
Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?	8.2
Did you feel that midwives and other health professionals gave you active support and encouragement about feeding your baby?	8.2
Did a midwife or health visitor ask you about your mental health?	9.8

"My midwives were absolutely amazing. There's not one single thing I would change about my labour, they left me feeling very happy about the whole experience".

"My midwifery care both antenatal and in labour and post labour were amazing! Such a wonderful service. Thankyou NHS".

"The surgery team in my Caesarean section and all the midwives in the maternity ward were so, so wonderful. I cannot speak highly enough of the care my baby & I received at North Tees hospital for the 36 hours we were in for delivery. I love the NHS and my experience was so positive, thank you".

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, 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 by clinical teams and are presented to the Patient and Carer Experience Committee for approval. As the national surveys for 2020/2021 were published between August 2021 to February 2022 all action plans are being considered by clinical teams.

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 2021-22 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**

"Service was excellent doctor and nurses were brilliant well done Hartlepool Hospital" [sic]

"Really long wait times, getting transfered to lots of different rooms. And most importantly it was not confidential at all. The doctor came to tell me my diagnosis in the waiting room with a room full of people!" [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.

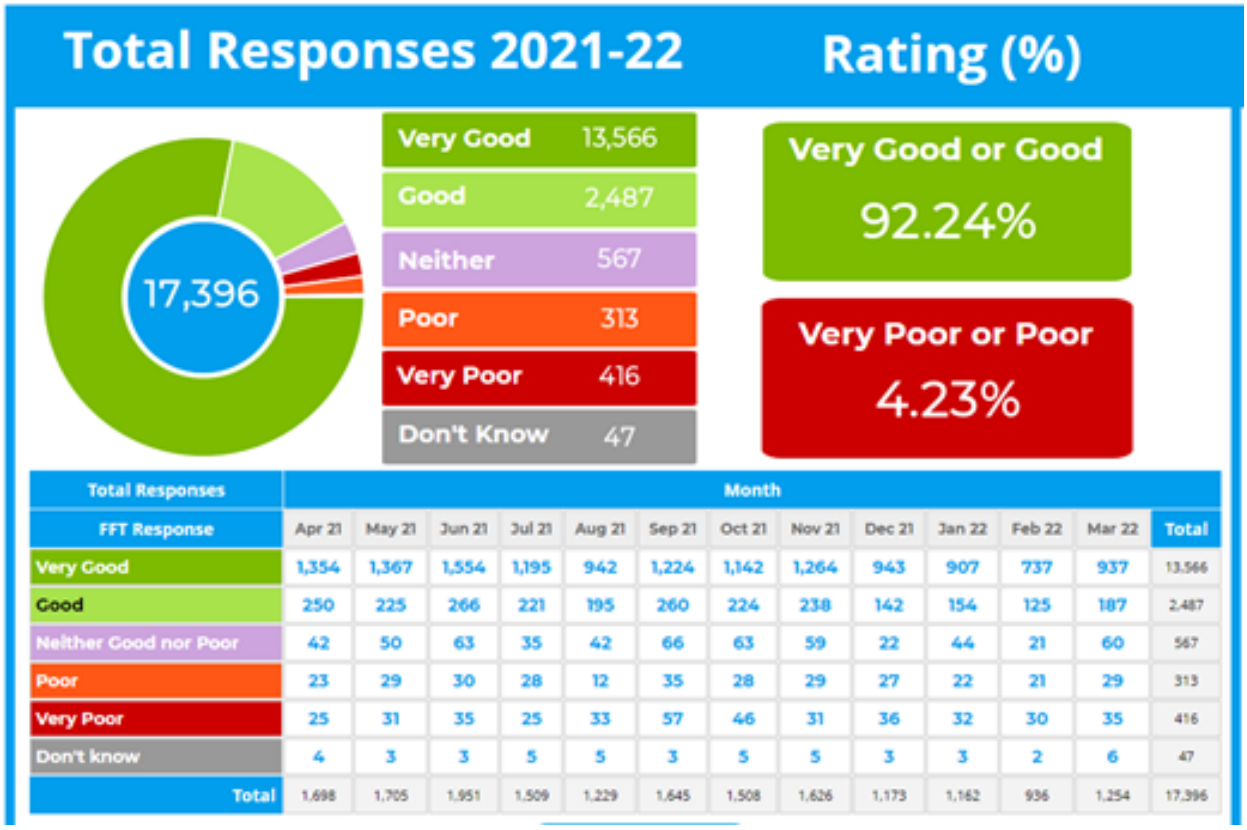
The Friends and family data can be found at:
https://www.england.nhs.uk/fft/friends-and-family-test-data/

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 2021 to 14 March 2022

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 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Total
Very Good	1,354	1,367	1,554	1,195	942	1,224	1,142	1,264	943	907	737	937	13,566
Good	250	225	266	221	195	260	224	238	142	154	125	187	2,487
Neither Good nor Poor	42	50	63	35	42	66	63	59	22	44	21	60	567
Poor	23	29	30	28	12	35	28	29	27	22	21	29	313
Very Poor	25	31	35	25	33	57	46	31	36	32	30	35	416
Don't know	4	3	3	5	5	3	5	5	3	3	2	6	47
Total	1,698	1,705	1,951	1,509	1,229	1,645	1,508	1,626	1,173	1,162	936	1,254	17,396

*Data from Trusts Friends and Family database and Inhealthcare

“Could not have done anything better every thing explained to me and given advice what to do excellent service.” [sic]

“It was very informative, very professional took time to answer all questions and made me feel comfortable.” [sic]

“Was triaged,saw a dr,had an xray, then spoke to dr again, all within 3 hours.1st class nhs experience.” [sic]

“Feel isolated and left to deal with health problems” [sic]

“The man who we seen was not very helpful and was quiet abrupt. I felt as though we shouldn't have been there. His attitude was not the best and I came out from the urgent care centre very frustrated.” [sic]

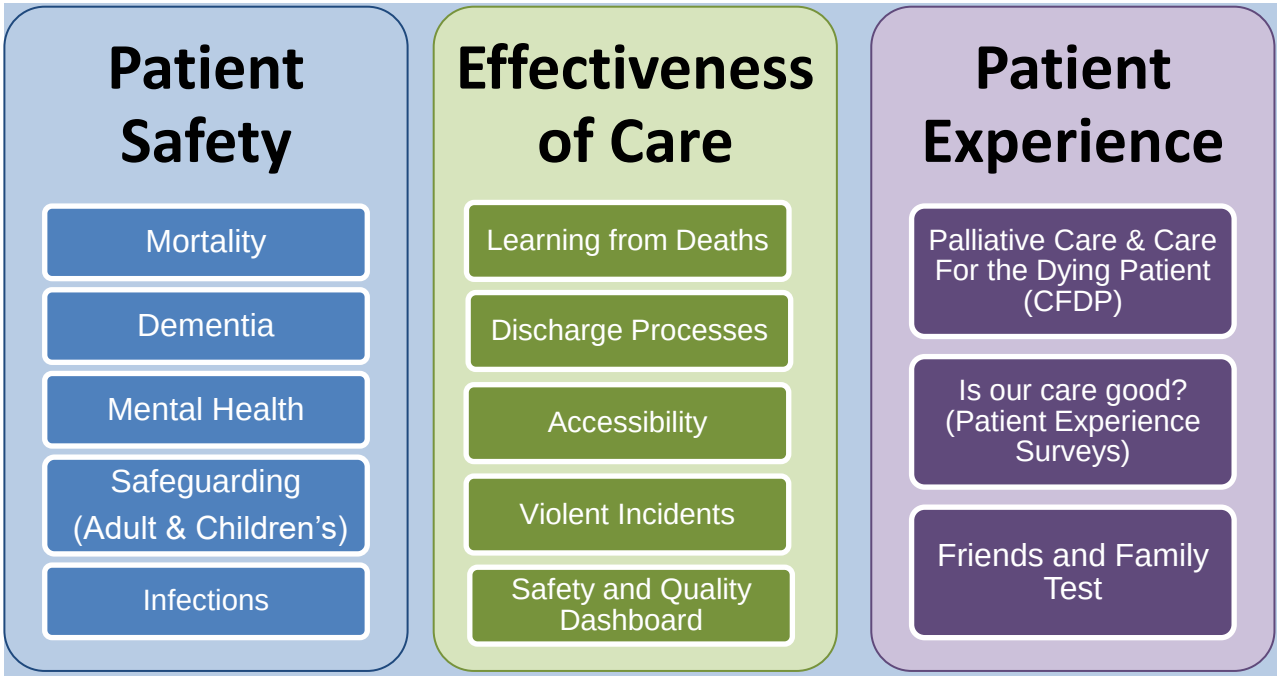
Part 2b: 2022-23 Quality Improvement Priorities

Introduction to 2022-23 Priorities

Due to COVID-19, the key priorities for improvement for 2022-23 have been rolled over from 2021-22. 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 2022-23

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 2022-23

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 2022-23 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

Priority 11 – Friends and Family Test

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

Overview of how we will do it
We currently ask patients to complete a questionnaire on discharge from hospital for in-patients, Accident & Emergency, 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 2021-22 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 2021-22 represents **100%** of the total income generated from the provision of relevant health services by the North Tees and Hartlepool NHS Foundation Trust for 2021-22.

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 2021-22 and this can be found on the following link:

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

During 2021-22, **47** national clinical audits and **2** national confidential enquiries covered the relevant health services that North Tees and Hartlepool NHS Foundation Trust provides.

During 2021-22, North Tees and Hartlepool NHS Foundation Trust participated in **96%** 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 2021-22 are as follows:

Mandatory National Clinical Audits	
Project name	**Provider organisation**
Case Mix Programme	Intensive Care National Audit & Research Centre (ICNARC)
Elective Surgery (National PROMs Programme)	NHS Digital
Pain in Children (care in Emergency Departments)	Royal College of Emergency Medicine
Infection Prevention & Control (care in Emergency Departments)	Royal College of Emergency Medicine
Fracture Liaison Service Database	Royal College of Physicians
National Audit of Inpatient Falls	Royal College of Physicians
National Hip Fracture Database	Royal College of Physicians
Inflammatory Bowel Disease Audit	IBD Registry
Learning Disabilities Mortality Review Programme (LeDeR)	NHS England
Maternal and Newborn Infant Clinical Outcome Review Programme	University of Oxford / MBRRACE-UK collaborative

National Diabetes Core Audit	NHS Digital
National Pregnancy in Diabetes Audit	NHS Digital
National Diabetes Footcare Audit	NHS Digital
National Inpatient Diabetes Audit	NHS Digital
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP): Paediatric Asthma Secondary Care	Royal College of Physicians
NACAP: Adult Asthma Secondary Care	Royal College of Physicians
NACAP: Chronic Obstructive Pulmonary Disease Secondary Care	Royal College of Physicians
NACAP: Pulmonary Rehabilitation	Royal College of Physicians
National Audit of Breast Cancer in Older Patients (NABCOP)	Royal College of Surgeons
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	Royal College of Psychiatrists
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Royal College of Paediatrics and Child Health
National Cardiac Arrest Audit	Intensive Care National Audit and Research Centre / Resuscitation Council UK
National Audit of Cardiac Rhythm Management	Barts Health NHS Trust
Myocardial Ischaemia National Audit Project (MINAP)	Barts Health NHS Trust
National Heart Failure Audit	Barts Health NHS Trust
National Comparative Audit of Blood Transfusion: 2021 Audit of Patient Blood Management & NICE Guidelines	NHS Blood and Transplant
National Early Inflammatory Arthritis Audit	British Society of Rheumatology
National Emergency Laparotomy Audit	Royal College of Anaesthetists
National Oesophago-gastric Cancer	NHS Digital
National Bowel Cancer Audit	NHS Digital
National Joint Registry	Healthcare Quality Improvement Partnership
National Lung Cancer Audit	Royal College of Physicians
National Maternity and Perinatal Audit	Royal College of Obstetrics and Gynaecology
National Neonatal Audit Programme	Royal College of Paediatrics and Child Health
National Paediatric Diabetes Audit	Royal College of Paediatrics and Child Health
National Perinatal Mortality Review Tool	University of Oxford / MBRRACE-UK collaborative
National Prostate Cancer Audit	Royal College of Surgeons
National Outpatient Management of Pulmonary Embolism	British Thoracic Society
National Smoking Cessation 2021 Audit	British Thoracic Society
Sentinel Stroke National Audit Programme	King's College London

