North Tees and Hartlepool NHS
NHS Foundation Trust

Board of Directors Meeting

Thursday, 29 July 2021
at 1pm

Boardroom
University Hospital of North Tees

University Hospital of North Tees
Hardwick
Stockton on Tees
TS19 8PE
Telephone: 01642 617617
www.nth.nhs.uk

22 July 2021

Dear Colleague

A meeting of the **Board of Directors** will be held, on **Thursday, 29 July 2021 at 1.00pm** in the **Boardroom, University Hospital of North Tees.**

Yours sincerely

Neil Mundy
Chairman

Agenda

			Led by
1.	(1.00pm)	Apologies for Absence	Chairman
2.		Declaration of Interest	Chairman
3.		Patient Story (verbal)	L Robertson
4.	(1.20pm)	Minutes of the meeting held on, 27 May 2021 **(enclosed)**	Chairman
5.		Matters Arising / Action Log **(enclosed)**	Chairman
Items for Information			
6.	(1.30pm)	Report of the Chairman **(enclosed)**	Chairman
7.	(1.40pm)	Report of the Chief Executive **(enclosed)**	J Gillon
Quality			
8.	(2.00pm)	Professional Workforce Annual Report **(enclosed)**	L Robertson
Strategic Management			
9.	(2.15pm)	Capital Programme Performance Q1: 2021-22 **(enclosed)**	N Atkinson

Performance Management

10. (2.25pm)	Integrated Corporate Report **(enclosed)**	L Taylor, L Robertson A Sheppard & N Atkinson

Governance

11. (2.40pm)	Learning from Deaths Report **(enclosed)**	D Dwarakanath

Operational

12. (2.50pm)	Responsible Officer's Medical Appraisal and Revalidation Report **(enclosed)**	D Dwarakanath
13. (3.00pm)	Nursing and Midwifery Revalidation **(enclosed)**	L Robertson
14. (3.10pm)	NHS Workforce Race Equality Standard 2021 **(enclosed)**	A Sheppard
15. (3.20pm)	NHS Workforce Disability Equality Standard 2021 **(enclosed)**	A Sheppard

Items to Receive

16. (3.30pm)	Freedom to Speak Up Guardian Annual Report 2020-21 **(enclosed)**	L Robertson
17.	Quality Accounts 2020-21 **(enclosed)**	L Robertson
18.	Equality, Diversity & Inclusion Annual Report 2020-21 **(enclosed)**	A Sheppard
19.	Carbon Reduction Programme Performance Targets **(enclosed)**	L Taylor
20.	Estates and Facilities Annual Report 2020-21 **(enclosed)**	L Taylor
21.	Health, Safety and Security Annual Report 2020-21 **(enclosed)**	L Taylor
22.	Organ Donation Annual Report 2020-21 **(enclosed)**	K Robinson
23.(4.30pm)	Any Other Notified Business	Chairman

26.Date of Next Meeting
(Thursday, 28 October 2021 Boardroom, University Hospital of Hartlepool)

Neil Mundy
Chairman

Julie Gillon
Chief Executive

Glossary of Terms

Strategic Aims and Objectives

Putting Our Population First

- Create a culture of collaboration and engagement to enable all healthcare professionals to add value to the healthcare experience
- Achieve high standards of patient safety and ensure quality of service
- Promote and demonstrate effective collaboration and engagement
- Develop new approaches that support recovery and wellbeing
- Focus on research to improve services

Valuing People

- Promote and 'live' the NHS values within a healthy organisational culture
- Ensure our staff, patients and their families, feel valued when either working in our hospitals, or experiencing our services within a community setting
- Attract, Develop, and Retain our staff
- Ensure a healthy work environment
- Listen to the 'experts'
- Encourage the future leaders

Transforming Our Services

- Continually review, improve and grow our services whilst maintaining performance and compliance with required standards
- Deliver cost effective and efficient services, maintaining financial stability
- Make better use of information systems and technology
- Provide services that are fit for purpose and delivered from cost effective buildings
- Ensure future clinical sustainability of services

Health and Wellbeing

- Promote and improve the health of the population
- Promote health services through full range of clinical activity
- Increase health life expectancy in collaboration with partners
- Focus on health inequalities of key groups in society
- Promote self-care

North Tees and Hartlepool NHS Foundation Trust

Minutes of a meeting of the Board of Directors
held on Thursday, 29 July 2021 at 1 pm
at the University Hospital of North Tees / Via Video Link

Due to the current position regarding COVID-19, the decision was made that the Board of Directors meeting would be conducted via video-conferencing. This approach enabled the Board of Directors to discharge its duties and gain assurance whilst providing effective oversight and challenge, and supporting the national guidance regarding social distancing.

These minutes represent a formal record of the meeting.

Present -

Neil Mundy, Interim Joint Chairman*	Chairman
Steve Hall, Vice-Chair/Non-Executive Director*	SH
Ann Baxter, Non-Executive Director**[via video link]*	AB
Philip Craig, Non-Executive Director* *[via video link]*	PC
Jonathan Erskine, Non-Executive Director* *[via video link]*	JE
Kevin Robinson, Non-Executive Director* *[via video link]*	KR
Rita Taylor, Non-Executive Director*	RT
Julie Gillon, Chief Executive*	CE
Deepak Dwarakanath, Medical Director/Deputy Chief Executive*	MD/DCE
Neil Atkinson, Director of Finance* *[via video link]*	DoF
Barbara Bright, Director of Corporate Affairs and Chief of Staff	DoCA&CoS
Levi Buckley, Chief Operating Officer* *[via video link]*	COO
Graham Evans, Chief Information and Technology Officer *[via video link]*	CITO
Lindsey Robertson, Chief Nurse/Director of Patient Safety and Quality*	CN/DoPS&Q
Alan Sheppard, Chief People Officer *[via video link]*	DCPO
Lynne Taylor, Director of Performance and Planning	DoP&P

In attendance: -

Professor Derek Bell, Joint Chairman (Designate)
Linda Hunter, Deputy Director of Planning and Performance (Observer) [*via video link*]
Tony Horrocks, Lead Governor / Elected Governor for Stockton [via video link]
John Edwards, Elected Governor for Stockton [via video link]
Pat Upton, Elected Governor for Stockton [via video link]
George Lee, Elected Governor for Hartlepool [via video link]
Pauline Robson, Elected Governor for Hartlepool [via video link]
Ruth McNee, Elected Governor for Sedgefield [via video link]
Angela Seward, Lead Governor, South Tees Hospitals NHS FT [via video link]
Alex Metcalfe, Local Democracy Reporter, Teesside Gazette/Teesside Live [via video *link]*
Posmyk Boleslaw, Chair, Tees Valley CCG [via video link]
Samantha Sharp, Personal Assistant (note taker)

BoD/4563 Apologies for Absence / Welcome

Apologies for absence were noted from Ada Burns, Vice Chair, South Tees Hospitals NHS FT.

The Chairman welcomed members to the meeting which included Governors of the Trust, Angela Seward, Lead Governor at South Tees Hospitals NHS FT, Posmyk Boleslaw, Chair of Tees Valley CCG and members of the press. In addition, Linda Hunter, Deputy Director of Planning and Performance was welcomed to the meeting as an observer to support her development.

The Chairman welcomed Professor Derek Bell OBE to the meeting who had been appointed the substantive Joint Chair for both the Trust and South Tees Hospitals NHS FT and would

---
* voting member

commence in post from 1 September 2021. Professor Bell would be meeting partners both internal and external to the two Trusts throughout August to gain further knowledge of the local area and the challenges faced in respect to population health and health inequalities. Following a request by the Chairman, Professor Bell introduced himself highlighting that it was a great privilege to have been appointed to the post and that he was looking forward to becoming part of the team. Professor Bell offered his formal thanks to the outgoing Chairman and the Board who had been welcoming and provided support following his appointment.

BoD/4564 Declaration of Interests

Declarations of interest were noted from the DoP&P and DoCA&CoS in respect to their roles with North Tees and Hartlepool Solutions LLP and SH (Non-Executive Director), RT (Non-Executive Director) and the DoCA&CoS in respect to their roles with Optimus Health Ltd.

A declaration of interest was also noted from the CITO in respect to his role in the ICS and KR (Non-Executive Director) who was a Non-Executive Director of Spectrum Community Health CIC.

BoD/4565 Patient Story

The CN/DoPS&Q was disappointed to report that the patient who was due to visit the meeting to provide their 'patient story' was unwell and unable to attend. The Chairman asked that best wishes for a speedy recovery were relayed to the patient from the Board.

Resolved: that, best wishes for a speedy recovery be relayed to the patient who was scheduled to provide their 'patient story' at this meeting.

BoD/4566 Minutes of the meeting held on, Thursday, 27 May 2021

Resolved: that, the minutes of the meeting held on, Thursday, 27 May 2021 be confirmed as an accurate record.

BoD/4567 Matters Arising / Action Log

a. BoD/4461 NHS Regulation Bill – White Paper: Integration and Innovation – Working together to improve health and social care for all

The DoCA&CoS advised that a date in September would be arranged for a development session for both the Board and Council of Governors on the White Paper

b. BoD/4533 Annual report and Accounts 2020/21

The DoCA&CoS reported that the Annual Report and Accounts for 2020/21 had been submitted to NHSI by 29 June 2021 in line with requirements. However, Value for Money certification from Deloitte was awaited which would be completed by the end of September, following which the Annual Report and Accounts would be laid before Parliament.

c. BoD/4536 Annual Operating Plan 2021/22 and Annual Self Certifications

The DoP&P reported that the Annual Operating Plan 2021/22 was submitted in line with NHSEI requirements. In addition, annual declarations were also uploaded to the NHSI Portal.

d. BoD/4537 NHS Resolution Clinical Negligence Scheme for Trusts (CNST)

The CN/DoPS&Q reported that the content of the declaration had been shared with Commissioners and submitted to NHS Resolution in line with requirements by 15 July 2021. A market place event would be scheduled to showcase work being done within Maternity Services as restrictions ease.

e. BoD/4539 Visit to the Infection Prevention and Control team

The Chairman reported that he had visited the Infection Prevention and Control team thanking them personally for their work to overcome challenges in the past 18 months around the pandemic.

Resolved: (i) that, the verbal updates be noted; and
(ii) that, a date in September be arranged for a development session for both the Board and Council of Governors on the White Paper; and
(iii) that, Value for Money certification from Deloitte be completed by the end of September, following which the Annual Report and Accounts for 2020/21 to be laid before Parliament; and
(iv) that, as restrictions ease, a market place event be scheduled to showcase work being done within Maternity Services.

BoD/4568 Report of the Chairman

A summary of the report of the Chairman was provided with no new information to report which was not included within his written report.

The Chairman noted that he would like to do justice to the presentation of a number of annual reports at the end of the meeting celebrating achievements in what had been a difficult year.

The Chairman again welcomed Professor Bell, highlighting some of the challenges faced in leading two Trusts and emphasising that he would be an important representative for the NHS within the ICS system going forward.

The Chairman highlighted the importance of staff health and wellbeing including that of the CE and the Board as the hospitals remained busy prior to the usual pressures of winter starting.

It was important that the Trust worked in partnership with key stakeholders recognising the importance of population health, providing stronger collaboration and a holistic approach. The Chairman highlighted the importance of working with partners to improve the longer-term health outcomes for the population by promoting healthy lifestyles and reducing health inequalities.

The Chairman placed on record his thanks, particularly to Steve Hall and the Lead Governors, who had worked hard to support him during the past six months. It had been a huge privilege and a pleasure and the Chairman wished the Trust and the Joint partnership every success for the future.

Resolved: that, the information be noted.

BoD/4569 Report of the Chief Executive

The CE placed on record her thanks to the outgoing Chair acknowledging his tenacity in supporting Teesside and the ambitions of the Tees and North Yorkshire Provider Collaborative.

A summary of the report of the Chief Executive included: -

- The organisation remained under pressure with COVID-19 having a major impact, particularly over the past two months. The Trust were the last organisation in the North East and North Cumbria (NENC) to be impacted by the third surge in cases and it was noted that community infection rates remained higher than the national England average which impacted upon the community and the organisation. It was noted that Hartlepool had the highest rate of cumulative infection within the NENC. Staff absence had reached a peak the previous week and the Trust continued to work with staff to ensure that they

felt supported. Analysis has shown that two thirds of those being admitted to hospital in June and July had not been vaccinated. Concern had been raised around the low uptake amongst younger people and steps were being taken to address this through a targeted campaign aimed at younger people. There were currently 66 confirmed COVID-19 cases within the Trust and it was noted that length of stays had reduced for those admitted. Reporting against the 62 day cancer standard had improved with a reduction in the backlog of cancer referrals. Compliance against the diagnostic standard had also improved. Staff were commended for their resilience during this time and it was noted that the health and wellbeing of staff was of paramount importance;

- The Trust had maintained its Better Health at Work award, made possible by the collaborative efforts across a number of services to ensure that the health and wellbeing of staff remained a priority. The Trust had also been awarded a special recognition award acknowledging the work undertaken, despite the pressures of the pandemic;
- The Trust had vaccinated nearly 30,000 individuals from across the heath and care sector and local community. This included 88.1% of Trust staff receiving the first dose and 79.6% receiving a second dose. A potential booster programme could begin in September 2021 in order to maximise protection in those who are most vulnerable. Work had begun across the NENC ICS on developing a coordinated approach to rolling out the COVID-19 booster and flu vaccination programmes;
- The Trust had recruited 773 patients to the RECOVERY trail to date. A successful bid was made to the National Institute of Health Research Clinical Research Network to employ additional staff to support COVID study delivery so that research staff could concentrate on reopening previously paused studies;
- The Trust held a very successful event on 18 June that brought together over 100 leaders in the organisation to focus on identifying courageous changes that they could take forward to benefit patient care and improve performance;
- The Trust participated in National Volunteers Week to celebrate the contribution and dedication of volunteers. The Trust used Volunteers Week as a 'time to say thanks' to every volunteer who provided support throughout the pandemic with a letter of appreciation and a medal from the CE;
- Consultant Appointments:-
    - Consultant Gastroenterology/GIM with an interest in Liver Medicine – Dr Rebecca Dunn and Dr Mohamed Sala Eldin Elzober Salih
    - Consultant in Public Health – Dr Esther Mireku
    - Consultant Radiologist (MSK) – Dr Matthew Bowa
    - Consultant Radiologist (General) – Dr Iffat Rehman
    - Consultant in Obstetrics and Gynaecology – Dr Jennifer Hoh
- The ICS Management Board continued to review the impact of the White Paper alongside the recently published ICS Design Framework;
- As Senior Responsible Office, the CE chaired the inaugural Health Inequalities Advisory Board on 2 July. This first meeting focused on the ambition and expectations around key outcomes and a summit would bring together collective views in preparing a strategy to tackle health inequalities in the communities served by the NENC;
- The NENC Provider Collaborative continued to focus on the intent, purpose, work programme and governance arrangements and fit to ICS delivery and restructure;
- An event with representation from this Trust, South Tees Hospitals and County Durham and Darlington NHS FTs, facilitated by Cap Gemini was held on 20 July. This event was structured to share the current position with respect to the Clinical Services Strategy, hearing insights from other systems and developing key areas of focus and outcomes for the next six months;
- The Trust were working in partnership with local, regional and national media partners to discuss the issues surrounding the aging estate;
- The Trust celebrated biomedical sciences week in June highlighting the work of the biomedical team;
- The Trust celebrated annual Pride Month in June showing its inclusive nature and commitment to staff, communities and patients;

- The Trust was 1 of 40 in the country piloting an innovative way of detecting bowel cancer with patients swallowing a special capsule to help detect bowel issues;
- The NHS Single Oversight Framework for 2021/22 was released in 2021 outlining the purpose and highlighting a single set of metrics developed across the ICS, Trusts, CCGs and Primary Care aligned to the five national themes of quality, access and outcomes, preventing ill health and reducing inequalities, leadership and capability, people and finances and use of resources. The Trust had prepared a gap analysis to ensure compliance against the indicators and contribution to the local acute collaboration and ICS outcomes.

SH sought to acknowledge the positive message broadcast on national BBC news around the pressures of COVID-19 and the importance of the vaccination programme commending those in the Trust who took part in the footage.

RT highlighted her disappointment around those in the younger age group not coming forward for the vaccine highlighting a lack of confidence and trust in the vaccination programme and local bodies asking how this could be tackled. The CE reported that the Trust were embarking upon a campaign to tackle this, thinking laterally. The DoCA&CoS reported that Ruth Dalton, Head of Communications and Marketing was leading on a campaign across the NENC targeting a younger audience. This campaign was entitled 'This isn't our Freedom' and sought to encourage younger people to come forward for their vaccine using 'influencers' and helping them to consider the impact on their local health service and community should they not accept the vaccine.

JE highlighted that one of the vaccines was being produced on Teesside creating jobs highlighting that this positive message needed to be communicated to the public. In addition, JE asked if there were any opportunities to begin to look at areas of research which were not clinically based but included service improvements and population health. The CE responded that this would be a positive step in tackling health inequalities.

Resolved: (i) that, the contents of the report and the pursuance of strategic objectives and collective work amongst the COVID-19 recovery programme and the return to services building on a new operating model be noted; and
(ii) that, the work toward tackling the aging estate be noted.

BoD/4570 Professional Workforce Annual Report

The CN/DoPS&Q reported on the annual position of the professional workforce which combined the nursing and midwifery, allied health professionals, medical and dental workforce annual review for 2020/21.

The CN/DoPS&Q provided an overview of the current professional workforce position and ways the Trust were recruiting and retaining staff and reducing the reliance on temporary bank and agency staff. In addition, the CN/DoPS&Q provided an update of service changes in response to COVID-19 that had impacted the professional workforce.

A review of current nursing and midwifery staffing had been undertaken within all wards and departments and demonstrated that all areas had the required nurse and midwifery staffing levels to provide safe patient care.

The CN/DoPS&Q reported that in May there were 72.2 WTE (5.3%) RN vacancies, 3.0 WTE (2.3%) RM vacancies, 21.3 WTE (3.3%) unregistered nursing vacancies and 3.6 WTE (33.8%) unregistered midwifery vacancies. Sickness absence averaged 8.7% across the year which included sickness due to COVID-19 symptoms and those due to COVID-19 related isolation.

The Trust had recently implemented a new 'Team Support Worker' role which offered a cohort of Band 2 staff with little or no previous NHS experience the opportunity to support clinical and

administrative teams across the organisation. The pilot had shown that this role had released nursing time to care, reducing the pressure on nursing teams. The value of the role continued to be monitored, early success had shown improved patient satisfaction, reduction in complaints and an increase in staff satisfaction.

In response to the need to remain flexible in the way nursing and midwifery staffing was planned, the Trust continued to utilise the Safe Care Live module (SCL) on a daily basis to safely and efficiently assess accurate staffing levels and redeploy nursing staff throughout the organisation as necessary.

A review of the Allied Health Professional workforce had been undertaken and vacancies were being actively managed. There was a high vacancy factor within speech and language therapy, podiatry and diabetic eye screening where some focused recruitment was being explored.

The CN/DoPS&Q reported that a review of the Medical and Dental workforce had been undertaken and it was highlighted that there was a shortfall of 24.26 WTE between the budgeted and contracted medical and dental workforce. However this did not necessarily reflect the actual number of vacancies and rota gaps which may differ due to changes in services, temporary rota redesign, skill mix or working restrictions. The average sickness absence rate between April 2020 and March 2021 was 1.8%, significantly lower than the Trust target of 4%. The average turnover rate for medical and dental staff between April 2020 and March 2021 was 7.10%.

A total of £718k was spent on agency locums during 2020/21, a decrease when compared to the previous year. The largest proportion of spend was due to the pandemic response and subsequent resilience measures.

RT reported that she had visited the Paediatric Day Unit where there were some newly qualified paediatric nurses who had been redeployed elsewhere in the Trust during times of pressure highlighting that they welcomed the opportunity to gain wider experience. RT acknowledged the higher acuity of patients which was both difficult and challenging for staff emphasising that staff continued to be able to access mental and practical support. The CN/DoPS&Q added that staff were able to access enhanced support if required and that the importance of this was recognised. The Chairman highlighted that all staff were individuals and responded differently to support methods available.

The CE commended the clinical oversight of the MD/DCE and CN/DoPS&Q highlighting that planning and forecasting for the future was also being considered. It was noted that the Trust had one of the lowest agency costs in terms of temporary staffing.

The thanks of the Board was passed on to all staff who continued to serve patients and their communities despite the challenges presented.

Resolved:
(i) that, the significant assurance provided within this report around safe nursing, midwifery, allied health professionals and medical staffing be noted; and
(ii) that, changes in workforce planning for the next annual Board report be noted; and
(iii) that, the impact of the COVID-19 pandemic on both patient acuity and increased staff sickness be noted; and
(iv) that, the huge effort in response to unprecedented pressures created by COVID-19 and the work undertaken to have safer staffing levels across the organisation be noted.

BoD/4571 Capital Programme Performance Quarter 1: 2021/22

The DoF reported that the Trust had an overall capital programme of £17m for 2021/22. The Trust was reporting a positive position at the end of Month 3, reporting capital spend of £1.2m,

£100k behind plan. The Trust were anticipated to achieve its capital spend at year-end.

The Respiratory Support Unit (RSU) business case for £2.5m was approved in May to upgrade the existing ward 24 respiratory ward into an RSU with specific enhancements to support the care of patients with major respiratory illnesses, such as COVID-19 or influenza.

The capital forecast for the year at June 2021 included the capital accelerator approved bid of £1.138m which was not cash backed, therefore creating a potential overspend. All other capital schemes were forecasting to plan.

A review of the wider estates structure was being undertaken and an Estates Strategy/SOC developed. It was hoped that funding may become available following this review which would help protect the Trust's internal capital spend plan for 2021/22. Further capital bids had been submitted relating to a Community Diagnostic Hub (jointly with South Tees Hospitals NHSFT) and the Laboratory Information Management System (LIMS).

The DoF provided an update on capital schemes in respect to the estate highlighting work ongoing around backlog maintenance, oxygen supply, theatre refurbishment, roofing repairs, concrete repair works, fire alarm replacements, endoscopy scope washer replacement, lift replacement, replacement of the combined heat and power unit and the six facet survey which looked at the physical condition of the site. An update on the medical equipment replacement programme was also provided and the CITO provided an update on both internal and external digital technology investment.

The Chairman commended the work of the DoF in achieving a positive position at Month 3.

Resolved: that, the contents of the report and the Month 3 capital position which was broadly on plan, be noted.

BoD/4572 Integrated Corporate Report

The DoP&P provided an overview highlighting performance against key access targets included in the Single Oversight Framework and the Foundation Trust Terms of Licence for the month of June 2021 in respect of performance, efficiency and productivity, quality and safety, workforce and finance.

The Trust had experienced increased pressures as a result of the COVID-19 pandemic which had ultimately impacted upon a number of indicators and overall efficiency and productivity. The DoP&P reported on changes to metrics around the 28-day faster diagnosis cancer standards and theatre metrics which had been revised and reviewed and aligned to model hospital methodology. COVID-19 pressures had increased significantly but focus remained on reducing overall waiting lists in respect to cancer, RTT and diagnostics. Pre-COVID-19 levels of activity were noted across both emergency and elective pathways.

Key points were:-

- Single Oversight Framework / Operational Efficiency and Productivity Standards: An improved position against cancer standards was noted, however the Trust failed to meet the 62 day cancer standards. A continual reduction in the number of patients waiting more than 52 weeks was noted, with 92 patients currently reported. RTT currently reported at 88.59% against the 92% standard. Diagnostic recovery against planned trajectory had been under pressure in June resulting in a rise in the overall waiting lists and the number of patients waiting more than six weeks. The overall position for the majority of key standards, including RTT, cancer and diagnostics, remained comparable to the national and regional position. Bed occupancy had seen a rise, reporting at 89.92% in June. Length of stays remained on track across both emergency and elective pathways. A working group had been established to understand the decline in

performance in respect to completed electronic discharge summaries. Ambulance handover delays were noted in June, reflective of increased pressures within the emergency care department;

- Quality and safety: The Trust continued to perform well against the majority of quality and safety metrics, including HSMR/SHMI, infection control measures and dementia standards. The main area of concern was compliance with venous thromboembolism assessment which was reporting below the national standard. There had been an overall reduction in the number of falls and all four categories of pressure ulcers fell within control limits. Hand hygiene compliance remained above the 98% standard and the IPC team were raising awareness around the wearing of gloves and aprons. The Trust reported one hospital associated C-Diff infection for June. The Trust remained within the expected range for both HSMR and SHMI values. There had been a rise in the number of complaints and work was underway to address the main theme which was around current restrictions on visit. A pilot on visiting continued and would be rolled out to an additional six wards.
- Workforce: Sickness absence had increased in June with COVID-19 contacts and associated isolation contributing to the higher absence rates. Sickness absence for May reported at 5.41% with 0.22% being attributable to COVID-19 related sickness. There were 140 further cases of COVID-19 related staff absence in June, 102 self-isolating for 14 days. Maintaining and supporting the Health and Wellbeing of staff remained important with Health and Wellbeing Champions in place in many areas. Eight staff networks had been introduced and Chairs appointed to support these which covered a number of protected characteristics. Overall compliance for mandatory training for June was 87.52%, above the 80% target and a 1% increase on the previous month. Appraisal compliance was 82.81% against the 95% standard. Turnover reported at 8.35%, an increase of 0.35%. The contribution of the volunteers was noted.
- Finance: At the end of Month 3 2021/22, the Trust reported a surplus of £1.206m, £706k ahead of plan. A year to day surplus of £3.026m was reported, £1.526m ahead of plan. Group income for Month 3 was £31.909m which included expected ERF income. The year to date contributions from Optimus and the LLP were both ahead of plan. Debtor days had improved by one day with creditor days worsening by four days when compared to 2020/21. The Group cash balance was £55.4m, which was £12.9m ahead of plan, driven by improvements to the surplus position and movement in creditor days. Month 3 capital expenditure was £1.2m of pre-committed items against a year to date plan of £1.3m.

PC, Chair of the Finance Committee reflected on a strong financial performance which continued from the previous year highlighting uncertainty around the financial framework for the second half of the year.

In response to a query raised by JE, the CN/DoPS&Q reported that acuity of patients does correlate with an increase in C-Diff cases and that focused work was being undertaken in respect to this. Patient pathways had been managed throughout the pandemic with transfers of patients being carefully considered. The CE added that a rise in occupancy can also lead to an increase in infections highlighting that the Trust currently had a limited supply of ventilated rooms and had minimal single occupancy rooms.

RT, Chair of the Workforce Committee reported that those areas of high sickness absence were brought before the committee to explore the reasons for sickness absence and to offer support.

SH highlighted that the information presented was of a high standard and assured the Board that this was tested and triangulated and robustly challenged through the committee structure.

Resolved: (i) that, the Trust's performance against the key operational, quality and workforce standards be noted; and

(ii) that, the ongoing operational pressures and system risks to regulatory key performance indicators and the intense mitigation work that was

being undertaken to address these going forward be acknowledged; and
(iii) that, the impact of wave 3 of the COVID-19 pandemic be noted.

BoD/4573 Learning from Deaths Report

The MD/DCE provided an update in respect of learning obtained through the review of deaths that occurred within the organisation.

The Trust's HSMR value had decreased to 95.54 (April 2020 to March 2021), reporting 3rd lowest in the North East and the 41st lowest nationally. The SHMI had decreased to 99.7 (February 2019 to January 2021), reporting 3rd lowest in the North East and 57th lowest nationally; both remained within the 'as expected' range.

During 2021-22, to the end of quarter 1, 15% of compulsory reviews had been completed. Additional scrutiny by the Medical Examiners team meant that 62% of all deaths during this quarter had been scrutinised or reviewed.

The MD/DCE outlined the trend in in-patient and A&E deaths and the monthly mortality trend and fluctuations since April 2017 highlighting the influenza winter peak of 2017/18 and the COVID-19 wave 1 and 2 peak of April 2020 and January 2021 respectively.

There were 19 mortality cases investigated as serious incidents during 2020/21; one remained under investigation and a further seven were awaiting Coroners inquests to complete the reviews effectively. In all cases investigated as serious incidents, Duty of Candour had been considered and applied appropriately. During 2021/22, to the end of Quarter 1, there had been no mortality cases reported and investigated as serious incidents.

The Chairman placed his thanks on record to the MD/DCE and his colleagues for a positive position.

Resolved: (i) that, the content of the report and the information provided in relation to the identification of trends to assist in learning lessons from the mortality reviews in order to maintain the reduction in the Trusts mortality rates be noted; and
(ii) that, the ongoing work programme to maintain the mortality rates within the expected range for the organisation be noted and that the Board be aware of the impact of the changes to COVID-19 coding as future statistics were published; and
(iii) that, the current quality improvement developments from various teams and groups across the Trust be noted.

BoD/4574 Responsible Officer's Medical Appraisal and Revalidation

The MD/DCE reported on the Trust's position in respect of medical appraisals and revalidation during 2020/21 highlighting that in March 2020, the GMC suspended the revalidation process for the period 17 March to 30 September 2020 to recognise the impact of the COVID-19 pandemic on doctors' ability to prepare for appraisal and revalidation. All doctors' under notice in this period had 12 months added to their due date. The suspension was extended again in early June to cover the period to 16 March 2021.

Each doctor impacted by the suspension of appraisals and revalidation was followed-up personally by the Revalidation Coordinator who worked with them to put a plan in place for completion of their appraisal in an achievable timescale.

The MD/DCE reported appraisal compliance of 90.26% for 2020/21. All of the 26 doctors with outstanding appraisals had been contacted to put into place action plans to assist them to get back on track.

During 1 June 2020 to 31 March 2021, there were 19 revalidation recommendations made to the GMC by the Trust with one doctor being deferred.

Resolved: that, the content of the report and assurance on the processes in place in the Trust be noted.

BoD/4575 Nursing and Midwifery Revalidation

The CN/DoPS&Q provided an update in respect to the revalidation process for nurses and midwives. The process builds upon existing renewal requirements to demonstrate that the registrant had the continued ability to practice safely and effectively. Registrants were required to revalidate every three years, and demonstrate they had achieved 450 practice hours, evidence 35 hours Continuous Professional Development (CPD), complete five pieces of written reflective accounts, and five records of feedback.

Revalidation remained the responsibility of the registrant with the Trust monitoring compliance and providing support as required. It was noted that the process for revalidation was well-embedded across the organisation with no specific issues being identified over the past year.

Following the most recent AuditOne report, three staff required further actions relating to their NMC registration status. Two of the staff had successfully revalidated and the third staff member had an honorary contract, had now retired and been removed from the system.

Resolved: that, the content of the report and that the processes in place to ensure robust assurance for nursing and midwifery revalidation compliance within the Trust be noted.

BoD/4576 NHS Workforce Race Equality Standard 2021

The CPO provided a summary of the results of the Trust's Workforce Race Equality Standards (WRES) for 2020/21, comparing results to previous years. This had been introduced as part of the NHS standard contract in 2015 to ensure that employees from Black, Asian and Minority Ethnic (BAME) backgrounds had equal opportunities and received fair treatment in the workplace. Key points included: -

- Overall percentage of BAME Staff in the workforce reported at 11% remaining consistent with the previous year and highlighting that the Trust was fairly well represented in comparison to the Government's Office for National Statistics, which report a 4.7% BAME population in the North East;
- BAME representation at Board level was underrepresented at 5.6% compared to a BAME workforce of 11%;
- Analysis of the Trust's data had shown that there was a higher likelihood of white staff being appointed from shortlisting. This was a significant outlier and the team were looking to understand the reason for this;
- Data suggested that BAME staff were less likely than white staff to enter formal disciplinary processes;
- White staff were more likely to access non-mandatory training and CPD opportunities. It was noted that the number of BAME staff accessing this type of training had not changed but that white staff accessing non-mandatory training / CPD opportunities had increased.
- The percentage of BAME staff experiencing harassment, bullying/abuse from the public and from staff had reduced;
- The percentage of BAME staff reporting that the Trust has equal opportunities for career progression and promotion had increased;
- The percentage of staff who have experienced discrimination at work had increased.

An action plan was currently being developed to focus on some of the key points in respect to ensuring that the Trust continued to provide equal opportunities for those from BAME backgrounds. The BAME staff network would be an essential tool to enhance engagement with staff and therefore the primary focus would be to continuously promote the network and recruit new members to ensure that the Trust had a mechanism for BAME colleagues to share their collective voice within the organisation.

Resolved: (i) that, the results of the Workforce Race Equality Standard be acknowledged; and
(ii) that, approval be given for the results to be submitted to NHS Digital Strategic Data Collection Service by the deadline of 31 August 2021; and
(iii) that, the results be published on the Trust's internet site by Friday, 31 October 2021.

BoD/4577 NHS Workforce Disability Equality Standard 2021

The CPO provided a summary of the results of the Trust's Workforce Disability Equality Standards (WDES) for 2020/21, comparing results to previous years. The WDES was introduced as part of the NHS standard contract on 1 April 2019 to compare the experiences of disabled and non-disabled staff to ensure that employees with disabilities had equal access to career opportunities and received fair treatment in the workplace. The overall percentage of staff in the workforce who had informed the Trust that they had a disability or long term health condition remained static at 2%. A disparity was noted against the number of staff who identified as having a disability on ESR (82) and the staff survey (415). Key points included:-

- There was an increased likelihood of disabled applicants being appointed from shortlisting;
- There have been no formal cases involving capability for disabled staff;
- The percentage of disabled staff experiencing harassment, bullying/abuse from the public had reduced;
- The percentage of disabled staff experiencing harassment, bullying/abuse from managers and colleagues has increased;
- The percentage of disabled staff reporting that the Trust had equal opportunities for career progression and promotion had reduced;
- The percentage of disabled staff who have felt pressured to come to work whilst unwell had increased;
- The percentage of disabled staff who felt valued by the organisation had reduced;
- The percentage of disabled staff who reported that the Trust had made adequate reasonable adjustments to enable them to carry out their work had slightly reduced;

A Chair for the Disability Network had recently been appointed and RT highlighted that herself and the CE had met with him highlighting that he would be a great asset to the group. RT highlighted that it was a positive step that the Trust had agreed to fund Chairs of the protected characteristic networks for two days dedicated time each month.

An action plan was currently being developed to focus on some of the key points in respect to ensuring that the Trust continued to provide employees with disabilities equal access to career opportunities and that they received fair treatment in the workplace.

Resolved: (i) that, the results of the Workforce Disability Equality Standards be acknowledged; and
(ii) that, approval be given for the results to be submitted to NHS Digital Strategic Data Collection Service by the deadline of 31 August 2021; and
(iii) that, the results be published on the Trust's internet site by 31 October 2021.

BoD/4578 Freedom to Speak up Guardian Annual Report 2020/21

The CN/DoPS&Q provided an overview of the work carried out by the Freedom to Speak Up Guardian (FTSUG) during 2020/21. It was noted that due to the pandemic some activities had been paused but the Guardian had continued to promote the service and had provided support for ten cases.

Fiona Gray had been appointed as the new Freedom to Speak Up Guardian with hours for this role being increased from 15 hours a week to 37.5. Seven FTSU champions had also been recruited across the organisation

Themes from 2020/21 included bullying and harassment and patient safety concerns which were the same as national themes. The number of concerns remained low.

Four cases remained ongoing in April 2021 and had been carried over to the new reporting year.

Working with NHS England, the National Guardian's Office had brought together four questions from the NHS Staff Survey into a 'Freedom to Speak Up (FTSU) Index'. These questions related to whether staff felt knowledgeable, secure and encouraged to speak up and whether they would be treated fairly after an incident. The 2021 Freedom to Speak Up Index for the Trust was 81.2% which had increased by 0.1% from 2020. The highest nationally was 87.6% and the lowest 66.6%. The CN/DoPS&Q highlighted that this was a positive position with the Trust ranking 4th regionally.

The Chairman reported that he had met with Henrietta Hughes who was stepping down as the National Guardian who had done a lot of work in respect to culture and attitude and how colleagues were treated. This learning was welcomed and Trusts should not feel threatened by this.

> **Resolved:** that, the content of the report and the progress to date in embedding and developing the FTSUG role be noted.

BoD/4579 Quality Accounts 2020/21

The CN/DoPS&Q presented the Quality Accounts for 2020/21 which had been prepared in line with national requirements as set out in the Health Act 2019 and updated in the Health and Social Care Act 2021.

The CN/DoPS&Q explained that due to the pandemic there had been a number of changes which included:-

- No requirement to externally audit the document;
- No quality report was required within the annual report for 2020/21;
- The Quality Accounts needed to be sent to NHS England and NHS Improvement to be added to their individual pages;
- There were no specific new requests to be added into this year's Quality Account.

The Quality Account summarised progress against the priorities and quality metrics that were agreed with external stakeholders in 2020/21 and demonstrated some significant achievements during the course of the year and showed improvements in the services delivered to local communities and stakeholders.

The pandemic had inevitably affected how the Trust delivered against a number of quality standards, however these continued to be monitored closely and was compared to national and regional positions where benchmarking allowed.

Governors and third parties had supported the production and review of the 2020/21 Quality

Accounts with third party declarations provided from a number of external stakeholders.

The CE highlighted the amount of work involved in producing the Quality Accounts and the overall focus on quality in the organisation. The CE reported that Healthwatch were to be invited onto the Council of Governors which would improve oversight and provide a different perspective.

The MD/DCE reflected on the Quality Accounts highlighting that people choose to work in the organisation because they were passionate about serving the community in which they lived and that the organisation was focused on improving upon the quality of care offered to patients. The COO added that from a Care Group perspective, everything on the agenda impacted upon quality.

SH recognised the time, effort and commitment in producing this report which reflected on the quality of services provided at the Trust, thanking members of the Executive Team and contributors to the report.

Resolved: (i) that, the performance against the quality standards within the document be noted; and
(ii) that, the ongoing excellent work undertaken by Trust staff in maintaining performance through what had been a very challenging time be acknowledged; and
(iii) that, the completion of the Quality Account within the required timescales and submission to NHS England and NHS Improvement be noted.

BoD/4580 Equality, Diversity and Inclusion Annual Report 2020/21

The CPO presented the 2020/21 Equality, Diversity and Inclusion Annual Report highlighting key achievements throughout the previous year.

The CE reported that she had met with most Network Chairs who had outlined their objectives highlighting that she continued to offer support helping all Networks to become embedded within the organisation.

Resolved: that, the 2020/21 Equality, Diversity and Inclusion Annual Report be accepted for publication.

BoD/4581 Carbon Reduction Programme Performance Targets

The DoP&P presented the Carbon Reduction Programme Performance Targets and drew members' attention to the key achievements highlighting the continued success and progress in achieving the targets of the Carbon Management Plan.

The Chairman placed on record his thanks to Mike Worden, Managing Director of NTH Solutions and his colleagues for the achievements made during the previous year.

In response to clarity sought by JE, the DoCA&CoS highlighted the amount of work being undertaken on the sustainable green plan presented at a recent Board Seminar highlighting that many initiatives needed wider involvement of partner organisations and the wider system to achieve their full potential. The Chairman agreed to raise this with the national body to address this. The DoCA&CoS highlighted that for future contracting and procurement, the supply chain needed to demonstrate their commitment to reduce carbon emissions.

Resolved: that, the report be received and that the continued success and progress in achieving energy reduction targets and site optimisation to drive down energy consumption, carbon emissions and costs in the support government targets be noted

BoD/4582 Estates and Facilities Annual Report 2020/21

The DoP&P presented the Estates and Facilities 2020/21 Annual Report and drew members' attention to the key points.

Thanks were placed on record to Mike Worden, Managing Director of NTH Solutions and his colleagues for a successful year.

Resolved: that, the Estates and Facilities 2020/21 Annual Report be noted and received.

BoD/4583 Health, Safety and Security Annual Report 2020/21

The DoP&P presented the Health, Safety and Security 2020/21 Annual Report highlighting performance against key performance indicators, key issues, future activity, key objectives and a proposed action plan for 2021/22.

The DoP&P highlighted the significant amount of work around fire safety and the training of fire wardens. Deep dives had been completed around the education and management of fire in the organisation and there was now an infrastructure in place to report and manage this. It was noted that the Trust would in future be fined for avoidable alarms and steps had been taken to manage this at a local level with oversight by site managers out of hours. The COO added that live and desk top training was being organised with Cleveland Fire Brigade.

In response to a query raised by the Chairman, the DoP&P highlighted that many false fire alarms were due to toasters and patients smoking in toilets.

Resolved: that, the Health, Safety and Security 2020/21 Annual Report be noted and received

BoD/4584 Organ Donation Annual Report 2020/21

KR, Chair of the Organ Donation Committee presented the Organ Donation 2020/21 Annual Report and drew members' attention to key points.

KR reported that the Trust had facilitated three actual solid organ donors resulting in 11 patients receiving a transplant during the year.

It was noted that Organ Donation Week would run between 20 and 26 September 2021.

Resolved: (i) that, the content of the report be noted; and
(ii) that, work continue with best practice for organ donation.

BoD/4585 Any Other Notified Business

a. Professor Derek Bell / Neil Mundy

On behalf of the Board, SH welcomed Professor Derek Bell to the Trust highlighting that the Trust had a reputation as a high performing trust with a culture in compassion. SH looked forward to working with Professor Bell and the leadership he would provide.

In addition, SH placed on record the thanks of the board to Neil Mundy for his leadership as Interim Joint Chair over the past six months. This had been a most challenging time for the NHS and SH acknowledged the progress made in respect to collaboration. In conclusion, SH wished Neil Mundy all the very best for the future. Neil Mundy responded by acknowledging that it had been a privilege and a pleasure to undertake the role for the past six months.

Resolved: that, the verbal update be noted.

BoD/4586 Date and Time of Next Meeting

Resolved: that, the next meeting be held on Thursday, 28 October 2021 in the Boardroom at the University Hospital of Hartlepool.

The meeting closed at 3:50 pm.