Serious Hazards of Transfusion (SHOT)	Serious Hazards of Transfusion
Society for Acute Medicine Benchmarking Audit (SAMBA)	Society for Acute Medicine
Trauma Audit & Research Network	The Trauma Audit & Research Network
Cytoreductive Radical Nephrectomy Audit	British Association of Urological Surgeons
Management of the Lower Ureter in Nephroureterectomy Audit	British Association of Urological Surgeons

National Confidential Enquiries (NCEPOD)
Transition from Child to Adult Health Services
Adult Epilepsy

The national clinical audits and national confidential enquiries that North Tees and Hartlepool NHS Foundation Trust participated in during 2021-22 are as follows:

Mandatory National Clinical Audits	
Project name	**Provider organisation**
Case Mix Programme	Intensive Care National Audit & Research Centre (ICNARC)
Elective Surgery (National PROMs Programme)	NHS Digital
Pain in Children (care in Emergency Departments)	Royal College of Emergency Medicine
Infection Prevention & Control (care in Emergency Departments)	Royal College of Emergency Medicine
Fracture Liaison Service Database	Royal College of Physicians
National Audit of Inpatient Falls	Royal College of Physicians
National Hip Fracture Database	Royal College of Physicians
Inflammatory Bowel Disease Audit	IBD Registry
Learning Disabilities Mortality Review Programme (LeDeR)	NHS England
Maternal and Newborn Infant Clinical Outcome Review Programme	University of Oxford / MBRRACE-UK collaborative
National Diabetes Core Audit	NHS Digital
National Pregnancy in Diabetes Audit	NHS Digital
National Diabetes Footcare Audit	NHS Digital
National Inpatient Diabetes Audit	NHS Digital
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP): Paediatric Asthma Secondary Care	Royal College of Physicians
NACAP: Adult Asthma Secondary Care	Royal College of Physicians
NACAP: Chronic Obstructive Pulmonary Disease Secondary Care	Royal College of Physicians
NACAP: Pulmonary Rehabilitation	Royal College of Physicians

National Audit of Breast Cancer in Older Patients (NABCOP)	Royal College of Surgeons
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	Royal College of Psychiatrists
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Royal College of Paediatrics and Child Health
National Cardiac Arrest Audit	Intensive Care National Audit and Research Centre / Resuscitation Council UK
National Audit of Cardiac Rhythm Management	Barts Health NHS Trust
Myocardial Ischaemia National Audit Project (MINAP)	Barts Health NHS Trust
National Heart Failure Audit	Barts Health NHS Trust
National Comparative Audit of Blood Transfusion: 2021 Audit of Patient Blood Management & NICE Guidelines	NHS Blood and Transplant
National Early Inflammatory Arthritis Audit	British Society of Rheumatology
National Emergency Laparotomy Audit	Royal College of Anaesthetists
National Oesophago-gastric Cancer	NHS Digital
National Bowel Cancer Audit	NHS Digital
National Joint Registry	Healthcare Quality Improvement Partnership
National Lung Cancer Audit	Royal College of Physicians
National Maternity and Perinatal Audit	Royal College of Obstetrics and Gynaecology
National Neonatal Audit Programme	Royal College of Paediatrics and Child Health
National Paediatric Diabetes Audit	Royal College of Paediatrics and Child Health
National Perinatal Mortality Review Tool	University of Oxford / MBRRACE-UK collaborative
National Prostate Cancer Audit	Royal College of Surgeons
National Outpatient Management of Pulmonary Embolism	British Thoracic Society
National Smoking Cessation 2021 Audit	British Thoracic Society
Sentinel Stroke National Audit Programme	King's College London
Serious Hazards of Transfusion (SHOT)	Serious Hazards of Transfusion
Society for Acute Medicine Benchmarking Audit (SAMBA)	Society for Acute Medicine
Trauma Audit & Research Network	The Trauma Audit & Research Network

National Confidential Enquiries (NCEPOD)
Transition from Child to Adult Health Services
Adult Epilepsy

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 2021-22, 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
Case Mix Programme	Yes	100%
Elective Surgery (National PROMs Programme)	Yes	100%
Pain in Children (care in Emergency Departments)	Yes	100%
Infection Prevention & Control (care in Emergency Departments)	Yes	100%
Fracture Liaison Service Database	Yes	100%
National Audit of Inpatient Falls	Yes	100%
National Hip Fracture Database	Yes	100%
Inflammatory Bowel Disease Audit	Yes	100%
Learning Disabilities Mortality Review Programme (LeDeR)	Yes	100%
Maternal and Newborn Infant Clinical Outcome Review Programme	Yes	100%
National Diabetes Core Audit	Yes	100%
National Pregnancy in Diabetes Audit	Yes	100%
National Diabetes Footcare Audit	Yes	100%
National Inpatient Diabetes Audit	Yes	100%
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP): Paediatric Asthma Secondary Care	Yes	100%
NACAP: Adult Asthma Secondary Care	Yes	100%
NACAP: Chronic Obstructive Pulmonary Disease Secondary Care	Yes	100%
NACAP: Pulmonary Rehabilitation	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	Yes	100%
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Yes	100%
National Cardiac Arrest Audit	Yes	100%
National Audit of Cardiac Rhythm Management	Yes	100%
Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%
National Heart Failure Audit	Yes	100%
National Comparative Audit of Blood Transfusion: 2021 Audit of Patient Blood Management & NICE Guidelines	Yes	100%
National Early Inflammatory Arthritis Audit	Yes	100%

National Emergency Laparotomy Audit	Yes	100%
National Oesophago-gastric Cancer	Yes	100%
National Bowel Cancer Audit	Yes	100%
National Joint Registry	Yes	100%
National Lung Cancer Audit	Yes	100%
National Maternity and Perinatal Audit	Yes	100%
National Neonatal Audit Programme	Yes	100%
National Paediatric Diabetes Audit	Yes	100%
National Perinatal Mortality Review Tool	Yes	100%
National Prostate Cancer Audit	Yes	100%
National Outpatient Management of Pulmonary Embolism	Yes	100%
National Smoking Cessation 2021 Audit	Yes	100%
Sentinel Stroke National Audit Programme	Yes	100%
Serious Hazards of Transfusion (SHOT)	Yes	100%
Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	100%
Trauma Audit & Research Network	Yes	100%

National Clinical Audits

The reports of **19** national clinical audits were reviewed by the provider in 2021-22 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
Myocardial Ischaemia National Audit Project (MINAP)	Evidence of improvement in the number of patients seen by a Cardiologist. The Cardiologist rota now includes work on weekends to further improve this figure. All relevant discharge medications scored 100% prescribed.
RCEM National Mental Health Audit	Mental health triage was not being done within 15 minutes of arrival. Some updates have since been made to the TrakCare portal and the risk assessment tool has been simplified, to make the process quicker.
NACAP Paediatric Asthma Audit	Smoking exposure was not always documented. Awareness of the discharge bundle has been raised. The Paediatric Admissions Unit has since opened and any positive effect of this should be seen in future reports. A local audit to focus on the 1-hour steroid standard will be undertaken collaboratively between the Emergency and Paediatric teams.
NELA 6th Annual Report	Good results were shown in case ascertainment, CT reported before surgery and pre-op consultant input. First antibiotic dose was not always given within 1 hour of suspicion of sepsis. A quality assurance process has been put into place with the lead surgeon to confirm initial data collection is validated.

National Heart Failure Audit Report	Patients documented as receiving a Cardiology follow-up was lower than expected. An improved process has been agreed with the Heart Failure Specialist Nurse Team to improve the documentation of this, and is being monitored via the ACE Committee.
RCEM Cognitive impairment in older people	Documentation of cognitive assessment, delirium bundle and associated discharge documentation were generally poor. Assessment bundles have since been added to TrakCare to support improvement of required documentation. This is currently being monitored via the ACE Committee.
National Fracture Liaison Service Facilities Audit	Local service identified as being under-resourced to deliver effectively. A service review is being undertaken in order to identify requirements to support improvement of the patient pathway and incorporate more digital solutions.
National Audit of Inpatient Falls	Areas for improvement include: • The need for increased use of the 'All about me' document. • Documentation of lying and standing blood pressure readings. • Mobility assessment within 24 hours. • Patient access to a walking aid within the first 24 hours of admission. Training and education to upskill nursing staff on targeted wards has begun. Every ward area has an identified falls representative and this now includes a therapist to facilitate more 'joined up' working. All care group involvement will have a bottom up approach to share ideas and feedback pertinent information at ward level.
National Paediatric Diabetes Audit: Patient Reported Experience Measures (PREMs) Report	When asked if the team respected religious and/or cultural belief, 10% of parents/carers chose 'No, but I don't mind'. To address this the team developed a 'My celebrations' sheet that includes information about important events in the child or young person's calendar to be kept by the child/family e.g. Ramadan, Easter, Diwali. This also provides an opportunity to give advice on how these events could affect diabetes management. A diabetes technology handbook on flash glucose monitoring has been developed and recognised by the regional network (and will be available as a regional document).
National Paediatric Diabetes Annual Report 2019/20	Many areas of good performance identified. There was an identified need to improve outcomes of those using technology for their diabetes management.
National Joint Registry 2020 Report	There were some technical issues with the national database when trying to upload local information, but

	following some collaborative working, this has been resolved. Consent for upper limb procedures was lower than desired, however a new “shoulder school” has been implemented to address this.
National Bowel Cancer Audit Annual Report 2020	It was noted that some of the data recorded for rectal cancer patients was not complete, therefore the radiotherapy data was not reviewed in this report. This has been highlighted and they are looking at how this data will be captured in future, to ensure completeness.
National Oesophago-Gastric Cancer Audit 2020 & 2021 Reports	A new rapid diagnostic centre has been introduced, to help improve emergency diagnosis rates. The trust have also appointed 2 new Gastroenterology consultants with therapeutic endoscopy expertise to ensure the service is more resilient.
NACAP COPD 2019/20 Report	There have been issues getting statements onto TrakCare for identifying patients early in admission. Nursing staff are currently identifying patients by visiting the wards, until a better electronic solution is established.

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

NCEPOD study	Participation	% cases submitted
Transition from Child to Adult Health Services	Yes	Data collection ongoing
Adult Epilepsy	Yes	100%

Local Clinical Audits

The reports of **63** local clinical audits were reviewed by the provider in 2021-22 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
Anaesthetics: Volatile Anaesthetic Gas Use	Minimise the use of Desflurane, Nitrous Oxide and Entonox, as these have significant impact on the environment.
Emergency Care: Correct Prescribing in Acute Alcohol Withdrawal	Departmental education and TrakCare development to improve use of CIWA (Clinical Institute Withdrawal Assessment for Alcohol), and resulting correct prescribing of chlordiazepoxide therapy.

Paediatrics: Safer Referral Audit	Bespoke training for A&E and Urgent Care Centre staff around safer referral processes, and monitoring of completion moving forward.
Obstetrics & Gynaecology: Surgical Site Infection following Emergency Caesarean Section (NICE NG 125 & QS 49)	The local guideline for rupture of membranes in caesarean section requires updating. The audit recommended vaginal decontamination to reduce likelihood of sepsis during procedure.
Nursing: Haematological Investigations in Suspected Non-accidental Injury	Raise awareness of current recommended haematological investigations. Train front line staff in identification and recording of birthmarks, to avoid unnecessary referrals.
Pathology: Molecular testing strategies for Lynch syndrome in people with colorectal cancer (NICE DG 27)	Previously, multiple markers were tested at different sites, requiring co-ordination of referrals to off-site labs. Now, molecular markers are all tested on the same platform at Newcastle Genomics to identify patients with Lynch Syndrome and provide Oncologists with specific treatment options for chemotherapy.
Radiology: Reasons for rejection of inpatient abdominal x-ray requests	Refresh referrer knowledge of valid clinical indications, via teaching and posters, with information on alternative imaging. Referrers to ensure that if request is no longer required, they must cancel with Radiology team. Discuss any queries with Duty Radiologist before making a referral.
Surgery: Gallstone Pancreatitis (NICE NG 104)	Indication for antibiotic prescribing needs to be more clearly documented.
Orthopaedics: Hand Trauma Clinic Audit	Clinics were seen to be regularly overbooked, causing logistical pressures. Education to relevant referring teams, plus TrakCare message has reduced overbookings significantly, easing pressure.
Out of Hospital Care: Transition between inpatient hospital settings and community or care home settings for adults with social care needs (NICE NG 27 & QS 136)	Improved information sharing for patients with a community health care need prior to admission to hospital, following integration of Great North Care Record with TrakCare.
Medicine: Management of Acute Severe Colitis	New local guideline drafted to include a checklist for x-ray and Dietitian review, plus Hypercholaemia risks. ICE request panel developed and implemented.

NB: *A significant number of our clinical audits during 2021-22 were directly affected by increased clinical pressures due to the COVID-19 pandemic, therefore numbers of completed audits and their clinical outcomes are not directly comparable to those years before COVID-19.*

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.

In 2020-21 and 2021-22However 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, and reviewed as required, 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. Duty of Candour training has been mandated for all staff grade 6 and above since 2018; the training is provided as e-learning with training levels are monitored monthly through the Trusts mandatory training reports.

During 2021-22, the Trust has been part of a national group reviewing the practical application of the regulatory requirements; this is ongoing however, the output from this group will be the development of some national best practice guidance and supporting material for staff to utilise.

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 (FTSUG)

The National Guardian Office and the Freedom to Speak Up Guardian role was established in 2016 following the events at Mid-Staffordshire NHS Foundation Trust and the recommendations from the subsequent inquiry led by Sir Robert Francis.

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. This role would facilitate staff to speak to in confidence about concerns at work including any public interest disclosure. It was acknowledged that staff should be listened to, taken seriously and would not suffer detriment for speaking up.

Philosophy

The Freedom to Speak Up ethos aims to help promote and normalise the raising of staff concerns ultimately for the benefit of patients. Speaking up not only protects patient safety but can also improve the lives of workers. Freedom to Speak Up is about encouraging a positive culture where people feel they can speak up, their voices will be heard and their concerns or suggestions acted upon. In the six years since Francis's recommendations, the Freedom to Speak Up role continues

to evolve and move away from a whistleblowing culture to one of permission, encouragement and openness.

The Trust positively encourages all employees to speak up if they have a concern about risk, malpractice or wrongdoing. Moreover, if there are any behaviours or acts which harm the services the Trust delivers, we have both a duty and right to speak up. 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)
- an inappropriate culture (e.g. bullying within a team or service)
- 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
- deliberate concealment of any of the above matters or information which has been or may be deliberately concealed.
- anything that gets in the way of doing a great job.

Trust progress 2021 - 2022

1. A full time dedicated FTSUG has been recruited and been in post since August 2021

2. The FTSUG completed National Guardian Office Training in September 2021 and is formally registered on the National Guardian database as the Guardian for North Tees and Hartlepool NHS Foundation Trust.

3. For resilience, a deputy FTSUG has been agreed (who is also a current Freedom to Speak up Champion). National Guardian Training was completed in January 2022 and contingency plans are being considered.

4. Freedom to Speak Up month, a national campaign from the National Guardian Office (NGO) took place in October 2021. This included communication from the Chief Exec introducing the new FTSUG and promoting the ethos of speaking up. The FTSUG met with a number of teams and services during this month, attended staff inductions, floor walked, encouraged staff to undertake "Speak Up" and "Listen Up" training and supplying posters containing contact details.

5. The Trust now has 10 Freedom to Speak up Champions which includes four new champions from NTH Solutions. The champions can support staff with concerns with the aim of resolution or signposting to the FTSUG. Champions do not handle cases but can provide initial support and guidance.

6. The FTSUG attends monthly North East regional network meetings with the aim of learning, sharing best practice, peer support and working collaboratively. An NGO

representative also attends this forum every other month for national information sharing.

7. The FTSUG has also established networking relationships with other Trusts and is now meeting monthly with the FTSUG at Northern Lincolnshire and Goole for further development and mutual support. This is in addition to a "buddy" relationship with a longer established FTSUG at Tees Esk Wear Valley Mental Health Trust and more recently, North Cumbria Integrated Care NHS Foundation Trust.

8. The FTSUG and FTSUG Team based at The James Cook University Hospital have met (January 2022) with the aim of establishing regular and ongoing communication for additional support and shared learning.

9. The FTSUG completed Mental Health First Aid Training Cohort 8 via NHS Leadership Academy in January 2022. This is to enhance support for staff during their speaking up process as well as to help signpost staff appropriately.

10. A Communications plan is underway to continue to promote FTSUG throughout the year. This plan include screen savers, newsletters, and potential engagement sessions with staff.

11. The FTSUG continues to promote the role via team meetings, floor walking, ward visits, attending staff networks and via the champion network.

12. Staff are actively encouraged to undertake "Speak Up" and "Listen Up" Training Modules on ESR.

13. "Keep in Touch" meetings have been established with all Exec and Deputy Exec staff including the Managing Director, NTH Solutions. These will occur every one – two months. The aim of these meetings is to build a relational approach to speaking up as well progressing any concerns raised.

14. The FTSUG and Medical Director have worked closely to introduce the role further amongst medical staff. A newsletter has been sent to all medical staff for awareness and how to make contact. As a result of this, the FTSUG has been invited to a medical "Train the Trainer" to talk more about the FTSUG role.

15. In addition to the Keep in touch meetings, the FTSUG meets monthly with the Chief Executive and the responsible Non-Executive Director

16. The FTSUG also attends:
    - Monthly meetings with Chief Nurse, Director of Patient Safety
    - Monthly meetings with Patient Safety Team discuss potential opportunities for collaboration and sharing best practice. FTSUG contact details are available on Datix,
    - Monthly staff inductions
    - Fortnightly meetings with Workforce Independent Lead Investigator
      "Keep in Touch" meetings with Care Group Directors for information sharing and promoting speaking up within their services and teams.
    - Nursing preceptorship programme to introduce the role
    - Meetings with Nursing Quality Lead and Head of Workforce to triangulate FTSU information with the Quality Dashboard and Staff Survey results.

17. A Freedom to Speak up staff leaflet which explains what staff can expect from the FTSU process has been produced. This leaflet has been submitted for ratification, expected approval March 2022.

18. A new Freedom to Speak Up Policy is underway from NHSE/ and expected after Q4.

Case Data

Between 1 April 2021 and 31 March 2022, **54** concerns were raised via the FTSUG route.
No cases were carried forward from 2020-2021.

27 cases have been closed / resolved and 27 cases will be carried forward into 2022-2023

Of the 54 cases, the following themes emerged within five specific service areas (both clinical and non-clinical):

- Senior management / bullying / culture
- Senior management / communication
- Senior Management / culture / patient safety
- Working Environment
- Policy best practice

All ongoing concerns and themes are being progressed or investigated and actioned accordingly. Where applicable, staff have received feedback on follow up recommendations.

The FTSUG submits case numbers every quarter to the National Guardian Office.

National Guardian Office 2021 -2022 Data submitted:
Q4 – 4 cases (January 2021 – March 2021)
Q1 – 0 Cases (April 2021 – June 2021)
Q2 – 2 Cases (July 2021 – September 2021)
Q3 – 34 Cases (October 2021 – December 2021)
Q4 – 14Cases (January 2022 – March 2022)

Staff Feedback

For quality assurance purposes, staff are invited to provide feedback at the end of the FTSU process. Staff also to continue to offer feedback on an ad hoc and voluntary basis during the FTSU process as well as general comments in team meetings.

Speaking up can be a challenging, worrying and sometimes lengthy experience. Timescales for investigations, communication, outcomes and support offered to staff therefore requires further consideration.

The 2021 National Guardian survey reports that many staff are still concerned about detrimental or disadvantageous responses after speaking up. The Follow Up training module is aimed at leadership collaboration in tackling this as well as setting the tone for a healthy speak up culture.

Final Comments

The FTSUG would like to express thanks for the ongoing support from colleagues in promoting and embedding the Freedom to Speak up ethos as well as thanks to all staff who have spoken up to raised concerns.

NHS number and general medical practice validity

North Tees and Hartlepool NHS Foundation Trust submitted records during 2021-22 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**	**99.92%**	Percentage for admitted patient care	**100%**
Percentage for outpatient care	**99.98%**	Percentage for outpatient care	**100%**
Percentage for accident and emergency care	**99.66%**	Percentage for accident and emergency care	**100%**

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

Information governance (IG)

The Trust reported five incidents to the ICO during 2021-22, three of which related to 'inappropriate access by staff' and two instances of 'disclosure in error'.

In order to further strengthen existing Trust policy and to prevent repeat incidents in areas where incidents have occurred during 2021-22 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 in 2021-22 sets out 110 mandatory evidence items in 38 assertions which cover these 10 standards that the Trust must evidence compliance against in order to gain compliance. For 2021-22 the deadline for submission of the DSPT is the 30 June 2021 so the final submission has not yet been made, however at the time of writing the Trust was in compliance with 86 of the 110 evidence items and the Trust remains on plan to submit the remaining evidence items by the June 2022 deadline. The 2021-22 DSPT was also subject to an external audit which was being undertaken at the time of writing this report.

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 2021-22 the Trust received 507 requests with a compliance level, as of 31 March 2022, of 97% with complete compliance data available after 30 April 2022. 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 Data Security and Protection (DSP) Toolkit and also as part of continuous assessment of the auditor.

	2018-19	2019-20	2020-21	2021-22
Primary diagnoses correct	91.00%	90.50%	90.50%	**91.00%**
Secondary diagnoses correct	93.56%	93.72%	85.98%	**89.19%**
Primary procedures correct	93.75%	90.82%	97.66%	**90.42%**
Secondary procedures correct	88.33%	91.49%	82.35%	**83.10%**

The audit is still being carried out but the services reviewed within the sample are 200 finished consultant episodes (FCEs) taken from the surgical specialties (gynaecology, general surgery, orthopaedics and urology) and include day cases. The results will be available in early March.

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 will be 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.

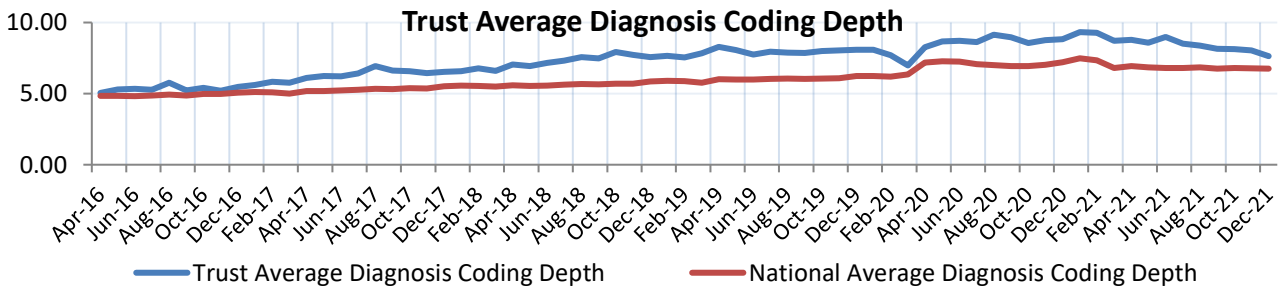
Unfortunately, due to the impact of COVID and losing three WTE coders, the department has failed to code the episodes within the required time scales. This has resulted in a backlog of workload and the difficult decision was taken to pull back from coding all medical episodes from case notes and use the discharge summary as the source documentation. There were exceptions, however, to minimise the impact on the mortality indicators and all long stay and deceased patients continue to be coded from the case notes. A contract coder has also been employed to help to reduce the backlog. There is a recovery plan in place and it is hoped the deadlines will be introduced again in the summer. The HSMR and SHMI mortality indicators are constantly being reviewed and so far, the change in coding practice, has not had a negative impact on them. When the medical coding does return to the case notes EAU and ambulatory will still be coded from the discharge summary as the 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 June 2021 the Coding Department started a twelve week homeworking trial period. After the initial trial period the homeworkers coding was audited and the results showed the quality of coding carried out at home was on a level with the coding carried out within the trust. As a result the home working was made permanent. Continuous audits will be carried out to ensure the levels of accuracy are maintained.

The department carries out monthly reviews of the coding which highlights any 'rule breakers'. The 'rule breakers' are any codes that have been assigned that break the national clinical coding standards. Any 'rule breakers' found are fed back to the clinical coder concerned and the coding is updated before the freeze date.