Signed: Derek Bell

Date: 28 October 2021

BoD Public

Date	Ref.	Item Description	Owner	Deadline	Completed	Notes
25 March 2021	BoD/4461	***NHS Regulation Bill – White Paper: Integration and Innovation – Working together to improve health and social care for all*** Board and Council of Governors' development sessions to be scheduled to look at how the ICS would function in the future	B. Bright			Joint CoG development session to be arranged to facilitate this topic. In addition, a Joint Board to Board would also be arranged
27 May 2021	BoD/4533	***Annual Report and Accounts 2020/21*** Final Annual Report and Accounts 2020/21 to be submitted to NHS Improvement in line with guidance, and laid before parliament	B. Bright			Submitted to NHSI by 29 June in line with requirements. Still require VfM certification from Deloitte which will be completed by September following which they will be laid before parliament
27 May 2021	BoD/4536	***Annual Operating Plan 2021/22 and Annual Self Certifications*** Final Operating Plan 2021/22 to be submitted to form part of the ICP Plan and the overarching ICS Annual Operating Plan.	L. Taylor		June 2021	Annual Plan Submission submitted in line with NHSEI requirements. In addition, annual declarations were also uploaded to the NHSI Portal
27 May 2021	BoD/4537	***NHS Resolution Clinical Negligence Scheme for Trusts (CNST)*** Content of the declaration be shared with Commissioners and to be submitted to NHS Resolution by 15 July 2021	L. Robertson	15 July 2021	15 July 2021	Complete and uploaded to portal
27 May 2021	BoD/4537	***NHS Resolution Clinical Negligence Scheme for Trusts (CNST)*** Market place event to be considered to showcase the great work being done within Maternity Services	L. Robertson			Agreed – date to be confirmed as restrictions ease
27 May 2021	BoD/4538	***Annual Report of the Vulnerability Unit, Safeguarding Adults, Children and Young People 2020/21*** Review of NCPOD report specifically related to young people, and the outcome to be shared with mental health colleagues	L. Robertson	13 September 2021		Agenda/discussion at Treat as One on 13 September 2021
27 May 2021	BoD/4539	***Director of Infection Prevention and Control Report 2020/21*** Visit to be arranged for the Chairman to visit the IPC Team	Private Office		7 July 2021	Chairman visited on 7 July 2021

Board of Directors

	Chairman's Report									
Date:	29 July 2021									
Prepared by:	Neil Mundy, Interim Joint Chairman									
Executive Sponsor:	Neil Mundy, Interim Joint Chairman									
Purpose of the report	This purpose of the report is to provide information to the Board of Directors on key local, regional and national issues.									
Action required:	Approve		Assurance		Discuss		Information	X		
Strategic Objectives supported by this paper:	Putting our Population First	X	Valuing People	X	Transforming our Services	X	Health and Wellbeing	X		
Which CQC Standards apply to this report	Safe	X	Caring	X	Effective	X	Responsive	X	Well Led	X
Executive Summary and the key issues for consideration/ decision:										

Introduction
It has been an extremely busy month for our staff with severe pressure building and affecting the staff of our Trust and of our partners. May I offer first our grateful thanks to Julie Gillon and the Teams within the Trust for their continued remarkable efforts on behalf of our patients.

The position was best expressed by Cath Monaghan and Chris Tulloch in their recent interviews on BBC News in which they described how they and their colleagues are tackling the current impact of the Pandemic and the backlog of treatment which has built up over the past year.

Week commencing 19 July saw a major relaxation in Government COVID-19 restrictions but the NHS and many in the community are continuing to maintain appropriate levels of protection and precautions. This is due to the increase regionally and nationally in the incidence of the COVID-19 Delta variant which is now affecting our area and Hospitals very seriously.

Staff achievements
I wish to congratulate Julie Gillon on her appointment as ICS Senior Responsible Officer for Health Inequalities to oversee planning and actions to tackle this most important priority. I am confident that Julie's passion and drive working with our partners in local government and the Voluntary Community and Social Enterprise (VCSE) will improve population health and the lives of those most affected in our communities.

We will be considering a number of annual reports for 2020/21, a year of exceptional challenge, but as set out in these reports the staff have delivered exceptionally strong performance both operationally and financially.

I mention in particular in the Quality Accounts the notably improved values in relation to the Hospital Standard Mortality Ratio (HSMR) and Summary Hospital – Level Mortality Indicator (SHMI). In this most difficult year, I also mention the positive results to improve infection prevention and control, thank you.

Working with our partners within the Integrated Care System
You will hear in the reports later in the meeting the progress being made to return to the levels of

services pre-COVID-19 and how waiting lists for treatment are being reduced. This is a national priority for our Trust and our partners in the region. It is imperative that we reduce the number of patients waiting more than 52 weeks as soon as possible.

The Integrated Care System (ICS) in the North East and North Cumbria is working collectively with the support of additional funding to address these pressures. Across the North East and North Cumbria, we perform well compared to many other parts of the country.

The design framework for the governance of the ICS has now been published though still subject to legislation. The Health and Care Bill is now passing through Parliament and has completed its second reading.

The emphasis is on a more permissive approach with the recognition that much of the services provided and the ability to reduce health inequalities will be at place-level. The Trust and its partners in the NHS, local government and the third sector in the Tees Valley and North Yorkshire must have the opportunity to help shape those arrangements.

It is important that we work together in the Tees Valley and North Yorkshire to ensure that the future policy and basis on which resources, including capital and revenue, are allocated to reflect the needs and the health inequalities that are present within our population; A situation which has been accentuated by COVID-19.

Whist there are clear signs that this priority for resources is being recognised, the Trust and its partners must actively work together within the local collaborative to secure a satisfactory outcome.

Developing our partnership and joint working
The Joint Strategy Board (JSB) with South Tees Hospitals NHS Foundation Trust at which County Durham and Darlington NHS FT was invited, met on 14 July. The meeting focused on current progress on collaborative working, including with our colleagues in County Durham and Darlington NHS FT, in addressing health inequalities and population health.

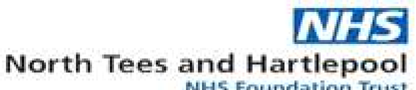
The JSB also heard from the Chief Executive of the Tees Valley CCG and Director of the ICS following the partnership engagement event on MS Teams which had taken place earlier on 14 July. We discussed the ways in which our Trusts can work most effectively under the proposed Integrated Care Board and Partnership and in supporting our local authority and other partners at place.

An agreed Joint Clinical Strategy for the Tees Valley and North Yorkshire is vitally important, and a joint system event was held on 20 July supported by the ICS and CCG at which current progress was reviewed and careful consideration given to next steps.

I was most grateful to the Chair of Tees Valley CCG for the kind invitation to join the meeting of the Board in June and to receive the very comprehensive Annual Report for 2020/21. It was a year dominated by COVID-19 but one which demonstrated great adaptability, innovation and dedication from the staff of all areas of the health and care system to provide the best care possible for our population.

I conveyed to the Chair of Tees Valley CCG the Trust’s appreciation for the many areas of support of the CCG during 2020/21.

Recruitment and appointment of the substantive Joint Chair
The recruitment of the substantive Joint Chair reached its final stages week commencing 28 June with focus groups on the 29 June and Interviews on 30 June. The recommendation from those interviews was reported to the Council of Governors at South Tees on 1 July and for North Tees on 5 July.



Both meetings decided unanimously to approve the recommendation to appoint Professor Derek Bell OBE as the substantive Joint Chair for North Tees and Hartlepool and South Tees Hospitals NHS FTs.

This most important and complex process has involved very close working between the Council of Governors and Nominations Committees of both our Trusts, with the support of the ICS, CCG and NHSE/I.

I am most grateful to the Lead Governors, Councils of Governors of both Trusts and their Nominations Committees who have worked tirelessly since April in taking this process forward stage by stage. Thank you also to our staff, partners and other stakeholders who have supported this important process.

Professor Derek Bell, who we will welcome at the Board on 29 July, will take up his role from 1 September. Derek will visit the Trust, to make introductions and formal induction over the coming weeks.

Visits and engagement
Visits this month included several opportunities to visit departments in the Trust including ITU, A&E, EAU and Infection and Prevention and Control, in some instances accompanying the candidates for the Joint Chair appointment.

I was delighted to visit those teams to understand the particular pressures they are facing and to thank them most emphatically for their amazing work during the past year under the most demanding of circumstances.

I was delighted to join staff side representative together with our Chief People Officer at their regular meeting on 14 July. It was a welcome opportunity for me to offer an update on progress with the collaboration with our partners in South Tees Hospitals NHS FT and, importantly, to offer details of Professor Derek Bell's appointment.

It was great to listen to the views and comments of staff colleagues and to answer their questions. I was delighted to hear the Staff from the three Trusts are meeting together to share experience and good practise.

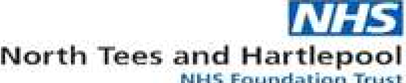
Particular areas of focus for the Board
There are four areas I wish to mention: -

- The wellbeing of the Chief Executive and Staff and their efforts to tackle the latest surge in COVID-19 and to prepare for the coming winter period
- Working collaboratively with our partners jointly to reduce the backlog in treatment
- To warmly welcome Professor Derek Bell OBE as our substantive Joint Chair and to offer our strongest support to him in settling into his new role
- Working collaboratively with South Tees Hospitals, County Durham and Darlington and other partners to develop a Clinical Strategy for Tees Valley and North Yorkshire

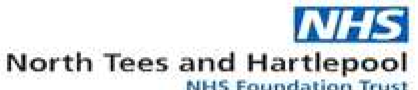
Conclusion
This is my last Board Meeting as Interim Joint Chair and I wish to record my profound thanks to Vice Chair Steve Hall, to our Chief Executive and staff, Board members, Governors and partners of the Trust who have been so supportive during the period I have acted in the interim role. It has been a great privilege and pleasure to work with you all.

I am confident that working closely with our partner Trust in South Tees Hospitals NHS FT and others within the collaborative, the Trust will ensure a stronger and more sustainable health and care system for our communities in the Tees Valley and North Yorkshire.

My thanks and very best wishes for the future.



How this report impacts on current risks or highlights new risks:	
Consideration will be given to the information contained within this report as to the potential impact on existing or new risks.	
Committees/groups where this item has been discussed	Items contained in this report will be discussed at Executive Team and other relevant Committees
Recommendation	The Board of Directors is asked to receive and note the content of this report



Board of Directors

<table>
<tr><td>Title of report:</td><td colspan="10">Chief Executive Report</td></tr>
<tr><td>Date:</td><td colspan="10">29 July 2021</td></tr>
<tr><td>Prepared by:</td><td colspan="10">Julie Gillon, Chief Executive
Barbara Bright, Director of Corporate Affairs and Chief of Staff</td></tr>
<tr><td>Executive Sponsor:</td><td colspan="10">Julie Gillon, Chief Executive</td></tr>
<tr><td>Purpose of the report</td><td colspan="10">The purpose of the report is to provide information to the Board of Directors on key local, regional and national issues.</td></tr>
<tr><td>Action required:</td><td colspan="2">Approve</td><td></td><td colspan="2">Assurance</td><td></td><td>Discuss</td><td>X</td><td>Information</td><td>X</td></tr>
<tr><td>Strategic Objectives supported by this paper:</td><td colspan="2">Putting our Population First</td><td>X</td><td colspan="2">Valuing People</td><td>X</td><td>Transforming our Services</td><td>X</td><td>Health and Wellbeing</td><td>X</td></tr>
<tr><td>Which CQC Standards apply to this report</td><td>Safe</td><td>X</td><td>Caring</td><td>X</td><td>Effective</td><td>X</td><td>Responsive</td><td>X</td><td>Well Led</td><td>X</td></tr>
<tr><td colspan="11">Executive Summary and the key issues for consideration/ decision:</td></tr>
<tr><td colspan="11">The report provides an overview of the health and wider contextual related news and issues that feature at a national, regional and local level from the main statutory and regulatory organisations of NHS Improvement, NHS England, Care Quality Commission and the Department of Health and Social Care.

In addition, information is provided on strategic delivery and positioning and operational issues not covered elsewhere on the agenda. Key issues for Information:
• COVID-19 update, annual operating plan, recovery including vaccination roll out
• Research team leading the way in COVID-19 treatment nationally
• Faculty for Leadership and Improvement
• Volunteers - Health care volunteers recognised in medal ceremony, 2 June 2021
• Consultant Appointments
• Integrated Care System/Integrated Care Partnership (ICS/ICP) Update
• NENC Health Inequalities Board
• NENC Provider Collaborative
• NENC Population Health and Prevention Board – 15 July 2021
• NHS Prevention Programme: Alcohol Teams second wave funding allocations for the NENC ICS
• Clinical Services Strategy Event – 20 July 2021
• Tees Valley and North Yorkshire Provider Collaborative
• The ageing infrastructure of North Tees and Hartlepool estate
• Biomedical Sciences Week
• Pride month
• Innovative way of detecting bowel cancer praised by patients
• Single Oversight Framework</td></tr>
<tr><td colspan="11">How this report impacts on current risks or highlights new risks:</td></tr>
<tr><td colspan="11">Consideration will be given to the information contained within this report as to the potential impact on existing or new risks.</td></tr>
<tr><td>Committees/groups where this item has been discussed</td><td colspan="10">Items contained in this report will be discussed at Executive Team and other relevant committees within the governance structure to ensure consideration for strategic intent and delivery.</td></tr>
</table>

Recommendation	The Board of Directors is asked to note the content of this report and the pursuance of strategic objectives and collective work amongst the COVID-19 recovery programme and the return of services building on a new operating model.

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

29 July 2021

Report of the Chief Executive

1. Introduction

This report provides information to the Board of Directors on key local, regional and national issues. In addition, information is provided on strategic delivery and positioning and operational issues not covered elsewhere on the agenda.

2. Key Issues and Planned Actions

2.1 Strategic Objective: Putting our Population First

2.1.1 COVID-19 Current Position and Phase 3 Recovery

As at the 20 July 2021, the Trust is caring for 34 COVID-19 positive patients, 5 of which require Critical Care intervention. This is reflective of the rise in community infection rates across Stockton and Hartlepool, with both local authorities reporting in the top 20 ranking for rates per 100,000 population (05 – 12 July period. However, whilst this is an increasing trend in admissions, early indication is that the rate of hospital admissions is much lower than previous waves of COVID, with a lower acuity of patients, requiring shorter lengths of stay.

The Trust continues to follow Infection Prevention and Control Guidance to ensure a COVID secure environment for staff, including regular review of personal risk assessments in line with Government guidance.

The increase in infection rates is inevitably impacting on staff absence, with a significant requirement to support clinical areas and to provide all elective and non-elective services.

The focus of the Trust continues to be on the recovery of normal service provision across diagnostics, outpatient, elective and community care. The Trust has committed to stretch targets for recovering performance, which will support both timely access to services for our community as well as providing support to the wider Tees Valley. The Trust is working closely with the North East and North Cumbria ICS system leaders on the recovery programme, with the key aims including equity of access to services, reducing variation in pathways and making best use of available resources.

Work is ongoing to monitor progress against recovery trajectories with a commitment to deliver at a faster pace, linked to the Accelerator programme and the associated funding streams, as part of the ICS approach.

The cumulative COVID position/impact on the Trust is included in Table 1:

Total COVID-19 Admissions	2845
Total Admissions Base Wards	2650
Total Admissions ITU	195
Number of Discharges	2296
% Discharged	80.7%
Number of Deaths Positive COVID-19	526
% Deceased	18.49%

Position as at 20 July 2021

2.1.2 Health and Wellbeing

As a Trust we have succeeded in maintaining the Better Health at Work award, made possible thanks to the collaborative efforts across a number of services to ensure that the health and wellbeing of our staff remains a priority. The Trust is also the proud recipients of the special recognition award, acknowledging the work undertaken, despite the pressures of the pandemic.

At the beginning of May, the Trust launched the NHS People Week with a focus on the NHS People Plan. The feedback from the event was shared as part of the 100 leaders network and an associated action plan developed with a view to positively impacting on future staff experience and service provision.

Work continues on developing the outside spaces attached to the Rainbow Rooms, with the intention of creating fit for purpose areas for staff and volunteers to enjoy in the summer weather. Work has also begun with leads from across the Trust to identify other smaller local recharge spaces close to wards and departments. An application is to be submitted to NHS Charities Together to bid for further funding, raised by Colonel Tom Moore, to fund the development of such spaces.

2.1.3 COVID and Flu Vaccination Programmes

As part of the original COVID 19 vaccination programme, the Trust vaccinated nearly 30,000 individuals from across the health and care sector and local community. This included 88.1% of Trust staff receiving a first dose and 79.6% receiving a second dose. The vaccination programme concluded on 15 May 2021 having fulfilled the original requirement of the Joint Committee on Vaccination and Immunisation (JCVI) in vaccinating priority groups 1-4.

The JCVI advises that a potential booster programme should begin in September 2021, in order to maximise protection in those who are most vulnerable to serious COVID-19 ahead of the winter months. Influenza vaccines will also be delivered in autumn, and JCVI considers that, where possible, a synergistic approach to the delivery of COVID-19 and influenza vaccination could support delivery and maximise uptake.

Work has commenced across NENC ICS on developing a coordinated approach to rolling out the COVID booster and flu vaccination programmes, minimising the impact on operations.

2.1.4 Research Team leading the way in COVID-19 treatment nationally

2.1.4.1 NOVAVAX Trial

All remaining unblinded participants have completed their cross-over trial. There is now a gap of 4 months until the final study visits are performed. To date no information has been received by the Research team regarding participation in a booster trial.

2.1.4.2 RECOVERY Trial

The Trust have 773 patients recruited to date. The R&D team still conduct daily screening of hospital systems to identify potential participants for the trial.

The Research and Development team were successful in applying for additional funding from the National Institute for Health Research Clinical Research Network, North East and North Cumbria to employ additional staff to support COVID study delivery so that research staff can concentrate on re-opening the previously paused studies.

Dr Ahmad Al Araj was invited to contribute his experience of being an associate primary investigator for RECOVERY trial at the Research Summit Event by RCP/NIHR on 1/7/2021.

2.2 Strategic Objective: Valuing our People

2.2.1 Faculty for Leadership and Improvement

The Trust held a very successful event on 18 June that brought together over 100 leaders in the organisation to focus on identifying courageous changes that they could take forward to benefit patient care and improved performance. People are working in 10 packs, led by a pack leader selected given they have an aptitude to motivate others, a desire to get things done and a will to work differently and innovatively. The pack leaders are supported by the executive team to help guide and unblock any barriers to change. The ideas for change are being honed into an achievable objective, with support from the Faculty, which includes Organisational Development, Quality Improvement, Business Intelligence and Programme Management Improvement Office.

2.2.2 Volunteers - Health care volunteers recognised in medal ceremony, 2 June 2021

I had the opportunity to participate in the National Volunteers Week, to celebrate the contribution and dedication of volunteers who work behind the scenes to support staff and help patients. Volunteers carry out a variety of duties that have evolved throughout the COVID-19 pandemic, from driving patients to hospital and collecting prescriptions to offering emotional support and a friendly face to both patients and staff.

The Trust used Volunteers Week as a ‘time to say thanks’ to every volunteer who provided support throughout the pandemic with a letter of appreciation and a medal from myself. The first recipient was Nicholas Day who supported Ward 36 during this unprecedented time.

2.2.3 Consultant Appointments

Since the last meeting held on 27 May 2021, the Trust has appointed to the following Consultant posts:

Consultant Gastroenterology/GIM with an interest in Liver Medicine	Dr Rebecca Dunn
Consultant Gastroenterology/GIM with an interest in Liver Medicine	Dr Mohamed Sala Eldin Elzober Salih
Consultant in Public Health	Dr Esther Mireku
Consultant Radiologist – MSK	Dr Matthew Bowa
Consultant Radiologist – General	Dr Iffat Rehman

2.3 Strategic Objective: Transforming our Services

2.3.1 Integrated Care System/Integrated Care Partnership (ICS/ICP) Update

2.3.2 Integrated Care System (ICS)

The ICS Management Board continues to review the impact of the White Paper – *Working Together to Improve Health and Social Care for all* and the potential implementation requirements, alongside the recently published *ICS: Design Framework (June, 2021).*

The design framework begins to describe the future ambition for the functions of the ICS NHS Body and ICS Partnership along with the governance and management arrangements each ICS will need to establish; the opportunity for partner organisations to work together to agree and jointly deliver shared ambitions; the key elements of good practice that will be essential to the success of ICSs; the financial framework that will underpin the future ambitions of systems; and the roadmap to implement new arrangements for ICS NHS bodies by April 2022

The future ambition is to focus on the underlying principles of collaboration with local flexibility required to ensure there is strong placed based partnerships.

Concentration will continue on a place based approach for Hartlepool and Stockton with an appropriate leadership structure supported by a strong voice and influence for Teesside. A meeting

was held with Sir Liam Donaldson, Chair of NENC ICS on 14 July 2021 to discuss the ambitions for the Tees Valley.

2.3.3 NENC Health Inequalities Board

As Senior Responsible Officer (SRO) for Health Inequalities across NENC, I chaired the inaugural meeting of the Health Inequalities Advisory Board on Friday, 2 July with attendance from a wide range of stakeholders including Health, Local Authority, Voluntary sector and Public Health partners. The first meeting focussed on the ambition and expectations around key outcomes and a summit will bring together collective views in preparing a strategy to tackle health inequalities in the communities served in the NENC.

2.3.4 North East and North Cumbria Provider Collaborative

The NENC Provider Collaborative continues to focus on the intent, purpose, work programme and governance arrangements and fit to ICS delivery, and restructure. Work is ongoing to build and evolve a prospectus, work plan, memorandum of understanding and responsibility agreement, which all providers can commit to taking forward in the new design framework.

2.3.5 North East and North Cumbria Population Health and Prevention Board

The terms of reference for the NENC Population Health and Prevention Board were reviewed at the meeting on 15 July 2021. In line with the objectives set out in the long term plan the Board focuses on the following workstreams alcohol, including the establishment of Alcohol Care Teams; Obesity, including access to weight management services in primary care and Tobacco, which includes a universal smoking cessation offer and smoke free pregnancy pathway. The reach is significant and the infrastructure is being built up to support improved outcomes.

2.3.5.1 NHS Prevention Programme: Alcohol Teams second wave funding allocations for the NENC ICS

The Trust was successful in its submission to the NHSE/I national team for funding to support the Alcohol Care Teams. The organisation has been awarded a funding allocation for 2021/22. It is anticipated that the funding will be used to pump prime services for a one year period.

2.3.6 ICS/ICP (Tees Valley Health and Care Partnership)

The Improving our NHS Together – Tees Valley Integration and Transformation Programme maintains a continued focus on the key work streams. The Clinical Services Strategy remains a significant piece of the work programme for the Tees Valley, with the supporting and enabling work streams of finance and efficiency, digital and workforce, continuing to support the move from vision to implementation.

2.3.6.1 Clinical Services Strategy Event – 20 July 2021

The Trust in conjunction with South Tees NHS Foundation Trust and County Durham and Darlington NHS Foundation Trust and other stakeholders held an event facilitated by Cap Gemini on 20 July 2021. The event was structured to share the current positon with regard to the Clinical Services Strategy, hear insights from other systems and develop key areas of focus and outcomes for the next six months, with a view to reenergise and refocus a sustainable service and financial provision.

2.3.7 Tees Valley and North Yorkshire Provider Collaborative

The Councils of Governors of North Tees and Hartlepool NHS Foundation Trust (NTHFT) and South Tees Hospitals NHS Foundation Trust (STHFT) have appointed a new permanent joint chair following a successful recruitment process. Professor Derek Bell OBE has been appointed and will commence on 1 September 2021. Professor Bell has 40 years' experience in the NHS and previously served as President of the Royal College of Physicians. He was awarded an OBE in 2018 for services to Unscheduled Care and Quality Improvement.

Professor Bell will take over from Neil Mundy, Interim Joint Chair who was appointed for both trusts in February 2021 to support the transition and recruitment of a permanent joint chair. We look forward to welcoming and working with Professor Bell.

The Trust continues to progress the potential for collaborative arrangements with South Tees Hospitals NHS Foundation Trust to deliver the best benefits for the population of the Tees Valley and North Yorkshire. A Joint Strategic Board meeting was held on 14 July 2021, which enabled discussion in respect to the Integrated Care System, the new design framework guidance and the Tees Valley Integrated Care Partnership in terms of the future direction and ambitions. Together with myself the Trusts newly appointed Consultant in Population Health, Esther Mireku attended the meeting to present a session on population health management and health inequalities, specifically on how this is impacting and affecting the population served and ideas to focus on high impact interventions and outcomes.

2.3.8 The ageing infrastructure of North Tees and Hartlepool estate

In recent weeks, the Trust has been working in partnership with local, regional and national media partners to discuss the issues surrounding the aging estate. This includes fit to the clinical services strategy, in ensuring the populations served see a health system sustainable for the future in collaboration with the specialist services with our partner Trust.

2.3.9 Biomedical sciences week

In June, the Trust celebrated biomedical sciences week. The role these colleagues play within the organsation has been amplified in the last 18 months. Examples of transforming services and achievements were shared with media partners across the internal and external communications channels to ensure the value of the biomedical sciences contribution is recognised.

To put this in context, the biomedical team have carried out more than 100,000 PCR tests for COVID-19 in the past 12 months as well as setting up a new testing process and becoming involved in a trial aiming to find new treatments for the virus.

2.3.10 Pride Month

The inclusive nature of the Trust continues to demonstrate the commitment to staff, communities and patients. In June 2021 the Trust celebrated the annual Pride month with colleagues across the organisation. From the emotive and compelling interview with trans colleague where Matthew explained “It’s not a new chapter, it’s a new book” to the LGBTQ+ month long campaign hearing from members of the community and allies of this community about the importance of recognising and celebrating pride.

2.3.11 Innovative way of detecting bowel cancer praised by patients

A special capsule people swallow to help detect bowel issues is being offered in Teesside – and patients are full of praise for the innovation. The new development at the Trust is already helping diagnose health issues including cancers. The pill-sized capsule has a small disposable camera, taking thousands of pictures as it travels along the gut – helping examine parts of the bowel other tests such as an endoscopy or colonoscopy might not always reach. The camera sends the images wirelessly to a data recorder worn on a patient’s waist.

The new procedure is led at the organisation by consultant in gastroenterology John Jacob and nurse endoscopist Dorisa Machan. The Trust is one of more than 40 across the country chosen by NHS England to pilot the capsule.

2.3.12 Single Oversight Framework

The NHS System Oversight Framework for 2021/22 was released in June 2021 outlining the purpose and highlighting a single set of metrics developed across the ICS, Trusts, CCGs and Primary Care, aligned to the five national themes of quality, access and outcomes, preventing ill health and reducing

inequalities, leadership and capability, people and finance and use of resources. The Trust has prepared a gap analysis to ensure compliance against the indicators and contribution to the local acute collaboration and ICS outcomes, as appropriate.

3. Recommendation

The Board of Directors is asked to note the content of this report and the pursuance of strategic objectives and collective work amongst the COVID-19 recovery programme and the return of services building on a new operating model.

Board of Directors

Title of report:	Professional Workforce Annual Report								
Date:	29 July 2021								
Prepared by:	Karen Sheard, Deputy Chief Nurse								
Executive sponsor:	Lindsey Robertson, Chief Nurse, Director of Patient Safety & Quality								
Purpose of the report	This report provides the Board of Directors with the annual position of the professional workforce, which includes Nursing, Midwifery, Allied Health Professionals, Medical and Dental. The National Quality Board (2016) articulated the requirement to undertake workforce reviews annually with an update on actions highlighted to the Board on a six monthly basis. This report provides the **annual** review for 2020/21 including updates from the last bi-annual review produced January 2021. The annual workforce review focuses on the clinical, quality, safety and financial importance of developing a workforce fit for purpose. It is vital to understand the nature of workforce pressures and actions to address, both in the long and short term. Within this annual review, the ongoing impact of COVID-19 has been considered when planning the workforce models.								
Action required:	Approve		Assurance	x	Discuss		Information	x	
Strategic Objectives supported by this paper:	Putting our Population First	x	Valuing People	x	Transforming our Services	x	Health and Wellbeing		
Which CQC Standards apply to this report	Safe	x	Caring	x	Effective	x	Responsive	x	Well Led	x

Executive Summary and the key issues for consideration/ decision:
The purpose of this annual report is to provide the Board of Directors an overview of the professional workforce capacity and advice upon compliance with national guidance. The review provides assurance in relation to the ongoing work and actions identified within this report. This is against a backdrop of significant demand and pressure as a result of the COVID-19 pandemic to ensure that we are responsive at the time of greatest need whilst mobilising recovery. The Trust has identified workforce challenges across all professional groups; the care groups and corporate support functions are proactive in their response with a number of innovative plans developed; with robust oversight and governance in place ensuring continuity and delivery of the safest patient services. Alternative staffing models are in place or in development across all professional groups; registered nurse, midwifery and un-registered nurse recruitment centres will continue to assist in reducing vacancy rates throughout the year. The Trust continues to plan and take forward retention strategies for all staff groups.

Technology is being utilised and implemented to support workforce planning and ensure the workforce effectively and efficiently deployed. It is also a key enabler in ensuring compliance with working hour's limits and rest requirements. By introducing new roles, improving working conditions, and supporting flexibility the Trust will realise the ambition to attract, retain, and develop the workforce. All of the efforts undertaken contribute to ensuring there are workforce safeguards in place, the right staff, with the right skills are in the right place at the right time, whilst being financially sustainable.	
How this report impacts on current risks or highlights new risks:	
Committees/groups where this item has been discussed	Professional work force panels across care groups; Medical Director & Deputy Chief Executive
Recommendation	The Board of Director is asked to note • the significant assurance provided within this report around safe Nursing, Midwifery, AHP and Medical staffing; • the changes in workforce planning for the next annual board report; • the impact of the COVID-19 pandemic on both patient acuity and increased staff sickness; and • the huge effort in response to unprecedented pressures created by COVID-19 and the work undertaken to have safest staffing levels across the organisation.

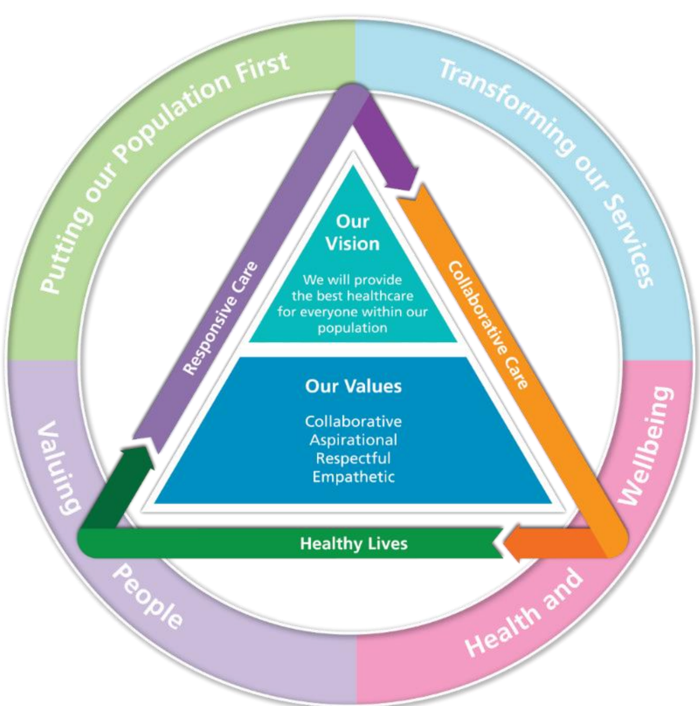
North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

29 July 2021

Professional Workforce Annual Report

Report of the Chief Nurse/Director of Patient Safety and Quality and the Medical Director

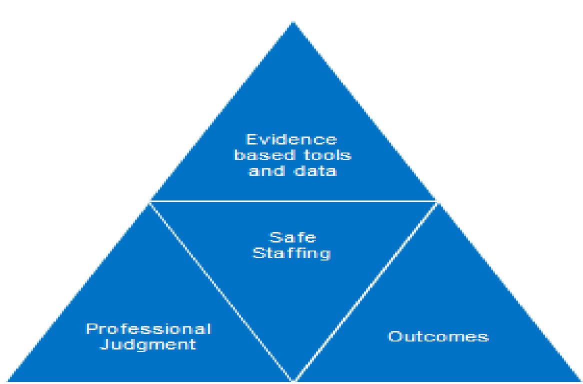


1. Introduction

1.1 This report provides the Board of Directors with an overview of the professional workforce, which includes Nursing, Midwifery, Allied Health Professionals, Medical and Dental. The National Quality Board (2016) articulated the requirement to undertake workforce reviews annually with an update on actions highlighted to the Board on a six monthly basis. This report provides the annual review 2020/21 including updates from the last bi-annual review produced January 2021.

1.2 In October 2018, NHS Improvement (NHSI) published Developing Workforce Safeguards, which supports providers to deliver high quality care through safe and effective staffing. The key principles of safe staffing 'triangulated approach' as identified by NHSI can be seen in figure 1 below.

Figure 1.



1.3 NHSI&E recognise the need for a more consistent approach to safe staffing levels across all clinical workforce groups, a clear focus on developing evidence based tools for assessing the impact of variation in patient acuity and dependency.

2. Purpose

2.1 The purpose of this annual report is to assure the Board of Directors of safe staffing by providing an update of the current professional workforce position across the organisation including:

- Recruitment and retention position
- Use of temporary bank and agency staff
- An update of the current workforce by Care Group; identifying areas where staffing establishments may require further review in line with the business planning process taking place throughout 2021/22
- An update of service changes in response to the Covid-19 pandemic that have impacted the professional workforce
- Assurance that workforce decisions are evidenced based and comply with the Care Quality Commission (CQC) fundamental standards

3. National and Local Position

3.1 Nationally workforce supply remains high on the agenda; the 2018/19 workforce statistics confirmed that nursing remains the key area of shortage and pressure across the NHS. The nursing vacancies nationally increased to almost 44,000 in the first quarter of 2019/20, which is equivalent to 12% of the nursing workforce (Health Foundation, 2019). To prevent nursing shortages growing further, urgent action is needed across all NHS organisations to improve retention.

3.2 Changes in skill mix can reflect a range of factors: changing patient needs, technological developments and legislative changes to allow some staff groups to expand the scope of their practice. It is important, however, that quality and safety are at the forefront of any skill mix change, changes are not introduced in an unplanned way in response to cost pressures or recruitment difficulties.

3.3 NHSI&E established a national Safe Staffing Faculty programme, directly supported by the Chief Nursing Officer for England. The aim of the programme is to strengthen Nursing and Midwifery scrutiny and oversight of staffing nationally and use the faculty to inform and support local and national work in relation to safer staffing. The interim

Head of Professional Workforce has already completed this programme and the Deputy Chief Nurse commenced this programme in March 2021.

3.4 The annual workforce review focuses on the clinical, quality, safety and financial importance of developing a workforce fit for purpose. It is vital to understand the nature of workforce pressures and actions to address, both in the long and short term. Within this annual review, the ongoing impact of Covid-19 has been considered when planning the workforce models.

4. Covid-19 Pandemic

4.1 Although this report is to provide an annual update, the extraordinary events and response to Covid-19 pandemic is included for information and assurance. The pandemic has had a significant impact on the professional workforce. Outlined below is a summary of the developments that have affected workforce during the most recent phase of the pandemic:

- The successful development of the Respiratory Support Units within two wards to ensure that patients receive the right care in the right place delivered by staff with the right skills
- Staff deployment to ensure safest staffing across the Organisation to maintain patient safety
- Changes in specialist nurse provision to include 7 day working, front of house support, palliative care support and maintaining closer links with community services and Local Authority to support patient discharge and admission avoidance
- Critical care surge was led and managed with close partnership working between the senior medical, nursing and AHP leaders
- Higher rate of staff sickness due to Covid-19 isolation alongside usual sickness absence resulted in Wards/beds closed when required to support safest staffing levels
- Virtual visiting was implemented to maintain contact between patients and relatives with a phased return to visiting over recent months
- Virtual clinics have continued in some areas with good response from patients

The extent of changes across the organisation during this surge cannot be underestimated and it is recognised the importance of leadership across all professional staff groups. There is a recognition that psychological support will need to continue for both patients and staff post the Covid-19 pandemic.

5. Nursing and Midwifery Workforce

Nursing and Midwifery workforce accounts for 27% of the total workforce in the Trust.

5.1 Methodology

5.1.1 Safer Nursing Care Tool (SNCT) data collection took place during April 2021. The SNCT is the only nationally approved, evidence-based tool to support safe staffing within in-patient areas; data collection is to take place for a minimum 20 days bi-annually (to allow for seasonal differences). Establishments are set based on this data once validated. The recommendation within the tool is to undertake at least two data sets before any changes are made to establishments. As this is the first data collection that has been carried out within the organisation, the results of the data collection will be shown but no

changes to establishment will be based purely on that data until this has been repeated in October 2021.

5.1.2 A comprehensive and thorough review of Nurse and Midwifery staffing was undertaken in May/June 2021. SNCT is only one aspect of safe staffing, professional judgement and patient outcomes are added in to fully triangulate the data and variables. Professional judgement panels were held which included membership from each team, ward/department matron, senior clinical matron, and Head of Nursing/Midwifery, Finance and Workforce Business partners, to discuss workforce planning (annual review) including forecast and pressures. The face-to-face panels support a 'bottom up' approach to workforce reviews and support the balanced discussion of hard data and soft intelligence. A template (see appendix 1) which is populated by the team prior to the panel ensured relevant data was available to review including:

- Budgeted establishment
- Skill mix (for RNs those within <12-month registration v numbers likely to retire in next 5 years)
- Vacancies
- Sickness/absence
- Recruitment plans
- Care Hours Per Patient Day(CHPPD)
- Results of SNCT (in-patient areas only)
- Mandatory training and appraisal compliance
- Incidents/patient harms linked to staffing levels
- Patient experience
- Staff satisfaction and morale
- Succession planning and talent spotting
- E-rostering compliance against KPIs/Safecare live compliance
- Use of temporary staffing, overtime and agency
- Environment/layout of ward/unit that impact on staffing levels
- Changes to patient case mix/acuity
- Changes since Covid-19 that impact staffing

5.1.3 For this annual review, the Head of Professionals also attended the panels to ensure the Allied Health Professionals (AHP) workforce was considered where appropriate and to support progression with any alternative workforce planning. In addition, the Advanced Clinical Practice (ACP) Lead attended the panels to support options to expand ACPs in clinical areas.

5.1.4 Specialist Nurse reviews have not been included for this report as plans to review all specialist nurse and practitioner roles is planned to take place at the 6 month review (last reported January 2021).

5.2 Healthy Lives Care Group

Healthy lives have a current vacancy position of 21wte (May 2021), the detailed breakdown can be seen in section 5.6.2

5.2.1 <u>The Holdforth Hub</u>

The hub is based on ward 3 in the University Hospital of Hartlepool where the area is used as a community clinic and provides a 24/7 service. The team is made up of staff who previously worked within the in-patient Holdforth Unit who have adapted well to

their new community setting. Community Matrons, part of a skill mixed team, provide direct clinical care, and support a home first model (delivering 72hrs of enhanced care and support to patients in their own homes), support the service. There is a an RN vacancy of 1.0wte and an unregistered nurse vacancy of 3.62wte where there are plans to skill mix this into B3 roles to support some of the more advanced skills required to meet the service needs. There are currently 5.0wte RN in the 55-70yr age range and coupled with the current RN vacancy; to support succession planning, the team have requested that they take final year nursing students so that the service can be promoted as a preferred area to work. It is felt that students currently do not see the career opportunities within this area during their training.

5.2.2 Out of Hospital Care

District Nursing Stockton delivers care to individuals in their own homes or residential care homes. The service is made up of Four Primary Care Networks (PCNs) in Stockton, which include Billingham/Norton, Stockton North, Stockton and BYTES (Billingham, Tennant Street, Lawson Street and Eaglescliffe Medical Centre). The PCNs provides complex care, palliative care and provide support to families and carers. Registered nurse vacancy is currently 4wte and unregistered nurse vacancy is 1.64wte with plans in place for recruitment into all posts. There is an RN sickness absence rate of 5.8%, which is higher than the trust recommended average; additionally there is pressure to cover unfilled shifts within rosters due to there being zero planned headroom built into the nursing establishment. To support the current 6.1% RN and 5.1% unregistered parental leave the team very successfully recruited into fixed term posts. The team are very experienced at supporting newly registered nurses and by September 2021, they will have seven new nurses across the PCNs with succession plans in place to prepare for some experienced District Nurse planned retirement. Advanced skills acquisition is in place across the team with RNs registered to complete non-medical prescribing and others planned to commence District Nursing Specialist Qualification from September 2021 onwards.

District Nursing Hartlepool have three PCNs in Hartlepool, including Hartlepool Health, One Life Hartlepool and Hartlepool Network. Registered nurse vacancy is currently 2.26wte and unregistered nurse vacancy is 1.2wte with plans in place for recruitment into all posts. There is an RN sickness absence rate of 6.3%, which is higher than the trust recommended average; again, additionally there is pressure to cover unfilled shifts within rosters due to there being zero planned headroom built into the nursing establishment. To support the current 6.1% RN and 9.7% unregistered parental leave the team successfully recruit into fixed term posts. Similarly, to the Stockton teams, there is a clear focus on the development of newly registered nurses and plans in place for constant succession planning through completion of the non-medical prescribing and the District Nursing Specialist Qualification. The current workforce model meets the demands of the service, although there are plans to over recruit band 5 posts, which will support the planned secondments throughout the year.

District Nursing Out of Hours is a small team and is a popular area to work so have few vacancies (0.33wte RN and 0.09wte HCA). Two RN sit within the 55-70yr age group but have no plans at present to retire and when this time does come it is agreed that 1.0wte band 6 role will likely be skill mixed to band 5 to further support the out of hours service. There are no proposals to change the current workforce model as it meets the demands of the service.

Macmillan Carers is also a small team of 3.6wte band 3 unregistered nurses that support patients and their families within their own homes in Hartlepool. There are no

plans to change the current workforce model as it meets the demand of the service although recently the band 3 job description has been reviewed which would enable future staff to support across the whole locality and not just Hartlepool.

Rapid Response is a crisis intervention team, providing health and social care to prevent hospital admission or to facilitate early discharge. The service works from two bases, one in Hartlepool and the other in Stockton and due to the previous merge of these teams, the current service consists of band 6 RNs. There is a requirement to carry out a skill mix review of the current workforce model, which will enable the model to change in the future when a proportion of band 6 RN retirement takes place (3wte). This service currently has 1.22wte RN (band 5) vacancies and 0.55wte HCA vacancies and active recruitment is in place.