Diagnosis Coding Depth National and Trust Trend (April 2016 to December 2021)

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 **7.63** (December 2021) compared with the National average of **6.76.**



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 **July 2020 – August 2021**.	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, **September 2020 – August 2021**

Time period	Over-dispersion banding	Trust Score	National Average	Highest – SHMI Trust Value in the country	Lowest – SHMI Trust Value in the country
July 2020 – Jun 2021	**Band 2 (As Expected)**	**0.9930**	**1.00**	**1.2017**	**0.7195**
Aug 2020 – Jul 2021	**Band 2 (As Expected)**	**0.9916**	**1.00**	**1.1847**	**0.7188**
Sep 2020 – Aug 2021	**Band 2 (As Expected)**	**0.9795**	**1.00**	**1.1848**	**0.7161**

SHMI Regional – September 2020 – August 2021

Trust	Trust Score
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	1.1746
SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST	1.1554
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	1.1272
GATESHEAD HEALTH NHS FOUNDATION TRUST	1.0413
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	1.0026
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	**0.9795**
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	0.9468

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 2020-21, 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 – **Jul 2020 – Aug 2021**	NHS DIGITAL

Percentage of deaths with palliative care coding, September 2020 – August 2021

Time period	Diagnosis Rate	Diagnosis Rate National Average	Highest – Diagnosis Rate	Lowest – Diagnosis Rate
Jul 2020 – Jun 2021	38.00	39.00	64.00	11.00
Aug 2020 – Jul 2021	39.00	39.00	64.00	11.00
Sep 2020 – Aug 2021	39.00	39.00	64.00	12.00

Latest Time Period benchmarking position – September 2020 – August 2021

Trust	Diagnosis Rate
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	55.00
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	46.00
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	44.00
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	40.00
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	**39.00**
GATESHEAD HEALTH NHS FOUNDATION TRUST	37.00
SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST	28.00

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 20 to March 21	*Groin hernia	*Varicose vein	Hip replacement – Primary	Hip replacement – Revisions	Knee replacement – Primary	Knee replacement – Revisions
Trust Score	No data	No data	0.515	No data	0.372	No data
National Average	No data	No data	0.475	0.329	0.319	0.285
Highest National	No data	No data	0.519	0.329	0.372	0.285
Lowest National	No data	No data	0.418	0.329	0.215	0.285

Apr 20 to Mar 21, Data from NHS Digital

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	0.468	0.338	0.394	0.394
Lowest National	No data	No data	0.409	0.307	0.312	0.295

Apr 19 to Mar 20, Data from NHS Digital

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 2020 to Mar 2021	Emergency readmissions within 28 days of discharge from hospital Apr 2019 to Mar 2020
0 to 15	Trust Score	**13.0**	**13.0**
	National Average	11.9	12.5
	Band	W = National average lies within expected variation (95% confidence interval)	W = National average lies within expected variation (95% confidence interval)
	Highest National	163.3	87.1
	Lowest National	2.8	1.9
16 or over	Trust Score	**14.9**	**12.7**
	National Average	15.9	14.7
	Band	B1 = Significantly lower than the national average at the 99.8% level	B1 = Significantly lower than the national average at the 99.8% level
	Highest National	322.5	244.1
	Lowest National	1.0	1.4

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)
2021-22	Not Available	Not Available
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 & 2020-21 data not available at the time of print

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**	**2021**
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	77	83	88	87	84
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	58	59	61	66	60
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	**67**	**71**	**72**	**74**	**70**
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	89	90	91	91	85
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	69	71	64	76	76
GATESHEAD HEALTH NHS FOUNDATION TRUST	81	81	82	80	75
SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST			70	71	65
North East	72	74	75	78	74
England	70	70	71	74	68
National High	**86**	**95**	**-**	**92**	**-**
National Low	**47**	**41**	**-**	**48**	**-**

Peoples Pulse – Staff

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

	April	July	*Oct	Jan
Percentage Recommended – Care	N/A	67%	74%	50%

*Oct 21 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'.

	April	July	*Oct	Jan
Percentage Recommended – Work	N/A	58%	69%	44%

*Oct 21 information taken from the NHS National Staff Survey

Care: 'Care of patients/Service users is my organisation's top priority'.

	April	July	*Oct	Jan
Percentage Recommended – Care	N/A	76%	69%	69%

*Oct 21 information taken from the NHS National Staff Survey

The **North Tees and Hartlepool NHS Foundation Trust** considers that this data is as described for the following reasons. The Trust continues to actively engage with and encourage staff to complete and return the Staff Survey along with the quarterly People pulse. The results from these surveys are shared with staff to ensure that two way conversations take place in relation to celebrating successes and considering improvements. Information is provided at Care Groups level, line manager level and staff level to ensure there is greater understanding of the information.

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. We have a range of opportunities for staff to be involved in develop changes across the organisation which ensures we each have a voice that counts with clear linkage to the NHS People Plan.

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	*2021	2021 National Average
19.90%	16.10%	18.90%	16.60%	15.90%	15.70%	**15.20%**	**19.50%**

*2021 released In March 2022

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	*2021	2021 National Average
90.50%	90.60%	93.2%	91.10%	88.90%	88.10%	**86.30%**	**82.50%**

*2021 released In March 2022

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

No new updates to this data has been provided by NHS Digital since Q3 2019-20.

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 2021-22	93%

*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	**49**	**16.38**	**12.27**	**41.53**	**0.00**
Apr 2019 – Mar 2020	53	13.20	10.71	64.61	0.00
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 2022, 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 19 – Mar 20

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 No Harm, Low Harm, Moderate Harm, Severe Harm or Death.

Falls with No Harm

During **2021-22** the Trust has experienced **995** falls resulting in No Harm; this has *increased* from **937** in the 2020-21 reporting period.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019-20	74	90	76	67	87	77	82	67	69	57	64	52	**862**
2020-21	59	55	74	74	74	74	91	85	100	91	78	82	**937**
2021-22	**64**	**76**	**65**	**97**	**106**	**72**	**86**	**79**	**110**	**90**	**75**	**75**	**995**

*Data obtained via the Trust's Incident Reporting database (Datix) – Mar 22

Falls with Low Harm

During **2021-22** the Trust has experienced **182** falls resulting in Low Harm; this has *decreased* from **201** in the 2020-21 reporting period.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019-20	19	21	21	21	20	17	12	17	21	14	19	11	**213**
2020-21	15	8	14	14	16	22	13	17	35	17	16	14	**201**
2021-22	**16**	**28**	**13**	**8**	**7**	**20**	**13**	**14**	**15**	**22**	**12**	**14**	**182**

*Data obtained via the Trust's Incident Reporting database (Datix) – Mar 22

Falls with Moderate Harm

During **2021-22** the Trust has experienced **20** falls resulting in Moderate Harm; this has *increased* from **12** in the 2020-21 reporting period.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019-20	1	2	0	0	1	0	0	5	0	1	5	2	**17**
2020-21	0	0	1	1	0	1	1	3	2	1	2	0	**12**
2021-22	**5**	**3**	**2**	**0**	**2**	**0**	**3**	**1**	**1**	**1**	**1**	**1**	**20**

*Data obtained via the Trust's Incident Reporting database (Datix) – Mar 22

Falls with Severe Harm

During **2021-22** the Trust has experienced **1** fall resulting in Severe Harm; this has *decreased* from **2** in the 2020-21 reporting period.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019-20	0	2	0	2	0	2	0	0	0	0	5	0	**12**
2020-21	0	0	0	0	0	1	1	0	0	0	0	0	**2**
2021-22	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**

*Data obtained via the Trust's Incident Reporting database (Datix) – Mar 22

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 with Death

During **2021-22** the Trust has experienced **1** falls resulting in Death; this has increased from ***zero*** in the 2020-21 reporting period.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019-20	0	0	0	0	0	0	0	0	0	0	0	0	**0**
2020-21	0	0	0	0	0	0	0	0	0	0	0	0	**0**
2021-22	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**1**

*Data obtained via the Trust's Incident Reporting database (Datix) – Mar 22

Reporting for 2021-22 indicates that there has been a slight increase in the number of falls when measured against the same period in 2020-21. Whilst the majority of falls result in no or low harm there has been a slight increase in moderate harm.

Improvements to the falls assessments and documentation is being supported by the digital team to ensure appropriate assessment, care plans and risk mitigation are considered. The recording of lying and standing blood pressures is now embedded using E-Obs, work is on-going to improve functionality to allow this to be prescribed electronically.

Post falls management continues to be supported by the falls response team which is now fully embedded contributing to the safe manoeuvring and management of the patient post fall.

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 **9** Never Events and they are broken down as follows:

2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
2	1	0	1	**1**	**1**	**3**

The NHS England report can be accessed via:

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

There has been **3** Never Events reported in the period of 2021-22 which were:

- ***wrong site procedure***
- ***Incorrect patient listed for an invasive diagnostic investigation***
- ***Retained foreign body – needle tip retained post operatively***

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 **2020-21** there were **540** medicines incident reports via Datix. In **2021-22** there has been **617** 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	2021-22
Prescribing	147	224	138	141	172	162	**141**	**155**
Administration	314	321	413	386	468	376	**305**	**345**
Dispensing	43	48	72	78	61	83	**42**	**56**
Other	50	16	62	65	74	57	**52**	**61**
Total	**554**	**609**	**685**	**670**	**775**	**713**	**540**	**617**

* Data from the Trusts Datix system

Medicines Safety Committee (MSC)

Medicines incident data is reviewed bi-monthly by the Medicines Safety Committee (MSC). The aim is to:

- Improve reporting and learning of medication incidents in the organisation;
- Analyse incident data, audit and other data to identify, prioritise and address medication risks to minimise harm to patients;
- Identify, develop and promote best practice for medication safety.
- Coordinate education and training support to improve the quality of medication error incident reports and safe medication practices; and assisting in development and review of medication-use policies and procedures.

The quarterly updates of medication incidents are presented in the Patient Safety Committee meeting and MSC to highlight incidents trends and learning points/ recommendations. There is also bimonthly/quarterly Medicines Safety Hotspots Bulletin that shares national medication safety updates and incident learning in the trust.

Pharmacy service improvements in promoting medicines safety

Pharmacy have rolled out monthly one minute medicines optimisation and safety briefings included in ward MDT huddles. This has recently included penicillin allergy, medication never events and pioglitazones safety alert.

Electronic prescribing and medicines administration continues to be developed further and rolled out in the Trust led by our Informatics Lead Pharmacist. This system has the potential to reduce medicines errors through (including longer term goals):

- Improve prescribing by encouraging more standardised prescribing (i.e. units, frequencies, formulary choices, tall man lettering etc.)
- New display of alerts for interactions/allergies etc. to make them more useful.
- Prioritisation of patients for pharmacy review using drugs classes
- Work ongoing to improve data reporting (including missed doses reports etc.)
- Integration with pharmacy system to reduce the amount of transcription and save time
- Paper charts still in use in trust to be incorporated in to EPMA
- Closed loop administration

Procurement of contracted medicines now includes a quality assessment for high risk products, and a process has been implemented at Trust level aimed at reducing potential harm from look-alike sound-alike products by highlighting known risk lines with the MSG'

The pharmacy department continues to lead on supporting the roll-out of Omnicell cabinets in clinical areas, most recently ward 38, 24, Day Case Unit (UHNT) and A&E Paediatrics. Omnicell technology provides a real-time solution to support staff in locating critical medicines, with the potential to prevent missed doses and supply medicines in a lean manner.

Work has been carried out to support the use of COVID vaccines and specialist drugs in the treatment of COVID-19 (tocilizumab, sarilumab, molnupiravir). This work has involved strong safety and governance components, which were required to safeguard our patients and ensure timely, accurate supply of treatment, including the utilisation of collaborative processes and record keeping.

Ward based pharmacy services and other initiatives to improve safe supply of medications:

- Pilot of a pharmacist working with Rheumatology Team to support prescribing of high cost drugs and patient experience
- Ongoing work with Informatics Lead Pharmacist to support safer prescribing of medicines, e.g. expanding use of order sets/sentences to reducing errors during the prescribing process, additional cautions/warning with regards to high risk medicines, introduction of questionnaires as a prompt/prescribing aid
- Roll out of the use of PharmOutcomes to support safer transfer of care back to primary care/community pharmacy where patients have has changes made to their medications.
- Development of a Job Description/New role for a Pharmacist to support the Frailty teams (still in development)
- Expansion of OPAT via Accufuser devices to support earlier discharge of patients with the most appropriate IV therapies
- Pilot project via fixed term funding to support ward-based discharge team for Maternity, enabling timely and appropriate discharge, with additional safety checks of VTE scores and appropriate LMWH dose/duration.
- Ongoing work to provide an interface between TrakCare and Ascribe, to remove errors during the transcribing process and make the ordering process more lean.

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 full financial year performance with a benchmark position against 2020-21 data and against the 2021-22 performance target.

	2020-2021 Performance	2021-22 Target	2021-22 Performance
Stroke – 80% of people with stroke to spend at least 90% of their time on a stroke unit	93.80%	**80.00%**	**89.59%**
Percentage high risk TIA cases treated within 24 hours	93.10 %	**75.00%**	**71.80%**

*Data from Trust Clinical Effectiveness Team

A decline in performance can be seen in 2021-22 for the ***Percentage high risk TIA cases treated within 24 hours***. Whilst relatively small numbers, general themes are a result of appointment availability and patients unable to make appropriate travel arrangements at short notice. That said all breaches are discussed within the clinical 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 ensure concerns and complaints are investigated.

Stage 1 - Informal	Dealt with at the time of complaint at ward level/ or received by the Patient Experience Team (PET) and sent to the ward/department to attempt resolution within 7 days.
Stage 2 - Formal	Following investigation, a meeting is arranged with the complainant to discuss the complaint with senior staff within the Care Group to provide feedback and achieve resolution.
Stage 3 - Formal	Following investigation a written response is produced by the appropriate Care Group for the complainant and signed off by the Chief Executive or Deputy.

Number of Complaints – 2021-22

The Trust received **1,404** complaints in 2021-22.

Stage 1 - Informal	1,222	Total 1,404
Stage 2 - Formal	80	
Stage 3 - Formal	102	

*Data for 2021-22 obtained from the Trsut Business Intelligence Platform - Yellowfin

2021-22 Complaints by complaint type:

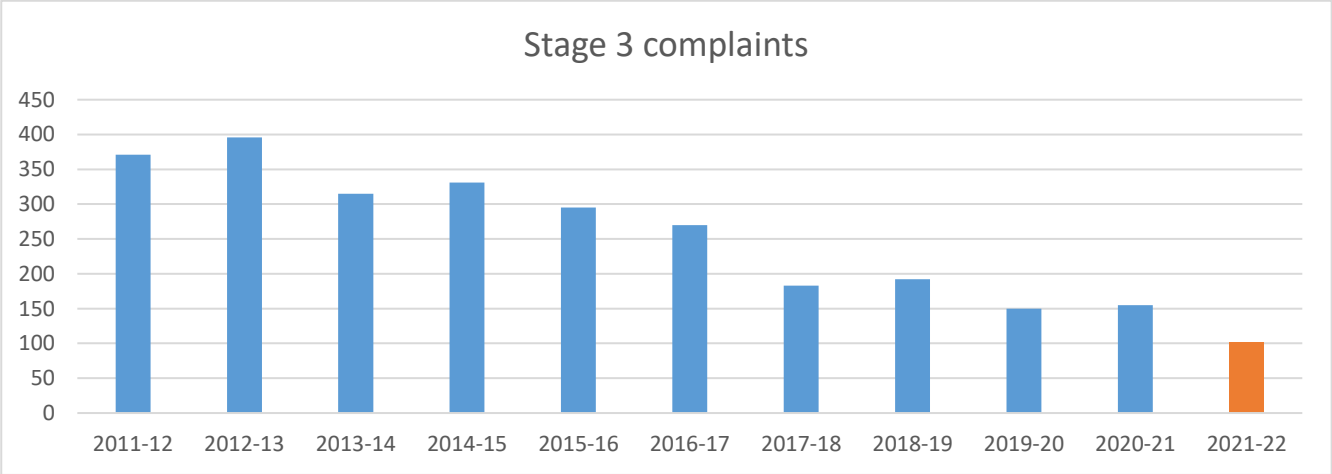
Please see the following breakdown for the Top 12 primary complaint themes from the **92 Stage 3** complaints received in 2021-22

Sub-Subject (Primary)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Attitude of staff		2	3	5	3	2		3	1	1		2	22
Communication - verbal / non verbal	2	1				4		1	4	1	2	4	19
Treatment and procedure delays	2	3	1		1	2	1	2			2		14
Care and compassion	1	1	2	1		4	1			1	1		12
Competence of staff member	1	1			1	3	2	2		1	1		12
Discharge arrangements	2	1	1		1	1				1		3	10
Failure to monitor				1			2	2		1	1	1	8
Delay to diagnosis			2				2	1					5
Timeliness of discharge				1					2	1			4
Errors of prescribing						1	1						2

*Data obtained from Datix as end of March 2022

Since April 2021, the Trust has received **1,404** complaints of which **102** have requested a formal written complaint response, this equates to **7.26%** of the complaints.

The number of Stage 3 complaints received over the last 10 year period is shown in the following table for comparison:



*Data obtained from Datix upto March 2022

The number, stage and themes of complaints are viewed weekly during the Safety Panel Meeting and Senior Clinical Professional meetings held within the Trust. Where there is a concern regarding specific departments or an increase in themes identified, managers are requested to review where services require improvement and provide additional support as required.

The complaint themes are collated and aggregated analysis is considered in the Trust's monthly Patient Experience report and quarterly Complaints, Litigation, Incidents summary report.

Additional Info: Trust's Patient Experience 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 increased for 2021-22 to 1,404 from 1,172 the previous year. The number of stage 3 concerns has reduced for the year from 155 for 2020-21 down to 102 for 2021-22 representing more complaints managed locally as a Stage 1 concern with faster resolution for complainants.

Complaints upheld by Trust

The number of Stage 3 complaints upheld is below:

Upheld – 12
Partly upheld – 41
Not upheld – 38
Open - 24

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. This decision/contact with the PHSO is via the complainant.

Complaints upheld by PHSO

During 2021-22 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 2020-21 was staff attitude. Civility Training has been rolled out within the Trust from Autumn 2020-21. Additionally, where specific staff are identified, their attitude/communication with service users and relatives is investigated and raised with staff directly, via their line manager. The staff are then supported to reflect on the concerns raised; in order to consider any individual areas of improvements that can be made.

During the Covid pandemic, there has been a requirement to limit the number of visitors in the Trust buildings, this was required to decrease the risk of infection transmission and avoid the spread of Covid-19 to our patients and staff. Unfortunately, this led to an increase in complaints regarding communication. Not having direct face to face communication with families has changed how information can be shared, not only by the patients but also by the clinical teams. A communication plan was introduced in January 2021, which included an improved clinical communication process, virtual visiting, the Linking Loved Ones Service and a personal possession baggage drop off facility.

The Patient Experience Team supports the "Linking Loved Ones Service" for patients and relatives by linking them together with letters and emails into the Trust. The team also continue to facilitate the Virtual Visiting facility to allow patients and relatives to meet virtually with the

assistance of Trust volunteers. More recently, a virtual visiting hub has been developed to centralise this service.

To support and improve clinical communication, the wards continue to provide clinical updates; a member of the relevant clinical team contacting families and carers to provide an update on their loved ones condition.

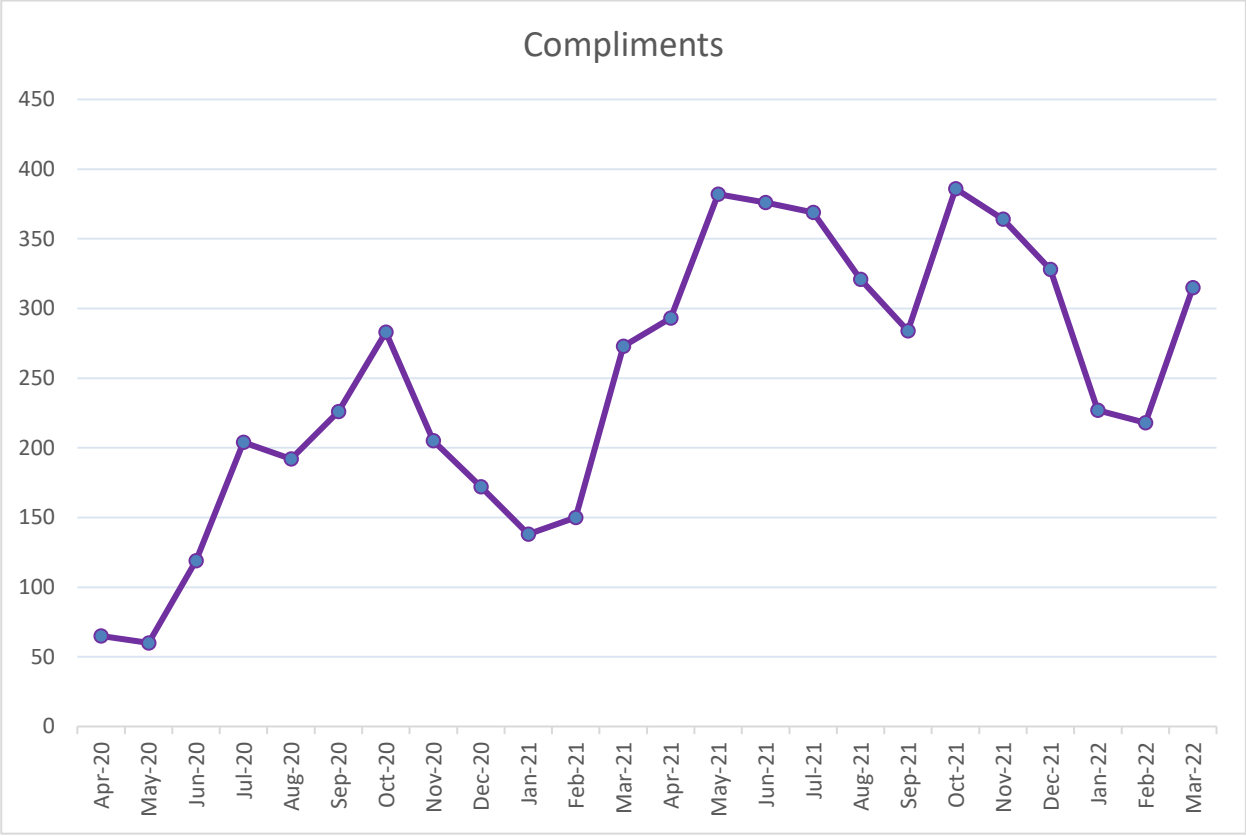
A new letter template for responding to Stage 3 complaints has been introduced and resulted in a reduction in the number of further contacts received, this will continue to be monitored.

The Trust has been accepted as an early adopter for implementation of the Parliamentary Health Service Ombudsman (PHSO) Complaint Standards Framework. The review has commenced and will involve Trust staff, community stakeholders and patients.

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.

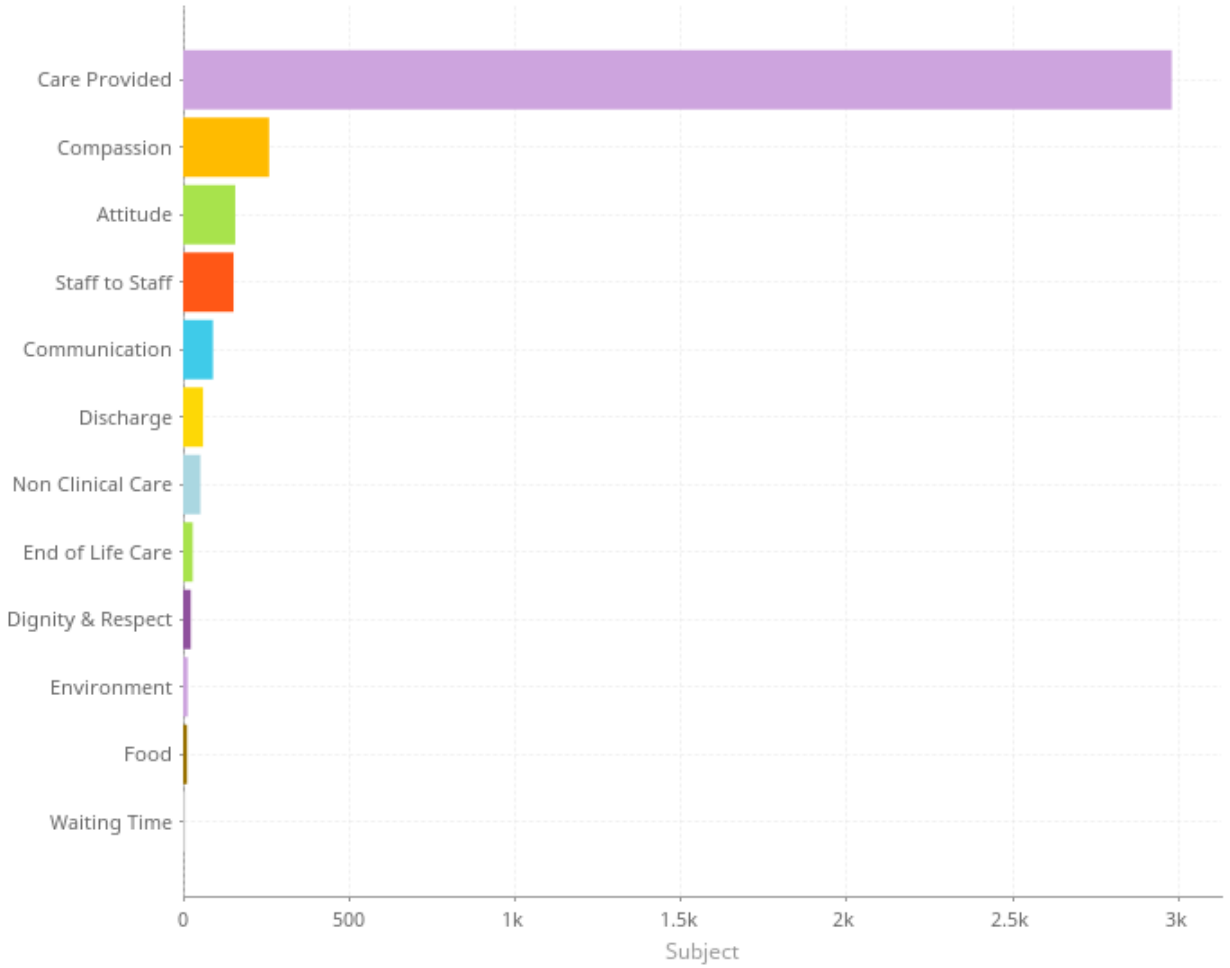
Financial Year	Number of Compliments
2020-21	2,087
2021-22	**3,863**