The **Community Matron** team comprises of 20wte band 7 nurses and have a current vacancy of 2.22wte that are recruited to. Whilst there are 8wte staff in the 55-70yr age range, there are experienced community matrons moving into primary care based settings where the type of clinical work can be more attractive due to higher pay bands being offered. The service is encouraged to maintain a very slight over recruitment when suitable candidates present in order to maintain a sustained average of full recruitment.

Community Dementia Liaison Service is a very small service with only 1wte RN and 1wte Occupational Therapist, which naturally causes resilience issues when absence occurs. Currently the 1.0wte OT is on an agreed secondment to Tees, Esk and Wear Valley (TEWV) services meaning that the team have struggled to recruit into a fixed term post. There is however, a plan in place to acquire temporary therapy cover from other specialist services in order to meet the demands of the service.

Single Point of Access Clinical Triage (SPA) Clinical Triage nurses are co-located and are integral to the wider Integrated SPA (ISPA). The service is operational 24/7 and consists of 8wte band 6 nurses. There is a current vacancy of 0.47wte where recruitment plans are in place. Succession planning is in place with 5wte staff in the 55-70yrs age range at the end of this year.

5.2.3 Outpatients and Rheumatology

This is a large service covering Lung Health, Medical Rehabilitation Day Unit (MRDU), Rheumatology, Orthopaedic outpatients, Women's outpatients and Main outpatients all set across three sites (North Tees, Hartlepool and Peterlee). Following the nursing workforce review that took place within Outpatients Departments in January 2019; an effective workforce model met the demands of the service and an implementation manager was recruited to help drive forward the initiatives associated with the productivity plan that included the nursing workforce. In 2020, the team had 74% of their nursing workforce approaching the end of their career and there was a requirement to 're-brand' to attract the nursing workforce to the service. This figure has now reduced to 29% with seven RNs across all services now approaching the end of their career. The current RN vacancy of 0.84wte reflects the significant work from the team to address recruitment and retention challenges. Plans are in place to skill mix some of the RN posts following planned retirement to create band 6 training posts in Rheumatology. This will allow career developmental opportunities across the services and succession planning for this speciality. Development of the unregistered workforce is also embraced by this service with 2wte staff due to complete their Nursing Associate (NA) training in September 2021 and another HCA planned to start their NA

training. The accommodation of these roles within the workforce model has already been scoped.

5.2.4 Specialist Palliative Care Team (SPCT)

SPCT delivers specialist palliative care advice and support to patients and professionals in their own homes and hospital settings. There has been a positive move to 7-day working within the team as an early response to Covid-19 escalation, which has proven to be an effective extension to the service providing support to patients and their relatives. The team continue to support band 3, band 5 rotations to upskill, and support the wider workforce. This service currently has no RN vacancies.

5.2.5 Home First

The Home First service continues to develop to maximise admission avoidance, keeping people safely at home and supporting timely discharge from hospital. For this to be successful it is recognised that an appropriately resourced community infrastructure is required which includes, in addition to securing a sustainable Community Hub model, provision of clinical triage 24/7 and increasing the capacity of the Community Matron service. Further developments to increase frailty coordinator capacity and the potential for community teams to in-reach to acute areas to support timely transfers of care. A measure of success of this service is the positive impact for patients with a shift in some activity from an acute inpatient base to a community setting. Improved coordination of patient flow in hospital continues; achieved through greater integration of the Clinical Site Managers, Bed Management team and the Integrated Discharge Team, which includes a new leadership structure and shared governance through the combined Care Group Senior Management Team. An additional key development during 2021 included the progression of the Enhanced Care project and associated deliverables in line with the Home First Model.

5.2.6 Women and Children's Services

Delivery Suite and Pre/Post Natal Ward utilise Birth rate plus (BR+) which is a nationally recognised tool for maternity services based on the number of deliveries and antenatal and post-natal care requirements, which is undertaken every three years. The most recent Birth rate plus data analysis took place in 2019 with recommendations to increase the midwifery establishment and skill mix within the postnatal ward area leading to the introduction of 2.0wte RN and 6.65wte band 3 maternity assistants. Across the two units, there is a minimal vacancy (2.24wte band 5/6) and recruitment plans are in place. A small amount of band 7 vacancy (0.16wte) is being held to support a required bereavement post. In order to maintain skills sets and to establish clear succession planning there is a fluid rotation of staff from the community coming into the ward settings. There are no proposals for a change to the workforce models as they meet the current demands of the service. There will however be further expected changes in workforce requirement in the near future in line with the national move towards the Continuity of Care model (CoC) and better births. There is a full project plan in place with identified work streams to support the CoC model throughout 2021/22.

The Maternity Assessment Unit is situated within the women's out patients department, sees over 650 women per month, and has 1.0wte band 2 vacancy. As the Unit Matron will potentially retire in the next two years, there is a succession plan in place to further develop existing midwives

The **Community Midwifery** team is distributed across three bases in Stockton, Hartlepool and Peterlee and includes an on call rota to support the escalation policy and the home birth service. The team has 2.51wte RM vacancy and 2.1wte band 4 vacancy with no proposals to change the current workforce model, again in line with the movement towards the CoC model. All newly recruited midwives are appointed on the basis they will work within the CoC model going forward.

The **Rowan Team** is a midwifery led unit within the community hub based in the University Hospital of Hartlepool. Team members are practice assessors and a Specialist Lead Midwife for CoC oversees the management of the unit.

Paediatric Ward / Paediatric Day Unit. The Paediatric Day Unit at the University Hospital of Hartlepool continues to provide pre and post-operative services for children undergoing elective surgery. Staff rotate across the department creating flexibility in the staffing across Inpatient, Assessment Unit and Out Patient services. At North Tees, Paediatric services have gone through significant change over the past six months. There are 20 in-patient beds (flex to 26 during winter months to accommodate surges with increased respiratory acuity and occupancy) and 15 beds in the Paediatric Initial Assessment Unit (PIAU), which is co-located within the Trusts Emergency Department (ED) and Integrated Urgent Care Centre (IUUC). The unit have zero RN vacancies with plans to skill mix current band 4 vacancy into band 2; planned maternity leave allows fixed term posts to be filled. Recruitment into this area is usually very successful with final year paediatric nursing students. Future expectations are that paediatric staff from ED and the PIAU/Ward will merge to create a fluid workforce rotating across all areas to develop and maintain specialist skills. Succession planning is not an immediate requirement but the services continue to provide development opportunities to all staff to ensure a highly skilled workforce is in place. There are no proposals to change the workforce model at present as it meets the demands of the service.

Special Care Baby Unit (SCBU) is a level 1 service with workforce based on the British Association of Perinatal Standards (BAPM) at an 80% occupancy level, which is 1 nurse to 4 babies within the unit. There is also the addition of a Nurse Practitioner (ANNP) being on the unit 24hrs per day, this role is required to maintain BAPM standards. There are no RN vacancies and the areas is popular with student nurses as they near the end of their training. There are no proposals to change the workforce model at present as it meets the demands of the service.

5.3 Responsive Care Group

Responsive Care continue to have the highest number of vacancies with 51.8wte (May 2021). A new cohort of newly registered nurses will take up positions in September 2021 to support a reduction in vacancies. The Care Group continues to strive for full recruitment of the nursing workforce; following some targeted work with performance and finance there is now pro-active measures to recruit to turnover rates in order to provide further resilience to safe staffing.

5.3.1 Emergency Care

Significant changes to the **Emergency Department** (ED) nursing workforce model took place back in 2017 to reflect the challenges at that time in ensuring the workforce had the skills and capacity to deliver safe, efficient and innovative new models of patient care following the mobilisation of the Integrated Urgent Care service (IUCC). A further review of the workforce has been required in 2021 following the remodelling of the department and an increased capacity that included the expansion of the

Resuscitation area. This workforce review reflects the challenges faced by the increased acuity of Type 1 attendances; recommendations from the Royal College of Nursing (RCN) and the Royal College of Emergency Medicine (RCEM) have been included in that review. The proposals are in the process of being presented to the Executive Team for further consideration, three cubicles within the department remain closed until this review has been completed. ED has minimal RN vacancies with plans in place to recruit and the Trust continues to await the appropriate national SNCT tool specifically for an ED to record the acuity and dependency levels of patients coming through the department, this will support future workforce planning. In the absence of this tool, colleagues at ECIST (Emergency Care Improvement Support Team) have supported with data analysis within the new workforce proposal. The proposal being to uplift the current establishment by 18.96wte to provide ratio one RN for four patients within majors (to flex to 1:3 between hours of 12pm – 8pm), provide resus area with 3x RN 24/7 and to provide additional unregistered nurse resource to support triage model.

The workforce model within the **Integrated Urgent Care Service** (IUCS) at North Tees and Hartlepool continues to meet the demands of the service but due to the recent changes to the physical estate, there is a requirement to review the level of administration support at the reception desk. The IUCC manage recruitment separately to the other areas within the Care Group due to the requirement of an advanced skills set and the established collaborative working with the North East Ambulance Service (NEAS) as part of the alliance. The service has 0.67wte band 6 vacancy and there are plans to convert this into a training post to support career development for junior staff wanting to move towards the advanced practitioner role. There is 1.46wte unregistered nurse vacancy that is recruited to. Future opportunities lie in the introduction of the senior AHP role within the IUCC. Many senior physiotherapists have advanced skills in MSK and injuries that can be easily transferable to the service that makes alternative workforce modelling very appealing.

The Emergency Assessment Unit (EAU) is a 42-bedded level 1 admitting area with an additional 10 ambulatory care beds, waiting area, initial assessment and a discharge lounge. Patient case mix includes those from paramedic, GP and ED acute medical admissions. EAU and the ambulatory care unit have seen significant changes throughout the Covid-19 pandemic, providing care for COVID positive/negative patients. EAU has 5.35wte band 5 RN vacancies and recruitment plans are in place, EAU proves a popular place to work with newly registered nurses due to the fast pace and the wide range of speciality exposure. There is also 4.45wte band 2 unregistered nurse vacancies, currently on hold to support the potential recruitment from the current Team Support Workers. With a larger workforce of band 6 coordinator roles there are many opportunities for succession planning and staff progress into this role in addition to the advanced practitioner role within the unit. There are no current proposals to change the workforce model associated with EAU as the model meets the demands of the service following the workforce review in June 2020 where an uplift of RNs was agreed to support the area. There are no proposals to change the workforce model at present as it meets the demands of the service.

5.3.2 In-Patient Wards/Departments

Respiratory

Ward 24 has seen changes in service provision over the last 18 months with an increasing demand for level 1.5 patients who have required non-invasive ventilation (NIV), tracheostomy care, chest drain insertion and management, high flow oxygen and more recently patients requiring continuous positive airway pressure (CPAP).

Significant estates work has recently started on ward 24 to create a bespoke Respiratory Support Unit (RSU) following the demand and potential future demand from the Covid19 pandemic. The creation of the RSU mirrors that of the RSU provision on ward 25, with a team of staff to manage the process and the mobilisation of the project. The unit is planned to have 28 beds of which 7 will accommodate level 1.5 patients in a bespoke monitored area. The ward has a nursing workforce model that will meet the demands of this service. In June 2020 the workforce model was reviewed to uplift both the registered and unregistered nursing workforce and to change the overall skill mix which ensured that the areas are both compliant with the national anaesthetic guidance for level 1.5 care which states that level 1 patients should be nurses with a ratio of 1:4 (registered nurse to patient). The ward has 7.1wte RN vacancies with active recruitment taking place and 2wte band 4 vacancy. Work continues in relation to alternative workforce modelling and plans in place to introduce the band 6 senior therapist role into the RSU. There are no proposals to change the workforce model at present as it meets the demands of the service.

Ward 25 is a 28-bedded unit with 7 level 1.5 beds in the RSU. The ward has a nursing workforce model that will meet the demands of this service. In June 2020 the workforce model was reviewed to uplift both the registered and unregistered nursing workforce and to change the overall skill mix which ensured that the areas are both compliant with the national anaesthetic guidance for level 1.5 care which states that level 1 patients should be nurses with a ratio of 1:4 (registered nurse to patient).

Ward 24 and 25 workforce models are identical so that across the respiratory floor sits two RSUs within the bed base. This will allow for 14 level 1.5 respiratory patients to be supported at any one time. Lessons learnt from current Covid19 demand indicate that this uplift will reflect the safe management of both covid positive and covid negative acute respiratory patients as we move through 2021/22. Ward 25 has a band 5 RN vacancy of 2.78wte and 1wte band 4 vacancy. As with ward 24, ongoing work in relation to alternative workforce modelling with a plan in place to introduce the band 6 senior therapist role into the RSU. There are no proposals to change the workforce model at present as it meets the demands of the service.

Gastroenterology

Ward 26 is a 31-bedded unit specialising in gastroenterology including pancreatic cancer, post endoscopy, palliative care and alcohol dependency. There is a band 5 RN vacancy of 3.57wte with the concern that gastroenterology is not an attractive area to work. Further focus is required concerning advertising the speciality to new nurses. There are a wide range of learning opportunities for staff including working alongside a vast MDT including various nurse practitioner and specialist nurse roles. During the Covid-19 pandemic, many of the staff from ward 26 acquired additional respiratory skills to support the increasing demand for acute respiratory care. Plans in place to maintain these skills to provide further support in this speciality if required in the future. There are no current proposals to change the workforce model associated with ward 26 as it meets the demands of the current service. There is an appetite to adopt an alternative workforce model in the future with opportunities for an occupational therapist role to support patients with alcohol dependency for example.

Ward 27 is a 30-bedded ward specialising in gastroenterology including liver disorders, alcohol dependency and eating disorders. Due to the complexity of nursing patients with eating disorders, there was an agreed uplift in the unregistered nurse workforce in June 2020. This uplift provides an additional unregistered nurse on a 24/7 basis to support the specialist 1:1 care that is required for these patients and by staff who have

the right skills to provide this care. There is a long-standing service level agreement in place where a Nurse Practitioner is based on Birch Unit (West Park Hospital – TEWV) to provide registered nursing care. The Nurse Practitioner facilitates the safe transfer of care for patients between the mental health and the acute inpatient settings.

As part of the workforce review in June 2020, it was agreed to introduce an Occupational Therapist (OT) into ward 27 providing Monday to Friday cover. When recruited, the OT will be based on the ward and will become an essential member of the team by providing expert knowledge and skills to patients struggling with an eating disorder and alcohol and drug dependencies if appropriate. There is a current band 5 RN vacancy of 2.58wte with plans to recruit. There are no further plans to change the workforce model as it meets the current demands of the service.

Acute General medicine

Ward 36 is a 30-bedded ward specialising in acute medicine, diabetes, deliberate self-harm and care for some ITU step down patients. Due to the various specialities, there is a need to provide a highly skilled and resilient workforce to meet the demand of the patient need. The ward has a band 5 RN vacancy of 4.36wte with 3.0wte of this vacancy filled from September 2021. There is a 1.0wte band 4 vacancy that is held in preparation for TNA registration and a forecasted 2.0wte unregistered nurse vacancy that will be used to support the Team Support Worker recruitment plans. Due to the complexity and the high acuity of the patients on ward 36, the nursing workforce model currently does not meet the demands of the service. A significant workforce review is required to uplift the nursing establishment to support the provision of safe, effective and efficient care to patients and to subsequently maintain the safety needs of all staff. To mitigate the current staffing requirement the ward currently has four beds closed whilst this review takes place. There is significant opportunity to introduce an alternative workforce model into ward 36 given the diversity of the patient group including the nurse practitioner, AHP and mental health roles.

Ward 38 specialises in haematology, oncology and acute general medicine and is a very popular speciality with no current vacancies. The management of the Medical Day Unit (MDU) also falls under the same workforce model and is open Monday to Friday. Due to success of the MDU, the overall demand has increased with more patients being required to attend for support with a wide range of procedures. In June 2020, a second registered nurse was added into the MDU to provide a highly skilled and resilient workforce within this department, thus meeting the demand of the service. There are no further plans to change the current workforce model.

Elderly Medicine

Ward 40 is a 30-bedded unit that provides all essential nursing care to the high number of frail and elderly patients. In 2019/20, a shift in the traditional 60/40 skill mix (registered nurse to unregistered nurse) to a 40/60 was deemed as more appropriate to support this patient mix. A skill mix shift allows an increase in unregistered nurses in the workforce model to support safe and efficient care to meet the needs of the patients. Enhanced care requirements remain significant on Ward 40 due to the patient type, which continues to create an increase in unregistered temporary staff usage. Ward 40 have a band 5 RN vacancy of 1.73wte and an unregistered nurse vacancy of 0.82wte and are actively recruiting into these posts with some great success at the recent student nurse recruitment centre in May 2021.There is an appetite for an alternative workforce model with scope to skill mix some under-utilised band 4 monies. A recent trial in this area saw therapy assistants starting their working day at 7:30am

in line with the nursing team and all staff have found this has greatly benefited the delivery of direct patient care. There are no proposals to change the workforce model at present as it meets the demands of the service.

Ward 41 is a 26 bedded admitting acute stroke unit, which incorporates the thrombolysis service and TIA assessment and supports the safe and efficient transfer of patients for thrombectomy service to the Royal Victoria Infirmary, Newcastle. The vision is that the unit has a workforce model that reflects a hyper-acute unit. In June 2020, there was an agreed uplift to the registered nurse workforce to reflect an acute level 1 admitting area to provide a safe and efficient workforce model to meet the demands of the service. There is a stroke coordinator available 24/7 in addition to the ward-based workforce model that is in line with national guidance. There is 2.22wte band 5 RN vacancy and recruitment plans are in place and a 1.0wte band 6 vacancy. There are many opportunities in place for staff career progression and subsequent succession planning such as stroke simulation training, and the 'managing a patient with stroke' academic course which is accredited by Sunderland University and supports progression into the stroke coordinator role. There are early discussions taking place relating to a future model in collaboration with South Tees, part of the clinical services strategy, where the Nursing, AHP and medical workforce will be reviewed and aligned. Due to this work, there are no workforce review proposals within this review.

Ward 42 An alternative workforce model has been in place on **ward 42** since 2018. The model created a 40/60 registered/unregistered nurse skill mix. This provides a safe and efficient workforce model that meets the needs of the service. In June 2020 the care group increased the night shift provision to 3 x RNs to support a more suitable registered nurse to patient ratio. Enhanced care requirements remain significant on ward 42 due to the dependencies of the patients; this creates an increase in unregistered temporary staff usage. There is minimal band 5 RN vacancy of 1.11wte. There is recognised potential to introduce bespoke roles such as AHP, Community and mental health nurses into the ward 42 model in the future to support patient pathways from hospital to home. There are no proposals to change the workforce model at present as it meets the demands of the service.

Acute Cardiology Unit (ACU) a 19 bedded unit that specialises in acute level 1 cardiology that requires a telemetry trained nurse each shift to manage the needs of the service and of the safe transfer of patient to James Cook University Hospital. The unit has 1.43wte band 5 RN vacancy and this vacancy has already been recruited into following the student nurse recruitment centre in May 2021. There is also a very small amount of unregistered nurse band 2 vacancy (0.43wte). As part of this review, the unit would benefit from a slight uplift in the B2 unregistered nurse workforce to further support with the personal care needs of the more dependent patients. Due to the nature of the speciality, the unit benefits greatly from experienced cardiology nurses of whom 3wte are approaching the final years of their career. To support succession planning junior staff are provided exposure to specialist services and education. There are no proposals to change the workforce model at present as it meets the demands of the service.

5.3.3 Day Units

The **Endoscopy unit** is compliant with the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation standards and will be due an on-site review in September 2022. The department is required to have adequately training and sufficient staff numbers to ensure that patients receive access to the best possible pathway from

referral to diagnosis and or treatment by correctly trained, efficient, safe and caring staff. As such, staff are competency trained in line with national recommendations by the British Society of Gastroenterology (BSG) and British Thoracic Guidelines. Throughout the covid-19 pandemic, many of the elective endoscopy pathways were paused and staff were redeployed to other areas to work. Throughout 2021, the team are actively managing the recovery phase to allow services to continue. The unit does require a full workforce review to ensure that the workforce model meets the needs of the current service which, following the pandemic has seen a significant increase in activity particularly within the field of therapeutic intervention. A workforce review options paper is being drafted within the care group that will require significant consideration by the Trust.

Haematology Day Unit can deliver treatment to up to 24 patients at one time for haematological malignance, blood transfusions, venesection, various infusions, bone marrow biopsy and the administration of complex injection regimes. The nurses in the unit are highly skilled with on-going study requirements to remain up to date with the various speciality treatment. The unit has minimal vacancies and is a popular place to work given the professional development opportunities available to the team. There is currently only a 0.6wte band 6 RN vacancy and already plans are in place to convert this to band 5 to support succession plans for future band 6.

Chemotherapy Day Unit delivers treatment, supports patients with a variety of cancer diagnosis, and can see up to 34 patients per day although face to face care has reduced over this past year due to the pandemic and the requirement to maintain social distancing within the unit. Similarly, to the Haematology unit it is a popular place to work and subsequently have zero vacancy. An element of skill mixing has already been completed which supports the demands of the service.

5.4 Collaborative Care Group

Collaborative Care have a current vacancy position of 27.3wte (May 2021), the detailed breakdown can be seen in section 5.6.2

5.4.1 Acute/Elective Pathways

Ward 32 specialises in patients with fragility fractures and emergency trauma. Due to the patients' dependency needs, there is a continuing reliance on enhanced care and temporary staffing. There are plans to uplift 1.0wte band 5 into a fixed term band 6 post to support with planned maternity leave in this role. There is a band 5 RN vacancy of 3.86wte and an unregistered nurse vacancy of 6.16wte that are proving challenging to recruit to. A full refresh of the adverts associated with this specialty have been completed and shared across all social media platforms and the team now have a clear place at the recruitment centres in an attempt to successfully recruit into these posts by the end of this year. There is ongoing discussion over the bed base given that the establishment is based on 30 patients yet the unit is currently planned for 22 patients. Despite the high number of vacancies, the risk is less due to the current bed base. The unit flexes the bed base to meet the demands of the service so there are no current plans to reduce the funded establishment. Ward 32 provides future opportunities in the introduction of an alternative workforce model. Many senior therapists have advanced skills in relation to fragility, fracture and rehabilitation, which makes alternative workforce modelling very appealing in this area.

Ward 33 specialises in orthopaedic trauma, diabetic foot post-surgery, and some elective care patients including spinal. This usually creates a mix of short and long stay

patients depending on the complexity of their needs. There is a 3.0wte band 5 RN vacancy; recruitment plans are in place and an element of band 2 unregistered nurse over recruitment by 1.52wte to support long-term sickness and an agreed 1.0wte band 2 secondment. There are approximately 4wte RN approaching the end of their career so succession planning is a priority. Various opportunities are made available to the team to support career progression. There are no proposals to change the workforce model at present as it meets the demands of the service.

Ward 31 is a 15-bedded (level 1) area with the ability to flex up by an additional 5 level zero beds to meet the needs of the service. Ward 31 cares for patients who have undergone major emergency and elective surgery. The skill sets of nursing staff in this area are advanced to support the acuity needs of patients and there are plans to progress to a rotational model whereby staff will move through ward 31 and into Critical Care whilst completing the national level 1 competencies. The team fully support newly registered nurses and in September 2021 will have 3 new nurses joining the team. There are 2wte band 5 RN vacancies planned but recruitment plans are in place and 1.0wte unregistered nurse vacancy that has also been recruited to. There are no proposals to change the workforce model at present as it meets the demands of the service.

Ward 28 is a 30-bedded unit and cares for a combination of long and short stay patients following surgery (urology, gynecological and gastro intestinal), occasional orthopaedic surgery and some medical patients. The ward has zero vacancies and has successfully recruited to turnover. The ward embraces the development of newly registered nurses, supports career progression and currently has 5wte newly registered nurses in post. By the end of this year, the ward will have 8wte RNs in the 55-70yr age range (approx. 40% of the RN workforce). To mitigate this, a robust succession-planning model is in place, which is managed via the annual appraisal process. There are no proposals to change the workforce model at present as it meets the demands of the service.

Ward 9 is now a nurse-led service, which manages the elective \`green\` pathway for lower limb, general and breast surgery and provides resilience for unplanned day case unit admissions. There is a current over recruitment of 1.2wte band 5 RN in preparation for RN retirement and an unregistered nurse vacancy of 1.85wte that has recently been recruited to. Over the next 5 years, it is anticipated that 5wte RN will come towards the end of their careers; this is factored into the recruitment and alternative workforce model discussions within the care group. The current workforce model meets the service demand.

Surgical Decisions Unit (SDU) now comprises of 20 beds, 3 triage trolleys and 2 clinical trolleys with the ability for patients to return to the unit into either diary slots or hot clinics. This followed recent changes to meet the demand of the \`green\` and \`amber\` Covid pathways. The team care for patients on a short stay basis where their needs can range from all surgical specialties. SDU is usually a popular area to work given the wide range of experience that staff can gain in this area with little band 5 RN vacancy (3.52wte) which is now recruited into from September 2021. The unit embraces the development of newly registered nurses and supports career progression, which supports the succession-planning model. The specialty now reflects that of the Medical Emergency Assessment unit model so discussions within the care group are now on-going relating to the requirement to have 1 band 6 coordinator on duty per shift with the potential ability to skill mix part of the existing band 5 establishment to support this. There are no proposals to change the workforce model at present as it meets the demands of the service.

Day Case and Access Lounge are based across both sites and staffing levels are planned around theatre list provision. There has been a recent external recruitment of a new band 7 with plans to review current workforce and potential skill mix changes for future provision.

The **Pre-assessment** team also provide cross-site working and although the current workforce model meets the demand of the service it has been agreed that there is scope to carry out skills matrix work to ensure the right roles are carrying out the right tasks. This is similar to that of the day case and access lounge team and may result in an element of appropriate skill mixing. There are 7wte RN (68% of the total RN workforce) who are approaching the 55-70yr age range providing an added pressure. With a lack of final year student nurses placed in this area, there is a recognised risk that the area is not well promoted to those who are due to register.

5.4.2 Theatre Anaesthetics, Recovery and Scrub

The anaesthetic and theatre services provide pre, intra and post-operative services. The services require a specialised, flexible, and highly skilled nursing workforce. Complex planning and continual monitoring of skills against lists and procedures is required within the care group and to ensure the workforce model meets the demands of the service. Theatres staffing workforce is complex and there is no nationally agreed workforce tool to determine how theatres should be staffed. This is a large workforce where the skill set required of theatre staff is significant due to the increasingly changing sub specialities. Further training, post registration, can take up to 18 months depending on the level of complexity to ensure full competence and to provide staff the opportunity to rotate across all aspects of the role. The most recent challenge has been the RN/ODP band 5 vacancy of 11wte across the three teams. In addition to this vacancy, there are 7.47wte band 5 RN on parental leave. The team have been advised to recruit into permanent position as minimal financial risk due to the overall size of the teams and the planned turnover. Many of these vacancies have recently been recruited into following a refresh of advertising and the presence of the Theatres team at the refreshed recruitment centres. To mitigate the short-term risk, there are plans to utilise some agency workers to provide the required skills set across the teams. There is a positive succession planning process in place with consistent opportunities for band 5 staff to act up into team leader posts, development of band 7 posts have been introduced for 6-month periods and the Theatre Support Worker role is offered opportunities to complete Operating Department Practice (ODP) training. The team recognise the importance in maintaining the training and development of staff both to the meet the demands of the service and to support retention of staff. Band 6 staff currently carry out theatre education and training for theatre staff when capacity to do so which is becoming more challenging so the care group have recently recruited a full time Clinical Educator for this area.

5.4.3 Critical Care and Outreach

Critical Care is a 16-bedded unit with a high level of training and support needed to produce a skilled workforce that can safely manage the acuity and dependency needs of patients. Due to the dynamic nature of this specialty, the nursing establishment accommodates changes in the level of patient care and flexes the nurse to patient ratio in accordance with national standards. The establishment in Critical Care is based on 100% occupancy of the unit. The Critical Care unit has an effective workforce model that meets the demands of the service, which continued during covid-19 pandemic with the redeployment of staff and investment in additional training for those staff new to the critical care environment. The unit has 3.64wte band 5 RN vacancy with an

additional 5.44wte RN (8.3% of the B5 workforce) on parental leave and 7.68wte (11.7% of the B5 workforce) on long-term sick leave. Unfilled shifts are covered within the team due to the advanced skill set required; recruitment into permanent and fixed term posts in critical care is usually very successful. Approximately 5wte RNs are approaching the end of their careers, the unit maintains a robust succession planning process creating opportunities for all staff to have exposure to higher band role and responsibilities including critical care outreach. National standards (GPICS) recommend that for every unit with 75 or more staff members should have a designated clinical educator. Following the workforce review in June 2020, to comply with this standard, the unit has recruited a 1.0wte clinical educator who will take forward the training and development needs of this large team. The Critical Care Unit is also embracing the introduction of new roles including the Advanced Critical Care Practitioner (ACCP), with 3wte due to commence training in September 2021. There are no proposals to change the workforce model at present as it meets the demands of the service.

Critical Care Outreach (CCO) team is comprised of band 6 RNs and is led by a newly appointed band 7 RN who is refining the concept of CCO. The skills set required by the team is significant and over the past 12 months, they have supported many clinical areas at the height of the covid-19 pandemic. There are no vacancies within the team but it is noted that with a collective workforce of 5.62wte there is only ever one nurse on duty at any given time, which includes the band 7 lead, resulting in little capacity to carry out management duties. Although there are no immediate concerns over the need to succession plan, there is a clear succession-planning programme in place to provide band 5 staff with at least six shadow shifts to enable them to support the team if unfilled shifts occur and allows for a seamless transition into outreach recruitment when required. Future opportunities lie in the introduction of the senior AHP role within the outreach team which currently is 100% nursing. Many senior physiotherapists have advanced respiratory and Critical Care skills, which makes alternative workforce modelling very appealing.

5.5 SNCT Data Collection

The full results of the SNCT data collection can be seen in Appendix 2. Whilst this nationally approved tool provides nursing workforce establishment requirements based on patient acuity, skill-mix requirements are not included and therefore need to be considered at local level. The SNCT also states that a minimum of 22% funded headroom should be included for all nursing and midwifery staff within in-patient areas. The trust currently has a funded headroom of 21% for registered staff and 19% for unregistered staff. To uplift this to 22% would result in a significant increase in financial resource. As this is the first data completion and therefore establishments will not be amended based solely on this data, the headroom will be further explored during the annual workforce review 2022. The tool collects data on the average number of patients by level of acuity (0, 1a, 1b, 2, 3) and average WTE recommended against current budgeted establishment.

As all in-patient areas need to be safely staffed for all funded beds, the tool advises that each empty bed is calculated as level 0.

The overall required establishment for all in-patient areas is based on the SNCT data collection was 803.45wte, with an actual establishment of 804.75wte this provides assurance that the overall establishment meets the demand based on patient acuity. However, it is important to note that there were areas of exception.

A summary of the areas of exception (over-established by 5wte+) as identified within this first data collection includes:

- SNCT data within the **Paediatric ward** suggested an over–establishment of 9.7wte. It must be noted that within the current establishment staff also manage the PDU and the new PIAU which is not included in the tool.
- **EAU** SNCT indicated an over-establishment of 8wte, however the EAU workforce also currently staff the waiting area, which is not included within the tool.
- SNCT for **Ward 32** suggested an over-establishment of 16wte; however, beds were only open to 20 beds at the time of the data collection despite being funded for 30 beds. The risk is mitigated due to a high number of nursing vacancies.
- **SDU** SNCT data suggested an over-establishment of 7wte; however, staff also manage the diary, swabbing and hot clinic processes that are not included in this tool.

A summary of the areas of exception (under-established by 5wte+) as identified within this first data collection includes:

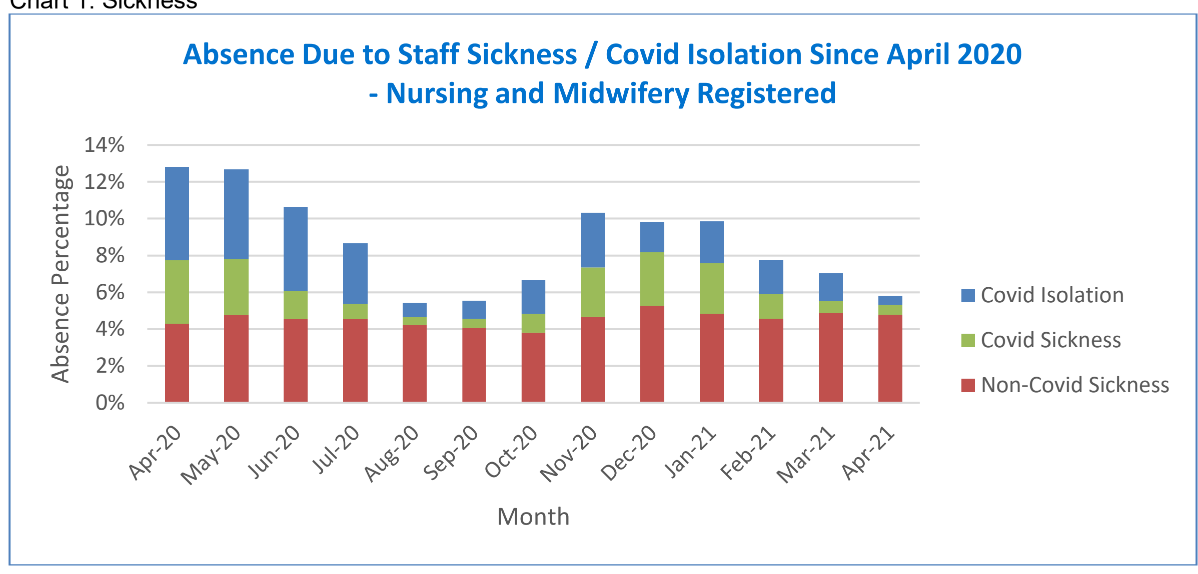
- **Ward 26** SNCT data showed an under-establishment of 9wte
- **Ward 24** SNCT data showed and under-establishment of 5.9wte, however the bed base on this ward is planning to reduce to 28 from 31 which would support this. Plans in place to fund 2 additional beds on ward 42 to help mitigate the risk of losing all 3 beds.
- Ward 36 SNCT data showed a significant under-establishment of 12.3wte. Despite this only being the first cycle of data collection the outputs do reflect the professional judgement of the area and support the requirement for further workforce review and bed closure to maintain safe staffing as an interim measure
- **Ward 38** SNCT data identified an under-establishment of 5.5wte, professional judgment indicates this ward **does** have safe staffing to support the patient mix
- Whilst **Ward 40** SNCT data suggested an over establishment of 5.4wte, at the time of the data collection 10 beds were closed. For the 30 funded beds the tool indicates an under establishment by 9.1wte. This supports the continued closure of beds
- **Ward 42** SNCT data showed a significant under-establishment of 14.6wte. Despite the funded bed base being 34, there is a regular flex to 36 beds which was the position at the time of the data collection

5.6 Workforce Metrics

5.6.1 Nurse and Midwifery Sickness

Chart 1 below shows the overall nurse and midwifery sickness absence April 2020 to April 2021. The average across those 13 months was 8.7%, which remains a significant challenge. April and May 2020 show the highest levels of sickness absence with a peak of 12.6%. It is important to note that this includes sickness due to Covid symptoms and staff absences due to Covid related isolation. The breakdown can be seen below. Within the funded headroom, 4% is allocated for both registered and unregistered nurses/midwives for predicted sick leave. The rates continue to be over and above this (4.5% average sickness absence for non-Covid related). It is important to note that community-nursing teams do not have funded headroom therefore any sickness cover has to come from existing staff or temporary staffing at additional cost.

Chart 1. Sickness



5.6.2 Vacancies and Turnover

Chart 2 below shows the Nurse and Midwifery vacancies April 2020 to May 2021 identifying a continued high monthly RN vacancy. The RN vacancies peaked at 84.7wte (6.2%) in June 2020 with the lowest vacancy rate in March 2021 at 46.9wte (3.4%). Unregistered nurse and midwifery vacancies peaked to 34.6wte (5.4%) in February with the lowest rate of 20.3wte (3.1%) in January. Registered midwife vacancy level peaked to 9.5wte (7.5%) in May with lowest rate of 0.4wte (0.3%) in March and April 2020.

Chart 2. Vacancies 2020/21

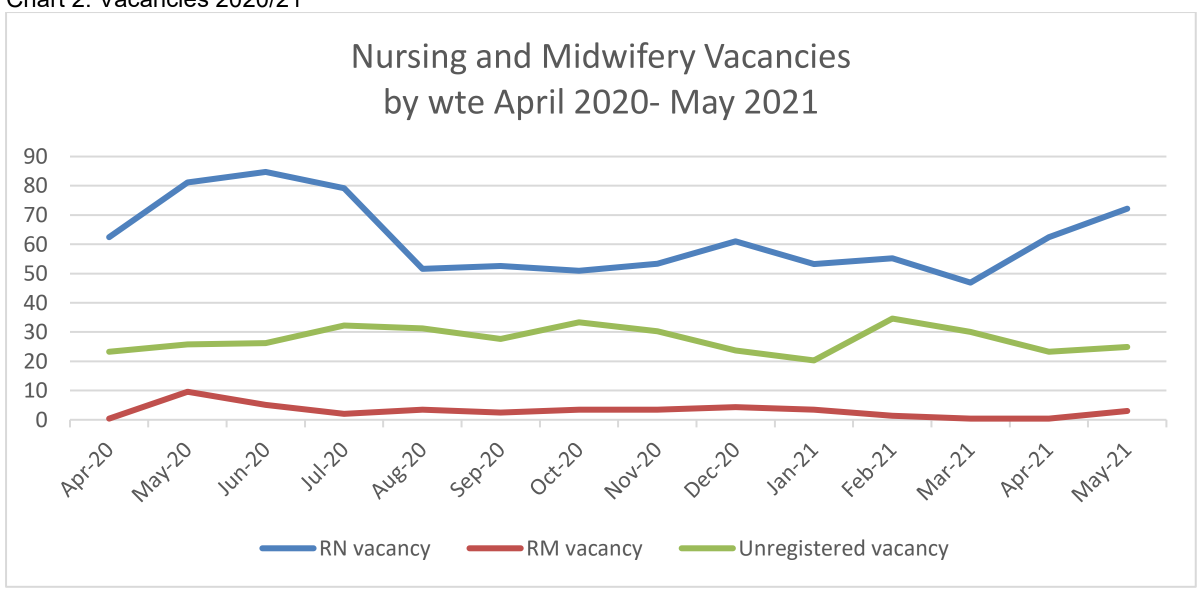


Table 1 below shows the breakdown of vacancies for May 2021

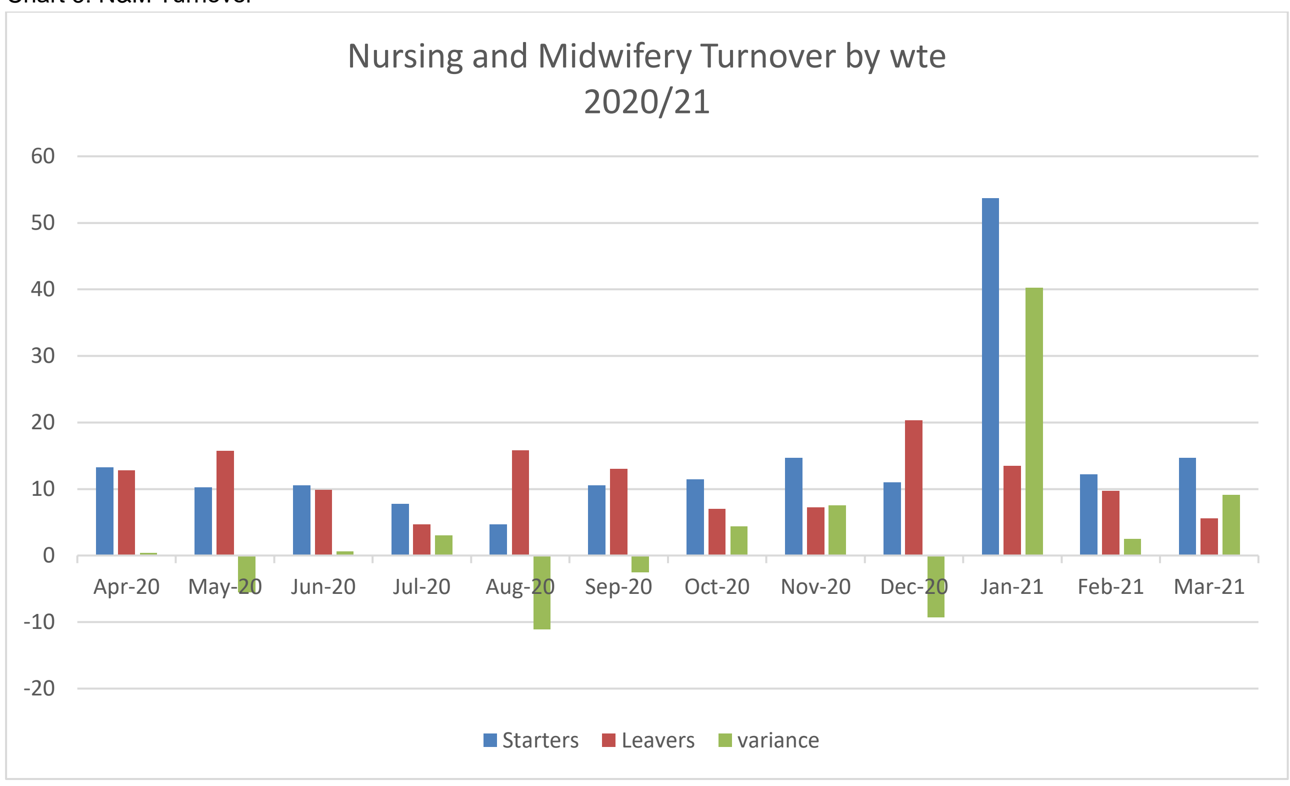
Table 1. Vacancies May 2021

Vacancy Position	Healthy Lives	Responsive Care	Collaborative Care	Total vacancy (% of budgeted workforce)
Reg. Nursing	12.6	36.3	23.3	72.2wte (5.3%)
Reg. Midwifery	3.0			3.0wte (2.3%)
Unreg. Nursing	1.8	15.5	4.0	21.3wte (3.3%)
Unreg. Midwifery	3.6			3.6wte (33.8%)
Total	**21wte**	**51.8wte**	**27.3wte**	**100.1wte (4.7%)**

The nursing and midwifery turnover 2020/21, as seen below in chart 3, shows the breakdown of starters and leavers each month. During the year, there has been a total of 174.6wte starting with 135.2wte leaving which gives an annual variance of 39.4wte.

Nursing and Midwifery turnover for 2020/21 was 8.11% overall and can be broken down to voluntary at 7.38% and involuntary at 0.72%. This is improvement from 1.7% involuntary turnover during 2019/20.

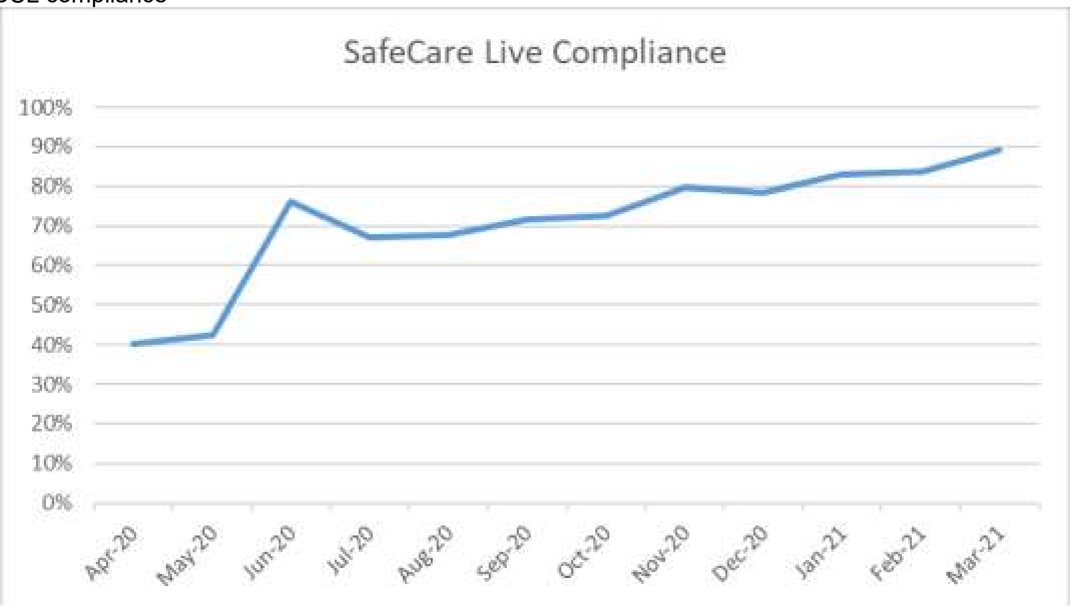
Chart 3. N&M Turnover



5.6.3 Planned and Actual Staffing

In line with the National Quality Board (NQB) publication, the organisation continues to report the planned and actual staffing data on a monthly basis to NHSI. Safe Care Live (SCL) generates both a required and an actual CHPPD for all inpatient areas twice per day. This gives a more accurate reflection of staff allocation and staff to patient ratios across a 24-hour period. In response to the need to remain flexible in the way nursing and midwifery staffing is planned, SCL is used on a day to day basis to safely and efficiently assess accurate staffing levels and to redeploy nursing staff throughout the organisation. SCL provides information on a shift by shift basis for each unit (ward/department) which includes whether there is an under or over utilisation of staff, the overall percentage of temporary staff working that shift, the detail of any unfilled shifts, the calculated nurse to patient ratio, CHPPD and skill mix. There has been some focused work to improve the overall compliance across the organisation. **Chart 4** below shows an improving position with a low compliance of 40% April 2020 to 90% March 2021. Validation of the data also takes place by the Senior Clinical Matrons on a monthly basis to provide assurance that the data captured accurately reflects the patient acuity and needs.

Chart 4 SCL compliance



A small number of areas within the Trust utilise bespoke nationally recognised tools combined with overarching professional judgement to identify their staffing needs including Birth Rate Plus (BR+) in maternity and the British Association of Perinatal Medicine (BAPM) Standards in the Special Care Baby Unit (SCBU).

5.6.4 Care Hours per Patient Day (CHPPD)

The overall average CHPPD figures for 2020/21 can be seen below in table 2, which shows that safe staffing was maintained throughout the year with a positive variance each quarter. It can be seen that the variance between required and actual significantly reduced in Q3 2020/21 as occupancy and staff unavailability increased which is aligned to the peak of wave 2 of the pandemic.

Table 2. Average CHPPD 2020/21

	Required CHPPD	Actual CHPPD	Variance
2020-21 Q1	6.17	7.67	1.50
2020-21 Q2	8.19	10.34	2.15
2020-21 Q3	7.85	8.05	0.60
2020-21 Q4	8.45	9.54	1.09
Total	**30.66**	**35.6**	**4.94**

The average fill rates (UNIFY data); as seen below in table 3, show a lower fill rate in RN during the day and a high rate of Health Care Assistants on nightshift. This often reflects the RN gaps and the increased provision needed for enhanced care. The fill rates in Q1 reflect the reduction in occupancy across the organisation throughout the initial Covid-19 response.

Table 3 N&M staffing fill rates (UNIFY data)

	RN Day	HCA day	RN Nights	HCA Nights
2020-21 Q1	68.5%	70.7%	73.2%	89.2%
2020-21 Q2	76.6%	82.8%	83.2%	111%
2020-21 Q3	80.2%	82.0%	87.6%	116.17%
2020-21 Q4	78.0%	74.0%	87.0%	96%

5.6.5 Monitoring of Clinical Outcomes

NICE guidance (2014) identified organisational approaches to safe nurse staffing of in-patient wards in acute hospitals. It aimed to ensure that patients receive the nursing care they need, regardless of the ward to which they are allocated, the time of the day, or the day of the week. Within this guidance, Nurse Sensitive Indicators are identified which include patient harm that could be sensitive to the number of available nursing staff, such as falls and pressure ulcers. Patient safety meetings take place across the organisation on a weekly basis where all potential and actual harms are discussed from the previous week with attention to any themes or staffing concerns. The continued work reviewing patient acuity and dependency helps to address whether the harms have occurred because of reduced nurse staffing.

Falls

A fall is defined as an unplanned or unintentional descent to the floor, with or without injury, regardless of cause. Although falls may be sensitive to the number of available nursing staff, falls prevention requires a multidisciplinary approach, and falls rates will be affected by:

- availability of physiotherapy, occupational therapy, pharmacy and medical staff
- knowledge and skills of all healthcare professionals and support staff
- safety of the environment, furniture and fittings
- access to mobility aids and equipment

Table 4 below shows the number of falls sustained across the trust during 2020/21. It can be seen that a high proportion (81%) of falls resulted in no injury with a marked reduction in falls with fracture from 13 during 2019/20 to 5 in 2020/21. This reflects the improvement work that has taken place to minimise the risk of harm from falls and the continued balance between patient mobility to prevent harm from deconditioning and the risk of a patient falling.

Table 4 Falls

Months	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Total
Fall No Injury	59	55	61	74	74	74	91	85	100	91	78	82	924 (81.2%)
Fall Injury, No Fracture	15	8	13	14	16	22	14	20	37	18	17	14	208 (18.2%)
Fall with Fracture	0	0	0	1	0	2	1	0	0	0	1	0	5 (0.4%)
	74	63	74	89	90	98	106	105	137	109	96	96	1137

Pressure Ulcers

A pressure ulcer is a localised injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear. The patient's pressure ulcer could be categorised as 1, 2, 3 or 4. Although pressure ulcers may be sensitive to the number of available nursing staff, pressure ulcers prevention requires a multidisciplinary approach, and pressure ulcers rates will be affected by:

- access to pressure ulcer prevention equipment and mobility aids
- availability of physiotherapy, occupational therapy, pharmacy and medical staff
- knowledge and skills of all healthcare professionals and support staff

Table 5 below shows the number of Hospital and Community acquired pressure ulcers during 2020/21, which shows the highest level of pressure ulcers, are category 1 and 2, 95% in hospital and 75% in the Community. This is comparable to the data during 2019/20 where 94% category 1 and 2 within the hospital and 75% in the community. Whilst it is nationally recognised that Pressure Ulcers are a Nurse Sensitive Indicator, there is no evidence that the pressure ulcers which have developed during 2020/21 are directly linked to staffing levels.

Table 5 Pressure Ulcers

		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Total
Hospital	Category 4	0	0	0	0	0	0	1	1	0	1	0	0	3
	Category 3	0	1	0	0	4	3	1	1	3	1	0	0	14
	Category 2	28	24	21	13	8	11	18	36	27	25	22	22	255
	Category 1	4	6	6	3	1	7	6	15	6	3	7	8	72
														344

		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Total
Community	Category 4	0	1	1	0	0	1	1	2	3	1	2	1	13
	Category 3	1	3	7	3	6	7	5	3	4	3	4	7	53
	Category 2	10	16	8	14	10	10	16	15	10	8	11	11	139
	Category 1	5	8	2	3	5	4	6	7	7	0	3	7	57
														262

5.6.6 Occupancy level

In addition to patient acuity, the occupancy rates within hospital are also important to monitor when reviewing staffing establishments. The occupancy during 2020/21 (inclusive of surge beds) can be seen in chart 5.

Chart 5. Occupancy

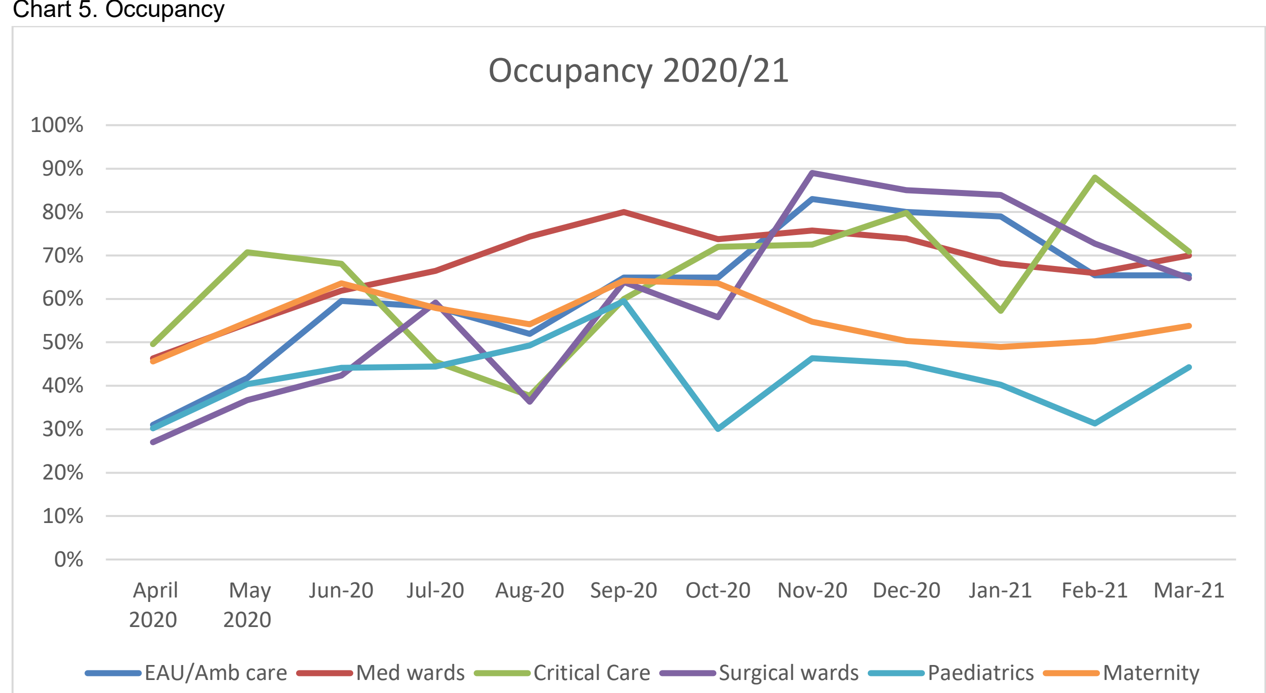


Table 6 below shows the overall monthly average percentage occupancy across all adult In-patient areas (excluding Paediatrics and Maternity).

Table 6. Average Occupancy

April 20	May 20	June 20	July 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
38.47 %	50.87 %	57.97 %	57.33 %	50.08 %	67.20 %	66.60 %	80.07 %	80.02 %	77.0 %	73.0 %	67.8 %

5.6.7 Nurse and Midwifery Recruitment

The Trust continues to undertake a number of recruitment initiatives with the aim to see a further increase in both the registered and unregistered nurse establishment across the organisation. Frequent use of social media platforms provides information to the public around vacancies and opportunities within the Trust with a particular focus on promoting the Trust as the employer of choice.

All band 5 Registered Nurse recruitment continues to be carried out via value based monthly recruitment centres and this method has proven to be a positive way of attracting pre-registered and registered nurses to the Trust. A successful candidate reserve provides a pool of staff awaiting posts in specific areas/specialities. This has proved successful, as many have taken up interim posts in other wards/departments until their preferred area of work declares a vacancy. They are then supported to transfer into that vacancy.

Bespoke recruitment continues to be successful in some specialist areas where recruitment had to be targeted to attract the right workforce with the right skills and experience (e.g. critical care, theatres).

There continues to be a significant number of unregistered nursing staff completing the Foundation Degree for Assistant Practitioners (APs) using the Apprenticeship Levy.

Trainee Nursing Associates have successfully completed a two-year pilot Foundation Degree programme with Health Education England (HEE) and Teesside University. The Nursing Associates are regulated by the Nursing and Midwifery Council (NMC).

Nursing Associate Apprentices are in practice in some areas with plans for future cohorts, based on workforce plans. These posts; where appropriate; enhance and support the care provided by Registered Nurses.

The Trust vision is to build the nursing workforce of the future and as such has continuous links with local schools, colleges and Higher Educational Institutes to raise the profile of nursing.

The organisation has recently implemented a new '**Team support worker'** role (6-month pilot) which offered a cohort of Band 2 staff, with little or no previous NHS experience, the chance to support clinical and administrative teams across the organisation. The pilot has shown that this role has released nursing time to care, reducing the pressure on nursing teams by undertaking tasks such as answering phones, patient buzzers, communicating with patients and relatives, stocking and tidying and general admin or patient care duties. The recruitment of these workers were fast-tracked with support from the recruitment team having been involved from the inception of this programme of work. Initial cohort interviewed in December resulted in timely recruitment to be in post early January 2021. There was a high level of interest in these posts from a variety of backgrounds. Each worker was integrated within the team/ward to provide a sense of belonging and identity for the wider team. The role also offers the opportunity to improve communication pathways between clinical services, support patient discharge and virtual visiting during a time when relatives are limited in their ability to attend the hospital to visit patients.

The value of the role continues to be monitored, early success has shown an improved patient satisfaction, reduction in complaints and staff satisfaction. Many of the workers have expressed an interest to progress to a Health Care Assistant; this is being supported with the opportunity for those interested to join the HCA apprenticeship scheme. For the remaining workers, they have been extended for a further 6 months to continue to measure the impact of the role.

5.6.8 Nurse Retention

Making the NHS the best place to work is a key commitment in both the Long Term Plan and the NHS People Plan. Recently NHS England and NHS Improvement published 'Retaining our People' retention programme (October 2019) which aims to empower leaders to provide greater development, flexibility and support options for staff which will all contribute to a more supportive working environment and will lead to a greater retention of staff.

From April 2021, a 'transfer window' was introduced whereby all nursing and midwifery staff (Bands 2 – 5) are provided an opportunity each quarter to apply for an internal

transfer. The transfer window supports offering fair and equitable opportunities for staff and provides a more structured process for the Care Groups to manage this process.

Monthly registered nurse development days were paused during the pandemic but will be revised by the Heads of Nursing to continue throughout 2021/22. There is a continued focus on personal and professional development and the health and wellbeing of staff.

Clinical skills days for the registered nursing workforce promote continuous learning and the consolidation of essential core clinical skills. Core skills development days continue monthly with band 5 registered nurses across all Care Groups attending the sessions that are planned and delivered by the Education Department.

The organisation continues to provide new staff with a block week of mandatory training immediately following the block week of preceptorship training. This ensures that all staff new to the organisation are fully compliant with their mandatory training prior to commencing work in clinical practice.

Substantive nursing staff are supported to move across specialities within the Care Groups and are given the opportunity to discuss the options of more flexible contracts and rotational posts, which aim to support staff in maintaining their work life balance and achieving their preferred skill sets.

Developing current and future leaders is a key priority of the Trust. In October 2018 NHSI published a 'Ward leaders' handbook' which is a guide for those who aspire to be a ward leader, those already in post and for Trusts that want to support and develop this important role. Developing leaders and managers within the Care Groups is essential in ensuring a stable workforce for the future. Career pathways and leadership modules are currently being explored to help support Registered Nurses moving into Matron and Deputy Matron posts.

Within the workforce reviews, there was focus to ensure teams have awareness of the potential retirement plans for nurses who are aged 55yrs+ to ensure that succession planning is in place as many of these nurses have advanced skill sets with many years of experience that is not easy to replace.

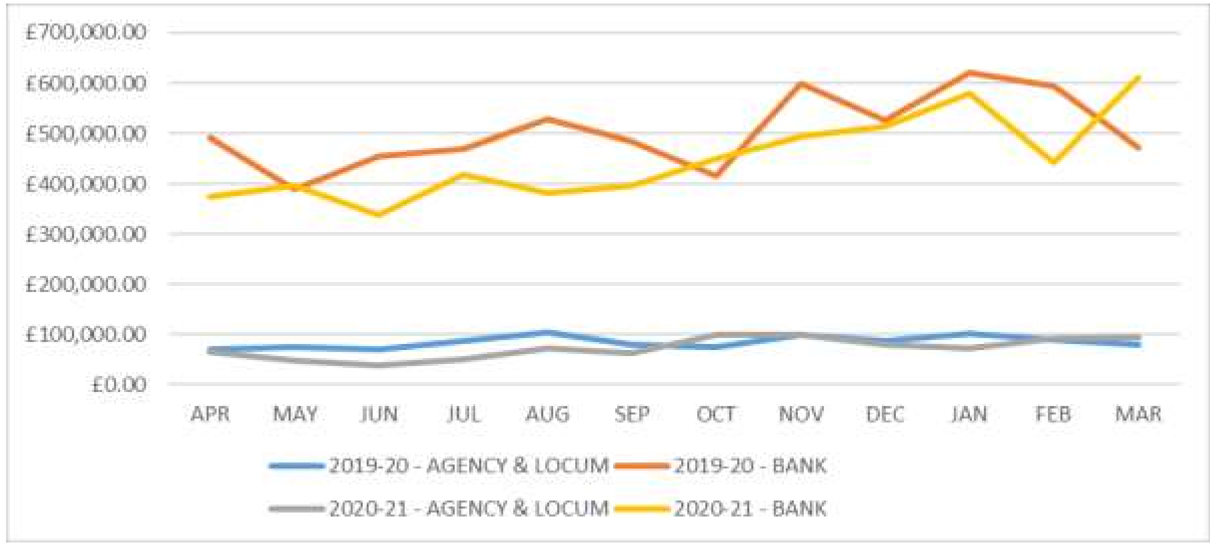
Work streams are in place to focus more consistently on RN recruitment and retention strategies throughout 2021/22, which include:

- Rotation through different areas and specialities
- Clinical training days
- Simulation training
- Aspiring Ward Matron meetings
- Continuation of Education panels
- Quality Improvement projects
- Quarterly Care Group band 6 and 7 development sessions.
- Quarterly Care Group Specialist Nurse/Practitioner development sessions
- Quarterly opportunities to transfer

5.6.9 Temporary Staffing Usage

Temporary staffing expenditure for Nursing and Midwifery staffing can be seen in chart 6 below. A year on year comparison is shown for Bank, Agency and Locum usage.

Chart 6. Temporary Staffing costs 2020/21



The improved position is notable, and the following mitigation can be applied to the year to date spend:

- Increase in bank rates from April 2020 in line with agenda for change pay award
- Increased agency rates in line with the increase in NHS Improvement price cap and framework compliance
- Costs associated with COVID-19 included in the expenditure summary
- Consistent temporary staffing demand within the Enhanced Care service

Agency expenditure trend is consistent with previous years and the reduction of agency usage across the organisation remains a key priority. Bank expenditure has reduced year on year and has not followed the same trend as in previous years, resulting in significantly reduced fill rates going into the winter period. This can be attributed to the pressures staff were under whilst working throughout the COVID-19 pandemic. Staff unavailability is unprecedented resulting in less availability of staff to fill bank shifts as well as working their contractual hours.

Table 7 below shows the fill rates between bank and agency for registered and unregistered nursing staff. It can be seen that there continues to be a higher fill rate for the unregistered nurses than the registered.

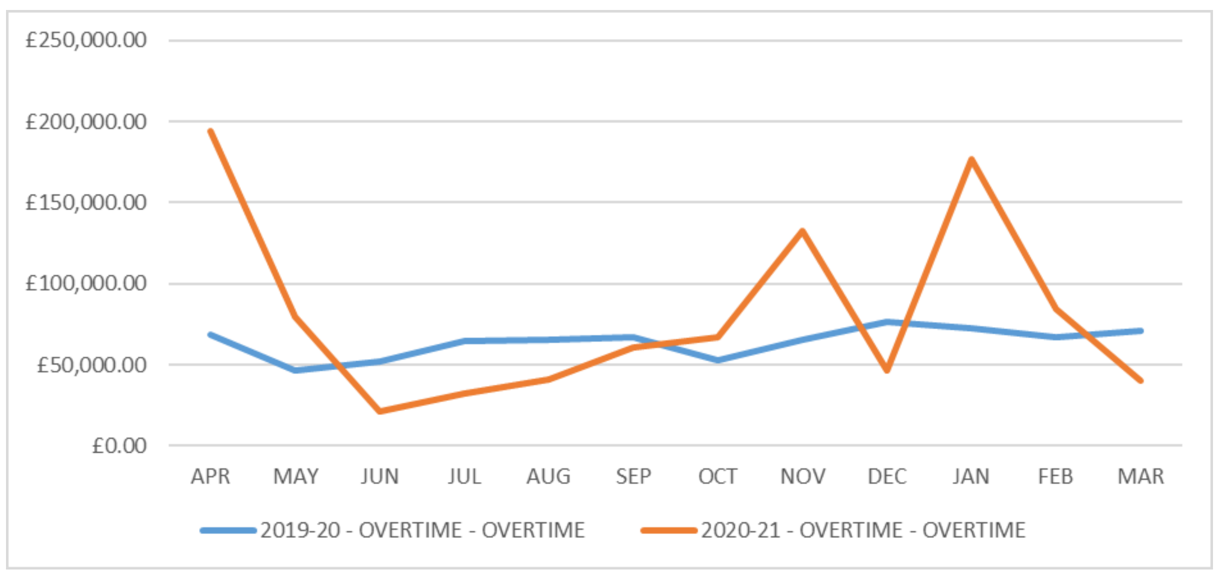
Table 7 Temporary Staffing fill rates

	RN Hours Requested	RN NHSP Filled Hours	RN % NHSP Filled Hours	RN Agency Filled Hours	RN % Agency Filled Hours	HCA Hours Requested	HCA NHSP Filled Hours	HCA % NHSP Filled Hours
Apr-20	14,622	6,390	43.70%	1,472	10.10%	15,974	13,278	83.10%
May-20	13,761	5,576	40.50%	1,429	10.40%	16,055	12,932	80.60%
Jun-20	11,750	4,851	41.30%	1,362	11.60%	14,231	11,767	82.70%
Jul-20	11,740	5,177	44.10%	1,258	10.70%	16,093	13,169	81.80%

Aug-20	12,163	5,820	47.90%	1,606	13.20%	16,482	14,687	89.10%
Sep-20	11,949	5,737	48.00%	1,630	13.60%	17,699	15,226	86.00%
Oct-20	13,765	5,850	42.50%	2,583	18.80%	20,635	16,045	77.80%
Nov-20	18,841	7,616	40.40%	2,515	13.40%	28,101	18,648	66.40%
Dec-20	19,256	6,393	33.20%	1,885	9.80%	24,975	15,051	60.30%
Jan-21	17,605	8,076	45.90%	1,962	11.10%	25,525	16,626	65.10%
Feb-21	15,404	7,131	46.30%	2,278	14.80%	19,085	13,281	69.60%
Mar-21	17,928	8,492	47.40%	2,452	13.70%	20,243	14,559	71.90%
Total	**178,784**	**77,109**	**43.43%**	**22,432**	**12.60%**	**235,098**	**175,269**	**76.20%**

Chart 7 below shows the overtime expenditure for Nursing and Midwifery staff. It can be seen that whilst some reduction between June – September 2020, there has been some significant spikes in overtime expenditure in April, November and January compared to a more consistent spend in 2019/20. The months of surge in expenditure during 2020/21 is aligned to the peaks in activity and sickness absence as part of the Covid-19 pandemic.

Chart 4 – N&M Overtime expenditure



5.6.10 <u>Electronic Rostering</u>

The progress of the Health Roster Implementation Project was significantly impacted by the covid-19 pandemic, however the project was completed in December 2020, with the understanding that continued work is required in some areas. The project resulted in the successful implementation of around 4000 clinical and non-clinical staff across all staff groups in the organisation, and ensures electronic payroll processes are in place removing the requirement for paper SVLs transferring between departments.

Flexible rostering is in use across a number of services within each Care Group with significant timesaving implications for managers and benefits for staff. Staff in these areas can now request 100% off-duty in line with agreed rules and restrictions for that area or team. Further roll out is being scoped on other clinical areas and was discussed as part of the professional judgement panels as part of the annual workforce review.

Regular budget and demand template reviews with Ward Matrons, Senior Clinical Professionals (SCPs) and Finance Business Partners (FBPs) are undertaken to ensure available shifts in the system do not exceed planned budgeted establishment and that the available budget is used efficiently and effectively in areas where the template cannot be simply aligned to the budget.

In June 2020, a Professional Workforce Assurance Group was developed to meet monthly to oversee the compliance against E-Rostering key performance indicators alongside other workforce metrics, including Temporary Staffing and acuity data.

6. Allied Healthcare Professionals (AHPs)

Allied Health Professionals account for 8% of the total workforce within the trust.

6.1 The 14 Allied Health Professions form the third largest clinical workforce in health and care. Healthy Lives Care Group employ Occupational Therapists, Physiotherapists, Podiatrists, Dietitians and Speech and Language Therapists. Responsive Care Group employ the radiographers. Each profession works with children and adults. There is also contracted work with a private orthotic Service. The breadth of AHPs' skills and their reach across people's lives and organisation makes them ideally placed to support change and improvement.

6.2 **Allied health professionals into action: next chapter**

In 2017, NHSE published the first AHP strategy – Allied health professions (AHPs) into action, which identified the transformative potential of AHPs and provided a framework demonstrating how the AHP workforce could support the NHS. As AHPs, it set out collective commitments and priorities to deliver significant impacts for patients, their carers, and communities.

6.3 Two years later, the NHS Long Term Plan committed to *"further develop the national AHP strategy, AHPs into action, to focus on the delivery of the Long Term Plan".* After strategy development was paused in 2020 in response to the pandemic, work has now resumed in 2021 and the strategy to replace AHPs into action is currently being created. Due to the pandemic, engagement has moved to a virtual space. To ensure health inequalities are not exacerbated and the voice of key groups are missed, additional measures are being taken to ensure inclusion and support access. Recent documents, including the Kings Fund (as below) highlights the work that can be done by AHPs in tackling health inequalities across our communities.

My role in tackling health inequalities
A framework for allied health professionals

May 2021

6.4 All AHPs across Healthy Lives are aligned to Senior Clinical Professionals and they report directly to the Head of Specialist Services, integration and Partnerships. Progress has been made implementing key Lord Carter principles and work is ongoing on job planning and clinical supervision. E-rostering is in place for all AHP groups. Flexible working hours is supported to meet clinical and service demand. A key focus of recent work has been on the standardisation of practice inclusive of length of appointments/sessions and numbers of patients seen in those sessions. Radiographers are aligned top the Head of Radiography in Responsive Care with Operating Department Practitioners (ODPs) aligned to the SCP structure in Collaborative Care.

6.5 Education and career pathways are offered for all AHPs from apprenticeship through to registered practitioner and onwards. Working with Higher Education Institutions (HEI) to deliver a sustainable placement programme ensures an appropriate supply of graduates entering NHS Service over the next 3 years and on-going continuing professional development supporting the increased use of Advanced Practice roles. Locally Physiotherapy (PT) and Occupational Therapy (OT) institutions are launching apprenticeship programs in autumn 2021. Appointment of a fixed term AHP practice placement facilitator and AHP placement support officer is facilitating this work with the ambition of working differently and expanding placement programs.

6.6 Measures are in place to embed succession planning systematically across AHPs to ensure a sustainable workforce and to consider the impact of both an ageing population and an ageing workforce.

6.7 There are new and emerging roles including AHP Consultant, Advanced Practice and Extended Scope Practitioner roles that can and will address medical recruitment gaps, providing senior clinical leadership and decision-making. Advanced practice opportunities feature across all local AHP groups. 2022 will see the first Physiotherapist to qualify with an ACP certificate. This trailblazing role offers us opportunities to work across emergency, primary and community care services.

6.8 AHPs will continue to work with partners to further develop the role of the non-medical prescriber in order to afford patients a greater opportunity of quickly accessing the right medications. This will better utilise workforce across the health system with financial savings. Areas for development include MSK, Respiratory Physiotherapy, Podiatry, Nutrition, and Dietetics.

6.9 In partnership with nursing colleagues, AHPs are working in collaboration with primary care networks across Hartlepool and Stockton. The integrated single point of access and new integrated roles across professions provide a platform to develop relationships with partners in primary care as well as delivering more support to our care homes utilising the *Enhanced Health in Care Homes* framework.

6.10 Locally the Physiotherapy and Occupational therapy teams are part of a collaborative intermediate care service, delivering reablement and rehabilitation to our local population. The acute Physiotherapy and Occupational therapy teams work with ward based teams and experienced nursing staff to facilitate discharge planning and promote independence and recovery for patients who find themselves in an acute hospital bed. The integrated discharge team (IDT) is led by therapists and social workers (along with voluntary sector workforce) and they form part of the wider team facilitating patient flow on a daily basis. AHP Leaders are actively involved in a regional network looking at the development of evidence based safe staffing models within acute areas. Learning from nursing colleagues to implement a model that works best for patients and staff will be acknowledged.

6.11 Recent changes to the Operating model and collaboration between Care Groups provides opportunity to review workforce requirements across pathways. AHPs play a vital role in many patient pathways including stroke, respiratory, frailty and diabetes. Within each pathway, there are opportunities to review how we can deliver the best care in the right place at the right time. AHPs are key to this conversation and are often best placed to innovate and facilitate change. This approach to transformation could support the growth of AHP roles whilst developing services in line with the strategic aims of the Organisation.

6.12 The AHP workforce has taken a lead on multiple strands of digital work, showing innovation and collaboration to achieve real success. The Trust has an AHP digital lead who supports this work and is linked with national programmes.

There is an understanding that the move towards a more digitally enabled workforce and population could potentially widen the inequality gap. Work is being progressed by the AHP team to ensure a system approach to mitigate this impact to ensure integration with the population, recognising that patient choice will still be important.

6.13 <u>Workforce Data</u>

Table 8 below shows the current vacancy factor across AHP Services. It can be seen that there is a high vacancy factor within SALT, Podiatry and Diabetic Eye Screening where some focused recruitment is being explored. The two universities that provide courses in Diabetic Eye Screening are Newcastle and Leeds, the majority of students choose to stay within the teaching hospitals post qualifying.

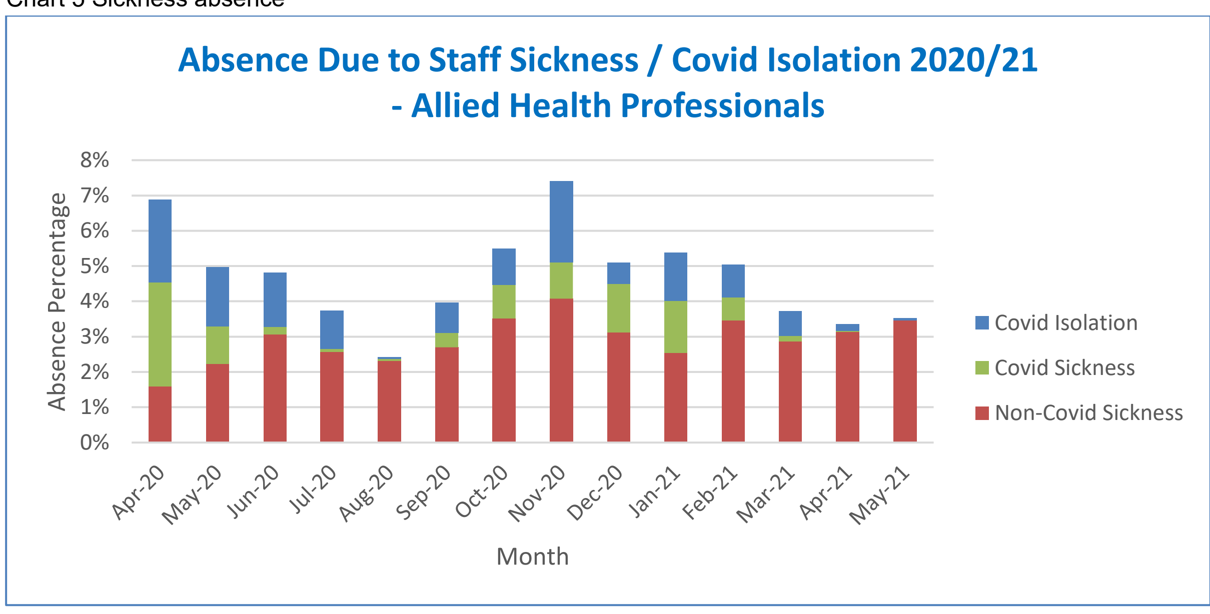
Table 8 Vacancy position

Profession	**Budgeted WTE**	**Vacancy**	**%**
Occupational Therapy	66.40	3.12	4.70%
Physiotherapy	163.61	2.38	1.45%
Nutrition & Dietetics	24.34	1.16	4.77%
SALT (Adults)	7.46	0.15	2.01%
SALT (Children)	68.34	23.69	34.66%
Podiatry	29.34	3.35	11.42%

Diabetic Eye Screening	5.67	1.55	27.34%
Audiology	11.05	0.07	0.63%
Radiology	106.68	7.85	7.3%

Sickness absence for AHPs from April 2020 to May 2021 can be seen below in chart 5. The average across those 13 months was 5%, which remains a challenge. April and November 2020 show the highest levels of sickness absence with a peak of 7.4%. It is important to note that this includes sickness due to Covid symptoms and staff absences due to Covid related isolation. The breakdown can be seen below.

Chart 5 Sickness absence



6.14 <u>Nutrition and Dietetics</u>

- A request to support an increased requirement for Dietetic provision to the Heptobillary (HPB) service was made due to the planned introduction of additional MDT clinics. There has been an increase in Dietetic referrals for the HPB service, without any additional resource. Dietetic input is imperative in this patient group, providing tailored specialised nutrition support advice alongside guidance on the use of pancreatic enzyme replacement therapy. Options are being explored to fund the additional 0.4wte Band 6 required to provide this service
- There is an aim to reduce prescribed treatments for Type 2 Diabetes in-patients referred to the Diabetes secondary care team. There is potential to expand the current service if successful, after exploration with CCG, could be open to GP referrals in the future. The pilot is continuing with the Type 2 Diabetes 'very low calorie diet' clinic
- Potential to explore dietetics role within Tissue Viability. Patients are currently picked up as part of a block contract in general clinics/ wards, team are looking at long term patient outcomes and costs in other Trusts
- There are two Dieticians currently undertaking the non-medical prescribing course (supplementary prescribing) to support extended roles in Pancreatic (HPB service as above), Diabetes and Critical Care. Pathways are clearly defined and supported by a medical prescriber with the use clinical management plans
- A regular review of skill mix continues to meet service needs. The team are currently undertaking a review of roles of staff required to deliver the Paediatric Nutrition & Dietetics service. The introduction of a B4 education role in the team has been well

received; the team have been able to increase the hours for this post by skill mixing a vacant B3 post
- Working closely with 3 local HEI's to develop, evaluate and implement new student training paperwork, creating a standardised approach and increasing the number of student training places to support future workforce development

6.15 Podiatry

- Despite recruitment challenges nationally for podiatrists, locally recruitment and retention of staff is positive
- As the acuity of patients requiring the support of Podiatry is changing, due to the increase in the Diabetic population, work is planned to review the skill mix within the team
- Competencies for staff are being developed for each Band of staff within the service
- There has been a new Clinical Team Lead appointed within the service

6.16 Physiotherapy (PT)

- Physiotherapy demand is growing and with the development of First Contact Practitioner (FCP) roles, supply may be a challenge
- Opportunities to deliver alternative workforce models in Respiratory care have been secured, with PT being afforded the opportunity to use community skills within acute care and vice versa
- The first round of apprenticeship PT students are planned for autumn 2021
- Provision of a high quality rotational experience for new graduates with opportunities that span Care Groups and pathways
- There is a plan to maintain, where appropriate, developing the private arms of services. Increasing the opportunity for staff to work within private practice and elite sport increases retention rate and is a draw for new graduates
- 2022 will see a PT qualify as an ACP, a unique competency profile enabling them to work across the boundaries of acute, community and primary care

6.17 Occupational Therapy (OT)

- We continue to provide a high quality rotational experience for new graduates with opportunities that span Care Groups and pathways
- Supporting the first round of apprenticeship OT students in autumn 2021
- Plan to further develop the local OT Forum, a platform for sharing good practice, staff development and to maintain professional contacts across areas
- Explore further investment in Specialist Posts to increase the number of staff and build on the work currently carried out by OTs in the Frailty Team, Hand therapy and Dementia
- Alternative workforce modelling has allowed the introduction of a qualified OT into the gastroenterology team to help support those patients with eating disorders
- From an acute care perspective to scope a role for an OT working in ITU to improve rehabilitation outcomes

6.18 Speech and Language Therapy (SLT)

- In addition to core staffing, the Childrens SLT service deliver a high number of external service level agreements within different settings (largely schools). Funding typically supports recruitment of 13 -14 staff. However, this significantly increases the demand for generalist therapists within the service and this is a continual pressure as staff within these posts are typically new graduates.
- Ongoing challenges around resilience in dysphagia. Increasing capacity in the team of dysphagia trained therapists to support resilience in the longer term within the Adult SLT team.
- There is agreement with South Tees to transfer some funding for a vacant specialist post in voice disorders. Despite caseload numbers being very small, we were unable to recruit to this post
- A mixed adult / children's post has been developed that is different to those generally advertised regionally which may support recruitment / retention

6.19 Radiology

- There are recruitment challenges both national and locally. This is recognised as a regional pressure, which has led to increased training numbers at Teesside University, which is the local training provider. Radiology continue to face a high level of Radiographer vacancies despite this increase in student numbers. Recruitment is targeted annually in advance of qualification
- Radiology AHPs are integral to the delivery of a safe and effective diagnostic service across both acute and community sites. Flexible working hours is integral to the service in order to meet both elective and acute demand
- The teams are led by a well-developed Advanced Practitioner structure which supports patient flow in addition to the timely reporting within several modalities to support the Radiologist team
- There is a well-developed skill mix with progression to Advanced Practice and the Ultrasound service is primarily AHP led. The “missing link” of progression from Band 4 Assistant Practitioner to Band 5 Radiographer has recently been introduced. This was driven by the regional Radiology group in conjunction with HENE and Teesside University. This will allow upskilling and investment in current staff and act as an alternative route into the profession
- In addition to the current Advanced Practitioner reporting roles, innovative roles such as leading and reporting cardiac CT, and DEXA reporting continue to support the wider service and reduce reliance on the medical workforce
- Recruitment of skilled specialist Radiographers continues to be a pressure and therefore training is undertaken within current Radiographer workforce which results in a pressure at Band 5 level
- There is a lack of availability of Bank/NHSP Radiographers and therefore shortfalls in workforce are very much reliant on overtime from existing workforce

6.20 Wheelchair Service

- There have been some staffing challenges in the past 12 months, which are now resolving. Experienced staff, including a Clinical Team Lead have been recruited externally
- The team plan to support both OT and Physiotherapy students, linking in and developing closer links with these respective services

6.21 Health Care Scientists

Audiology

- Staff retention within the service has been strong; however nationally there are challenges with regard to undergraduate training- this has an impact on recruitment to vacant posts. The service is supporting a current band 4 member of staff to complete her Audiologist training; this will then allow an uplift to band 5

Diabetic Eye Screening

- The service have reviewed the skill mix within the team and by uplifting and existing Band 4 to Band , the team have been able to develop a Band 5 role with additional leadership responsibilities, this is to allow for succession planning
- Following flexi- retirement of one of the team, the service has been able to recruit an experienced member of staff externally

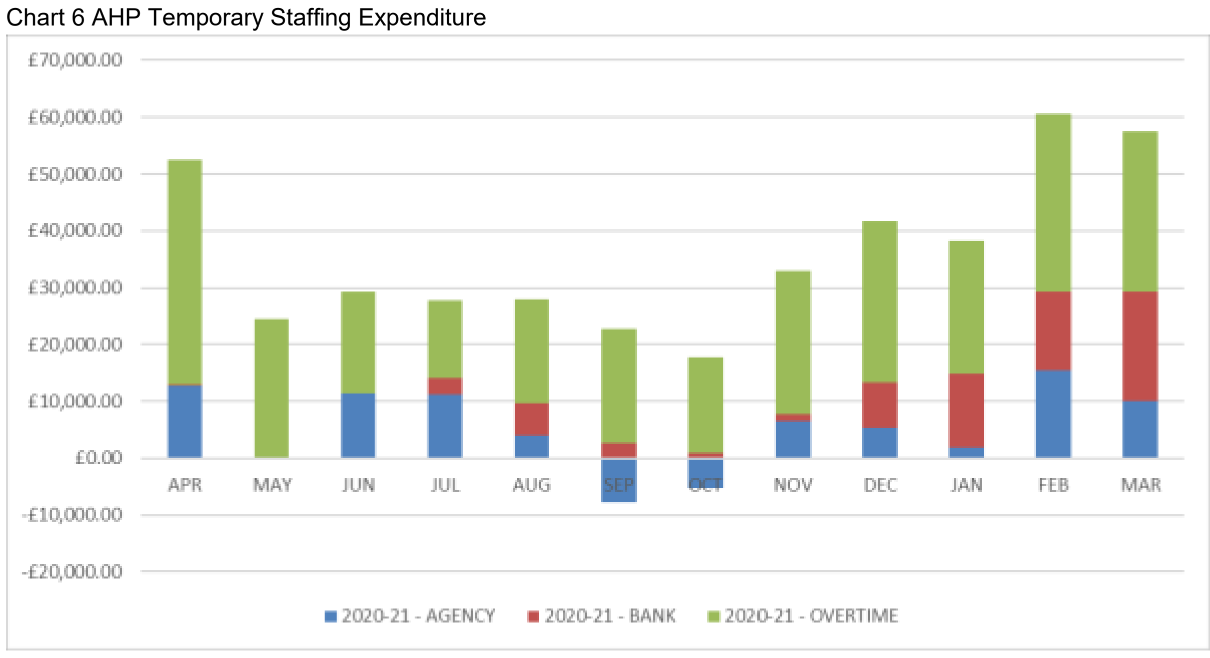
Community Dental Services

- There is currently an interim operational service manager in post whilst the longer term skill mix and leadership structure with the service is reviewed
- Skill mix is being reviewed within other aspects of the service, both within the admin team supporting the service, and also within the Oral Health Promotion service where a Band 4 post has been introduced

6.22 Temporary Staffing

Temporary staffing continues to be used to backfill gaps within the AHP workforce. Chart 6 below shows the expenditure 2020/21. It can be seen that the highest expenditure is consistently around overtime with a smaller bank expenditure. Progression has already been made to transition some AHP staff onto NHSP with a marked increase since December 2020. Further progress is continuing to transition AHP workforce across to NHSP with the aim to reduce overtime spend and increase the use of a lower bank cost.