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

> “We would just like to say a massive thankyou for looking after our baby girl when she made her early entrance into the world. Everyone has been really lovely & supportive, which has made this experience easier for us. [sic]”

Compliment Subject



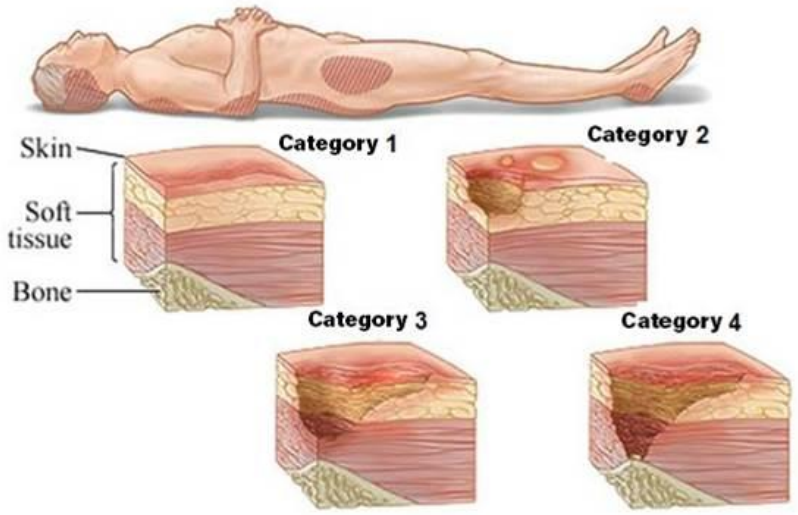
To improve the numbers and qualitative data around compliments, the Trust has established a Greatix system within the existing incidents platform to capture the relevant data.

> "we both thought very highly of you and thank you for everything [sic]

> Just wanted to say thank you for the care and support given to the family member. [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	2021-22
Category 1	78	39	38	54	92	64	48
Category 2	258	128	189	198	299	233	272
Category 3	12	9	20	35	34	14	16
Category 4	1	1	2	2	3	3	2
Total	**349**	**177**	**249**	**289**	**428**	**314**	**338**

*Data obtained via the Trusts Incident Reporting database (Datix) – March 2022

Year on Year Comparison – Out of Hospital *Acquired*

Reporting Period	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
Category 1	83	68	159	55	59	50	41
Category 2	337	253	359	173	152	128	153
Category 3	21	36	85	69	75	46	51
Category 4	8	5	21	9	19	12	14
Total	**449**	**362**	**624**	**306**	**305**	**236**	**259**

*Data obtained via the Trusts Incident Reporting database (Datix) – March 2022

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 audits by the directorates are undertaken and the TVN and quality teams are looking at enhancing the use of internal audit data, presented on the Trust dashboards, to continue to improve quality. 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.

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 champion's day is a full day of study and is planned for July 2022. Last year's event was sadly cancelled due to the pandemic. The TVN team have developed a training matrix for the champions to work towards and are developing from this a competency programme. The annual "Stop the Pressure" event was again very successful in November 2021 with a well-circulated campaign. The "Stop the Pressure" event will be repeated in 2022. There are information and resources for staff available on the Trust intranet site which provides advice to staff on a full range of tissue viability topics. This year a significant development has been the tissue viability "Learning Hub" with key topics being showcased via video links from the intranet site. The TVN team offer planned and bespoke training events throughout the year on a rolling program to address the needs of the developing workforce. There has also been some newly developed sessions with combining training of different types to maximise attendance. A measure of the success of the training delivered by the TVN team, and industry, is reflected by very complex wounds being managed in the community that would not have been possible to manage a decade ago, and in-patients quickly being commenced on correct treatment plans without the need of direction of the TVN team members - as the skills now exist in the workforce.

Communication between services continues to be improved 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. The TVN team are exploring further ways of enhancing communication between services.

The TVN team are exploring a project to reduce the number of skin tears in out of hospital care and also to reduce unplanned calls asked of the community nurse teams. It is hope this will be of significant impact

to reduce the number of unplanned calls for skin tears that can be managed initially with first aid, subject to an effective training program delivered by the TVNs.

The Trust will move, this year, to a new pressure ulcer risk assessment tool. Significant amounts of training has been delivered to staff members across the trust in the new risk assessment tool (Purpose-T), including ESR training programs and voice over training presentations, as well as planned question and answer sessions to ensure the workforce are comfortable with the new risk assessment tool before implementation. Community areas will move to Purpose-T in February 2022 and hospital in-patient areas later in the year. The risk assessment tool will give the benefit of being patient centred and allow the assessor to select the appropriate care plans and equipment with the aid of a newly developed equipment selection guideline.

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	2021-22 Performance	2020-21 Performance	Achieved (cumulative)
Cancer 31 day wait for second or subsequent treatment – surgery (2021-22)	94%	92.43%	91.39%	X
Cancer 31 day wait for second or subsequent treatment – anti cancer drug treatments (2021-22)	98%	99.71%	99.06%	✔
Cancer 62 Day Waits for first treatment (urgent GP referral for suspected cancer) (2021-22)	85%	76.89%	77.74%	X
Cancer 62 Day Waits for first treatment (from NHS cancer screening service referral) (2021-22)	90%	86.94%	87.01%	X
Cancer 31 day wait from diagnosis to first treatment (Apr 21 to Mar 22)	96%	97.41%	91.39%	X
Cancer 2 week wait from referral to date first seen, all urgent referrals (cancer suspected) (Apr 21 to Mar 22)	93%	90.95%	92.19%	X
Cancer 2 week wait from referral to date first seen, symptomatic breast patients (cancer not initially suspected) (Apr 21 to Mar 22)	93%	92.32%	90.30%	X
Maximum time of 18 weeks from point of referral to treatment in aggregate, patients on incomplete pathways (Mar22 frozen)	92%	85.58%	85.14%	X
Referral to Treatment 52 Week Waits (Mar 22 frozen)	0	45	371	X

Number of Diagnostic waiters over 6 weeks (Mar 22)	99%	92.25%	76.16%	X
Community care data completeness – referral to treatment information (2021-22)	50%	97.64%	98.30%	✔
Community care data completeness – referral information completeness (2021-22)	50%	97.06%	98.82%	✔
Community care data completeness – activity information completeness (2021-22)	50%	97.51%	98.58%	✔
Community care data completeness – patient identifier information completeness (Shadow Monitoring) (2021-22)	50%	97.51%	98.58%	✔
Community care data completeness – End of life patients deaths at home information completeness (Shadow Monitoring) (2021-22)	50%	83.79%	84.20%	✔
Compliance with access to healthcare for patients with learning disabilities (2021-22)	100%	Full compliance	Full compliance	✔
Other National and Contract Indicators	**2020-21 Target**	**2021-22 Performance**	**2020-21 Performance**	**Achieved**
Cancelled Procedures for non-medical reasons on the day of op (Apr 21 to Mar 22 provisional)	0.80%	0.46%	0.32%	✔
Cancelled Procedures reappointed within 28 days (Apr 21 to Mar 22 provisional)	100%	91.17%	74.32%	X
Eliminating Mixed Sex Accommodation	Zero cases	0	0	✔
A&E Trolley waits > 12 hours (Apr 21 to Mar 22)	Zero cases	40	0	X
Stroke – 90% of time on dedicated Stroke unit (Apr 21 to Mar 22)	80%	89.59%	93.80%	✔
Stroke – TIA assessment within 24 hours (Apr 21 to Mar 22)	75%	71.88%	93.10%	X
VTE Risk Assessment (2021-22)	95%	94.46%	95.39%	X
Sickness Absence Rate (Feb 22)	4.0%	6.44%	5.59%	X
Mandatory Training Compliance (Mar 22)	80%	89.19%	87.12%	✔
Turnover Rate (Mar 22)	10.0%	12.10%	7.66%	X

Operational Efficiency Indicators	2020-21 Target	2021-22 Performance	2020-21 Performance	Achieved
New to Review Ratio (Apr 21 – Feb 22)	1.45	1.25	1.31	✔
Outpatient DNA (new) (Apr 21 to Mar 22)	7.20%	8.03%	8.32%	X
Outpatient DNA (review) (Apr 21 to Mar 22)	9.00%	8.32%	7.23%	✔
Length of Stay Elective (Apr 21 to Mar 22)	3.14	2.03	1.64	✔
Length of Stay Emergency (Apr 21 to Mar 22)	3.35	3.55	3.47	X
Readmission Elective (Apr 21 to Jan 22)	0.00%	4.22%	4.05%	X
Readmission Emergency (Apr 21 to Jan 22)	9.37%	13.66%	15.30%	X
Occupancy (Trust) (Apr 21 to Mar 22)	85%	89.91%	79.69%	X
Quality Indicators	**Standard/Trajectory**	**2021-22 Performance**	**2020-21 Performance**	**Achieved**
Clostridium Difficile – variance from plan (objective) (Apr 21 – Mar 22)	64	50	49	✔
Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia (Apr 21 – Mar 22)	0	0	1	✔
Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia (Apr 21 – Mar 22)	25	38	25	X
Escherichia coli (E.coli) (Apr 21 – Mar 22)	117	78	26	✔
Klebsiella species (Kleb sp) bacteraemia(Apr 21 – Mar 22)	24	15	10	✔
Pseudomonas aeruginosa (Ps a) bacteraemia (Apr 21 – Mar 22)	11	14	3	X
Trust Complaints - Formal CE Letter (Stage 3) (Apr 21 – Mar 22)	<=135	102	135	✔
Trust Complaints Compliance within agreed timescalse (Apr 21 – Mar 22)	95%	100.00%	100.00%	✔
Trust Falls Severe (Apr 21 – Mar 22)	<=5	1	5	✔

In Hospital Pressure Ulcers Grade 4 (Apr 21 – Mar 22)	2	1	3	X
Medication Error (Apr 21 – Mar 22)	<=540	617	540	X
Friends and Family Test - Very Good/Good (Apr 21 – Mar 22)	>=92.25%	92.36%	92.25%	✔
Never Events (Apr 21 – Mar 22)	0	3	1	X
Hand Hygiene (Apr 21 – Mar 22)	95%	97.58%	96.38%	✔
Hospital Standardised Mortality Ratio (HSMR) (Jan 21 – Dec 21)	< 102	85.28	101.19	✔
Summary Hospital-level Mortality Indicator (SHMI) (Nov 20 – Oct 21)	< 106	96.12	97.87	✔

Additional Assurance:

https://www.england.nhs.uk/financial-accounting-and-reporting/quality-accounts-requirements-2021-22/

There is no national requirement for NHS trusts to obtain external auditor assurance on the quality account or quality report, with the latter no longer prepared. Any NHS trust or NHS foundation trust may choose to locally commission assurance over the quality account; this is a matter for local discussion between the Trust (or governors for an NHS trust) and its auditor. For quality accounts approval from within the Trust's own governance procedures is sufficient.

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 2021/22.

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 debate and discussion 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 continued to face a challenging 2021/22 as a result of the Covid pandemic. The CCGs would like to commend the Trust on the commitment and dedication demonstrated during this difficult time especially in respect of the increased pressure on staffing levels. The CCGs would like to acknowledge the work the Trust has undertaken to support patients with long COVID.