Chart 6 AHP Temporary Staffing Expenditure



6.23 AHP Priorities

- To introduce evidence based safe staffing models for AHPs working within acute Hospital settings
- To effectively plan workforce requirements linked to the Long Term Plan to move rehabilitation into the community setting; define and enhance the capacity/capability within the community setting with a view to deliver a 'Home First' approach
- To work together to deliver the right care in the right place at the right time by the right person or professional
- To continue to represent AHPs at regional level to maintain connections across core and specialist service
- to ensure the workforce plans for all professions are connected and produced in partnership

7. Medical and Dental Workforce

Medical and Dental account for almost 10% of the total workforce within the Trust.

7.1 The Trust currently has a workforce of 600 doctors/dentists, which includes 66 doctors employed on zero hour's contracts to support with workforce shortfalls. A breakdown of the medical workforce, excluding zero hour workers, is shown in table 9.

Table 9: Medical and Dental Headcount June 2021

Grade	Headcount
	203
Specialty Doctors & Associate Specialists (SAS)	44
Trust Doctors	42
Doctors in Training (DiTs)	238
Dental	7
Total	**534**

7.2 The budgeted establishment for the medical workforce at M2 is 546.84 whole time equivalents (wte), according to the finance general ledger there are 522.58 wte in post, creating a shortfall of 24.26 wte between budgeted and contracted. However, this does not necessarily reflect the actual number of vacancies and rota gaps, which may differ due to changes in services, temporary rota, re-design, skill mix, or working restrictions. Therefore, actual vacancy data has been collected from the workforce team and directorates themselves as detailed in section 6.5.1.

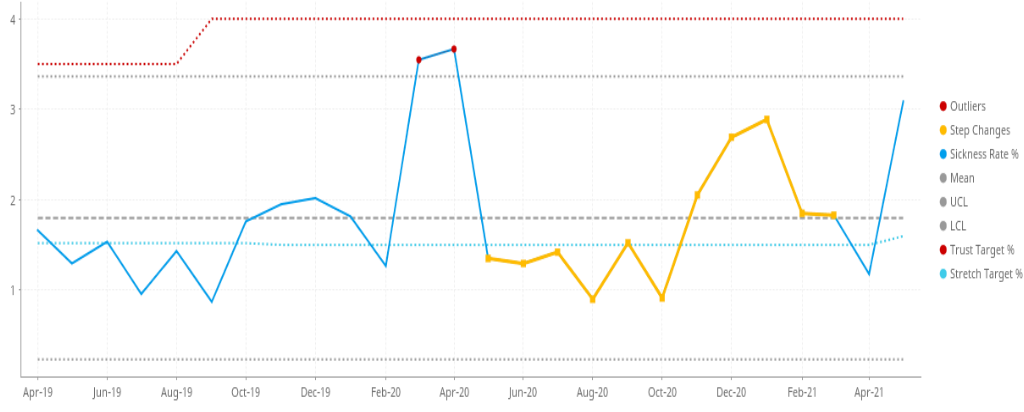
7.3 The average turnover rate for medical staff between April 2020 and March 2021 is 7.10%. This is calculated on the number of leavers as a percentage of the average headcount of medical staff over the 12 month rolling period. If attrition rate for non-voluntary leavers were included, the rate would increase to 9.95% as shown below in table 10. Figures exclude zero hour workers, flexi-retirees, and trainees who rotate between specialties or trusts every four to six months.

Table 10: Starters, Leavers and Turnover

M&D Staff Starters, Leavers and Turnover 2020-21					
Directorate	**Starters**	**Leavers**	**Voluntary**	**Involuntary**	**Combined**
345 Accident and Emergency Directorate	2	1	5.56%	0.00%	5.56%
345 Anaesthetics Directorate	6	4	9.09%	0.00%	9.09%
345 EAU/Ambulatory Directorate	0	1	10.00%	0.00%	10.00%
345 Endoscopy Directorate	1	1	0.00%	33.33%	33.33%
345 Healthy Lives Management Directorate	0		0.00%	0.00%	0.00%
345 In-Hospital Care (Healthy Lives) Directorate	0		0.00%	0.00%	0.00%
345 In-Hospital Care (Responsive Care) Directorate	2	2	4.60%	0.00%	4.60%
345 Medical Director Directorate	1		0.00%	0.00%	0.00%
345 Obstetrics and Gynaecology Directorate	1	1	5.88%	0.00%	5.88%
345 Orthopaedics Directorate	5	2	2.99%	2.99%	5.97%
345 Out of Hospital Care Directorate	1	1	8.33%	0.00%	8.33%
345 Paediatrics Directorate	1	2	6.90%	0.00%	6.90%
345 Pathology Directorate	3	2	19.05%	0.00%	19.05%
345 Radiology (Collaborative Care) Directorate	0		0.00%	0.00%	0.00%
345 Radiology (Responsive Care) Directorate	0	1	6.06%	0.00%	6.06%
345 Research and Development Directorate	0		0.00%	0.00%	0.00%
345 Resilience Directorate	1		0.00%	0.00%	0.00%
345 Surgery and Urology Directorate	7	7	9.52%	12.70%	22.22%
345 Workforce Directorate	1	3	22.22%	44.44%	66.67%
Grand Total	**32**	**28**	**7.10%**	**2.84%**	**9.95%**

7.4 The average sickness absence rate for Medical and Dental staff between April 2020 and March 2021 is 1.80%, lower than the Trust target of 4%. There was a spike in the absence rate in April 2020 and January 2021 due to the coronavirus pandemic, despite the spikes the figures continued to be below 4%. These figures, as seen below in chart 7, do not include reported sickness for trainees employed by the LET as the Trust does not hold this information centrally.

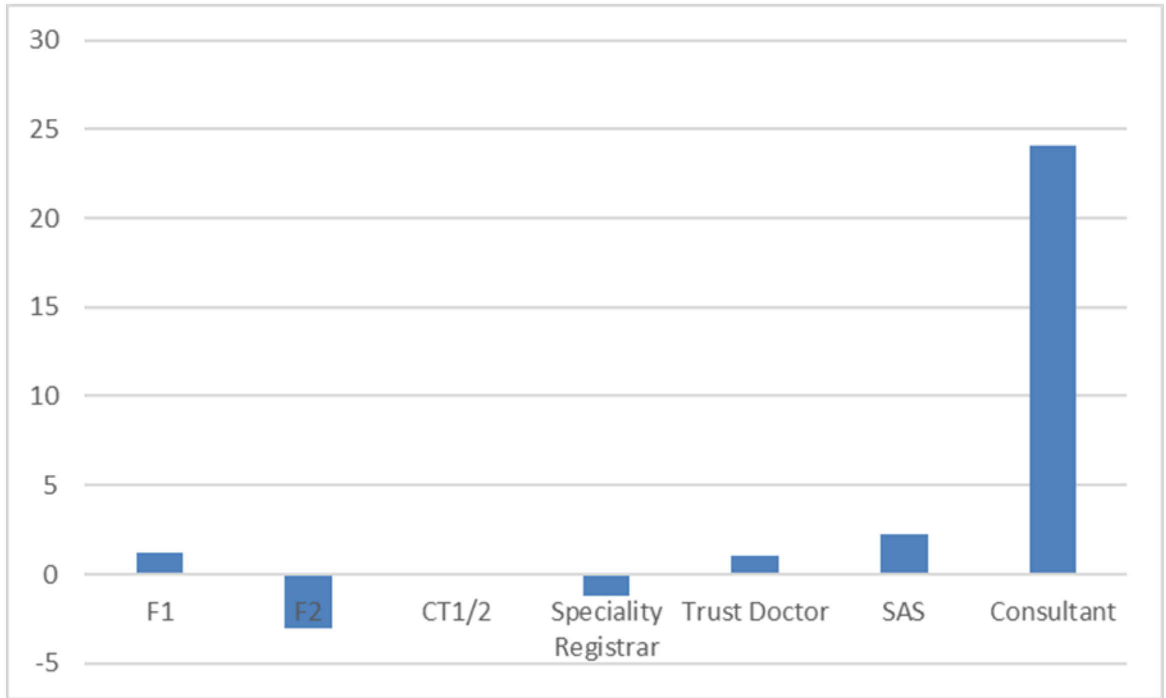
Chart 7: Medical and Dental Sickness Absence Rate



7.5 Vacancies and Recruitment

7.5.1 According to data collected from directorates, there are 24.26 WTE vacancies across the Trust, 24.03 WTE relate to consultant posts and 2.28 WTE to SAS grade posts. The graph in chart 8 shows the vacancy breakdown for all grades including locally employed doctors (LEDs) and doctors in training (DiT's).

Chart 8: Medical and Dental Vacancies (wte) – June 2021



7.5.2 The Trust continues to undertake a number of recruitment initiatives to address medical workforce shortages across all specialties. These include international recruitment schemes to attract workers from overseas, such as the Medical Training Initiative (MTI) scheme and international medical training fellowships.

7.5.3 In order to fill consultant vacancies, a number of areas are targeting trainees approaching completion of their specialist training and about to achieve their 'certification of completion of specialist' training (CCST).

7.5.4 Other initiatives continue including development of medical associate roles (MAPs) to support the medical workforce; such as advanced critical care practitioners, surgical care practitioners, physician's associates, and physician's assistants. These healthcare professionals work alongside doctors and can help ease workload pressures by assisting with certain duties. They can also provide some cover and stabilisation during trainee rotational periods and support trainee doctors in attending training, clinics, and theatres. The General Medical Council (GMC) will be taking on the regulation of Physician Associates and Anaesthesia Associates.

7.5.5 The Trust continues to undertake a number of recruitment initiatives to address medical workforce shortages across all specialties. These include international

recruitment schemes to attract workers from overseas, such as the Medical Training Initiative (MTI) scheme and international medical training fellowships.

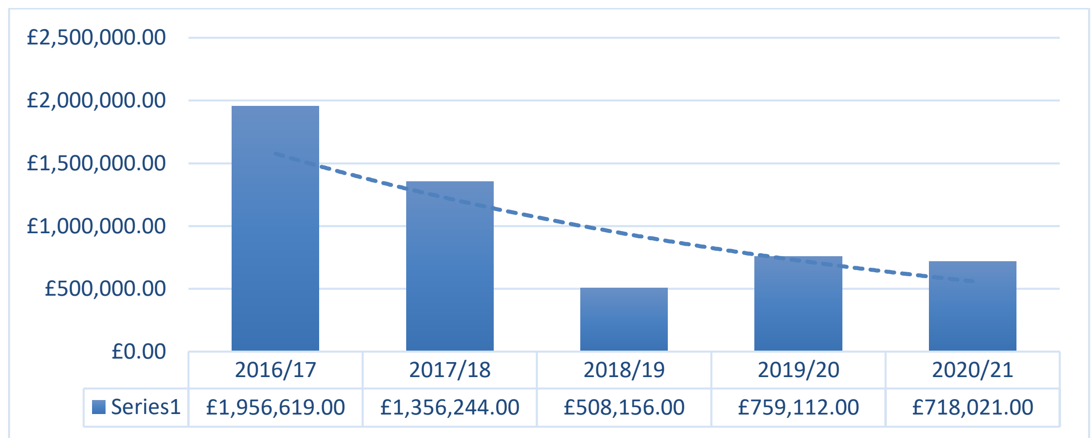
7.5.6 In order to fill consultant vacancies, a number of areas are targeting trainees approaching completion of their specialist training and about to achieve their 'certification of completion of specialist' training (CCST).

7.5.7 Other initiatives include development of medical associate roles (MAPs) to support the medical workforce; such as advanced critical care practitioners, surgical care practitioners, physician's associates, and physician's assistants. These healthcare professionals work alongside doctors and can help ease workload pressures by assisting with certain duties. They can also provide some cover and stabilisation during trainee rotational periods and support trainee doctors in attending training, clinics, and theatres. The General Medical Council (GMC) will be taking on the regulation of Physician Associates and Anaesthesia Associates.

7.6 Temporary Staffing – Medical Locums

7.6.1 A total of 718k was spent on agency locums during 2020/21, a decrease of £36k when compared to 2019/20 expenditure. Chart 9 shows the expenditure trend over the last five years.

Chart 9: Medical and Dental agency spend



7.6.2 The largest proportion of spend (£201k) is attributable to the pandemic response and subsequent resilience measures. A further £425k is attributable to Pathology, Surgery and Urology, and Anaesthetics, which have held long-standing consultant and SAS grade vacancies.

7.6.3 Agency medical locums can command very high premium rates, to keep costs to a minimum the organisation has clear governance processes in place, which ensures all other options are fully explored before proceeding to agency.

7.6.4 The LET collaborative bank went live in December 2017 and provides cover for training grades and Trust equivalent grades. A total of 937 shifts were released to the bank between April 2020 - March 2021, 622 of these shifts were filled whilst 315 remained unfilled, providing a Trust fill rate of 66%.

7.6.5 The total 2019/2020 annual budget for medical and dental staff was £52.2m, the actual spend was £56.3m; an overspend of £4.1m. To help maintain

service delivery and patient safety, substantive staff and those on zero hour contracts work additional hours. Internal consultants have delivered a number of additional activities outside their agreed job plan.

7.7 Workforce Planning and Deployment

7.7.1 In response to the coronavirus pandemic, working patterns and duties have been amended at short notice to reflect any temporary service changes and ensure back-up cover for any related absences. The medical workforce has worked flexibly over the last year to support the Trust in this unprecedented time. The current job planning annual round has been temporarily paused and a new target date of August 2021 for full sign-off has been set by the Medical Director.

7.7.2 Despite the disruption caused by the pandemic, electronic rostering has continued to be rolled out to all doctors in training, providing visibility of the workforce and supporting effective deployment. Medicine, Emergency Medicine, Orthopaedics, Surgery, Anaesthetics, Paediatrics and Obstetrics and Gynaecology are all using electronic rostering, which provides mobile access to rosters and the ability to electronically request annual leave. These systems are also being used to roster on-call and record unavailability for consultants.

7.7.3 All rota templates have been amended to ensure compliance with the changes to working hour's limits and rest requirements outlined in the revised 2016 doctors in training contract. There were three rotas in Emergency Medicine, which did not meet the maximum of one weekend in three rule, two of which became compliant in August 2020, and the remaining outlier is compliant from August 2021. In line with the provisions in the contract, they have sought formal agreement to continue with a weekend frequency of 1 weekend in 2.67. In order to reduce the weekend frequency, they will need to increase the number of doctors who contribute to the out of hours' work.

7.8 Safe Working Hours

7.8.1 Our doctors and dentists have worked flexibly over the last 12-months to support the Trust in its response to the coronavirus pandemic. The Guardian continues to champion safe working practices and is currently working with leads to ensure compliance with working rules is maintained.

7.8.2 Exception reporting continues to be the mechanism used to highlight additional hours worked, non-compliance with safe working hours, lack of support, and missed educational opportunities. A total of 83 exceptions were submitted between April 2020 and March 2021, mainly by foundation year one trainees in medicine specialties for additional hours worked.

7.8.3 NHS Employers and the British Medical Association (BMA) have issued a joint statement on the application of the 2016 contract limits for the duration of the pandemic emergency. This statement provides guidance on where working hour's limits and rest requirements outlined in the terms and conditions of service (TCS) can be flexible. As the contract provisions are in place to ensure the health and safety of trainees, this should be as limited as possible and for as short a time as necessary. If required, it should be done in discussion with trainees and the Guardian of safe Working Hours.

7.9 Care Group Update: Healthy Lives

7.9.1 Obstetrics and Gynaecology has successfully recruited to two consultant vacancies, one of which will be made permanent form June 2021.

Vacancy for a Middle Grade Trust Doctor to be advertised June 2021 to replace an outgoing member of staff.

7.9.2 Paediatrics currently has 2.0WTE vacancies in acute and community care settings. These vacancies are being advertised as temporary for 6 months while the service completes a review of the workforce. Currently we have a reciprocal agreement with South Tees who are supporting North Tees and Hartlepool respiratory patients, whilst we are supporting South Tees cardiology patients.

7.9.3 Palliative Medicine is currently experiencing long-term sickness of 0.65WTE, with a Consultant 0.7wte due to return from maternity in the next month. Work has been completed on how best to deploy the team, which included plan-do-study-act cycles around increasing the profile of the in-hospital team. Work is being undertaken around discussing with system partners the Tees wide Consultant on call process to look at making this more robust.

7.9.4 Community Dental Services currently has an interim Clinical Lead, who has a reduced clinical caseload as they are undertaking the leadership role. There is a vacant Consultant Post in Special Care Dentistry. The service is working with the Care Group to review options to recruit to this post. There is a regional shortage of Special Care Dentists. The service has 0.5 wte rotational Dental Core Trainee post, which is shared with Durham & Darlington CDS, and has 0.2wte fixed term post, which is a specialist post in Paediatric dentistry.

7.10 Care Group Update: Responsive Care

7.10.1 Emergency Medicine continues to have difficulty in recruiting into consultant vacancies. The position had improved to 3.32 WTE vacancies following the extension of the locum consultant and the recruitment into a cross site-working consultant between NT&HFT and JCUH. However, the locum consultant has offered notice and is due to leave in late July. The situation has been further challenged in regards to covering maternity leave and some long-term sickness. A post has recently been advertised, as there has been an expression of interest from one of the specialty doctors, if successful this post would commence in September. The department will continue to advertise the posts in the hope of attracting qualifying trainees and do consider numerous options to generate interest.

7.10.2 In addition to the consultant vacancies, the department has gaps in the associate specialty and specialty doctor rotas. This situation has improved slightly in May with the appointment into one post; another post will potentially be filled in September. Any gaps are covered by the substantive workforce and regional bank, this does prove challenging due to availability of resource to support. The CT3 position is relatively stable.

7.10.3 Trainee rotas have previously not met the maximum of one weekend in three rule. The current situation of 1 weekend in 2.67 is due to change in September when the rota will be compliant. Doctors in Training gaps will remain. The

position is supported by the Advanced Nurse practitioners and Physicians Associates.

7.10.4 Medicine currently have consultant vacancies in Stroke and Diabetes, with a further in Elderly Medicine. One Stroke consultant vacancy has been successfully appointed into. The Locum Cardiologist has now been appointed into a substantive post. In addition, we have been able to appoint an additional Gastroenterologist. A small element of long-term sickness is being supported by the substantive consultants.

7.10.5 The introduction of the new training programme for doctors in training with a 3-month rotation into Critical Care will result in some rota gaps. Initially in Respiratory followed by Gastroenterology. Proactive appointment into Advance Nurse Practitioner posts to cover will alleviated some of the pressure. Attempts to cover any rota gaps for trainees is achieved with the availability of internal locums and regional bank. If this approach is unsuccessful then attempts to cover using agency will be considered. Wards and areas continue to utilise the skills of both the Nurse Practitioners and Physicians Associates, with a new way of working to offer a more stable approach being explored.

7.10.6 Pathology have explored opportunities with recruitment agencies to help fill 3.8wte consultant vacancies, as continuous rolling adverts have failed to yield any suitable candidates via NHS jobs. Additional locum cover has been sought from agencies but has been extremely difficult to secure due to escalating rates and national workforce shortages. Substantive consultants are undertaking additional workload and activities to absorb some of the demand with some routine work outsourced to an external company to avoid delayed turnaround times. This additional workload presents a risk to the wellbeing of the existing consultant workforce and is being closely monitored.

7.10.7 Radiology recently appointed a qualifying radiology registrar into a vacant consultant post, the successful candidate commenced in post on 9th March 2020. As a shortage specialty, there are very few radiologists around to appoint. The service estimates an additional shortfall of four to six consultant radiologists on top of this vacancy to meet demands. However, due to recruitment challenges this is covered through internal locums and outsourcing. All consultants have home working stations to allow for reporting at home, increasing productivity. Regionally there has been support for an increase in registrar numbers, which will begin to positively affect consultant numbers in the next 3-5 years.

7.11 Care Group Update: Collaborative Care

7.11.1 Anaesthetics has 3wte consultant vacancies and 1wte SAS grade vacancies. Recruitment has been a challenge; however, the current position is particularly positive when compared with the previous position of 8 wte vacancies at SAS level. Despite these challenges the department have kept agency spend to a minimum due to internal locums cover, zero hour (bank) workers, and rota re-design.

7.11.2 The department has utilised recruitment agencies to assist in substantive recruitment, which has led to the appointment of three specialty doctors. In addition to this, two doctors have been appointed through Trust recruitment

processes. Pre-employment checks have taken longer to complete due to delays occurring because of covid, however successful candidates are now in post. . The department continues to have challenges in relation to age profiles of the consultant workforce and requests to reduce their on call commitment. Work is ongoing to identify an agreed phased reduction of on call responsibility. A workforce review is underway to establish longer-term plans for addressing workforce shortfalls.

7.11.3 Urology currently has appointed into the 1wte Consultant vacancy with a substantive post on a zero hours contract. This Consultant will now move onto a 10PA fixed term contract for six months. The long term 1wte SAS grade vacancy has also been appointed into substantively. The service had relied heavily on agency locum prior to this.

7.11.4 General surgery currently has appointed 2wte consultants, one in colorectal to facilitate a career break, and the other in breast/endocrine surgery as part of succession planning. Both candidates will start October 2021. The department has 2 wte Trust doctor vacancies and additional shifts/locums are supporting until the replacements start in July and August. The department have successfully recruited into Trust posts for August 2021.

7.11.5 Trauma and Orthopaedics currently are fully established. From August 2021, there will be one core trainee gap and 1 specialty-training gap. Interviews ongoing to replace with Trust posts on fixed term contracts. The department will no longer receive 3 GT trainees from August 2021. An additional doctor has been secured from the Foundation Programme and the other posts will be replaced by Trust posts going forward.

7.12 Workforce Challenges and Risks

7.12.1 The impact of COVID-19 continues to pose a number of challenges for the workforce; staff shortages due to sickness, imposed isolation and caring responsibilities, disruption or cancellation of elective activities and training activities. This could have an impact on anticipated learning and trainee progression if they fail to meet some of their curriculum requirements.

7.12.2 All rotations for Doctors in training have resumed as normal. Trust induction has been adjusted to ensure social distancing is maintained. All new Foundation Year 1 Doctors have an appointment arranged for fit testing and will be shown how to use personal protective equipment.

7.12.3 Overseas trainees due to start in August may be delayed because of the pandemic, resulting in vacancies and rota gaps. There are 37 overseas new starters across the region and the LET will keep Trusts updated on any potential risks to start dates. The Trust has been informed of 3 doctors whose start date is delayed due to Covid and as such will be unable to join the Trust until December. These posts will be filled by current DiT who started their rotations later and will therefore fil the gaps from August to December

7.12.4 Meeting the new requirements of the 2016 doctors in training contract was a challenge during 2020, particularly within Emergency Medicine where all three rotas needed to be re-designed. The junior and intermediate rotas became compliant from August 2020; however, agreement was reached at

LNC to continue to run the Registrar rota with a higher weekend frequency beyond the deadline for compliance. This rota has now been redesigned and will become compliant from August 2021.

7.13 Workforce Initiatives and Next Steps

7.13.1 The Director of Medical Education worked with directorates to produce a phased escalation plan for the re-deployment of doctors in training to ensure that it was centrally managed and in line with national guidelines.

7.13.2 There have been a number of changes made to ways of working across departments. This has included changes in rota patterns; staff working from home; flexing working hours over varying times of the day to ensure adherence to social distancing rules; and trainees being placed on standby duties to provide cover for last minute absences. Some areas have also introduced remote teaching sessions.

7.13.3 On the 16 April, the Trust welcomed a cohort of 18 newly qualified doctors from Newcastle Medical School as part of a special national drive to help the NHS respond to the coronavirus pandemic. These doctors have been deployed to medical wards under supervision. Where possible, the Medical Education Team also brought foundation trainees back into the Trust who were on placement in a non-hospital setting to support areas with staffing.

7.13.4 To ensure that doctors felt supported during this unprecedented time and able to feedback concerns, the scheduled junior doctors' forums went ahead using Microsoft Teams. The meeting was very well attended and positive feedback was received on the management and adjustments of rotas.

7.13.5 Other support offered to staff during the pandemic include but not limited to free car parking, free refreshments and lunches, break out areas away from work areas, support and wellbeing hotline, listening in action app, and vans for bands (sleeper bus) offering respite for clinicians.

7.13.6 The Trust continues to implement the recommendations from the fatigue and facilities charter. The doctors lounge is fully refurbished and is well utilised, the additional rest room is also available. The Trust is also working towards implementation of recommendations outlined in the rostering best practice guidance, and the SAS charter. This will help improve the working environment, support training, support professional development, improve work life balance, and retain loyal trust doctors.

7.13.7 Further engagement with senior trainees to fill potential consultant vacancies, including consideration of generic engagement half-days. As well as international recruitment, including the MTI scheme, and international medical training fellowships to address trust doctor and SAS grade gaps.

7.13.8 Local Clinical Excellence awards (LCEA) have been halted because of the coronavirus pandemic in line with national guidance. This will enable clinicians and managers to focus on immediate priorities. Employers have been advised that the funding for this awards round should be redistributed equally among eligible consultants as a one-off, non-consolidated payment. This includes any money rolled over from the last two years.

7.13.9 The Annual Review of Competence Progression (ARCP) assessments for doctors in training normally takes place between May and July each year. In light of the pandemic, the Statutory Education Bodies considered the adjustments required to ensure the ARCP process could proceed this year. This included a reduction in portfolio requirements for trainees, temporary suspension of penultimate year assessments (PYAs), and changes to the format of the panel. Any adjustments were in line with the governing rules outlined in The Reference Guide for Postgraduate Foundation and Specialty Training in the UK

8. Conclusion

The purpose of this annual report is to provide the Board of Directors an overview of the professional workforce capacity and advice upon compliance with national guidance. The review provides assurance in relation to the ongoing work and actions identified within this report.

The Trust faces a number of workforce challenges and is monitoring the situation closely. There are a number of initiatives being taken to address issues, ensure continuity, and deliver safest patient services. Alternative staffing models are being explored; registered nurse, midwifery and un-registered nurse recruitment centres will continue to assist in reducing vacancy rates throughout the year.

The Trust continues to plan and take forward retention strategies for all staff groups.

Technology is being utilised and implemented to support workforce planning and ensure the workforce is being deployed effectively. It is also a key enabler in ensuring compliance with working hour's limits and rest requirements.

By introducing new roles, improving working conditions, and supporting flexibility the Trust hopes to attract, retain, and develop the workforce.

All of the efforts being undertaken contribute to ensuring there are workforce safeguards in place, the right staff, with the right skills are in the right place at the right time, whilst being financially sustainable.

9. Recommendations

The Board of Directors is asked to note:-

- the significant assurance provided within this report around safe Nursing, Midwifery, AHP and Medical staffing;
- the changes in workforce planning for the next annual board report;
- the impact of the covid-19 pandemic on both patient acuity and increased staff sickness; and
- the huge effort in response to unprecedented pressures created by covid-19 and the work undertaken to have safest staffing levels across the organisation.

Lindsey Robertson, Chief Nurse, Director of Patient Safety and Quality

Dr Deepak Dwarakanath, Medical Director

North Tees and Hartlepool NHS FT

Professional Workforce Review – May/June 2021

Care Group:	**Number of RN within 12 month registration:**
Ward/Department/Speciality:	**Number of RN with <5yrs service remaining:**
Funded bed base:	**Number of staff under practice restriction:**
Head of Nursing/Professional:	**Safe Care Live compliance %**
Senior Clinical Matron/Professional:	**Mandatory training compliance %**
Ward/Dept Matron/Manager:	**Appraisal compliance % 100%**
Ward/Dept Deputy Matron/Manager:	**Occupancy during SNCT data collection %**
	Current agreed headroom %

Staff Group	Current budget wte	Contracted wte	Vacancy wte	Parental leave	Sickness absence	Other leave
Band 7						
Band 6						
Band 5						
Band 4						
Band 3						
Band 2						
Total wte						

Safety and Quality data over previous 12 months (2020/2021)

Falls	Pressure	Infections	Compliments	Complaints	Friends and	Medication	Violent	Staffing

Ward/Dept layout, shift patterns and paid/unpaid break agreements	
Specific training requirements for the area/speciality	
Specialist/Advanced Practitioner input into the area/speciality	
Succession planning (requirements and plans)	
E-Rostering (KPI compliance)	
Use of temporary staffing/agency	
Use of additional hours/overtime	

Any national guidance / other factors to consider when planning establishment?		
CHPPD for Mar/Apr 2021	Required:	Actual:

Current budgeted total WTE total nurse establishment	Average of total WTE nurses recommended by multipliers following SNCT data collection	Variance of total recommended versus total currently budgeted
Workforce establishment and model proposals for May/Jun 2021 including rationale for proposals		
Summary of discussion at Professional Judgement Panel		

Name of staff present	Position/Job Title

Quality Impact Assessment (for any requested changes to the workforce profile):

	Yes/No (if yes complete all sections)	Risk description	Impact	Local risk (Yes/No)	Corporate risk (Yes/No)	Rating (Red/ Amber/ Green)	Mitigations	Post mitigation rating	KPI monitoring
Impact on quality (CQC/constitution and standards)?									
Impact on patient safety?									
Impact on clinical outcomes?									
Impact on patient experience?									
Impact on staff experience?									

Ward/Dept	Average total patients	Average total Level 0	Average total Level 1a	Average total Level 1b	Average total Level 2	Average total Level 3	Average of total WTE nurses recommended by multiplyers	Budgeted total WTE nurse establishment	Variance total recommended v total budget	Notes
9	10.26	5.59	3.47	4.94	0	0				
Multiplier		0.99	1.39	1.72	1.97	5.96				
Output		5.53	4.82	8.50	0.00	0.00	18.85	20.91	2.06	10.26 + 3.74 empty (level 0)
24	29.6	11	4.1	10.5	4.3	0				
Multiplier		0.99	1.39	1.72	1.97	5.96				
Output		10.89	5.70	18.06	8.47	0.00	43.12	37.16	-5.96	29.6 + 1.4 empty (level 0)
25	24.9	9.2	7.3	7.1	4.2	0				
Multiplier		0.99	1.39	1.72	1.97	5.96				
Output		9.11	10.15	12.21	8.27	0.00	39.74	37.16	-2.58	28 + 3.1 empty (level 0)
26	29.95	10.75	7.2	13.05	0	0				
Multiplier		0.99	1.39	1.72	1.97	5.96				
Output		10.64	10.01	22.45	0.00	0.00	43.10	34.01	-9.09	31 + 1.05 empty (level 0)
27	28.75	15.8	0.3	13.9	0	0				
Multiplier		0.99	1.39	1.72	1.97	5.96				
Output		15.64	0.42	23.91	0.00	0.00	39.97	37.15	-2.82	30 +1.25 empty (level 0)
28	27.1	22.9	0.15	8.4	0	0				
Multiplier		0.99	1.39	1.72	1.97	5.96				
Output		22.67	0.21	14.45	0.00	0.00	37.33	34.79	-2.54	31 + 3.9 empty (level 0)
30/SDU - Adult	17.1	6.15	10.3	3.9	0	0				
Multiplier		0.99	1.39	1.72	1.97	5.96				
Output		6.09	14.32	6.71	0.00	0.00	27.11	40.24	13.13	20 +2.9 empty (level 0)
30/SDU	17.1	6.15	10.3	3.9	0	0				
Multiplier - EAU		1.27	1.66	2.08	2.26	5.96				
Output		7.81	17.10	8.11	0.00	0.00	33.02	40.24	7.22	Using Emergency assessment unit multipliers
31	18.55	3.9	5.45	4.35	6.3	0				
Multiplier		0.99	1.39	1.72	1.97	5.96				
Output		3.86	7.58	7.48	12.41	0.00	31.33	35.4	4.07	20 + 1.45 empty (level 0)
32	16.6	6.55	1.55	11.95	0	0				
Multiplier		0.99	1.39	1.72	1.97	5.96				20 + 3.4 empty (level 0)
Output		6.48	2.15	20.55	0.00	0.00	29.19	45.26	16.07	Beds only open to 20 at time of data collection but budget based on 30 beds, average for 30 beds = 43.78wte
33	17.9	10	1.85	10.1	0	0				
Multiplier		0.99	1.39	1.72	1.97	5.96				
Output		9.90	2.57	17.37	0.00	0.00	29.84	25.48	-4.36	22 + 4.1 empty (level 0)
36	29.2	5.5	3.4	19.3	1.8	0				
Multiplier		0.99	1.39	1.72	1.97	5.96				
Output		5.45	4.73	33.20	3.55	0.00	46.91	34.56	-12.35	30 + 0.8 empty (level 0)
ACU/37	20.2	1	13.75	3.45	0.95	0				
Multiplier		0.99	1.39	1.72	1.97	5.96				
Output		0.99	19.11	5.93	1.87	0.00	27.91	25.65	-2.26	20 - 1 (level 0) = 19 bed base
38	14.95	3.65	3.25	10.1	0	0				
Multiplier		0.99	1.39	1.72	1.97	5.96				16 + 2.05 empty (level 0)
Output		3.61	4.52	17.37	0.00	0.00	25.50	19.98	-5.52	Removed 2wte from est (MDU staffing)
40	19.8	6.6	1.55	11.87	0	0				
Multiplier		0.99	1.39	1.72	1.97	5.96				20 +0.2 empty (level 0)
Output		6.53	2.15	20.42	0.00	0.00	29.10	34.51	5.41	Budget based on 30 beds - only open to 20 beds at time of data collection, average for 30 beds = 43.65wte
41	24.6	2.35	4.6	18.7	0.3	0				
Multiplier		0.99	1.39	1.72	1.97	5.96				
Output		2.33	6.39	32.16	0.59	0.00	41.48	37.18	-4.30	26 + 1.4 empty (level 0)
42	34.05	4.7	0.2	29.15	0	0				
Multiplier		0.99	1.39	1.72	1.97	5.96				
Output		4.65	0.28	50.14	0.00	0.00	55.07	40.43	-14.64	Budget based on 34 beds
EAU/Ambu	46.5	27.6	12.3	9.25	2.85	0				
Multiplier - EAU		1.27	1.66	2.08	2.26	5.96				52 + 5.5 empty (level 0)
Output		35.05	20.42	19.24	6.44	0.00	81.15	89.55	8.40	Data doesn't account for NP in budget and staffing of non inpatient areas (waiting areas).
										removed 11.89 band 6/7 roles coordinating
Paediatrics	16.7	14.4	1.1	4.1	0.3	0				
Multiplier - Paeds		1.9	2.32	2.38	2.59	5.89				20 + 3.3 empty (level 0)
Output		27.36	2.55	9.76	0.78	0.00	40.45	50.19	9.74	Data doesn't account for staffing PDU - new PIAU
SCBU	8.6	1.5	0	7.4	1.05	0.05				
Multiplier - Paeds		1.9	2.32	2.38	2.59	5.89				
Output		2.85	0.00	17.61	2.72	0.29	23.48	20.17	-3.31	10 + 1.4 empty (level 0)
ITU	12.5	3.5	0.15	0.5	3.85	8				
Multiplier		0.99	1.39	1.72	1.97	5.96				16 +3.5 empty (level 0)
Output		3.47	0.21	0.86	7.58	47.68	59.80	64.73	4.93	calculations considering B5 provision only, coordinator, team leads, admin and outreach removed.

Board of Directors

Title of report:	Capital Programme Performance Q1 – 2021/22							
Date:	29 July 2021							
Prepared by:	Steven Taylor, Assistant Director of Estates and Capital NT&HS LLP							
Executive sponsor:	Neil Atkinson, Director of Finance							
Purpose of the report	The purpose of this report is to provide the Board of Directors with an update as of 30 June 2021 (Quarter 1) on the progress of delivering the 2021/22 capital programme, along with the current forecast position, highlighting any risks in delivery.							
Action required:	Approve		Assurance		Discuss	X	Information	X
Strategic Objectives supported by this paper:	Putting our Population First		Valuing our People		Transforming our Services	X	Health and Wellbeing	

Which CQC Standards apply to this report	Safe	X	Caring		Effective	X	Responsive	X	Well Led	X

Executive Summary and the key issues for consideration/ decision:

Capital Programme Delivery 2021/22

The Trust has an overall capital programme of £17.0m for 2021/22.

	Capital Expenditure Plan 21/22 £'000
Respiratory ward reconfiguration	2,500
Estates	5,011
Medical Equipment	3,000
IT	1,128
Contingency	477
Internal	12,116
External	4,908
Grand total	**17,024**

At the end of month 3, the Trust incurred capital spend of £1.2m, which is £0.1m behind plan. This is a positive position at Q1.

Respiratory Support Unit (RSU)

The RSU business case for £2.5m was approved in May 2021 to upgrade the existing ward 24 respiratory ward into an RSU unit with specific enhancements to support the care of patients with major respiratory illnesses such as COVID 19 or Influenza. The unit will be designed with three flexible areas within the ward with the ability to escalate care and dedicate further sections as the clinical need requires.

The same design team and contractor have been appointed who successfully completed the recent A&E project on budget under significant time pressures. This project also comes with significant time pressures with the work anticipated to commence on site on 12th July and the unit targeted for completion by November 2021.

Forecast

The capital forecast for the year at June 2021 includes the capital accelerator approved bid £1.138m which is not cash backed, therefore creating a potential overspend. All other capital schemes are forecasting to plan.

Further capital bids

A review of the wider estates structure is being undertaken and an Estates Strategy / SOC developed. It is hoped that funding may become available following this review, which would help protect the Trust internal capital spend plan for 2021/2022.

Further capital bids have been submitted relating to Community Diagnostic Hub (jointly with South Tees) and the Laboratory Information Management System (LIMS). Further updates will be provided in due course.

How this report impacts on current risks or highlights new risks:

This report doesn't highlight any new risks.

Committees/groups where this item has been discussed	Capital and Revenue Management Group
Recommendation	The Board is asked to; • Note the contents of this report and the reported M3 capital position is broadly on plan.

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

29 July 2021

Capital Programme Performance Q1 2021/22

Report of the Director of Finance

1. Introduction / Background

1.1 The purpose of this paper is to provide an update as of 30 June 2021 (Quarter 1) on the progress of delivering the 2021/22 capital programme and also provide an update on any recent changes that have been announced nationally and regionally that will impact on the Trust's programme.

1.2 The NHS Improvement Compliance Framework requires that a minimum of 85% and a maximum of 115% of the original capital allocation should be spent on a monthly basis. Only goods and services that have been received or invoiced may be counted as expenditure.

2. Main content of report

2.1 The Trust has an overall capital programme of £17.0m for 2021/22. At the end of month 3, the Trust incurred capital spend of £1.2m, which is £0.1m behind plan. This is a positive position at Q1.

2.2 **Estates**

Total expenditure on Estates schemes is £0.7m at the end of June 2021 (including Respiratory Support Unit development) against a year to date budget of £0.6m, so ahead of plan.

2.3 **Medical Equipment**

Total expenditure on Medical Equipment schemes is £0.2m at the end of June 2021, against a year to date budget of £0.1m, so ahead of plan.

2.4 **Information and Technology Services and Digital Strategy**

Total expenditure on I&TS schemes is £0.2m at the end of June 2021, against a year to date budget of £0.3m, so slightly behind plan.

2.5 **Forecast 2021/22**

The capital forecast for the year at June 2021 includes the capital accelerator approved bid £1.38m which is not cash backed, therefore creating a potential overspend. All other capital schemes are forecasting to plan.

2.6 **Capital bids 2021/22**

A capital accelerator bid has been submitted across the ICS for £10m and has been approved by NHSE/I. For the Trust, this is total additional expenditure of £1.138m but is not cash backed and therefore will create an approved overspend against the Trust CDEL limit. Work is ongoing across the ICS to review this to ensure that future bids would provide funding.

A review of the wider estates structure is being undertaken and an Estates Strategy / SOC

developed. It is hoped that funding may become available following this review, which would help protect the Trust internal capital spend plan for 2020/2021.

Bids awaiting approval

- A joint ICP bid with South Tees Acute Hospitals Trust was submitted in May 2021 for a total of £8.5m relating to Community Diagnostic Hub proposals. The bid relates to improving population health outcomes, increasing diagnostic capacity, improving patient experience and productivity and efficiency. The outcome of the proposal is expected mid-August following a number of national reviews. Confirmation has been received with regards to the early adopter bids and there will be a total of approximately £900k funding, revenue only. This will be funded jointly between the Trust and South Tees Acute Hospitals NHS Foundation Trust and will be for the use of increasing capacity within existing services. A Task and Finish Group has been established to take this forward.

- A substantial capital bid for 2022/23 is being produced for a Community Diagnostic Hub and for a Pathology Laboratory Information Management System across five trusts for approximately £8.8m.

2.7 The overall detailed work-stream reports for Q1 are presented in **Appendix 1**.

2.8 The overall financial summary for the period to 30 June 2021 is presented at **Appendix 2**.

3. Recommendation

3.1 The Board is requested to receive this report and note the position on capital schemes up to 30 June 2021.

Neil Atkinson
Director of Finance

Prof. Graham Evans
Chief Information and Technology Officer/SIRO

Appendix 1 - Work Stream Reports

1. Estates Backlog Maintenance Programme

The 20/21 backlog maintenance capital allocation was broken down into categories and specific projects to target high and significant risk backlog issues. An overall programme covering all backlog projects was developed and project managers assigned for each project. A detailed spend profile project by project was developed. This allowed for monthly reporting against time and cost for the overall programme (as required by NHSI). £5.3m has been allocated to Backlog Maintenance and £2.5m has been allocated to the development of the Ward 24 Respiratory Support Unit (RSU).

Ambulatory Care Oxygen Capacity improvements: Work within Ambulatory Care was commenced and completed in June to increase the local oxygen capacity by nearly four fold (from £350 l/m to 1350 l/m). This work was split into 2 phases to minimise disruption to clinical services. The department also received a re-decoration, with lighting and other maintenance improvements also undertaken.

Theatre 7 Refurbishment UHNT: Theatre 7 obstetric theatre was the oldest theatre plant within the Trust estates and in need of refurbishment to avoid disruption to services. Work commenced on site in June and has progressed to be 90% complete by the end of June. The project is planned to be completed with the theatre fully operational by the 19th July. The theatre is equipped with 2 LED operating lights, 2 medical gas pendants and integrated and uninterrupted power supplies (IPS/UPS) to improve patient safety.

Theatre 1 Refurbishment UHNT: Theatre 1 refurbishment has been planned with Care Group 3 in Q1 to minimise disruption to theatre services. Theatre 1 refurbishment is a high priority from a backlog maintenance point of view as the theatre plant is shared by theatre 1 2 & 3. Any faults or downtime on this end of life plant risks affecting 3 theatres. The scope of the refurbishment works includes a dedicated ventilation plant for theatre 1 (reducing the above risk) and installation of IPS / UPS to improve patient safety. The design and procurement of the plant is planned to take place during Q2 with work on site planned to commence at the end of Q3 and be completed in early Q4.

The 5-year backlog plan includes the refurbish of two theatres per year for the remaining years of the 5-year programme. Discussions are ongoing to agree the programme with the elective care group to minimise disruption to catch up services.

Roofing Repairs: A multi-year programme continues to progress, awarded to Group Tegula Ltd following a mini-competition in FY20/21. The contract value is capped at £2m, and includes flexibility to address the high risks roofs and other roofs in dilapidated conditions. The project is anticipated to deliver further urgent roofing repairs within FY 2021/22. During Q1 roofing replacements were completed on Theatre plant-room roof and North Wing roof on the UHNT site. Work is planned for OPD department roof on the UHH site during Q2 and Q3 to maintain buildings in a safe and operational manner.

Roofing repairs will remain a feature of the backlog capital 5 year programme over the remaining years programme.

Concrete Repair Works - Tower Block UHNT: The scope of works will repair the damaged concrete, preventing structural damage to the building and apply a coloured protective coating guaranteed for 10 years. The total cost of the works is £455k, split over 2 years (£195K in year 1 and £260K in year 2). Overall, the project is now 90% complete, with the North, East and South elevations now complete. The year 2 works continue with the West elevation anticipated to be completed in early Q2.

Fire Alarm Replacement UHNT: Installation was completed in December 2020. The testing /commissioning of the system was completed in Q4. The existing system continues to be fully operational until the changeover takes place. The changeover will take place once the training has been completed for the fire response team members, to ensure staff are competent to use the new

system. Extensive briefing and communications have been undertaken within Care Groups, Trust Resilience Forum and Executive team to ensure the changeover is successfully managed. The Fire Brigade have also been informed of the planned changeover dates. The changeover is planned to be complete by the end of July.

Once the changeover has been completed the old system will be decommissioned and removed.

Fire Alarm Replacement UHH: The business case was approved in May 2020. Following an OJEU procurement tender, the project was awarded to TFS. The overall project cost is £1m, with £50K of spend in FY20/21 and the remaining spend in FY21/22. The installation is now 15% complete, with the majority of plant-rooms and estates areas complete. The project team is working closely with the clinical teams to arrange access to clinical areas and using installation methods agreed with Infection Prevention and Control. The installation is anticipated to be completed by the end of Q4 with staff training and change over anticipated to be in Q1 of 2022/23.

Endoscopy Scope Washer Replacement UHH: The business cased was approved in June 2021 to replace the aging end of life endoscopy washers within the Rutherford Morrison Unit (UHH). The existing washers are 13 years old and were planned to be replaced as part of the Backlog Maintenance capital programme in the FY2021/22. However, the equipment was becoming unreliable and to prevent disruption to clinical services the case was approved at Capital Revenue Management Group (CRMG) to replace the equipment in FY 2021/22 and fund the required £215K from the existing capital Backlog Maintenance allocation. The new endoscopy washers have been ordered and are anticipated to be installed in Q2.

Lift Refurbishment UHNT: The overall project completion was expected in February 2021 (from October 2020 due to Covid 19). Lift 1, 2, 3, 4, 5 and 6 on Tower block have been refurbished and have now been synchronized to improve the efficiency of response to landing calls and reduce energy usage and carbon emissions. The completion of the theatre goods lift replacement was delayed to minimize disruption to theatres services and is now expected to complete in early Q2 of 21/22 (was planned for end of Q1).

Replacement Of The Combined Heat And Power Unit (CHP) UHH: Work has been undertaken to scope and size the replacement of the end of life CHP unit on the UHH site. The CHP generates the electricity for the site and the waste heat from the engine is used to heat the hot water and heating requirement for site whilst reducing the energy bill for the Trust. As the challenge to achieve net zero carbon gathers pace, the unit will be designed to use a blend of hydrogen and natural gas to reduce carbon emissions when the gas network is capable of a blended supply. The plant will also form the resilient backup and provide flexibility to support future renewable energy plant, such as solar PV and ground source heat pumps (which cannot provide consistent energy 24/7). The new CHP will ensure energy is provided consistently when required on site. The CHP will be a part of the sites future energy mix to deliver net zero carbon. The procurement stage has commenced with a bidder day arranged for July and a new plant anticipated to be installed by the end of Q4.

6 Facet Survey UHNT: A 6 Facet survey has been commissioned by the Trust to be undertaken by WS Atkins Group and Faithful and Gould (Part of WS Atkins Group) for the UHNT site. This survey primarily provide independent expert advice on the current physical condition and remaining life of the existing building and engineering systems on the UHNT site. This information will be key to inform the Estates Redevelopment Strategy and provide certainty to the Trust when making major investment decisions going forward. The survey will also report on the functional suitability of the estate to fill future health functions, general compliance with current standards, fire safety and health and safety compliance of the built estate. An early indication structural report is due by the end of July with the full report due at the end of August.

2. Other Estates Capital Developments

Ward 24 Respiratory Support Unit (RSU): The business case was approved in May to upgrade the existing ward 24 respiratory ward into an RSU unit with specific enhancements to support the care of patients with major respiratory illnesses such as COVID 19 or Influenza. The unit will be designed with three flexible areas within the ward with the ability to escalate care and dedicate further sections as the clinical need requires.

The ward will include:-

- A 7 single bedroom specialist RSU area with 3 specific gowning lobbies for infectious patients, dedicated staff base, dedicated dirty utility and WC facilities for patients.
- The unit will have two dedicated ventilation plants providing 10 air changes / hour in line with the latest COVID 19 guidance and improving infection control standards.
- A significant increase in oxygen capability, increasing the existing 700l/m for the floor to 2000l/m for the floor.
- The design will significantly improve patient observation with the use of smart glass to all patient rooms.
- The design also includes the installation of specialist patient monitoring equipment in the RSU areas to allow staff to be provided with key information on the patients condition in real time.

The same design team and contractor have been appointed who successfully completed the recent A&E project on budget under significant time pressures. This project also comes with significant time pressures with the work anticipated to commence on site on 12th July and the unit targeted for completion by November, prior to winter pressures.

Endoscopy UHNT: External funding of £901k has been secured to form an 8th endoscopy room. The estates enabling works are quoted at £300k. Project design work has been undertaken and agreed. Strip out work commenced and completed in FY20/21, with construction of the dirty corridor to allow the department to operate normally. The room has a dedicated ventilation plant, IPS/UPS system to improve patient safety and the medical gases have been upgraded to the latest standards. The project was completed in June and the room is now fully operational.

Staff Recharge Hub Link Staircase From The Tees Dining Room (UHNT): As part of the 100 Leaders Challenge within the Trust and NTH Solutions, nominated candidates were asked to bring forward ideas to improve the estate for patients, visitor and staff. One of the early ideas that received significant support was to create a link from the Tees Dining room down to the staff recharge hub located on the floor below. This link would significantly improve access to the indoor and outdoor staff facilities within the recharge hub. The design team has been appointed to develop the plans in Q1.

3. Medical Equipment Replacement Programme

The Capital Medical Equipment Replacement Programme has been prioritised against an initial allocation of £3m, of which £206k has been spent to date. Items currently in progress are;

Iodine Seed Probe: An Iodine seed probe has been purchased, received and placed into service. This was given an urgent priority as the previous device failed leading to list cancellations.

During Q1 orders are placed for the following medical equipment:-

- **Dental Equipmen**t for the relocation of Guisborough dental into new premises.
- **Cardio Tocograph CTG** machines for recording fetal heartbeat and uterine contractions for Maternity assessment.
- **Nebuliser Compressors** used to provide the compressed air needed to atomise a drug for breathing via a nebuliser for Ward 24 Respiratory ward.
- **Wall mounted Otoscope/Ophthalmoscopes** for eye and ear examinations.
- **Tendon Hammers** for EAU.

The clinical requirements have been established for the following items of equipment that will be ordered in Q2:-

- **Sterility test** pump for the QC Labs.
- **Transcutaneous CO2 monitors** for CO2 monitoring in children.
- **Upper limb Stack** for Theatres.
- **Ventilators** for ITU.
- **Ionic RF Lesion Machine** for electrosurgery.
- **ECG machines** for heart function recording.
- **Bladder Scanners** for bladder function scanning.
- **TCI Infusion pumps** for Pain management**.**
- **Hoists** for assisting with patient manual handling.
- **Treadmill** for heart function testing Cardiology.

Trials are also underway with the clinical teams to determine the most appropriate equipment solutions for the following items:-

- **Operating tables** for UHH General surgery.
- **Ionic RF Lesion Machine** for electrosurgery at UHH.

4. Information and Technology Services (I&TS)

The current I&TS capital plan incorporates elements of the Trusts Information and Communications Technology (ICT) and broader Digital Programmes capital projects.

CISCO Network Upgrade: Now complete, this is a 5-year deal which incorporated a full upgrade of the wired network to the latest technology and replacement of the wireless network to support Trust-wide projects.

Desktop PC replacements: Now complete, this is a three-year contractual payment plan to replace aging desktop computers to allow migration to the warranted Windows 10 operating system.

TrakCare Hardware refresh: Now complete, this project was to replace the Infrastructure on which the TrakCare Electronic Patient Record (EPR) platform runs, ensuring continual reliability of the system and support.

Out of Hospital Services tablet replacement: To replace Out of Hospital services equipment which is an ongoing scheme, that has encountered some delivery delays due to the impact of the COVID pandemic.

Laptop replacement: This is an on-going scheme to replace laptops/mobile devices within the Trust on a rolling programme basis.

Networking Hardware / Infrastructure

- Network switch replacement – Ongoing scheme to upgrade and replace end-of-life hardware. Hartlepool core network to be upgraded from 4Tbps (Terabits per second) backbone speed to 12Tbps with supervisor 6T cards.
- Fibre Cable replacement – Ongoing scheme to replace the remaining legacy fibre cabling for both (North Tees and Hartlepool) data networks. New cabling will support higher data transfer rates of up to 10Gbps (Gigabits per second).
- UPS replacement – Ongoing scheme to maintain and replace UPS devices throughout the Trust that are used to provide uninterruptable power for ICT services.
- Firewall Switch replacement – Ongoing scheme to upgrade and replace end of life firewall hardware.
- Cyber Security – Vectra AI (Artificial intelligence) appliance to be upgraded at Hartlepool. Vectra AI is used to listen and monitor for network threats on all devices throughout the network.

Servers & Storage

- Server replacement – Ongoing scheme to replace end of life server hardware.
- File Storage – Dell / EMC Cyber Sense which is an off line cloud based backup storage service which enables the secure off site storage of data.

Telecommunications

- Video Conferencing expansion – Additional video conference facilities to support both Microsoft Teams (MS-Teams) and Cisco Meeting Service (CMS) collaboration, integration and interoperability.
- Switchboard Infrastructure – Refurbishment of critical switchboard facilities.

5. Digital Strategy – Electronic Patient Record

The '*Digital Hospital of Things*' programme, was initiated following success of the Trust being announced within the second wave of NHS Digital pioneers or 'fast followers' to the first wave of Global Digital Exemplars (GDE) Trusts. The aim of the national fast follower programme is to support Trusts who have the potential to reach a higher level of digital maturity within an enhanced timescale, allowing them to benefit from work already undertaken by the Global Digital Exemplar (GDE) Trusts.

The GDE Fast Follower (FF) programme enabled NTHFT to receive £5m of Public Dividend Capital (PDC) funding on a matched funding basis over a three-year programme, the associated funding payments being split into multiple milestones payable on delivery (and in arrears) of a specific set of outputs and outcomes being successfully delivered.

The Trust successfully completed the fifth and final milestone within the GDE programme in Q4 FY19/20. In delivering our planned digital ambitions outlined in our "*Digital Hospital of Things*" programme, the Trust achieved level 5-maturity status within the Healthcare Information and Management System Society (HIMSS) and Electronic Medical Record Adoption Model (EMRAM). It is our intention to move quickly toward an independently accredited HIMSS level 6/7 status.

FY2021/22 allocation is £2.03m, this includes approved underspend from FY2020/21 being carried forward. There is an acknowledgement that the majority of this spend being outside of the Digital Programme team control.

Below is a brief overview and update on schemes within the digital programme:

Maintenance Upgrade – The planned upgrade to TrakCare T2020, unfortunately this upgrade was aborted due to an unforeseen error in the final step of the upgrade process. The decision to roll-back the system in order to ensure minimum disruption to services was unavoidable. A revised go live date is being looked at which will likely be Sept 21 based on staff availability and operational pressure considerations.

The Great North Care Record (GNCR) - The regional Health Information Exchange (HIE), a core module of the GNCR continues to expand. – NTHFT initially went live on 17 March 2021 to view GP data, the HIE now includes acute, GP and Community data from across the region.

Gateshead Health NHS Foundation Trust, County Durham and Darlington together with Sunderland City Council (SCC) are the latest organisations contributing data to the Health Information Exchange (HIE). NTHFT also successfully achieved a go live during March 21 allowing the sharing of key data items, i.e. patient allergies, visits, appointments and demographic data.

The GNCR Team released the new version of the Cerner HIE on 1 June. The Digital Programme Team have completed the design for correspondence items. The functional specification for TrakCare is under development.

GNCR - Patient Engagement Platform (PEP) - The HIE integration for correspondence items to be used to provide documents to the PEP. Structured, Health Level Seven International (HL7) messages are available in the Trust Integration Engine (TIE) to provide the required Application Programming Interface (API) messages.

Closed Loop Medicines Administration (CLMA) – simulation exercise scheduled 12th July to run through the proof of concept (PoC) with clinical staff. Unfortunately, due to staffing pressures clinical staff were not able to attend. However, the PoC went ahead with the Project Team and pharmacy representative, a report capturing the findings will be shared with the wider teams for information.

Clinical Communication system – The Business Case providing options for Vocera (and another) is near completion, final figures awaited from finance and then can be issued to Care Groups for discussion of responsibility around revenue implications.

HealthCall – Prostate Cancer, Stratified follow-up functionality is now available in the test environment and successfully tested by the Digital Programmes team. The extract, which reflects the requirements for pulling PSA results from ICE and patient recall dates, through the TIE to NetCall has been complete.

Future process maps are in their first draft along with the user manual, pending sign off by the service. The next step is to have the functionality available within the HealthCall App, enabling delivery of the full Stratified follow-up process and allowing patients to fully access and manage their care. Digital Outpatients - Demonstration scheduled Friday 9th July. Long COVID - App developed locally based on Yorkshire/Newcastle screening tools. Service testing prior to deployment.

A&E Observation machines – this is a two phased approach, (a) central monitoring system to be installed and linked to the Mindray observation devices, (b) to provide an Interface between Mindray and TrakCare. First phase is now complete with the service being able to monitor observations centrally. Interface needs to wait until after the T2020 upgrade at which point will take approximately 11-20 days to develop and test the solution.

ITU TrakCare + Hardware – Business Case is being reviewed in readiness for submission.

Imprivata phase 2 – High level planning has commenced and recruitment of ICT role is underway in readiness for the implementation.

Theatre Electronic Prescribing Medicines Administration (EPMA) – all areas now live and handover to business as usual is complete. Project closure report submitted for approval from the Digital Programme Steering Group in July.

EPMA Phase 2 (includes Infusions and will remove all remaining cardex) - Steering Group re-established 1st July with revised Terms of reference. The roll-out approach has been agreed which is to roll-out in a number of separate 'build groups'. Build group one (consists of 12 enhancements) have been successfully tested and will be applied once the T2020 upgrade is in and change freeze lifted. A communication campaign will commence to support the roll out.

Active Clinical Notes (ACN).
Nursing Admission - Discovery Stage and Business change work stream ongoing. Key aspects of hardware Business Case presented at ACN Working Group on 8th June 2021. Design Approach work underway and the As Is process mapping and time in motion studies are continuing.

Clinical Pathways - Ongoing design of ED (Asthma, Hip Injury) / Paediatrics (Cerebral Palsy) /General (Community IP Referrals) / ITU (Admission Document, Daily Assessment Document) and Clinical Pathways (PE, DVT) Go lives are detailed in the programme plan, which is linked to the T2020 Upgrade.

EDM2 – The supplier, IMMJ, have reported they are having significant technical resourcing issues due to the number of NHS customer projects coming back on stream post lockdown. As our EDM2 implementation is heavily reliant on technical resource due to the migration and bespoke QC module development, this is likely to push our technical go live date to the end of the year. Discussions with IMMJ to develop a recovery plan and arrangements to offset the financial impact that the delay will cause are taking place.

All current and future state mapping is now complete and meetings with stakeholders to review and sign off are now underway.

CareScan+ (CS+) - Following the delivery of a comprehensive training programme to key staff within Hartlepool Theatres, CS+ went Live on 26/10/2020.Since this time, ther has been a steady and gradual deployment to all theatres across both North Tees and Hartlepool sites and recently commenced scanning in Cardiology Day Unit Cath Lab.

The system has been adopted with ease and users are now routinely scanned and collected data relating to location, patient, staff, products (implants and consumables), medical devices and CSSD instrument trays.

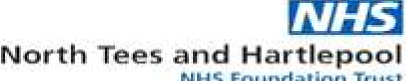
A business case to identify and secure funding to establish a permanent CS+/Scan4Safety team submitted and presented to the DET (Deputy Exec Team) early June 2021. The DET agreed funding to establish a small fixed term team until March 2022 with a review point in early 2022, this is to review the benefits achieved and to consider any progress made with external commercial opportunities with NHSX/NHS Digital and SCCL (Supply Chain Coordination Ltd) formally NHS Supply Chain.

Appendix 2 – Capital Programme Financial Position as at 30th June 2021

Capital Plan, Actual and Commitments

Reporting period: 1st April 2021 to 30th June 2021

	Annual Plan £'000's	YTD Plan £'000's	YTD Expenditure £'000	YTD Variance £'000	Total actual and forecast 2021/22 £'000's	Commitments 2020/21 £'000
INTERNALLY AND EXTERNALLY FUNDED CAPITAL SCHEMES AGREED BY ICS						
Estates Backlog						
Building Sub Structure	559	59	283	(224)	559	320
Compliance	1,554	165	120	45	1,554	1,044
Energy Conservation	530	56	0	56	530	4
Patient Environment	1,482	158	277	(119)	1,482	252
Service Developments	1,186	126	35	91	1,186	685
Estates Backlog Total	**5,311**	**565**	**716**	**(151)**	**5,311**	**2,305**
Medical Equipment						
Medical Equipment	3,000	87	207	(120)	3,000	366
Medical Equipment Total	**3,000**	**87**	**207**	**(120)**	**3,000**	**366**
IT						
ICT	1,128	279	89	190	1,128	439
IT Total	**1,128**	**279**	**89**	**190**	**1,128**	**439**
Respiratory Ward Configuration						
Respiratory Ward Configuration	2,500		6	(6)	2,500	1,924
Respiratory Ward Configuration Total	**2,500**	**0**	**6**	**(6)**	**2,500**	**1,924**
Service Developments						
Contingency	177	272	0	272	229	0
NENC Accelerator	0	0	0	0	1,138	
Service Developments Total	**177**	**272**	**0**	**272**	**1,367**	**0**
GDEFF						
GDEFF	2,065	38	122	(84)	2,013	63
GDEFF Total	**2,065**	**38**	**122**	**(84)**	**2,013**	**63**
Carescan						
Carescan	74	0	17	(17)	74	**59**
Carescan Total	74	0	17	**(17)**	**74**	**59**
Regional Digital Radiology						
Regional Digital Radiology	768	0	14	(14)	768	557
Regional Digital Radiology Total	**768**	**0**	**14**	**(14)**	**768**	**557**
ICS AGREED CONTROL TOTAL (£15,023m)	**15,023**	**1,241**	**1,170**	**71**	**16,161**	**5,713**
SCHEMES OUTWITH ICS AGREED CONTROL TOTAL						
Donated						
Donated	**399**	**99**	**64**	**35**	**399**	**29**
Donated Total	**399**	**99**	**64**	**35**	**399**	**29**
Digital Pathology						
Digital Pathology	1,602	0	0	0	1,602	0
Digital Pathology Total	**1,602**	**0**	**0**	**0**	**1,602**	**0**
EXTERNALLY FUNDED SCHEMES TOTAL	**2,001**	**99**	**64**	**35**	**2,001**	**29**
GRAND TOTAL	**17,024**	**1,340**	**1,235**	**105**	**18,162**	**5,742**



North Tees and Hartlepool NHS Foundation Trust
Board of Directors

<table>
<tr><td>Title of report:</td><td colspan="10">Integrated Compliance and Performance Report</td></tr>
<tr><td>Date:</td><td colspan="10">29 July 2021</td></tr>
<tr><td>Prepared by:</td><td colspan="10">Lindsey Wallace, Head of Planning, Performance and Development</td></tr>
<tr><td>Executive Sponsor:</td><td colspan="10">Lynne Taylor, Director of Planning and Performance
Lindsey Robertson, Chief Nurse/ Director of Patient Safety and Quality
Alan Sheppard, Chief People Officer
Neil Atkinson, Director of Finance</td></tr>
<tr><td>Purpose of the report</td><td colspan="10">To provide an overview of the integrated performance for compliance, quality, finance and workforce.</td></tr>
<tr><td>Action required:</td><td>Approve</td><td></td><td colspan="2">Assurance</td><td>x</td><td colspan="2">Discuss</td><td>x</td><td>Information</td><td>x</td></tr>
<tr><td>Strategic Objectives supported by this paper:</td><td>Putting our Population First</td><td>x</td><td colspan="2">Valuing People</td><td>x</td><td colspan="2">Transforming our Services</td><td></td><td>Health and Wellbeing</td><td>x</td></tr>
<tr><td>Which CQC Standards apply to this report</td><td>Safe</td><td>x</td><td>Caring</td><td>x</td><td>Effective</td><td>x</td><td>Responsive</td><td></td><td>Well Led</td><td>x</td></tr>
<tr><td colspan="11">Executive Summary and the key issues for consideration/ decision:</td></tr>
</table>

The report outlines the Trust's compliance against key access standards in June including quality, workforce and finance.

Key issues

- Focus continues on reducing the overall waiting list in relation to cancer, RTT and Diagnostics.
- Covid-19 pressures have increased significantly.
- Pre Covid-19 levels of activity noted across emergency and elective pathways.

Summary

- The pandemic continues to have an impact on a number of operational standards and overall efficiency and productivity. Performance continues to be monitored closely through the established internal governance structures and is comparable to national and regional position.
- Effective uses of resources remains a priority, with good progress made across a number of operational efficiency indicators.
- The diagnostic recovery against planned trajectory has been under pressure this month resulting in a rise in the overall waiting list and number of patients waiting more than 6 weeks.
- Ambulance handover delays have been noted which is reflective of the pressures within the emergency care department, with a similar picture across the system.
- The Trust continues to perform well against the quality and patient safety indicators, including HSMR/SHMI, infection control measures and dementia standards.
- The Trust has seen a decline in compliance against the Venous Thromboembolism standard. The Heads of Nursing are working with the clinical teams to improve compliance with assessment, focusing on key areas.
- Sickness has increased in June, with Covid contacts and associated isolation contributing to the higher absence rates.
- Additional resilience measures have been introduced to manage the increasing pressures, including senior management oversight.

How this report impacts on current risks or highlights new risks:	
Continuous and sustainable achievement of key access standards across elective, emergency and cancer pathways, alongside a number of variables outside of the control of the Trust within the context of system pressures and financial constraints and managing Covid-19 pressures, recovery, winter and staffing resource.	
Committees/groups where this item has been discussed	Executive Team Meeting Audit and Finance Committee Planning, Performance and Compliance Committee
Recommendation	The Board of Directors is asked to note: • The performance against the key operational, quality and workforce standards. • Acknowledge the significant on-going operational pressures and system risks to regulatory key performance indicators and the intense mitigation work that is being undertaken to address these going forward. • The impact of wave 3 Covid-19 pandemic.

NHS
North Tees and Hartlepool
NHS Foundation Trust

Integrated *Corporate* Report

July 2021

Responsible Directors

NHS
North Tees and Hartlepool
NHS Foundation Trust

Lynne Taylor
Director of Planning & Performance

Single Oversight Framework

Efficiency & Productivity

Lindsey Robertson
Chief Nurse and Director of Patient Safety & Quality

Safety & Quality

Alan Sheppard
Chief People Officer

Workforce

Neil Atkinson
Director of Finance

Finance

Introduction

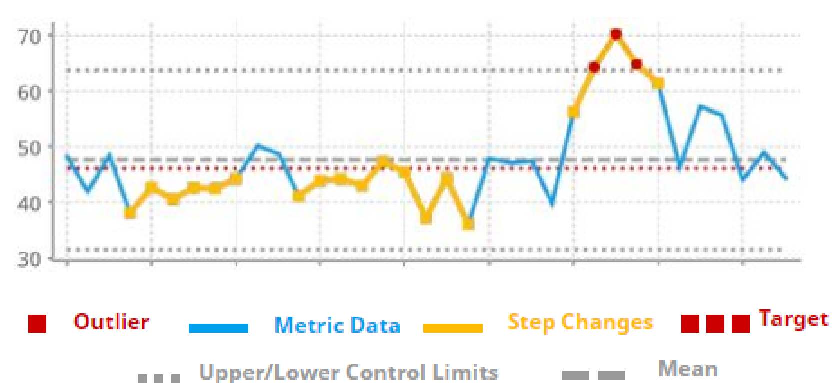
The Integrated Corporate Dashboard and Board report has been reviewed, redesigned and transformed into the Trusts new Business Intelligence tool, 'Yellowfin'. Performance highlights against a range of indicators including the Single Oversight Framework (SOF) and the Foundation Trust terms of licence remains. The report is for the month of June 2021 and outlines trend analysis against key Compliance indicators, Operational Efficiency and Productivity, Quality, Workforce and Finance.

Statistical Process Control (SPC) Charts

Outliers occur when a single point is outside of the Upper or Lower Control Limits.

A **Step Change** occurs when there are 4 or more consecutive points above or below the *mean*. The Trust chose 4 data points as opposed to the general rule of 7 points to enable a more timely response to variance in performance.

The *Upper and Lower control limits* adjust automatically so they area always 2 Standard Deviations from the *mean*.



Contextual Information

A third wave of the pandemic is in sight as the Trust begins to see a rise in the number of Covid-19 positive admissions from June onwards. Senior managers and matrons are managing a flexible bed base and staffing resource on a daily basis to manage the pressures, with increased command and control in place to manage resilience alongside recovery and business as usual.

The Trust has continued to deliver the safest, quality and timely services to its population, reviewing and transforming pathways to accommodate the challenges that have arisen.

The NHSIE System Oversight Framework 2021/22 has now been published, including a revised set of performance metrics. These new measures are under review and development, with the aim to include within the Integrated Performance Report in the future.

Executive Summary

SOF and Efficiency & Productivity

Key Messages

The Trust continues on its elective recovery journey, whilst managing capacity and demand pressures faced linked to the increased covid admissions and staff absence. The overall position for the majority of key standards, including RTT, cancer and diagnostics, remain comparable to national and regional position. Focus remains on reducing the overall waiting list position in line with national directive.

Despite these pressures, clinical teams are working hard to maintain business as usual alongside recovery, with strong oversight and management through the Trust's governance structures.

Operational efficiency and productivity remains a key focus of the Trust, ensuring outcome measures across Outpatients, Theatres and Emergency pathways continue to be monitored and managed closely. Additional high-level narrative is outlined within the individual sections of the report.

Changes to metrics

- 28-day faster diagnosis cancer standard
- Theatre metrics revised and reviewed and aligned to model hospital methodology

Safety & Quality

Key Messages

The overall position for the majority of key quality standards, including HSMR, infections, falls and complaints remain comparable to national and regional position, with high quality care maintained despite the pandemic pressures.

Whilst HSMR has shown a decrease from the rebased previous value of 97.90 to 95.54 (rebased April 2020 to March 2021) it remains within control limits with the same trend evident in the latest SHMI value.

Control of infection remains a priority with all 7 standards displaying natural cause variation and remain within control limits.

Stage 1 Informal complaints have seen a slight decrease in June 2021 from the previous reporting period, whilst Stage 2 - Meeting and Stage 3 Formal Letter have both seen a slight increase from the previous reported period.

Changes to metrics

No Standards have been amended in this months report.

Executive Summary

Workforce

WorkForce ICS network meetings have been established to support collaborative working, shared learning and consistency in approach across the ICS. The group meets monthly.

The Trust is working collaboratively with South Tees to introduce a consistent Job matching approach. South Tees are adopting our Trust policy and we are working towards introducing joint matching and evaluation panels.

A terms and conditions panel has been established to consider any requests from departments to amend payments for employees, which fall outside of nationally agreed terms and conditions. The panel ensures independent, equitable and consistent decision making taking into account service pressures and recruitment and retention issues.

As an open and inclusive employer, eight Staff Networks have been introduce, to ensure all staff voices are heard. Network Chairs have been appointed and there will be monthly meetings to discuss issues relevant to the specific groups.

The people development team continue to work collaboratively with various services across the trust. There has been a regular wellbeing topic of the month to ensure that there are a wealth of offers to staff. The regular staff newsletter continues, with plans to expand this to be more representative of the work taking place across the trust. Planning and preparations are underway for the upcoming flu vaccinations and Covid boosters. The team have been delivering wellbeing sessions across the trust to support staff. Work continues to build on learning from the staff survey.

As at 30 June 2021, the number of active volunteers has increased to 180. All returning volunteers and new recruits continue to be 'buddied up' with existing volunteers to support their transition into or back into the organisation. Interest remains positive, with 20 successful applications currently in progress resulting from interviews in June, in addition 37 people have expressed an interest and are due to commence the selection process.

The service continues to develop and grow in scope, with a number of initiatives continuing to progress across the organisation.

Finance

At month 3, the Trust is reporting an in-month surplus of £1.206m and a year to date surplus of £3.026m, which is £1.5m ahead of plan. This represents a continued improvement and assurance that the planned £3m surplus at the end of H1 will be delivered.

Elective Recovery Fund (ERF) income is being closely monitored and income is being offset by accrued expenditure due to the uncertainty relating to actual receipt of ERF income. From 1st July 2021, the achievement of ERF trajectories increased from 85% to 95%.

Total Group income in M3 is £31.909m (including expected ERF income).

Month 3 pay expenditure totalled £21.413m of which £0.251m is additional spend related to the Covid-19 response (including testing costs).

The M3 non-pay expenditure totalled £9.29m of which £0.060m is additional spend related to Covid-19.

The Month 3 YTD net contribution from Optimus is £0.072m against a plan of £0.026m (£0.046m ahead of plan) and the YTD net contribution from the LLP is £0.630m against a plan of £0.544m (£0.086m ahead of plan).

At Month 3, the Group cash balance is £55.4m, compared to a plan of £42.5m. This is ahead of plan due to improvements to the surplus position and movement in creditor days.

Month 3 capital expenditure is £1.2m of pre-committed items against a year-to-date plan of £1.3m, so is broadly on plan.

Key risks at M3 remains to be the uncertainty relating to ERF income and H2 funding arrangements, and implications of the White Paper.

Single Oversight Framework

Standard	Month	Performance	Standard	2 Year Trend
New Cancer Two Week Rule	May-21	94.16%	93.00%	
Breast Symptomatic Two Week Rule	May-21	93.26%	93.00%	
28-day Faster Diagnosis	May-21	84.20%	75.00%	
New Cancer 31 Days	May-21	99.15%	96.00%	
New Cancer 31 Days Subsequent Treatment (Drug Therapy)	May-21	100.00%	98.00%	
New Cancer 31 Days Subsequent Treatment (Surgery)	May-21	92.31%	94.00%	
New Cancer 62 Days	May-21	80.80%	85.00%	
New Cancer 62 Days (Screening)	May-21	73.77%	90.00%	
New Cancer 62 Days (Consultant Upgrade)	May-21	92.86%	85.00%	

Narrative

Cancer

The Trust reported an improved position against the Cancer Standards, achieving the two-week rule, breast symptomatic two-week rule and two of the 31-day standards. However, pressures continue to affect the cancer standards with some delays to pathways unavoidable. Capacity across the ICS, complexity, patient choice and swabbing requirements continue to impact on pathways.

The 62-day Referral to Treatment Standard reported at 80.80% (50.5 out of 62.5 patients treated within the 62-day timescale) compared to 76.38% the previous month. The regional average for May was 74.84%, with no Trust achieving the 85% target, demonstrating the continued pressures across the region. Nonetheless, at 80.80%, the Trust performed at its highest level since July 2020, showing positive signs of improvement and second highest across the region. Performance ranged from 70.71% to 83.84%.

The 62-day screening standard reflects the impact of increased activity, reporting at 73.77% (22.5 out of 30.5 patients treated) compared to the regional position of 76.02%.

The 31-Day 'Surgery' Standard reported at 92.31% against the 94% target, however noting this related to one breach of the standard. The Trust is now reporting against the 28-day faster diagnosis standard with compliance noted at 84.2% against the 75% standard. Regional reported at 79.92% with performance ranging from 70.08% to 90.13%.

The Trust continues to monitor and manage cancer pathways within the operational management structure, with a focus on the reduction of longer waiters alongside recovery of the waiting times standards.

Single Overseight Framework

Single Oversight Framework

Statistical Process Control (SPC) Charts

Cancer - 31 Day Drug Treatment

Month	Performance	Standard
May-21	100.00%	98.00%

Cancer - 31 Day Surgical Treatment

Month	Performance	Standard
May-21	92.31%	94.00%

Cancer - 62 Consultant Upgrade

Month	Performance	Standard
May-21	92.86%	85.00%

Cancer - 62 Days Screening

Month	Performance	Standard
May-21	73.77%	90.00%

Cancer - 62 Days

Month	Performance	Standard
May-21	80.80%	85.00%

Cancer - 31 Days

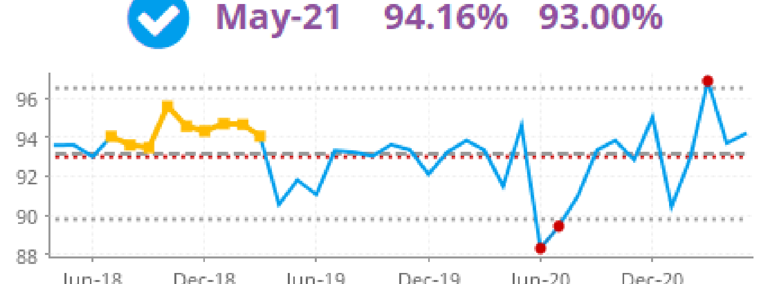
Month	Performance	Standard
May-21	99.15%	96.00%

Single Oversight Framework

Statistical Process Control (SPC) Charts

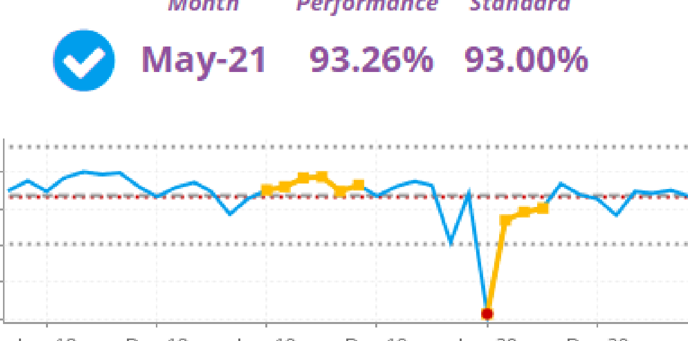
Cancer - 2 Week Rule

Month	*Performance*	*Standard*
May-21	**94.16%**	**93.00%**



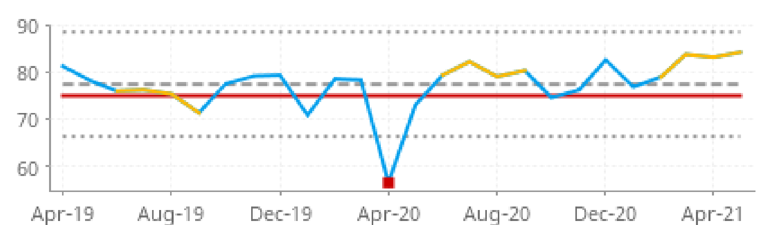
Cancer - Breast Symptomatic

Month	*Performance*	*Standard*
May-21	**93.26%**	**93.00%**



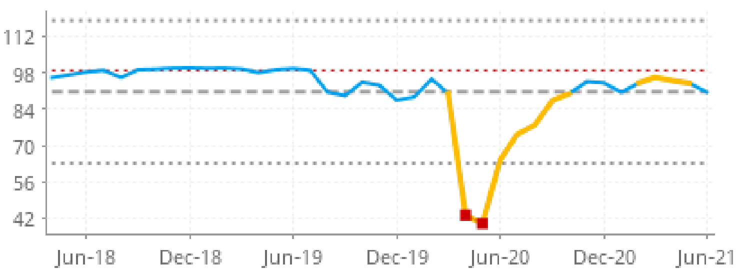
Cancer - 28day Faster Diagnosis

Month *Performance* *Standard*



Diagnostic Waiting Times

Month *Performance* *Standard*

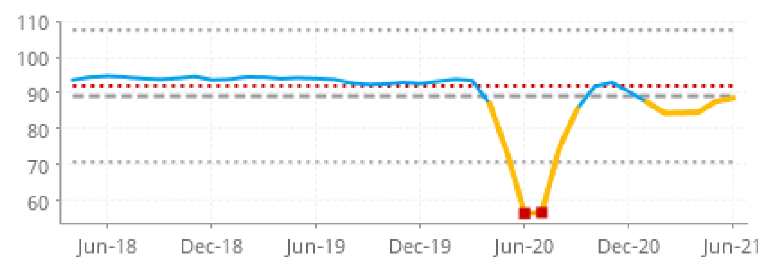


Single Oversight Framework

Statistical Process Control (SPC) Charts

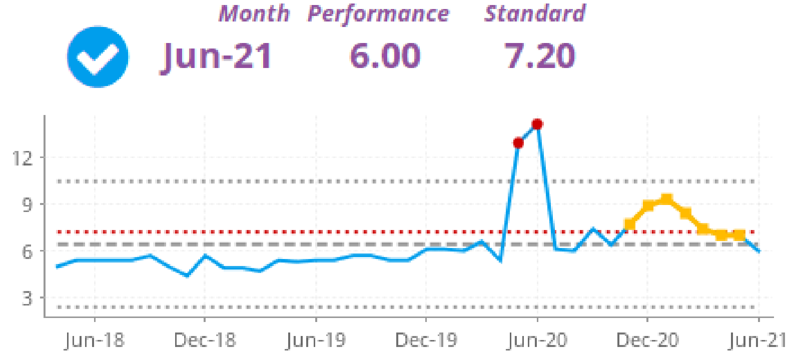
Referral To Treatment- Incomplete Pathways Wait (92%)

Month	Performance	Standard
Jun-21	88.59%	92.00%



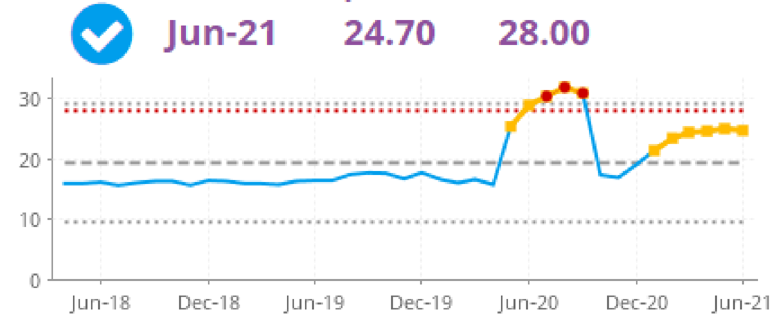
Referral To Treatment - Incomplete Pathways Wait (Median)

Month	Performance	Standard
Jun-21	6.00	7.20



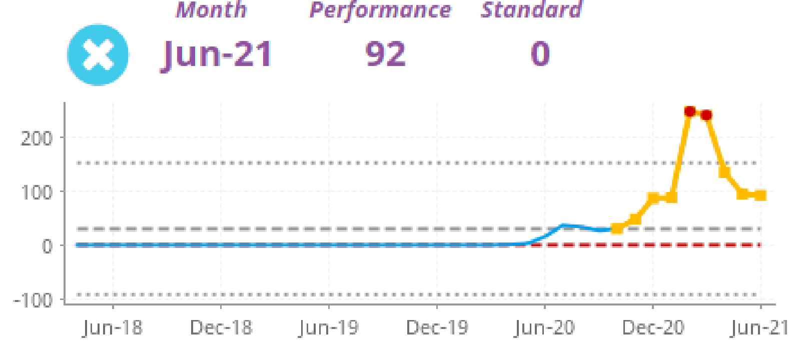
Referral To Treatment - Incomplete Pathways Wait (92nd percentile)

Month	Performance	Standard
Jun-21	24.70	28.00



Referral To Treatment- Incomplete Pathways Wait (>52 Week Wait)

Month	Performance	Standard
Jun-21	92	0

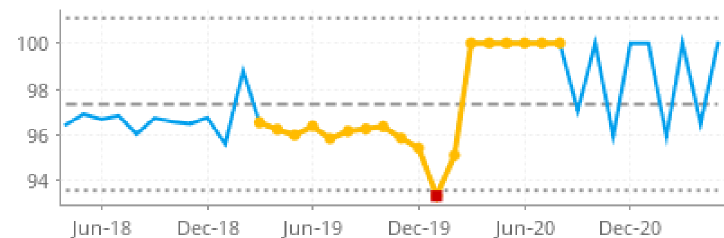


Single Oversight Framework

Statistical Process Control (SPC) Charts

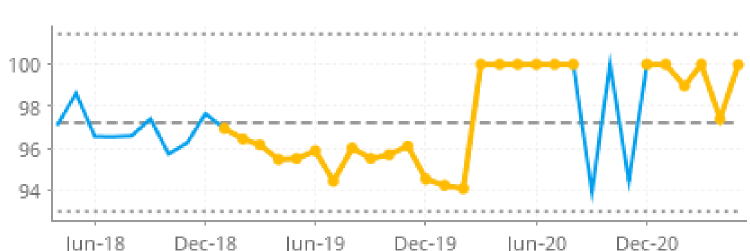
Community Information Dataset - Referral Information

Month	Performance	Standard
May-21	100.00%	50.00%



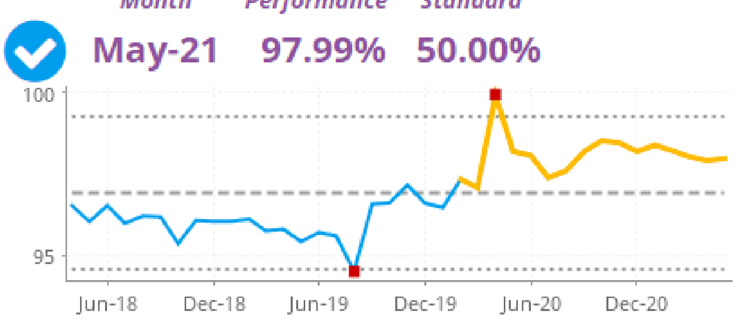
Community Information Dataset - Treatment Activity Information

Month	Performance	Standard
May-21	99.98%	50.00%



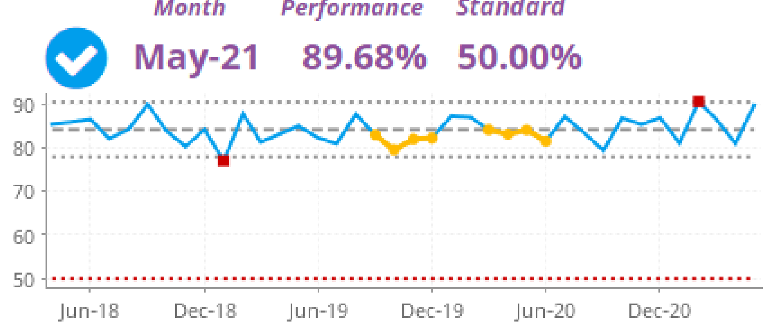
Community Information Dataset - Referral to Treatment Information

Month	Performance	Standard
May-21	97.99%	50.00%

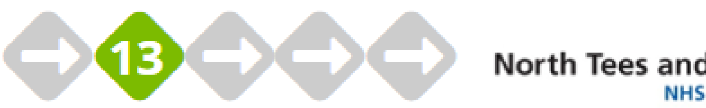


Community Information Dataset - End of Life

Month	Performance	Standard
May-21	89.68%	50.00%



Efficiency & Productivity



Standard	Month	Performance	Standard	Status
Outpatient Did Not Attend (New)	Jun-21	6.97%	7.20%	Achieved
Outpatient Did Not Attend (Review)	Jun-21	7.11%	9.00%	Achieved
Average Depth of Coding	Jun-21	6.17	3.01	Achieved
Length of Stay - Elective	Jun-21	1.99	3.14	Achieved
Length of Stay - Emergency	Jun-21	2.94	3.35	Achieved
Day Case Rate	Jun-21	86.49%	75.00%	Achieved
Pre-op Stays	Jun-21	0.93%	4.50%	Achieved
Trust Occupancy	Jun-21	89.92%	85.00%	Not achieved
Re-admissions Rate 30 Days (Elective and Emergency)	Apr-21	13.03%	7.70%	Not achieved

Narrative

Efficiencies

Despite Covid pressures impacting on key performance standards the Trust has effectively managed to maintain both efficiency and productivity.