Commissioners are pleased to note from the 2021/22 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. Furthermore, the utilisation of national and regional agreed tools to ensure that this position is upheld is acknowledged. The Commissioners would like to express gratitude to staff who continue to contribute towards maintaining this position in challenging times. Commissioners will continue

to provide robust scrutiny and challenge in relation to mortality outcomes during 2022/23 and will continue working with the Trust to identify opportunities for shared learning across the health economy.

The Commissioners recognise the Trust's initiatives to improve infection, prevention and control, noting that due to Covid no annual Clostridium Difficile trajectories were set. It is recognised that the Trust reported fifty cases during 2021/22 which is a slight increase compared to forty nine cases in 2020/21, however this remains a positive position by comparison regionally. Commissioners support the Trust's continued efforts to improve clinical infection, prevention and control practices. The Trust has reported zero cases of Methicillin Resistant Staphylococcus Aureus (MRSA) during 2021/22 and the CCG would like to congratulate the Trust on this significant achievement, acknowledging the concerted and coordinated work to achieve this, and noting that this remains a priority for 2022/23.

For other infections, recognising the national mandated changes in reporting criteria, it is difficult to understand if the increase of Methicillin-Sensitive Staphylococcus Aureus (thirty eight cases compared to twenty five the previous year) arises from this change or an actual increase in case numbers. This may also be the case underpinning the upward trend of cases in the number of HCAIs reported including Escherichia coli, Klebsiella, Pseudomonas aeruginosa and catheter-associated urinary tract infections. Clarity around any trends associated with this may become clearer next year when comparison data is available.

The CCG recognises the ongoing focussed work within the Trust to address and reduce these, and all infections. Examples of the effectiveness of their long standing improvement approach include the impact of targeted antibiotic prescribing upon HCAIs cases. This is further supported by the Trust's thorough investigation process to support identification of areas for improvement where appropriate.

Commissioners appreciate the challenges that the Trust faces in terms of the dementia agenda. They acknowledge the extensive work undertaken by the Trust to improve the care provided to patients who are, or may be, diagnosed with this condition. Initiatives such as the introduction of the 4at delirium assessment tool into the new falls pathway, the development of a new North Tees and Hartlepool Dementia Strategy. Furthermore the Commissioners recognise the partnership working with Tees Esk and Wear Valley NHS Foundation Trust by cross referencing potential/definitive diagnosis of dementia patients within respective IT systems is to be applauded.

The CCGs recognise the Trust's progress in achieving the "Treat as One" initiative during 2021/22 and commend the numbers of staff that have undertaken the mandatory mental health awareness training. The Trust's intention to continue this work throughout 2022/23 is noted and Commissioners look forward to seeing the impact of this work over the coming year.

Throughout 2021/22, the Trust continued to make significant advances in its safeguarding adults' agenda and it is encouraging to see how the Trust and other agencies work in partnership to protect the vulnerable. Such developments allow enhanced sharing of pertinent

information and learning; hence the CCGs would like to extend their gratitude to the Trust for this ongoing achievement.

However the CCGs note that the number of concerns involving the Trust continues to rise, including an increase in safeguarding concerns during 2021/22 (93). The Trust has identified common themes and the Commissioners look forward to the outcomes of the Trust's improvement work regarding discharge, pressure ulcer incidents and medication errors in 2022/23. The Trust's improvement of the Safeguarding children's agenda is acknowledged; highlights include increased visibility of the Safeguarding team within acute clinical areas, established supervision for clinicians, embedded Schwartz rounds and the development of eLearning training packages. The CCGs welcome the new initiatives that the Trust has identified for the coming year including the Child Protection Medical Suite, strengthened partnership working and engagement with the MACE contextual safeguarding hub.

In 2021/22 the Hartlepool and Stockton Children's Partnership work undertook four Local Safeguarding Children Practice Reviews (LSCPR) and the Trust identified significant learning in 3 of these cases. The CCGs note that there is continued monitoring in respect of this learning with ongoing actions; Commissioners look forward to receiving assurance around these. The CCGs acknowledge the commitment to optimizing learning from deaths. This includes work relating to the management of the deteriorating patient, surgical mortality reviews and also a range of specifically Learning Disabilities focused reviews. The CCGs look forward to seeing how this work is used to improve the care delivered to patients, families and carers.

The CCGs acknowledge the ongoing dedication the Trust has demonstrated in their commitment to learning from deaths with a particular focus on LeDeR, continued staff training and the implementation of the 'Learning Disability Acute Diamond Pathway'. Other essential work the Trust has undertaken in reviewing the management of the deteriorating patient and surgical mortality reviews is also recognised. The Trust has established the Deteriorating Patient Group to provide oversight in relation to this area and is working collaboratively with the Regional Deteriorating Patient Group. The Trust clearly demonstrates the importance of learning from all deteriorating patients cases to ensure any improvements identified are implemented within practice.

The Commissioners support the review of the handover process to ensure that there is effective, consistent communication between staff providing clinical care in the hospital. The Trust is hopeful that the review will result in a supportive digital solution and is currently trialling a proposed clinical handover system Commissioners look forward to the outcome of this proposal.

The Commissioners welcome the development of the Deteriorating Patient Dashboard which has the ability to display all Key Performance Indicators in relation to the deteriorating patient and includes compliance with mandatory training such as NEWS, Basic Life Support (BLS), Immediate life Support (ILS), Acute Illness Management (AIMs), sepsis, acute kidney injury (AKI) prevention. Furthermore, the Dashboard can provide analysis of deteriorating patients

cases, to examine trends the identification and management of such incidents and associated learning.

During 2021/22 the Trust continued to embed and expand several discharge initiatives which the CCGs supported. The sustained effort to ensure discharge occurs in a safe and timely manner is to be applauded, with increased seven-day services and further integrated work involving several agencies. Commissioners welcome seeing the outcome of these initiatives within the coming year.

The overall monitoring of patient care via the Safety and Quality Dashboard remains a significant development and one that the CCGs fully support. The ability to recognise and respond to any potential trends and themes is encouraged.

The CCGs recognise the important objective in maintaining excellent palliative and end of life care and wholly supports the continued implementation of 'Family's Voice'. The CCGs also welcome the introduction of a new Palliative and End of Life Lead and look forward to the impact this will have upon this invaluable service.

The Trust provided a mixed response to their CQC National Inpatient Data 2020, with some commendable improvements and some domains which demonstrated a deterioration. However, the Trust scored disappointingly worse within some domains. Commissioners look forward to the presentation of the respective improvement action plans and receiving appropriate assurances around progress.

The Commissioners welcome the introduction of a Freedom to Speak up (FTSU) Guardian, the collaborative work occurring with local Trusts and the promotion of the 'Speak up' and 'Listen up' campaign. Furthermore the Commissioners acknowledge the initiatives to improve effective communication between the FTSU Guardian and clinical staff.

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

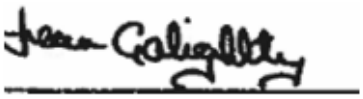
Unfortunately, in 2021/22 the Trust reported three 'Never Events'. All serious incidents are managed through the serious incident process and the Commissioners will continue to work with the Trust to identify and share learning and appropriate improvement actions.

The CCGs note that due to COVID-19, the key priorities for improvement for 2022-23 have been rolled over from 2021-22 with the focus on the three key areas: Patient Safety, Effectiveness of Care and Patient Experience.

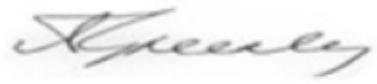
The CCGs can confirm that to their best knowledge the information provided within the NTHFT 2021/22 Annual Quality Account is an accurate and fair reflection of the Trust's performance. It is clearly presented in the format required and the information it contains accurately represents the Trust's Quality profile.

The CCGs look forward to continuing to work in partnership with the Trust to assure the quality of services commissioned in 2022/23.

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 – 17 June 2022

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

First, may I put on record our sincere thanks for providing Healthwatch Hartlepool with such a detailed presentation in respect of the Trust's Quality Accounts earlier this year prior to the publication of the Draft Quality Accounts 2021 - 22.

As agreed, please find below our Third-Party narrative that the Trust may publish but also may wish to consider when crafting the Trust's future priorities.

Overall members felt that the information provided was incredibly informative and an improvement on the data received last year. One of the long-standing issues we wish to alert the Trust to again is concerns around communication. On several occasions, we have suggested Financial Assistance availability to be promoted at the time appointment letters are issued. We were assured this was in the process of being adopted yet the population we have consulted state this is still not happening.

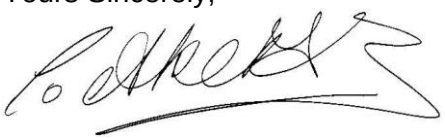
In respect of accessibility, we would welcome intervention by Estates when considering the reconfiguration of services at Hartlepool hospital. A prime example is the location of the lung clinic, which is difficult to access given the physical journey through the hospital that may exacerbate a patient's condition. Any transport provided to Hospital should also have regard for location of appointments within the Hospital's estate.

Communication could be improved around patient leaflets and equality of access to patients who may be Deaf/ Blind /Visually impaired or with dual sensory loss. There is a need for appropriate & improved signage for patients especially those living with a disability. 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.

Finally patient care to be considered for dementia sufferers who are admitted with another diagnosis as the primary reason for hospitalisation. Following on from this 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.

I sincerely hope the above is helpful in the Trust formulating their Quality Account and please contact me should you require any further information.

Yours Sincerely,



Christopher Akers-Belcher

Chief Executive - Healthwatch Hartlepool

Stockton Healthwatch – 16 June 2022

Healthwatch Stockton-on-Tees are pleased to report back on the 2021/22 Quality Accounts and note the significant achievements and the 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 has maintained ongoing involvement with Healthwatch Stockton-on-Tees and taken account of our thoughts and recommendations where they were helpful.

We noted the Covid-19 pandemic having 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 716 people across the Borough who have died in hospital since March 2020. We also note the setting up of the Long Covid Clinic with 660 patients referred so far showing the impact Covid continues to have.

It was helpful to also note the continuing reduction in mortality rates (based on re-coding work) and the rates now lie in line with national expectations especially as this work was impacting on the quality of care and treatment provided.

We are pleased to see the Trust maintained their "Good" CQC inspection outcome and are following through on recommendations with the expressed aim of achieving "Outstanding" in the future. It is positive that there is a stated aim of focusing on continuous learning and quality improvement at all levels throughout the organisation. We also noted the work to action recommendations from the 19 national clinical audits which the Trust were involved in.

We noted the ongoing positive work on supporting people with dementia whilst in hospital especially around support for carers and level 3 training for staff as Trust Dementia Champions. It was also pleasing to read about the Treat As One Group work focusing on supporting people with mental health issues and how this has progressed with comprehensive staff training.

We noted the overall increase in reported Safeguarding concerns and see this as a positive indication of the improvements in staff training. It was however disappointing to note the increased number of concerns against the Trust especially around discharge issues and poor communication. This seems to go against all the positive work being undertaken jointly between the Trust and the local authority social care team to implement the discharge policy and reduce delayed transfers of care. There also seems to be associated positive work ongoing with the Integrated Single Point of Access, Frailty Coordinators, District Nurse In-Reach and Home First pilots.

We also noted how the introduction of Yellowfin business intelligence software last year has helped improve the processing and quality of data and now allows for the demonstration of useful information via automated Safety and Quality dashboards. This is providing close monitoring of nurse sensitive patient indicators on a day to day basis and has a visual impact for quickly reviewing areas of concern.

Regarding some of the available data we noted disappointing results with the increasing number of violent incidents and also big increases in verbal abuse/disruption and concerns to do with personal safety. Also disappointing was the increasing negative patient experiences within Urgent Care and Maternity services. We also noted three "Never Events" which could have led to tragic consequences and although a low number this was more than in previous years. It was also disappointing that overall complaints were increased from the previous year although complaints

reaching Stage 3 did reduce. On a more positive note the number of compliments increased significantly especially around the care received by patients.

We welcome the introduction of PalCall, a 24/7 telephone advice line for patients who are anticipated to be in their last year of life. We also were pleased to read about the work on Learning from Deaths especially for people with learning disabilities and the positive feedback from multi-professional reviews and families' comments.

Healthwatch Stockton-on-Tees has continued to have a strong working relationship with the Trust over 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.