DNA rates have continued to report at a reduced rate, potentially aligned to the positive impact of virtual appointments and despite the operational pressures, lengths of stay remain on track across both emergency and elective pathways.

Bed occupancy has seen a rise, reflecting the surge in demand across the region.

Readmissions

Readmission audits were temporarily paused during the pandemic in 2020/21. These have since been reinstated. The clinical teams undertake audits to understand avoidable and unavoidable admissions, with the aim to undertake improvement actions to reduce the risk of readmission. Findings are monitored via the Journey to Excellence operational group.

Efficiency & Productivity

Standard	Standard Achieved	Month	Performance	Standard	2 Year Trend
Electronic Discharge Summaries	✗	Jun-21	78.26%	95.00%	
Cesarean -Section Rates	✓	Jun-21	15.53%	15.60%	
Trolley Waits (over 12 hours)	✓	Jun-21	0	0	
Time to Initial Assessment (mean) Type 1 & 3	✓	Jun-21	10.68	15.00	
Number of Ambulance Handovers waiting more than 30 Mins	✗	Jun-21	30	0	
Number of Ambulance Handovers waiting more than 60 Mins	✗	Jun-21	9	0	
Super Stranded	✓	Jun-21	43	61	

Narrative

Ambulance handover

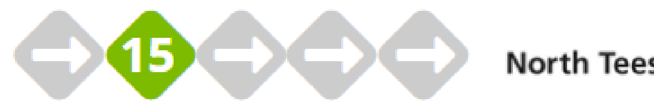
Ambulance handover delays are noted in June, reflective of increased pressures within the emergency care department. The department continues to review front of hours pathways, working closely with NEAS colleagues to ensure timely handover processes are in place.

The North East (NEAS reports) average handovers greater than 30 minutes reported at 156 (range 29-282), with the average over 60 minutes reporting at 17 (range 0 – 83).

Electronic Discharge Summaries (EDS)

A working group has been established to understand the decline in performance as noted within the SPC.

Efficiency & Productivity



Standard		Month	Performance	Standard	2 Year Trend
Touch Time Utilisation	✗	Jun-21	72.48%	80.00%	
Overrun Sessions	✓	Jun-21	26.63%	36.00%	
Session Utilisation	✗	Jun-21	88.49%	92.50%	
Cancelled on Day of Operation %	✓	Jun-21	6.06%	8.80%	
Cancelled procedure - Non medical	✓	Jun-21	0.37%	0.80%	
Not reappointed within 28days	✓	Jun-21	0	0	

Narrative

Theatre

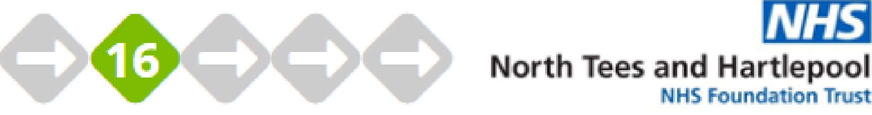
Revised infection control procedures (IPC) have been introduced into Theatres to reduce the potential impact of Covid-19 infections. This includes pre-operative swabbing of patients and pre-operative isolation.

All theatre metrics have been reviewed and realigned to reflect the same methodology, where possible, to that of the model hospital. SPCs generally indicate a positive position across most of the revised metrics, with controlled variability evident. Session utilisation is showing an upward trend with good recovery noted and likewise for 'touch time utilisation' (total operation time). Theatre scheduling has been reviewed to incorporate the revised IPC measures.

Stretch targets will be set accordingly to improve benchmarked position against appropriate standards.

Recovery is monitored on a weekly basis, including all activity taking place within the Independent Sector. Robust governance processes are in place to support prompt and appropriate decision-making, with the Perioperative Steering Group re-instated to review theatre productivity and efficiencies.

Efficiency & Productivity



Statistical Process Control (SPC) Charts

Outpatient Did not Attend (New)

Month	Performance	Standard
Jun-21	6.97%	7.20%

Length of Stay - Elective

Month	Performance	Standard
Jun-21	1.99	3.14

Outpatient Did Not Attend (Review)

Month	Performance	Standard
Jun-21	7.11%	9.00%

Length of Stay - Emergency

Month	Performance	Standard
Jun-21	2.94	3.35

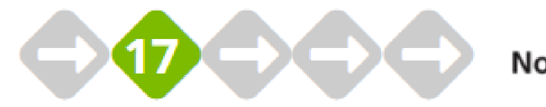
Average Depth of Coding

Month	Performance	Standard
Jun-21	6.17	3.01

Day Case Rate

Month	Performance	Standard
Jun-21	86.49%	75.00%

Efficiciency & Productivity



Statistical Process Control (SPC) Charts

Pre-op Stays

Month	Performance	Standard
Jun-21	0.93%	4.50%

Re-admissions Rate 30 Days (Elective and Emergency Admission)

Month	Performance	Standard
Apr-21	13.03%	7.70%

Electronic Discharge Summaries

Month	Performance	Standard
Jun-21	78.26%	95.0[illegible]

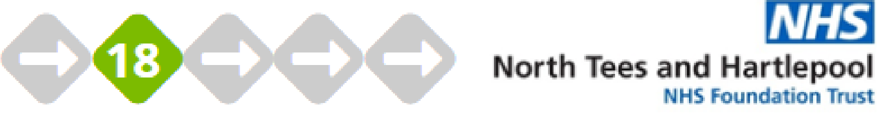
Cesarean-Section Rates

Month	Performance	Standard
Jun-21	15.53%	15.60%

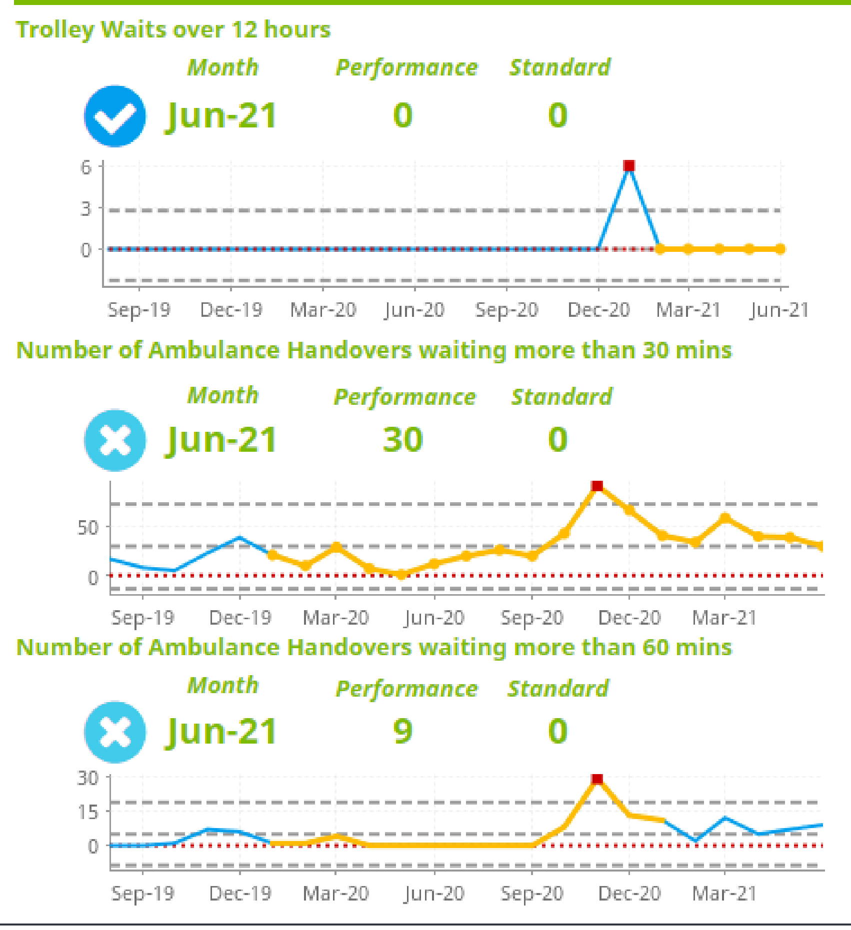
Trust Occupancy

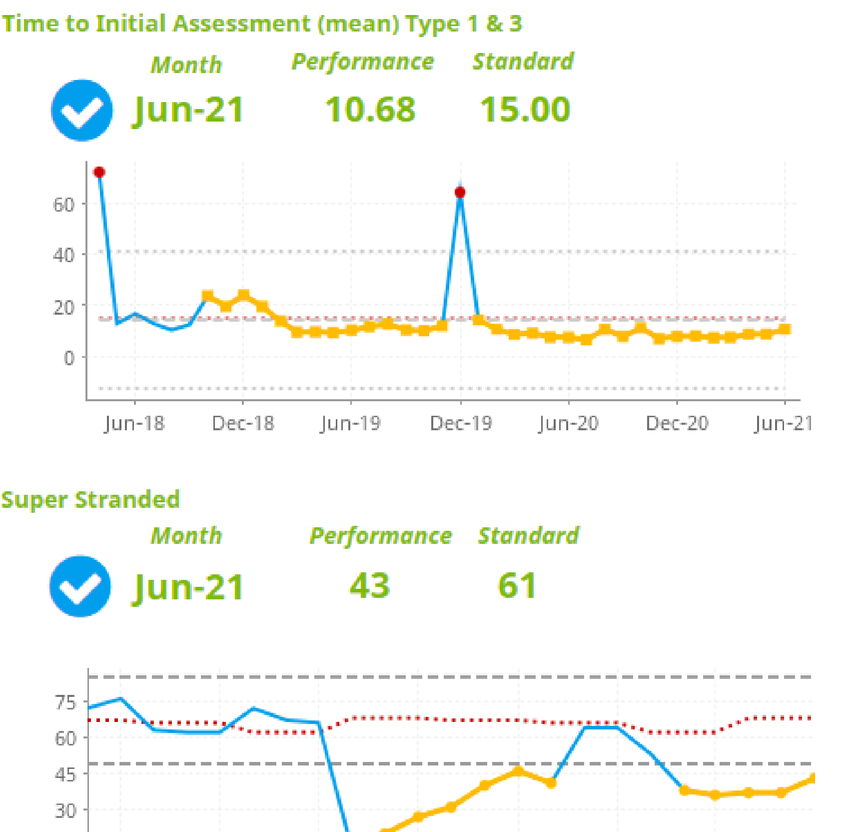
Month	Performance	Standard
Jun-21	89.92%	85.00%

Efficiency & Productivity

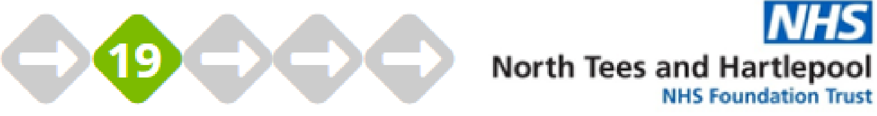


Statistical Process Control (SPC) Charts





Efficiency & Productivity



Statistical Process Control (SPC) Charts

Touch Time Utilisation

Month	Performance	Standard
Jun-21	72.48%	80.00%

Overrun Sessions

Month	Performance	Standard
Jun-21	26.63%	36.00%

Sessions Utilisation

Month	Performance	Standard
Jun-21	88.49%	92.50%

Cancelled on Day of Operation %

Month	Performance	Standard
Jun-21	6.06%	8.80%

Cancelled Procedure - Non Medical

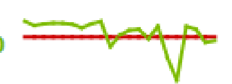
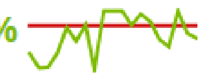
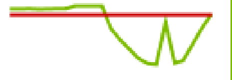
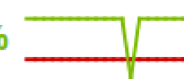
Month	Performance	Standard
Jun-21	0.37%	0.80%

Not reappointed within 28days

Month	Performance	Standard
Jun-21	0	0

Efficiency & Productivity

Standard | Standard Achieved

Standard		Month	Performance	Standard	2 Year Trend
TCS24 - % of Patients achieving improvement using a EQ5 validated assessment tool		Jun-21	92.17%	93.50%	
TCS35b - % of Wheelchair referrals not completed within 5 weeks but completed within 18 weeks		Jun-21	90.50%	90.00%	
Diabetic Retinopathy Screening		Jun-21	94.64%	95.00%	
The % of Patients treated within 18weeks of referral to Audiology		Jun-21	100.00%	95.00%	
Audiology non-admitted wait (92nd Percentile)		Jun-21	5.00	18.30	

Narrative

Diabetic Retinopathy Screening

Diabetic retinopathy screening has been affected by the pandemic, with all screening services paused during the first wave, in line with national guidance. Work is now on-going to address the backlog of invites, with the national focus shifting from achievement of the current standard to recovery. This will be achieved through a phased approach based on capacity. An upward trend is evident on SPC.

TCS Standards

Staffing issues in a relatively small team continues to impact on standards. Recruitment is underway and the availability of residential rehabilitation beds within the community settings is under review.

TCS 24 marginally missed the standard this month although improvement is noted. Pressures increased as the number of discharges. Q1 position reports at 93.08%.

The SPC in relation to TCS35 is beginning to show recovery. Delays in the main are around electric wheelchairs with capacity issues from the contractor side.

Efficiency & Productivity

Standard	Standard Achieved			
	Month	*Performance*	*Standard*	*2 year Trend*
PHQ - Emergency Admissions for Acute Conditions that should not usually require hosptial admission	Mar-20	110.50	155.41	
PHQ - Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	Mar-20	12.24	17.38	
PHQ - Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)	Mar-20	49.50	69.66	
PHQ - Unplanned hospitalision for respiratory tract infections in under 19s	Mar-20	23.36	37.82	
Stroke admisisons - 90% of time spent on dedicated stroke unit.	Jun-21	97.56%	80.00%	
High Risk Trans Ischaemic Attack assessed and treated within 24hrs	Jun-21	70.00%	75.00%	

Narrative

PHQ Indicators

The PHQ indicators are a set of metrics, which monitor the impact of community services on avoidable admissions for a set of key conditions. A year on year improvement is monitored against these indicators as a measure of avoidable admissions.

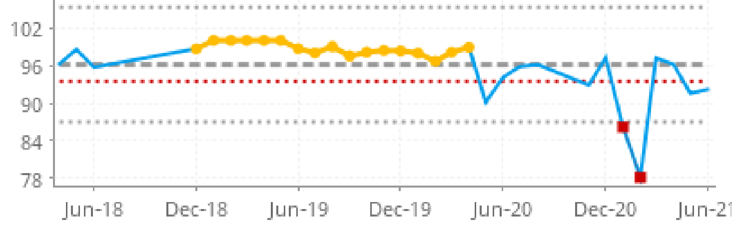
No exceptions to report within the SPC charts, with controlled variation across all the standards, however recognising the impact of the Covid pandemic and associated changes in pathway management.

Efficiency & Productivity

Statistical Process Control (SPC) Charts

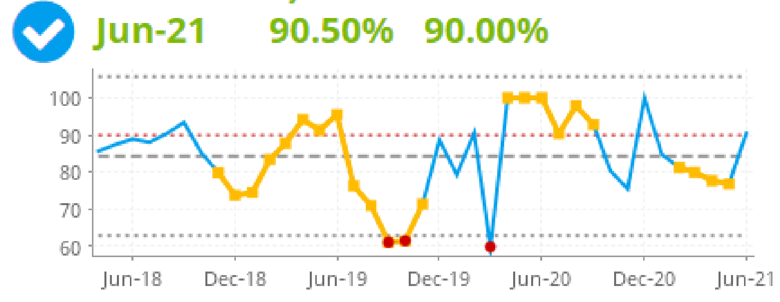
TCS24 - % of Patients achieving improvement using a EQ5 validated assessment tool

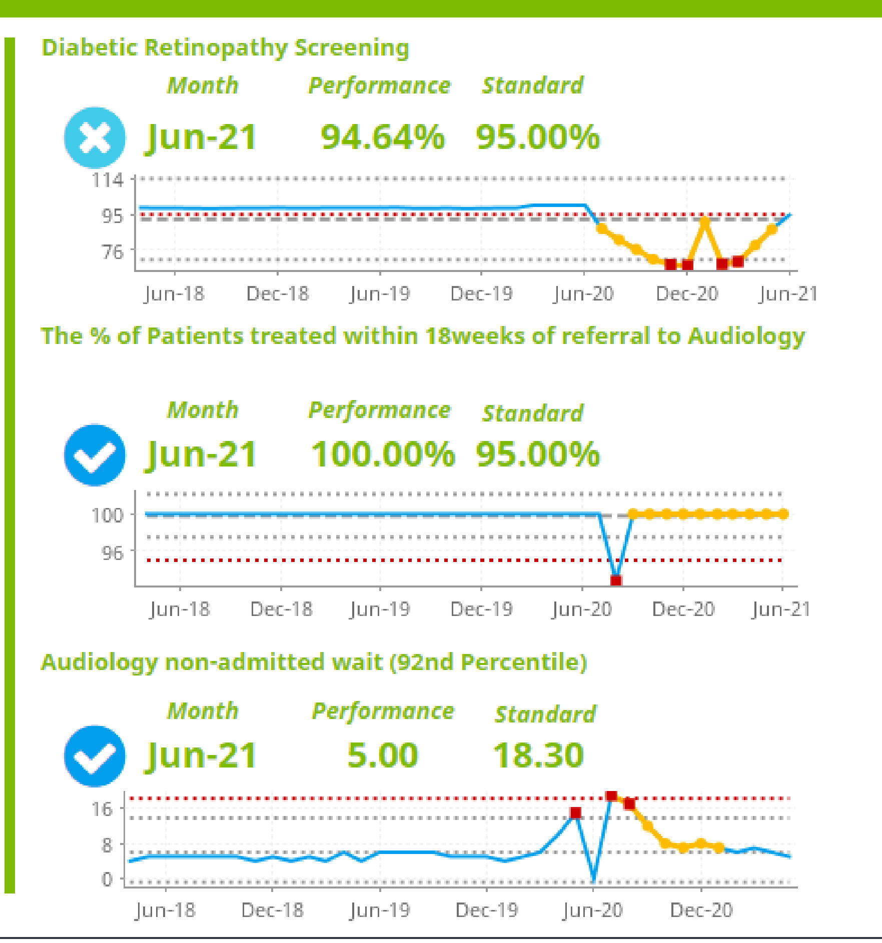
Month	Performance	Standard
Jun-21	92.17%	93.50%



TCS35b - % of Wheelchair referrals completed within 18 weeks

Month	Performance	Standard
Jun-21	90.50%	90.00%





Diabetic Retinopathy Screening

Month	Performance	Standard
Jun-21	94.64%	95.00%

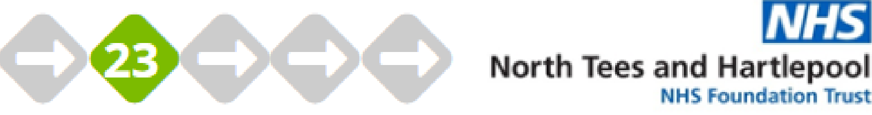
The % of Patients treated within 18weeks of referral to Audiology

Month	Performance	Standard
Jun-21	100.00%	95.00%

Audiology non-admitted wait (92nd Percentile)

Month	Performance	Standard
Jun-21	5.00	18.30

Efficiency & Productivity



Statistical Process Control (SPC) Charts

PHQ - Emergency Admissions for Acute Conditions that should not usually require hosptial admission

Month	Performance	Standard
Mar-20	110.50	155.41

500
0
Jun-19 Sep-19 Dec-19 Mar-20 Jun-20 Sep-20 Dec-20 Mar-21 Jun-21

PHQ - Unplanned hospitalisation for asthma, diabetes and epilepsy in unders 19s

Month	Performance	Standard
Mar-20	12.24	17.38

50
0
Apr-19 Aug-19 Dec-19 Apr-20 Aug-20 Dec-20 Apr-21

PHQ - Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)

Month	Performance	Standard
Mar-20	49.50	69.66

200
0
Apr-19 Aug-19 Dec-19 Apr-20 Aug-20 Dec-20 Apr-21

PHQ - Unplanned hospitalision for respiratory tract infections in under 19s

Month	Performance	Standard
Mar-20	23.36	37.82

200
0
Apr-19 Aug-19 Dec-19 Apr-20 Aug-20 Dec-20 Apr-21

Stroke admisisons - 90% of time spent on didicated stroke unit.

Month	Performance	Standard
Jun-21	97.56%	80.00%

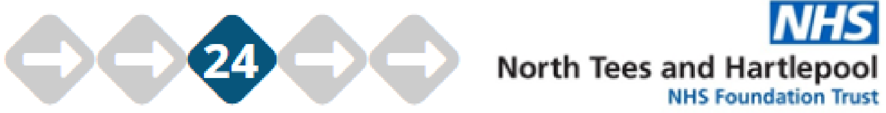
96
88
80
Sep-19 Dec-19 Mar-20 Jun-20 Sep-20 Dec-20 Mar-21 Jun-21

High Risk Trans Ischaemic Attack assessed and treated within 24hrs

Month	Performance	Standard
Jun-21	70.00%	75.00%

108
81
54
Sep-19 Dec-19 Mar-20 Jun-20 Sep-20 Dec-20 Mar-21 Jun-21

Safety & Quality



Standard	Month	Performance	Trend
Hospital Standardised Mortality Ratio (HSMR)	Apr 20 - Mar 21	95.54	
Summary Hospital-Level Mortality Indicator (SHMI)	Feb 20 - Jan 21	99.70	
Dementia KPI 1	Jun-21	100.00%	
Dementia KPI 2	Jun-21	100.00%	
Dementia KPI 3	Jun-21	100.00%	

Standard	Month	Performance	Standard	Trend
Stage 1 Complaint	Jun-21	106	88	
Stage 2 Complaint	Jun-21	6	4	
Stage 3 Complaint	Jun-21	12	12	
Compliments	Jun-21	376	209	

Narrative

Mortality

The latest HSMR value is currently reporting at 95.54 (rebased April 2020 to March 2021) which has decreased from the previous rebased value of 97.90 (March 2020 to February 2021). The latest SHMI value is now 99.70 (February 2020 to January 2021) which has decreased from the previous rebased value of 100.18 (January 2020 to December 2020).

Complaints

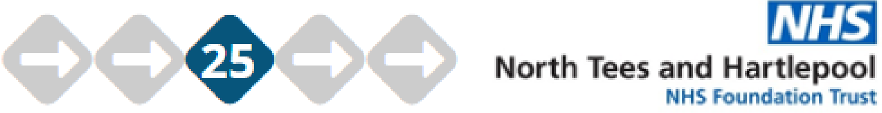
Due to Covid-19 restrictions, visiting remains limited, to reduce the transmission of Covid, whilst supporting families through Johns Campaign and those at end of life. However, following a successful pilot on two wards within the Trust, face to face visiting will be rolled out to an additional six wards. There are strict visiting regulations in place to ensure visiting is undertaken in a safe a secure way for our patients, visitors and staff. The re-introduction of visiting is led by the Infection, Prevention Control team and in line with local Covid 19 transmission rates.

During June 2021, attitude of staff replaced communication as the highest reported issue in concerns raised to the Trust. The key areas are reviewing this trend and are taking action to improve communication with patients and their relatives. Following the introduction of the Communication Plan in January 2021 within the ward areas, the number of concerns relating to communication have reduced significantly. The plan incorporates virtual visiting, regular telephone updates, property and letters of love drop off service. The profile for complaints types had changed delivery during Covid, due to restriction on visiting, to allow more stage 2 resolutions to be completed virtually, as face to face meetings were restricted, this is beginning to increase through the use of technology and relatives more comfortable to attend the Trust in person.

Compliments

The Trust records the compliments received onto the Greatix platform. For June 2021 the number of compliments received is 376, consistently higher than complaints. It is recognised that work still needs to be done to increase the recording of compliments across the Trust.

Safety & Quality



Standard	Month	Performance	Standard	Trend
Red Risks	Jun-21	1	5	
Never Events	Jun-21	0	0	
VTE %	Jun-21	88.81%	95.00%	
Fall No Harm	Jun-21	65	74	
Fall Low Harm	Jun-21	13	17	
Fall Moderate Harm	Jun-21	2	1	
Fall Severe Harm	Jun-21	0	0	

Narrative

Venous Thromboembolism Compliance %

The Trust is reporting that 88.81% of patients admitted to hospital were risk assessed for venous thromboembolism (VTE) during June 2021; this is below the National Standard of 95.00%.

The recent reinvigoration of the VTE process for chasing up on those assessments not completed on admission was proving to be successful. However, during June 21 there has been a significant drop in compliance on VTE assessment on admission. Contributing factors for the drop are an increase in activity combined with a reduced workforce due to sickness and/or Covid related abscence.

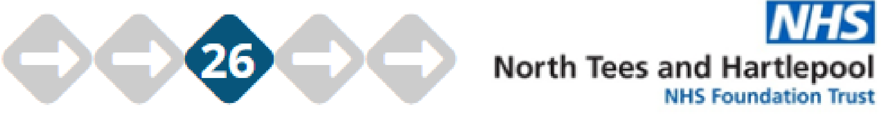
The Heads of Nursing are working with the clinical teams to improve compliance with assessment, focusing on key areas.

Falls

There has been an overall reduction in the number of falls reported in June 2021, with the majority resulting in no harm. There have been two falls currently identified as Moderate harm which are being investigated.

Improvement strategies to mitigate the risk of falls includes, training package for all medical staff, the falls lead working with the education department to deliver these sessions.

Safety & Quality



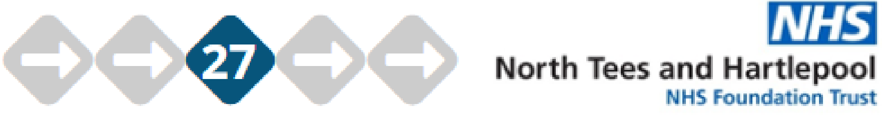
Standard		Month	Performance	Standard	Trend
Pressure Category 1 (inpatient)	✔	May-21	4	6	
Pressure Category 2 (inpatient)	✔	May-21	15	23	
Pressure Category 3 (inpatient)	✔	May-21	2	2	
Pressure Category 4 (inpatient)	✔	May-21	0	0	

Narrative

Pressure Ulcers

In the May 2021 reporting period, all four categories of Pressure Ulcers fall within the control limits. A pressure ulcer assurance framework is currently under development to further support pressure ulcer management.

Safety & Quality



Standard		Month	Performance	Standard	Trend
Hand Hygiene	✔	Jun-21	98%	95%	
Clostridium difficile	✔	Jun-21	2	4	
MRSA	✔	Jun-21	0	0	
MSSA	✖	Jun-21	3	2	
Ecoli	✖	Jun-21	6	3	
Klebsiella	✔	Jun-21	0	1	
Pseudomonas	✖	Jun-21	2	0	
CAUTI	✖	Jun-21	30	25	

Narrative

Hand Hygiene

The overall Trust compliance score for hand hygiene is 98% for June 2021; this has remained the same from the previous reported period. Clinical areas carry out monthly audits with a quarterly assurance check by the IPC team. The IPC team are also focusing on glove misuse and raising awareness of when to and when not to wear gloves.

Infections

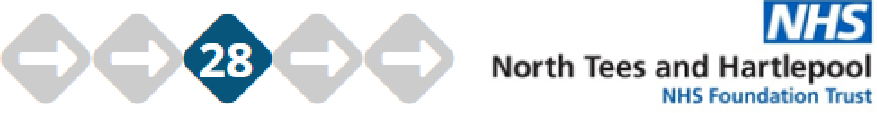
For June 2021, the Trust is reporting 2 Trust attributed case of Clostridium difficile infection (1 HOHA - Hospital Associated Healthcare Associated and 1 COHA - Community Associated Healthcare Associated). The 2 cases for June 2021 is Lower than the mean for the past two years for Clostridium difficile which is 4.

For MSSA, the Trust is reporting 3 cases for June 2021, this is higher than the mean for the past two years which is 2. For Ecoli, the Trust is reporting 6 cases for June 2021, this is higher than the mean for the past two years which is 3 cases.

All seven infections continue to display natural cause variation and remain in their respective upper and lower control limits.

Community prevalence is on the increase within the North East and strict IPC measures and testing, including staff Latteral Flow Tests (LFTs) is stringly advised.

Safety & Quality



Standard	Month	Performance	Standard	Trend
Friends and Family Test (FFT) - Emergency	Jun-21	87.00%	75.00%	
Friends and Family Test (FFT) - Inpatients	Jun-21	93.00%	75.00%	
Friends and Family Test (FFT) - Maternity	Jun-21	100.00%	75.00%	
UNIFY - RN Day	Jun-21	77.71%	>=80% and <=109.99%	
UNIFY - RN Night	Jun-21	84.56%	>=80% and <=109.99%	
UNIFY - HCA Day	Jun-21	88.84%	>=80% and <=109.99%	
UNIFY - HCA Night	Jun-21	114.21%	>=110% and <=125.99%	

Narrative

Friends and Family Test

For June 2021 the Trust received 1,649 FFT returns, this is in line with the previous months returns with a Very Good or Good response of 92.36%.

All three FFT metric percentages fall within their relevant control limits with the recent trends displaying natural cause variation. Work continues to promote FFT particularly from the in-patient areas to improve the amount of feedback.

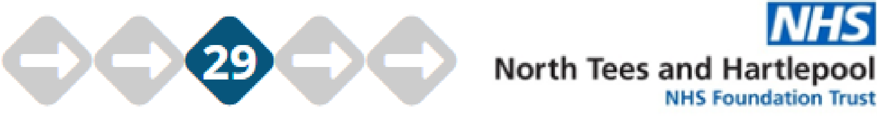
UNIFY

Nursing fill rates have continued to be a challenge due to a gradual increasing vacancy factor compounded by higher than usual sickness and covid isolation requirements. These challenges have been safely managed through appropriate routes of escalation up to the Deputy Chief and Chief Nurse. The outputs of this escalation have resulted in some temporary bed closures at times and the ability to flex capacity where and when appropriate in line with safe staffing regulations.

The nursing fill rates presented in June 2021 show that some of these pressures are still evident, the overall fill rate for registered nurses has reduced from 81% to 77.7% in June. Twice daily safe staffing meetings review the acuity of all in patients to ensure safe decision making around staff redeployment to support the fill rates of all areas. Throughout June 2021 safe nurse staffing levels have been in place for all areas and in the absence of a registered nurse role it has been deemed that an alternative model utilising our nursing associate and un-registered nurse roles hasremained appropriate in line with patient acuity and dependence and professional judgement.

The registered nurse vacancy level will reduce significantly from September 2021.

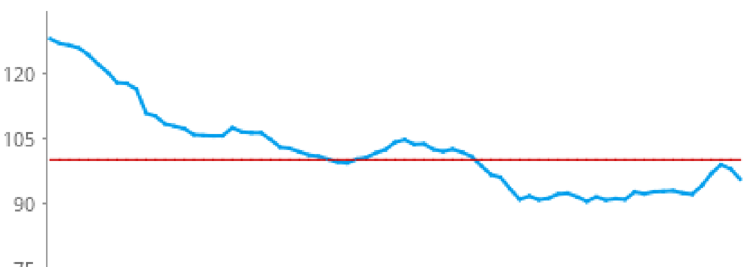
Safety & Quality



Additional Detail Charts

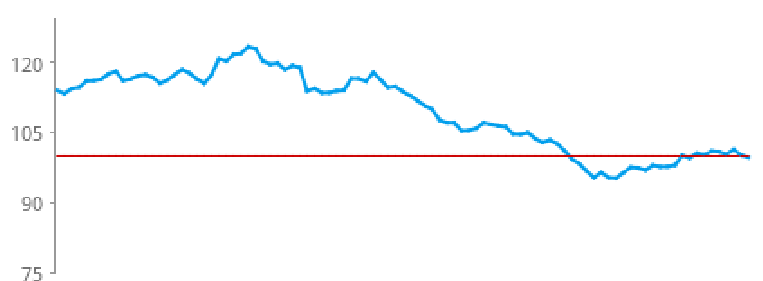
Hospital Standardised Mortality Ratio

	Month	*Performance*
	Apr 20 - Mar 21	95.54



Summary Hospital-Level Mortality Indicator

Month	*Performance*
Feb 20 - Jan 21	99.70

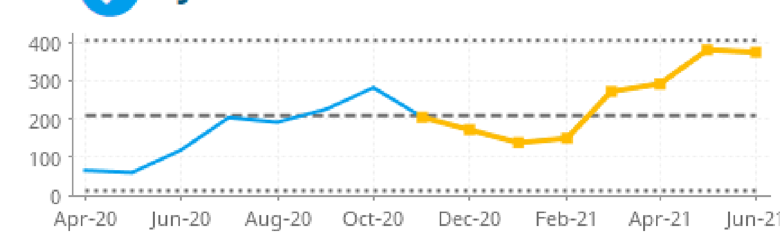


Dementia

		Month	*Performance*
Dementia KPI 1		Jun-21	100.00%
Dementia KPI 2		Jun-21	100.00%
Dementia KPI 3		Jun-21	100.00%

Compliments

	Month	*Performance*	*Standard*
	Jun-21	376	209



Safety & Quality

Statistical Process Control (SPC) Charts

Stage 1 - Informal

Month	Performance	Standard
Jun-21	106	88

Stage 2 - Meeting

Month	Performance	Standard
Jun-21	6	4

Stage 3 - Formal

Month	Performance	Standard
Jun-21	12	12

Red Risks

Month	Performance	Standard
Jun-21	1	5

Never Events

Month	Performance	Standard
Jun-21	0	0

VTE %

Month	Performance	Standard
Jun-21	88.81%	95.00%

Safety & Quality

Statistical Process Control (SPC) Charts

Fall No Harm

Month	Performance	Standard
Jun-21	65	74

Fall Moderate Harm

Month	Performance	Standard
Jun-21	2	1

Fall Low Harm

Month	Performance	Standard
Jun-21	13	17

Fall Severe Harm

Month	Performance	Standard
Jun-21	0	0

Safety & Quality

Statistical Process Control (SPC) Charts

Pressure Ulcer Cat 1

Month	Performance	Standard
May-21	4	6

Pressure Ulcer Cat 3

Month	Performance	Standard
May-21	2	2

Pressure Ulcer Cat 2

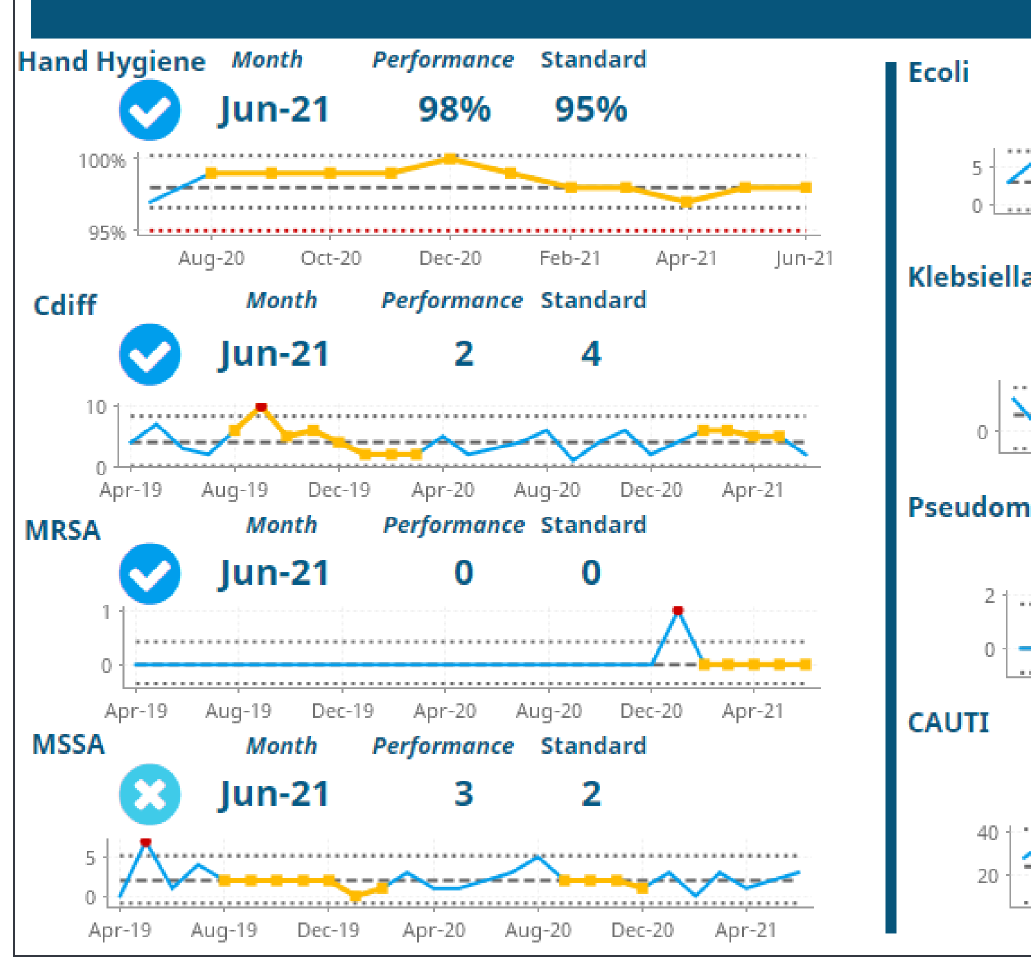
Month	Performance	Standard
May-21	15	23

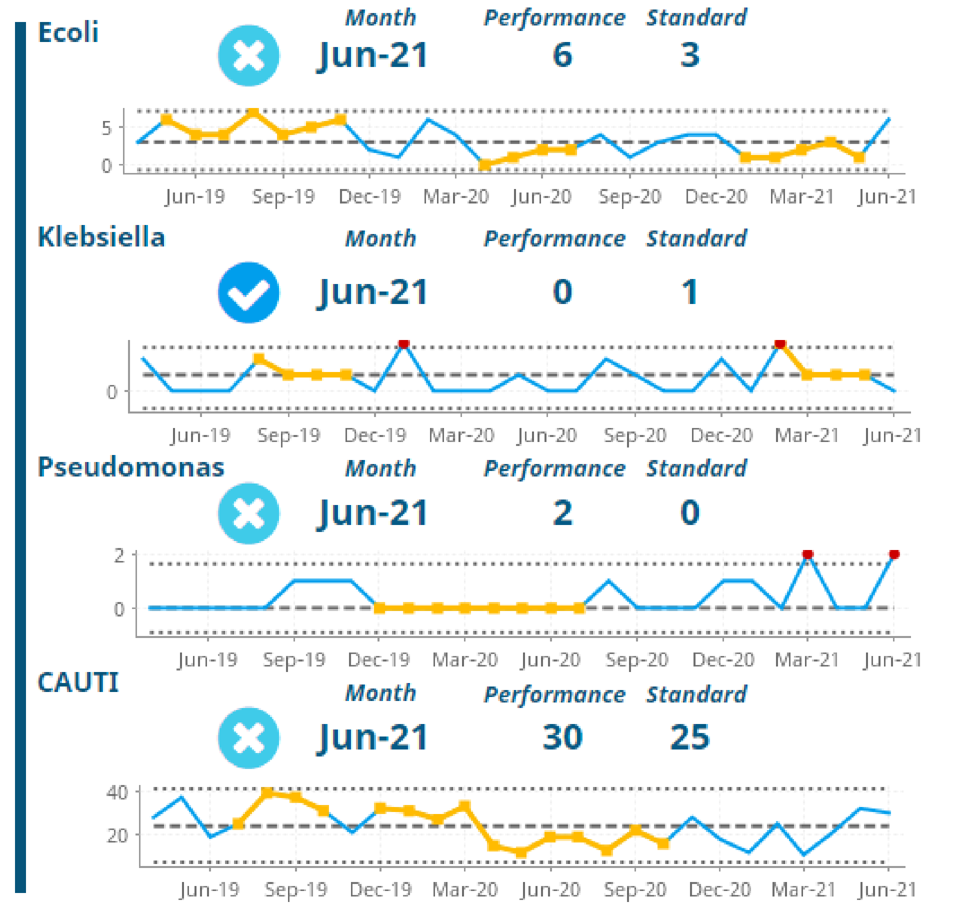
Pressure Ulcer Cat 4

Month	Performance	Standard
May-21	0	0

Safety & Quality

Statistical Process Control (SPC) Charts



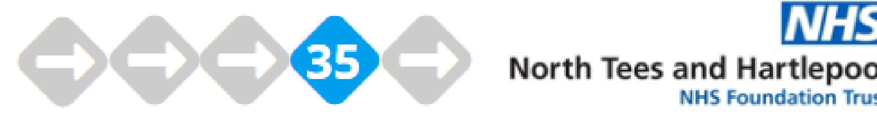


Safety & Quality

Statistical Process Control (SCP) Charts

Measure	Month	Performance	Standard
FFT Emergency Care	Jun-21	87.00%	75.00%
FFT Inpatient	Jun-21	93.00%	75.00%
FFT Maternity	Jun-21	100.00%	75.00%
UNIFY RN Day	Jun-21	77.71%	>=80% and <=109.99%
UNIFY RN Night	Jun-21	84.56%	>=80% and <=109.99%
UNIFY HCA Day	Jun-21	88.84%	>=80% and <=109.99%
UNIFY HCA Night	Jun-21	114.21%	>=110% and <=125.99%

Workforce



Standard	Month	Performance	Standard	2 Year Trend
Sickness (not achieved)	May-21	5.41%	4.00%	
Appraisals (not achieved)	Jun-21	82.81%	95.00%	
Turnover (achieved)	Jun-21	8.35%	10.00%	
Mandatory Training (achieved)	Jun-21	87.52%	80.00%	

Narrative

The sickness absence rate for May 2021 is reported at 5.41%, an increase of 0.56% compared to the previous month. This is broken down into 0.22% attributable to Covid-19 related sickness and 5.18% attributable to other sickness. The cost of sickness absence is reported as £349,584, a decrease of £18,433 compared to April (£368,017). There were 140 further cases of Covid-19 related staff absence in June 2021, broken down into 38 staff absent for 10 days and 102 who self-isolated for 14 days.