Peter Smith (Chair of Healthwatch, Stockton-on-Tees)

The Trusts Council of Governors – 17 June 2022

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 is 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 sub-committee structure. During 2021/22, the ongoing presence of the COVID-19 pandemic meant that some of the Trust's key meetings were undertaken on a virtual basis as well as reduced capacity in order to adhere to statutory guidelines. Development sessions were facilitated for Governors and included the People Plan, Estates Strategy, Stroke Services, Special Care Baby Unit and Community Diagnostic Centres.

The schedule of reports provided for Council of Governor meetings continue to be regularly reviewed to make sure that topical matters are shared in a timely manner and ensure that the meetings provide a valuable opportunity for the Governors to review the Trust's performance and seek assurance or raise any concerns with the Non-Executive Directors in attendance. This supports the role of Governors in being able to hold the Board to account. There is now an established formal Council of Governor pre-meeting prior to every meeting, which provides the Governors with the opportunity to discuss the papers for the meeting in great detail and to be able to highlight any areas where further information is required or to raise any concerns. A formal response is then provided to the whole Council of Governors.

Within the sub-committee structure the Strategy and Service Development Committee reviews new developments and strategic plans. At this Committee presentations were provided in respect of the Yellowfin Business Intelligence tool, the COVID-19 Vaccination Hub, 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.

The other Sub-Committees include the Membership Strategy Committee, Nominations Committee, and the External Audit Working Group, which meets as required.

Although restricted activity due to COVID-19 has continued, the Trust ensured that regular communication was maintained with Governors to be kept up to date regarding key developments and announcements. Plans for 2022/23 are to continue to move to a business as usual approach with statutory restrictions being lifted.

Hartlepool Borough Council – Audit and Governance Committee – 21 June 2022

Audit and Governance Committee – Third Party Declaration 2021/22

Following consideration of the North Tees and Hartlepool NHS Foundation Trust Quality Accounts on 28th February 2022, Hartlepool Borough Council's Audit and Governance Committee agreed the following:

In relation to quality improvement priorities carried forward in to 2021/22, the Committee commended the Trust on their successes in the below during very challenging times:-

Patient Safety;
Effectiveness of care; and
Patient Experience.

The Committee welcomed the opportunity to commented specifically in relation to the:

- Positive impact of improved treatment pathways on covid-19 patient outcomes;

- Operation of virtual wards;
- Need for accurate long Covid data
- Importance of accessibility and the need for the provision of appointment letters in appropriate formats (e.g. braille);
- Concern regarding the increase in violent incidents.

The Committee supported the carry forward of the 2021/22 priorities in to 2022/23.

Yours faithfully
STATUTORY SCRUTINY MANAGER

Stockton Borough Council – Adult Social Care and Health Select Committee – 17 June 2022

The Committee once again welcomes the opportunity to comment on the Trust's latest Quality Account document and do so in recognition of the overarching and continuing ramifications of the COVID-19 pandemic. Focusing on dealing with the emergence of a virus which transformed the world has inevitably impacted many other aspects of health and care provision, and as the country has returned to a more normal existence over the course of 2021-2022, there is now much to address within the sector.

Trust representatives presented their usual overview of the year's performance to the Committee in March 2022, and Members engaged in subsequent discussions with those staff in attendance around the key issues raised. This session remains a cornerstone of the Committee's annual activity and Members always welcome the Trust's openness and transparency in highlighting both positive achievements and any areas of concern.

Maintaining a pleasing trend, the Trust's mortality measures continue to compare favourably to the national and regional picture. Key to this has been the extensive coding work undertaken to ensure a patient's true level of sickness is identified when admitted to hospital, and this has contributed to the Trust remaining below the national Hospital Standardised Mortality Ratio mean rate since early-2018. Whilst the Trust has also done a significant amount of work to improve care, a focus on ensuring patients spend their last days in their preferred place has had an impact on these figures too.

Reduced admissions due to the ongoing COVID-19 pandemic continues to impact upon the rates of patients with dementia / delirium. That said, the Committee was encouraged by several developments including the attainment of Dementia Friendly status for the Trust's Stockton and Hartlepool hospitals, the ongoing Dementia Champion programme, the creation of a separate quieter area in A&E, and the continuing support offered to carers of those with dementia (e.g. the Trust's decision to continue allowing visitors throughout the pandemic for those eligible patients as part of the John's Campaign).

As per 2020-2021, there remains little documented progress against the 'Mental Health' quality indicator. Although the Committee applaud the high uptake of mandatory mental health awareness training amongst staff, further detail around this established priority is again desired (e.g. impact of Schwarz Rounds), particularly given the anticipated increase in mental health issues following the emergence of COVID-19.

From a safeguarding perspective, the increase in concerns / enquiries raised within the Trust (well over double since 2016-2017) and the rise in concerns against the Trust itself (nearly double since 2016-2017) is noted. Members acknowledge that improved awareness-raising of potential causes for concern and reporting routes may contribute to an escalating trend, but encourage the Trust to keep these identified themes under close observation in order to strengthen practice moving forward.

Regarding infection control, the Committee commend the progress made in relation to Clostridium difficile, an infection that was a significant issue in the early-2000s. The rise in the number of some other infections (albeit still within targets) was perhaps understandable as admission numbers increased following the easing of COVID-related social restrictions, though attention is required around both E.coli and catheter-associated urinary tract infection rates. As for COVID-19, the Omicron variant was a further unwelcome challenge in terms of admissions and gave a reminder that the virus remains capable of diverting attention and resources from other much-needed core activity. The Committee praised the Trust's role in developing treatments which had relieved pressure on the Intensive Care Unit and look forward to receiving updates on the long-COVID service.

Turning to the 'Effectiveness of Care' priority, another year of no patient deaths being (more likely than not) attributed to problems with care was very positive. The rise in the number of medication errors is, however, noted and Members are keen to understand how this is being addressed. Maternity services were put into the spotlight following the recent publication of the Ockenden review of Shrewsbury and Telford Hospital NHS Foundation Trust, and the Committee will be seeking assurance that local services are aware of, and are acting on where required, recommendations from this high-profile report.

By virtue of a previously completed scrutiny review, the Committee continue to receive detailed input from the Trust regarding discharge processes as part of post-review monitoring arrangements. Members are grateful that senior Trust staff remain willing and able to engage with the Committee in this (and other) important work and are enthused about the recommenced and much-valued Home But Not Alone scheme, supporting the stated expansion of its original scope.

As in previous years, the Committee was alarmed by the rising number of violent incidents towards staff – whilst some of this may be attributable to changes in reporting processes, there is simply no excuse for such behaviour. Members did, however, request an update on what the Trust was doing to address the large increase in 'concerns to do with personal safety'.

In terms of 'patient experience', results from national surveys highlighted areas that could be improved, not least the very poor indicator around asking patients to give views on the quality of their care, and the deterioration of elements of communication / information-sharing with those people using Urgent Care. Feedback from the CQC national maternity survey also highlighted some concerning aspects which the Committee are keen to probe further.

Data around the levels of compliments and the more effective addressing of complaints demonstrated a commendable picture. Members welcome the positive results from the Friends and Family Test (FFT) and urge the continued push to ensure as many people as possible (including carers) provide feedback so satisfaction levels amongst those accessing services can be gauged.

The Committee supports the roll-over of quality improvement priorities for 2022-2023, though remains conscious that many cancer standards continue to be missed. The enduring ripple of COVID-19 has adversely impacted many areas of the NHS, and, like others, the Trust has a huge challenge in getting key services and their associated waiting lists back to some form of equilibrium as it transitions into the new Integrated Care System (ICS) framework.

Healthcare User Group (HUG) – 16 May 2022

Third Party Statement from the Healthcare User Group (HUG)

The Healthcare User Group (HUG) is 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" but 2021 too, had many other pressures to exert upon the NHS, as the Alpha, Beta and Delta variants and lately, the Omicron variant had swept through the country and our region. So, 2021 - 22 was another year when there were no HUG visits to inpatient wards or outpatient clinics, but those members of our group who were able to attend meetings remotely continued to do so.

The very infectious Omicron variant and its numerous sub-variants have meant many staff were having to report sick or isolating, putting even more pressure on those at work and we have to commend those staff for working under those conditions. As the year has progressed it is worth noting that these absences have continued to fall and "normal working" is beginning to become more of a reality. However, demand on services has increased with mounting pressures due to increased A&E demands both nationally and locally and the mounting backlog of delayed procedures weighs heavily on the Trust's ability to return to business as usual.

We have reviewed the Quality Accounts and conclude they are a true representation of the position the Trust finds itself at the end of yet another extraordinary year, as the Health Service and the Trust try to return to somewhat more normal (the new normal?) operating practices. We can only commend the fantastic work being done within the Trust as it has tried to recover to reduce the backlog of treatments created when the government closed down elective procedures in order to prioritise Covid-19 treatment. With the constant threat of yet more delays to treatments should the country need to lockdown again, and the ongoing threat of yet further outbreaks, the Trust has made great strides to accelerate its roll out of services again.

The Trust has continued to target those three key NHS priorities and worked to improve its mortality rates, investing in reducing infection rates and striving towards the delivery of excellence of care to all patients.

With the value of some of the data presented remaining questionable due to changes in reporting and assessing, the Mortality rates within the hospital remain excellent when compared to the national and regional figures. Considering the Trust's position in those league tables not so many years ago, the fact it now rates so highly is down to the changes made in coding and reporting and with patients receiving the most appropriate care as quickly as possible.

Dementia remains a concern across our region and the rise in diagnosis is projected to be high and so the Trust has worked to create a welcoming environment, to ensure all staff have appropriate training and to conduct an audit to ascertain what is working well and areas

within which it can improve. As can be seen from the data, 2019 – 2021 had been affected by Covid-19, with few hospital admissions but the rise over the last year can be expected to increase further. Although families visiting patients had to be stalled due to Covid-19, John's Campaign has allowed some carers to support their loved ones during their stay in hospital.

The "Friends and Family Test" results continue to provide a high level of assurance by patients of the care they have received with the Trust, and now using a text option which will engage those using this sort of technology. However, it is also pleasing to see that the Trust continues to take 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 of complaints can be resolved at the informal level. Very few complaints go on to Stage 3. Staff have been under great pressure over the last two years and the number of complaints stating "Staff attitude" could be due to either a misunderstanding or a perceived slight. Communication skills are always promoted within the Trust and staff work to try to make themselves understood without resorting to confusing medical terms.

The rise in the number of violent incidents against staff/patients is a very worrying trend, and has risen again. This is, to most people, unacceptable. No person comes to work to be abused by the people they are trying to help. The "Zero Tolerance" approach means staff can refuse to treat those persons who do offend but we know they will try to negotiate and treat everyone as appropriate.

Worryingly, the workforce pressures continue. Staffing will become a major issue for all NHS Trusts as an ageing healthcare workforce (reaching retirement), those opting to move careers completely due to stress and the increasing population demands. There are many areas across the nation where there are unfilled gaps in staffing, especially in specialist areas. This will continue to be a problem not only at NTHFT but at every Trust.

The key priorities for 2022/23 are relatively unchanged from those of previous years, but HUG supports this approach and will do all it can to help and support in any way possible. With ward visits about to restart we look forward to seeing the 'new hospital' as it has been so long since we last spoke with staff and patients.

Our thanks go out to all those people working in the Trust, whether physicians, nurses, physiotherapists or any of the other support staff including the cleaners, those serving meals, those volunteers offering a warm welcome to new patients and visitors and applaud their commitment and dedication to the care of their patients, namely, our neighbours.

Healthcare User Group

May 2022

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:

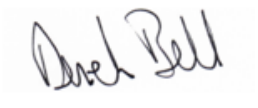
- the content of the Quality Report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2021-22* and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2021 to April 2022
  - papers relating to Quality reported to the Board over the period April 2021 to April 2022
  - feedback from commissioners dated xx *2022*
  - feedback from governors dated 17 *2022*
  - feedback from local Healthwatch organisations dated 16 June *2022&* 17 June *2022*
  - feedback from the Adult Services and Health Select Committee and Audit and Governance Committee dated 17 June *2022 &* 21 *2022*
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated *Q4 2021-22*
  - 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 2022 Date 31 May 2022

Chief Executive



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

There is no national requirement for NHS trusts to obtain external auditor assurance on the quality account or quality report, with the latter no longer prepared. Any NHS trust or NHS foundation trust may choose to locally commission assurance over the quality account; this is a matter for local discussion between the Trust (or governors for an NHS trust) and its auditor. For quality accounts approval from within the Trust's own governance procedures is sufficient.

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: **nth-tr.PatientExperience@nhs.net** 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 154ardex)	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
PalCall	Palliative care, out-of-hours telephone helpline for patients and carers registered with our services
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