'Anxiety/stress/depression' was the top sickness reason in May, accounting for 32% of all sickness absence during the month. 'Chest & respiratory problems' (under which Covid-related sickness is recorded) was fifth highest, accounting for 7% of sickness absence.

Other workforce metrics for June 2021 (also quarter 1) are:

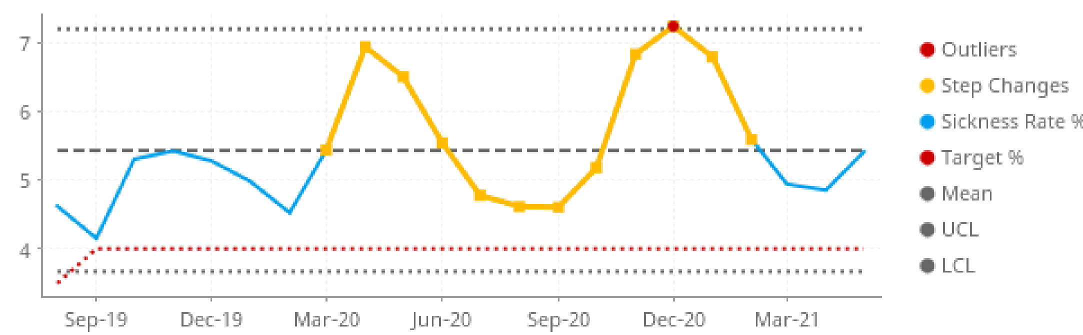
- Appraisal compliance reported as 83%, a 1% increase from the previous month
- Mandatory Training compliance reported as 88%, a 1% increase on the previous month
- Staff Turnover reported as 8.35%, an increase of 0.35%

Workforce

Statistical Process Control (SPC) Charts

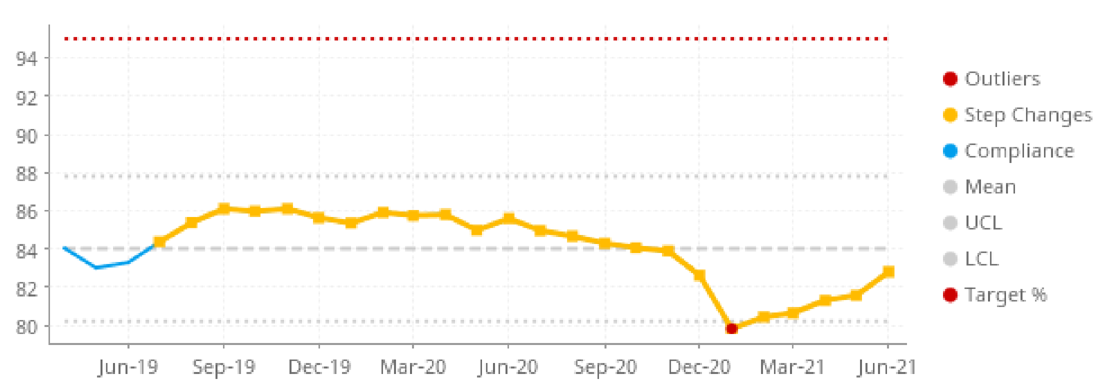
Sickness

Month	Performance	Standard
May-21	5.41%	4.00%



Appraisal

Month	Performance	Standard
Jun-21	82.81%	95.00%



Workforce

Statistical Process Control (SPC) Charts

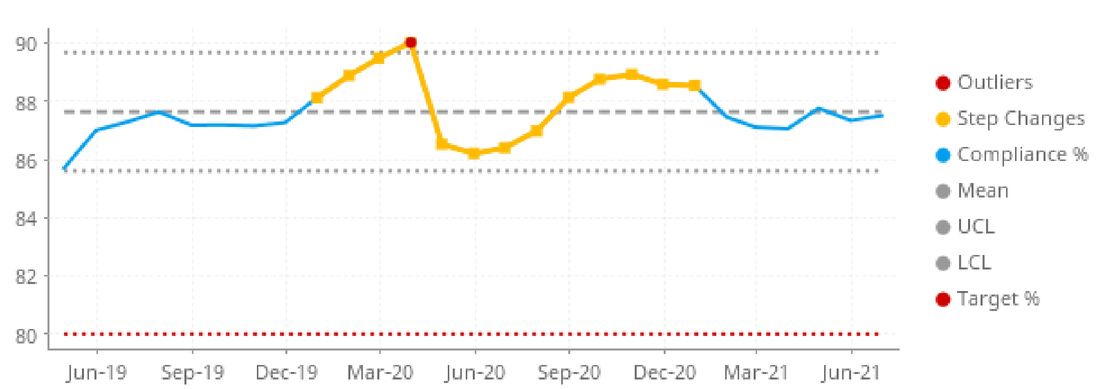
Turnover

Month	Performance	Standard
Jun-21	8.35%	10.00%

Outliers
Step Changes
Turnover %
Mean
UCL
LCL
Target %

Mandatory Training

Month	Performance	Standard
Jun-21	87.52%	80.00%



Finance

38

NHS North Tees and Hartlepool NHS Foundation Trust

Finance Overview - Month 3

Income/Expenditure

	Plan (£000)	Actual (£000)
In Month	500	1,206
Year to Date	1,500	3,026

Balance Sheet

	£m
Cash Actual	55.4
Cash Forecast*	42.5

*Ahead of forecast due to improved I&E and Creditor days

Capital

	Plan (£m)	Actual (£m)
In Month	0.4	0.3
Year to Date	1.3	1.2

Use of Resources*

Metric	Rating
Capital Service Cover Rating	1
Liquidity Rating**	4
I & E Margin Rating	1
I & E Margin Distance from Plan	1
Agency Rating	1
Risk Rating After Overrides	3

*UOR suspended in 2020-2021 - manual calculations

** Rating will only improve with increased cash reserves

Appendix 1

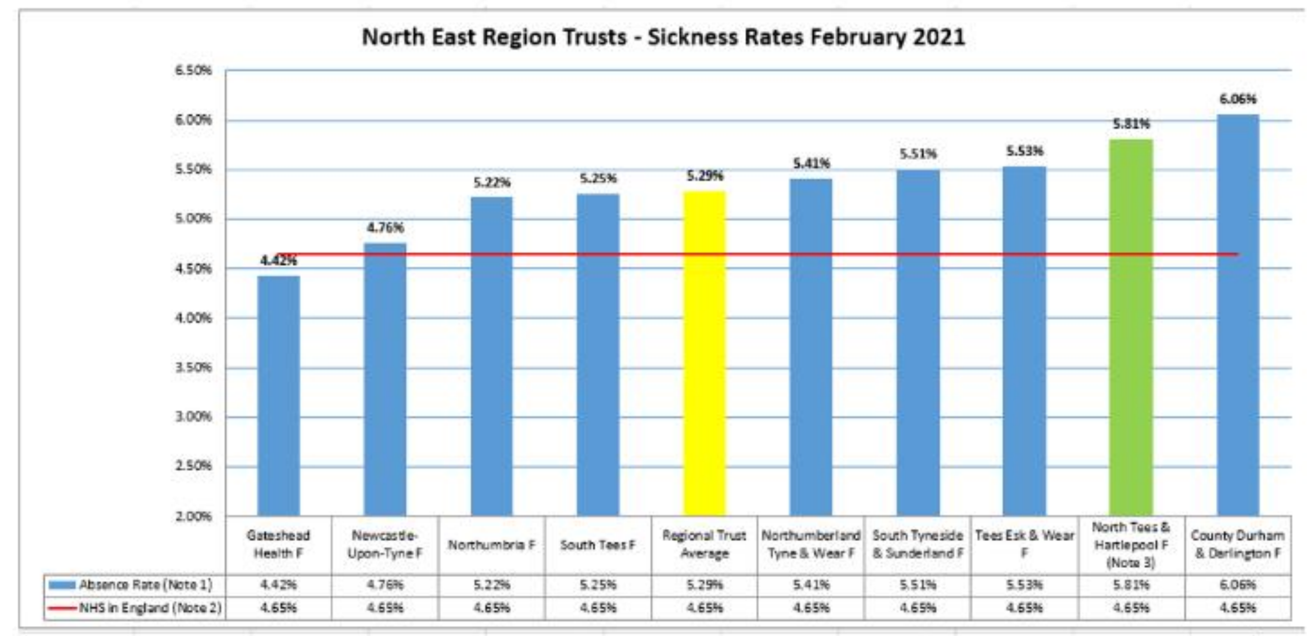
RTT and Cancer

Measure	National	North East	North Tees & Hartlepool	S Tyneside & Sunderland	N Cumbria	Gateshead	Newcastle	Northumbria	S Tees	Durham & Darlington
RTT - May 21										
Incomplete Pathways waiting <18 weeks	67.4%		87.6%	87.6%	64.2%	80.3%	72.7%	88.0%	65.8%	74.8%
Half of incomplete patients wait less than	11		7	6	12	8	10	8	11	8
Half of admitted patients wait less than	11		12	14	32	10	12	9	6	9
19 out of 20 admitted patients wait less than	72		51	39	90	64	71	43	75	68
Half of Non admitted Pathways waited less than	6		3	5	7	4	7	5	4	5
19 out of 20 non admitted patients wait less than	43		24	23	49	30	39	31	31	28

Cancer 62 Day Standard - May 21	National	North East	North Tees & Hartlepool	S Tyneside and Sunderland	N Cumbria	Gateshead	Newcastle	Northumbria	S Tees	Durham & Darlington
Breast	Data not available	90.13 (137/152)	90.48 (19/21)	100 (1.5/1.5)	100 (8.5/8.5)	96.36 (26.5/27.5)	85.37 (17.5/20.5)	96.3 (26/27)	92.86 (13/14)	78.13 (25/32)
Lung		60 (45/75)	44.44 (4/9)	93.1 (13.5/14.5)	37.5 (1.5/4)	50 (2/4)	55.88 (9.5/17)	77.78 (3.5/4.5)	50 (5/10)	50 (6/12)
Gynae		32.65 (16/49)	50 (0.5/1)	100 (1/1)	57.14 (2/3.5)	15.38 (2/13)	66.67 (4/6)	25 (1/4)	34.78 (4/11.5)	16.67 (1.5/9)
Upper GI		62.71 (37/59)	100 (3.5/3.5)	41.18 (3.5/8.5)	50 (0.5/1)	88.89 (4/4.5)	50 (6.5/13)	87.5 (3.5/4)	60 (12/20)	77.78 (3.5/4.5)
Lower GI		65.38 (68/104)	92.31 (12/13)	72 (9/12.5)	36.36 (2/5.5)	66.67 (5/7.5)	38.89 (7/18)	68.42 (13/19)	66.67 (12/18)	76.19 (8/10.5)
Uro (incl testes)		76.25 (130/170.5)	72.73 (8/11)	96.15 (37.5/39)	91.3 (10.5/11.5)	80 (8/10)	59.21 (22.5/38)	74.55 (20.5/27.5)	69.7 (23/33)	0 (0/0.5)
Haem (incl AL)		53.33 (24/45)	100 (2.5/2.5)	54.55 (3/5.5)	37.5 (1.5/4)	57.14 (2/3.5)	65 (6.5/10)	100 (2/2)	43.75 (3.5/8)	31.58 (3/9.5)
Head & Neck		78.38 (29/37)	0 (0/0.5)	82.35 (7/8.5)	60 (1.5/2.5)	0 (0/0)	78.13 (12.5/16)	0 (0/0)	93.33 (7/7.5)	50 (1/2)
Skin		93.49 (158/169)	0 (0/0)	100 (7/7)	100 (15.5/15.5)	0 (0/0)	91.23 (52/57)	72.41 (10.5/14.5)	100 (31/31)	95.45 (42/44)
Sarcoma		80 (4/5)	0 (0/0)	0 (0/0)	0 (0/0.5)	0 (0/0)	85.71 (3/3.5)	0 (0/0)	100 (1/1)	0 (0/0)
Brain/CNS		0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)
Children's		0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)
Other		71.43 (5/7)	100 (1/1)	0 (0/1)	0 (0/0)	0 (0/0)	100 (2/2)	0 (0/0)	0 (0/1)	100 (2/2)
All		74.84 (653/872.5)	80.8 (50.5/62.5)	83.84 (83/99)	76.99 (43.5/56.5)	70.71 (49.5/70)	71.14 (143/201)	78.05 (80/102.5)	71.94 (111.5/155)	73.02 (92/126)

Appendix 2

Workforce



	Gateshead Health F	Newcastle-Upon-Tyne F	Northumbria F	South Tees F	Regional Trust Average	Northumberland Tyne & Wear F	South Tyneside & Sunderland F	Tees Esk & Wear F	North Tees & Hartlepool F (Note 3)	County Durham & Darlington F
Absence Rate (Note 1)	4.42%	4.76%	5.22%	5.25%	5.29%	5.41%	5.51%	5.53%	5.81%	6.06%
NHS in England (Note 2)	4.65%	4.65%	4.65%	4.65%	4.65%	4.65%	4.65%	4.65%	4.65%	4.65%

North East Region Trusts - Sickness Rates February 2021 (*latest available)

The chart above shows the sickness absence figures for Acute and Mental Health Trust's in the North East region for February 2021. North Tees and Hartlepool NHS Foundation Trust is represented by the green column. The average rate for all North East Acute and Mental Health Care Trust's is shown by the yellow column. The red line is the average rate for the whole of the NHS in England.

The sickness rate for North Tees and Hartlepool is 5.81%, which is the second highest in the north east region this month.

Gateshead Health NHS Foundation Trust report the lowest sickness absence rate for February 2021 at 4.42%.

County Durham and Darlington NHS Foundation Trust report the highest sickness in February 2021 at 6.06%.

Standard Indicator Set: Operational Efficiency	Trust Performance			Benchmarking		
Indicator	Current	Previous	Change	Peer	National	Position
30-day PbR emergency readmission rate (12 mth rolling) HES Inpatients (Jun 2021)	9.66% (Mar 2020 - Feb 2021)	9.51% (Feb 2020 - Jan 2021)	0.15 ↑	7.71%	8.15%	
2-day emergency readmission rate (12 mth rolling) HES Inpatients (Jun 2021)	2.56% (Mar 2020 - Feb 2021)	2.49% (Feb 2020 - Jan 2021)	0.07 ↑	2.24%	2.14%	
7-day emergency readmission rate (12 mth rolling) HES Inpatients (Jun 2021)	5.43% (Mar 2020 - Feb 2021)	5.33% (Feb 2020 - Jan 2021)	0.10 ↑	5.05%	4.59%	
14-day emergency readmission rate (12 mth rolling) HES Inpatients (Jun 2021)	7.74% (Mar 2020 - Feb 2021)	7.66% (Feb 2020 - Jan 2021)	0.08 ↑	7.35%	6.51%	
28-day emergency readmission rate (12 mth rolling) HES Inpatients (Jun 2021)	10.71% (Mar 2020 - Feb 2021)	10.59% (Feb 2020 - Jan 2021)	0.12 ↑	10.10%	8.75%	
Outpatient DNA rate (12 mth rolling) HES Outpatients (Jun 2021)	6.73% (Apr 2020 - Mar 2021)	6.91% (Mar 2020 - Feb 2021)	-0.18 ↓	7.37%	6.75%	
Outpatient New to Follow-up ratio (12 mth rolling) HES Outpatients (Jun 2021)	2.58 (Apr 2020 - Mar 2021)	2.58 (Mar 2020 - Feb 2021)	No Change	2.45	2.31	
Outpatient cancellation rate (12 mth rolling) HES Outpatients (Jun 2021)	0.00% (Apr 2020 - Mar 2021)	0.00% (Mar 2020 - Feb 2021)	No Change	14.32%	12.44%	
Cancer waiting times - 2-week wait to be seen after GP referral (12 mth rolling) Cancer Waiting Times (Jun 2021)	92.58% (May 2020 - Apr 2021)	92.38% (Apr 2020 - Mar 2021)	0.20 ↑	76.15%	87.56%	
Cancer waiting times - 31-day wait for first treatment after decision to treat (12 mth rolling) Cancer Waiting Times (Jun 2021)	96.38% (May 2020 - Apr 2021)	95.95% (Apr 2020 - Mar 2021)	0.43 ↑	95.35%	94.77%	
Cancer waiting times - 62-day wait for first treatment after GP referral (12 mth rolling) Cancer Waiting Times (Jun 2021)	76.82% (May 2020 - Apr 2021)	77.41% (Apr 2020 - Mar 2021)	-0.59 ↓	76.48%	74.38%	
RTT - Referral within 18 weeks (admitted pathway) (12 mth rolling) RTT (Jun 2021)	73.19% (May 2020 - Apr 2021)	76.62% (Apr 2020 - Mar 2021)	-3.43 ↓	66.79%	61.88%	
RTT - Referral within 18 weeks (non-admitted pathway) (12 mth rolling) RTT (Jun 2021)	86.17% (May 2020 - Apr 2021)	86.66% (Apr 2020 - Mar 2021)	-0.49 ↓	82.54%	76.91%	
RTT - waiting less than 18 weeks (incomplete pathway) (12 mth rolling) RTT (Jun 2021)	84.81% (May 2020 - Apr 2021)	85.09% (Apr 2020 - Mar 2021)	-0.28 ↓	65.21%	57.03%	
Day case realisation rate (12 mth rolling) HES Inpatients (Jun 2021)	96.62% (Apr 2020 - Mar 2021)	96.59% (Mar 2020 - Feb 2021)	0.03 ↑	95.11%	95.67%	
Day case rate (12 mth rolling) HES Inpatients (Jun 2021)	83.82% (Apr 2020 - Mar 2021)	82.88% (Mar 2020 - Feb 2021)	0.94 ↑	84.88%	68.26%	

Indicator	Current	Previous	Change		Peer	National		
Average excess length of stay (12 mth rolling) HES Inpatients (Jun 2021)	0.06 (Apr 2020 - Mar 2021)	0.08 (Mar 2020 - Feb 2021)	-0.02 ↓		0.26	0.36		
Average length of stay (12 mth rolling) HES Inpatients (Jun 2021)	3.26 (Apr 2020 - Mar 2021)	3.33 (Mar 2020 - Feb 2021)	-0.07 ↓		3.90	4.44		
Average elective length of stay (12 mth rolling) HES Inpatients (Jun 2021)	1.31 (Apr 2020 - Mar 2021)	1.26 (Mar 2020 - Feb 2021)	0.05 ↑		3.68	4.64		
Average non-elective length of stay (12 mth rolling) HES Inpatients (Jun 2021)	3.46 (Apr 2020 - Mar 2021)	3.56 (Mar 2020 - Feb 2021)	-0.10 ↓		3.93	4.40		
Average pre-operative length of stay (12 mth rolling) HES Inpatients (Jun 2021)	0.21 (Apr 2020 - Mar 2021)	0.22 (Mar 2020 - Feb 2021)	-0.01 ↓		0.24	0.25		
Average elective pre-operative length of stay (12 mth rolling) HES Inpatients (Jun 2021)	0.01 (Apr 2020 - Mar 2021)	0.01 (Mar 2020 - Feb 2021)	No Change		0.03	0.03		
Average non-elective pre-operative length of stay (12 mth rolling) HES Inpatients (Jun 2021)	0.35 (Apr 2020 - Mar 2021)	0.35 (Mar 2020 - Feb 2021)	No Change		0.43	0.46		
Average post-operative length of stay (12 mth rolling) HES Inpatients (Jun 2021)	0.91 (Apr 2020 - Mar 2021)	0.95 (Mar 2020 - Feb 2021)	-0.04 ↓		1.02	0.97		
Average elective post-operative length of stay (12 mth rolling) HES Inpatients (Jun 2021)	0.16 (Apr 2020 - Mar 2021)	0.16 (Mar 2020 - Feb 2021)	No Change		0.32	0.24		
Average non-elective post-operative length of stay (12 mth rolling) HES Inpatients (Jun 2021)	1.40 (Apr 2020 - Mar 2021)	1.45 (Mar 2020 - Feb 2021)	-0.05 ↓		1.63	1.67		
Non-elective zero-day spells (12 mth rolling) HES Inpatients (Jun 2021)	34.85% (Apr 2020 - Mar 2021)	34.62% (Mar 2020 - Feb 2021)	0.23 ↑		35.14%	33.15%		
Elective stranded rate (12 mth rolling) HES Inpatients (Jun 2021)	3.67% (Apr 2020 - Mar 2021)	3.43% (Mar 2020 - Feb 2021)	0.24 ↑		13.34%	12.74%		
Emergency stranded rate (12 mth rolling) HES Inpatients (Jun 2021)	17.80% (Apr 2020 - Mar 2021)	18.18% (Mar 2020 - Feb 2021)	-0.38 ↓		18.55%	21.13%		
Elective super-stranded rate (12 mth rolling) HES Inpatients (Jun 2021)	0.27% (Apr 2020 - Mar 2021)	0.30% (Mar 2020 - Feb 2021)	-0.03 ↓		2.45%	3.44%		
Elective zero-day pre-op length of stay (12 mth rolling) HES Inpatients (Jun 2021)	93.00% (Apr 2020 - Mar 2021)	93.09% (Mar 2020 - Feb 2021)	-0.09 ↓		77.75%	77.20%		
Elective pre-op length of stay >3 days (12 mth rolling) HES Inpatients (Jun 2021)	0.19% (Apr 2020 - Mar 2021)	0.23% (Mar 2020 - Feb 2021)	-0.04 ↓		1.05%	0.98%		
Relative risk length of stay (12 mth rolling) HES Inpatients (Jun 2021)	80.30 (Apr 2020 - Mar 2021)	82.41 (Mar 2020 - Feb 2021)	-2.11 ↓		101.16	99.37	Low (>95%)	

Board of Directors

<table>
<tr><td></td><td colspan="10">Learning from Deaths Report, Quarter 1, 2021-22</td></tr>
<tr><td>Date:</td><td colspan="10">29 July 2021</td></tr>
<tr><td>Prepared by:</td><td colspan="10">Janet Alderton</td></tr>
<tr><td>Executive sponsor:</td><td colspan="10">Medical Director</td></tr>
<tr><td>Purpose of the report</td><td colspan="10">To provide an overview of the learning obtained through the review of deaths that occur within the organisation. Also, to provide details from the clinical teams around actions that have been implemented as a result of the overall learning and, where available, to provide an evaluation of the impact of these.</td></tr>
<tr><td>Action required:</td><td colspan="2">Approve</td><td>X</td><td>Assurance</td><td colspan="2">X</td><td>Discuss</td><td>X</td><td>Information</td><td>X</td></tr>
<tr><td>Strategic Objectives supported by this paper:</td><td colspan="2">Putting our Population First</td><td>X</td><td>Valuing our People</td><td colspan="2"></td><td>Transforming our Services</td><td></td><td>Health and Wellbeing</td><td>X</td></tr>
<tr><td>Which CQC Standards apply to this report</td><td>Safe</td><td>X</td><td>Caring</td><td>X</td><td>Effective</td><td>X</td><td>Responsive</td><td>X</td><td>Well Led</td><td>X</td></tr>
<tr><td colspan="11">Executive Summary and the key issues for consideration/ decision:</td></tr>
<tr><td colspan="11">1. The Trusts HSMR value in the latest period has decreased to 95.54 (April 2020 to March 2021), the SHMI has decreased to 99.7 (February 2020 to January 2021). Both remain within the national “within expected” ranges.
2. There has been a sustained improvement in the level of care being documented which has helped sustain the current reported national mortality statistics. The rebasing of the HSMR at the end of the financial year reflects the impact of the changes made as coding details are enhanced, resulting in the Trusts HSMR remaining below 100 following this data refresh.
3. During 2021-22, to the end of quarter 1, 15% of compulsory reviews have been completed. However, the additional scrutiny by the Medical Examiners team means that 62% of all deaths during this quarter have been scrutinised or reviewed.
4. There are a number of work streams in place, to support ongoing clinical and service improvements. There are updates in relation to the current progress for implementation of the Medical Examiners, Learning Disability reviews, Maternity Stillbirth reviews and also the work of the Deteriorating patient group.</td></tr>
<tr><td colspan="11">How this report impacts on current risks or highlights new risks:</td></tr>
<tr><td colspan="11">Any new risks identified through mortality review processes are assessed and added to the risk register as needed.</td></tr>
<tr><td>Committees/groups where this item has been discussed</td><td colspan="10">• Trust Outcome Performance, Delivery and Operational Group
• Patient Safety & Quality Standard Committee
• Clinical Quality Review Group (following Board presentation)</td></tr>
<tr><td>Recommendation</td><td colspan="10">1. The Board of Directors is asked to note the content of this report and to derive assurance that there is continued focus to ensure in depth multidisciplinary learning being is obtained from mortality review processes.
2. The Board is asked to recognise the continued sustained levels in the national mortality statistics.</td></tr>
</table>

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

29 July 2021

Learning from Deaths Report, Q1, 2021-22

Report of the Medical Director

1. Introduction/Background

1.1 In March 2017, the National Quality Board (NQB) published national guidance "Learning from Deaths: A Framework for NHS Trust and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care". The guidance provides requirements for Trust to implement as a minimum in order ensure there is a focused approach towards responding to and learning from deaths of patients in our care.

1.2 The Trust strives to improve the care provided to all of our patients; the overall aim is to identify, understand and implement improvements where any issues are related to the provision of safe and effective quality care. It is considered that if such safety and quality improvements are initiated effectively and embedded, then the mortality statistics will naturally show improvement.

1.3 The information presented in this report provides an overview of learning from deaths that has been obtained from mortality reviews undertaken by the Trust. The Trust policy identifies some key areas where all deaths will be reviewed and also identifies additional randomly selected cases will also be included in the review process. Some compulsory review areas have small numbers; therefore, learning is presented as a summation of all reviews to reduce the risk of identifying cases directly.

1.4 The report provides details of learning and actions implemented in relation to maternity, Learning Disability and the Deteriorating patient group.

1.5 The numbers of mortality reviews undertaken by the Trust has been reduced during the Covid-19 pandemic; the capacity of clinical staff to undertake required mortality reviews has been significantly restricted. There are currently additional sessions planned to ensure relevant cases are reviewed and the required learning for improvement identified.

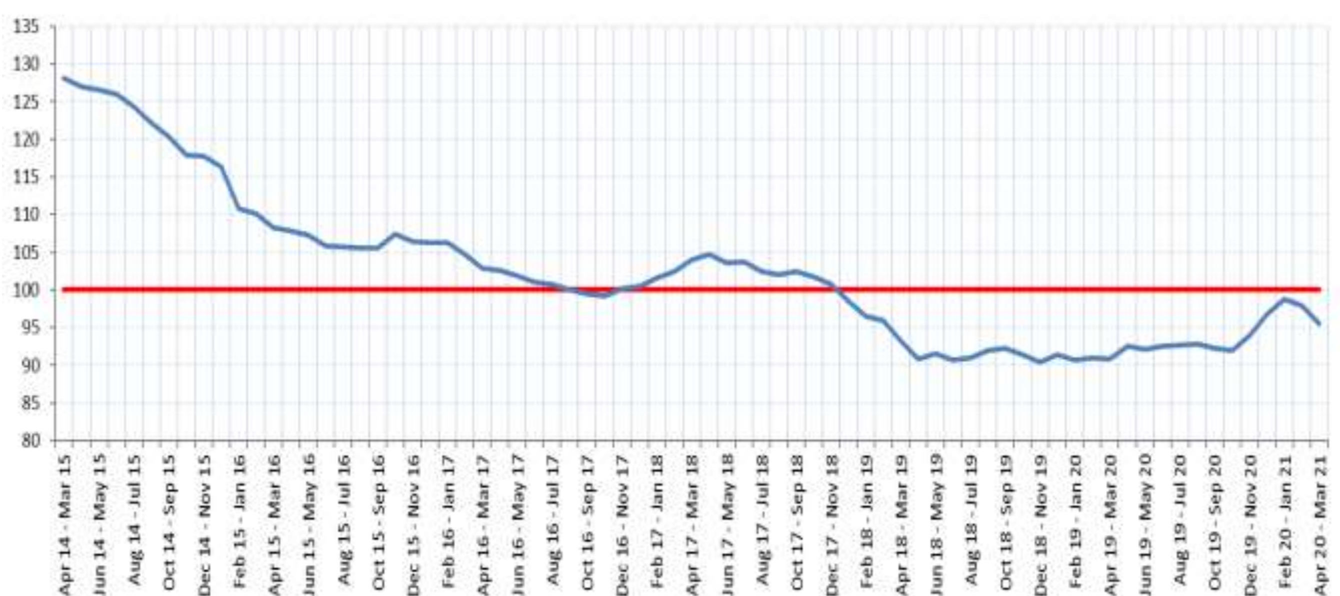
2. Mortality Data

2.1 Information related to mortality is gathered from data provided routinely by the Trust to a national system where all hospital episode statistics (HES Data) is collated. Hospital Standardised Mortality Ratio (HSMR) examines information covering 56 diagnostic groups that are identified as accounting for 80% of hospital deaths nationally.

This information is used to calculate an overall HSMR taking into account, gender of the patient, age, how the patient was admitted (emergency or elective), levels of deprivation, how many times they have been admitted as an emergency in the last year, if palliative care was provided and various details relating to presenting complaint on admission.

2.2 The latest HSMR value is now **95.54** (April 2020 to March 2021), this has decreased from the previously reported **101.19** (February 2020 to January 2021). It should be noted that the data across 2020-21 was re-based, which had resulted in a backdated change to HSMR across the year which resulted in in the HSMR for the Trust now being recorded as below 100 throughout the year.

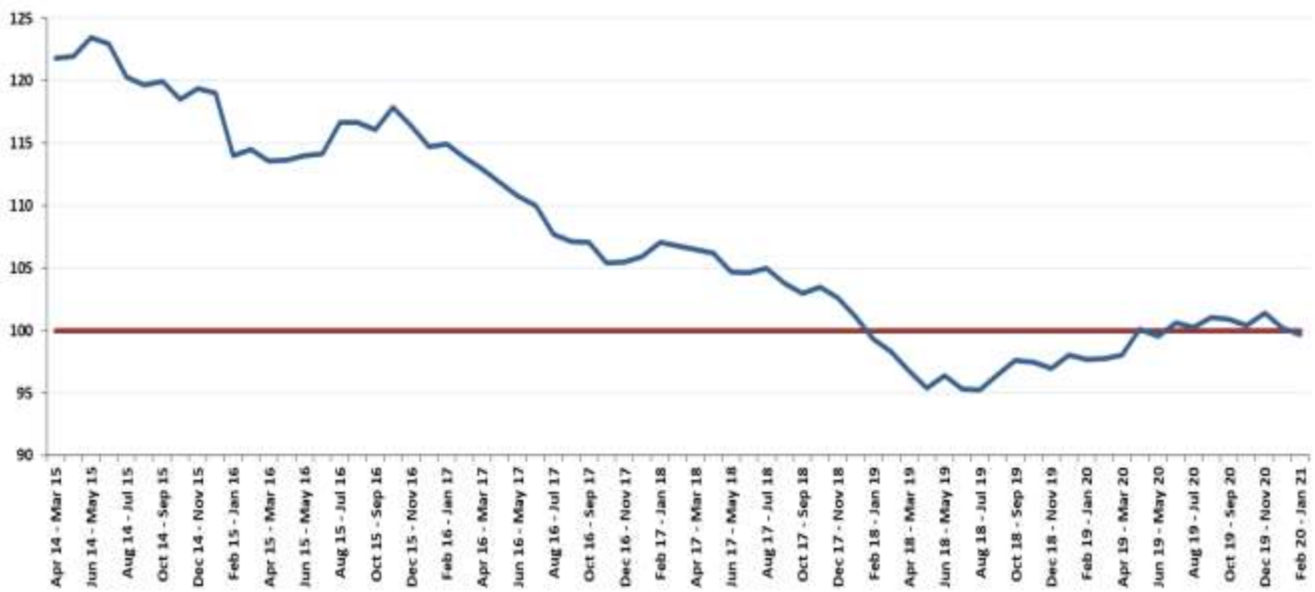
2.3 The value of 95.54 continues to remain inside the ‘as expected’ range. The following chart displays the 12 month rolling HSMR trends, with rebased data, from April 2014 to March 2021:



2.4 The Trust currently has the 41st lowest HSMR value from the 124 Trusts nationally, and 3rd lowest value out of the 7 North East Trusts.

2.5 The Summary Hospital-level Mortality Indicator (SHMI) is a ratio between the number of actual (observed) deaths to the “expected” number of deaths for an individual Trust, including deaths in hospital and up to 30 days following discharge. The ratio is calculated with consideration of gender, age, admission method, admissions in the last year and diagnosis being treated for the last admission.

2.6 The latest SHMI value is now this has decreased slightly to **99.7** (February 2020 to January 2021) from the previously reported value of **100.18** (January 2020 to December 2020). The value of 99.7 continues to remain inside the ‘as expected’ range. The graph below shows the 12 month rolling SHMI from April 2014 to January 2021:



2.7 The Trust currently has the 57th lowest SHMI value from the 123 Trusts nationally, and 3rd lowest value out of the 7 North East Trusts.

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

2.8 The increased focus on this should allow the Trust to maintain clearer clinical records but also maintain the current statistical mortality rates during the Covid-19 pandemic when there are nationally more deaths occurring. The changes in coding highlighted in the previous report, as having the potential to lead to an increase in the mortality statistics, has led to an increase in the rates as expected. If this continues as the Covid Pandemic develops, the longer term impact on the statistics will need to be examined further.

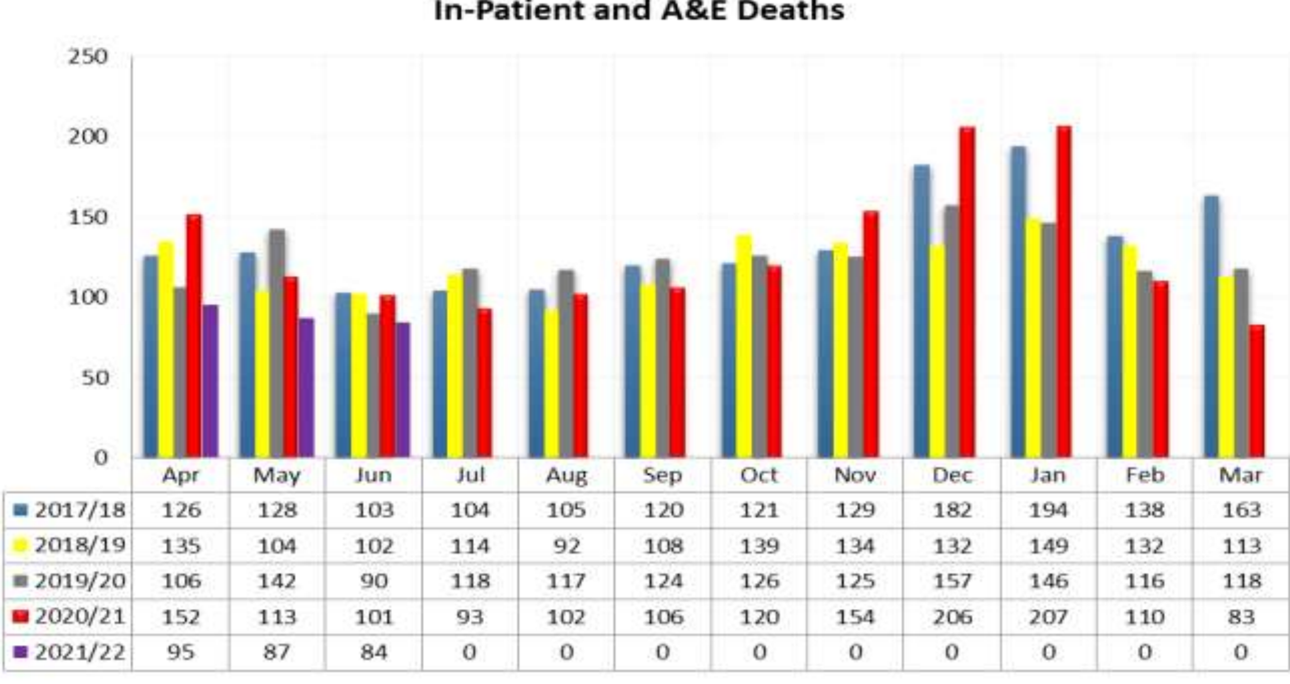
3. Mortality reviews

3.1 The Trust currently uses a mortality review tool is based on the “PRISM” methodology, one of the review tools recommended in the national guidance. This is a structured judgement style review of a case record, carried out by clinicians not involved in the patient’s care, to determine whether there were any problems in care.

There is a plan to move towards implementing an alternative structured judgment review tool that can be used in a similar manner across a wider range of case reviews, not purely for mortality. As the changes progress further updates will be provided in future reports.

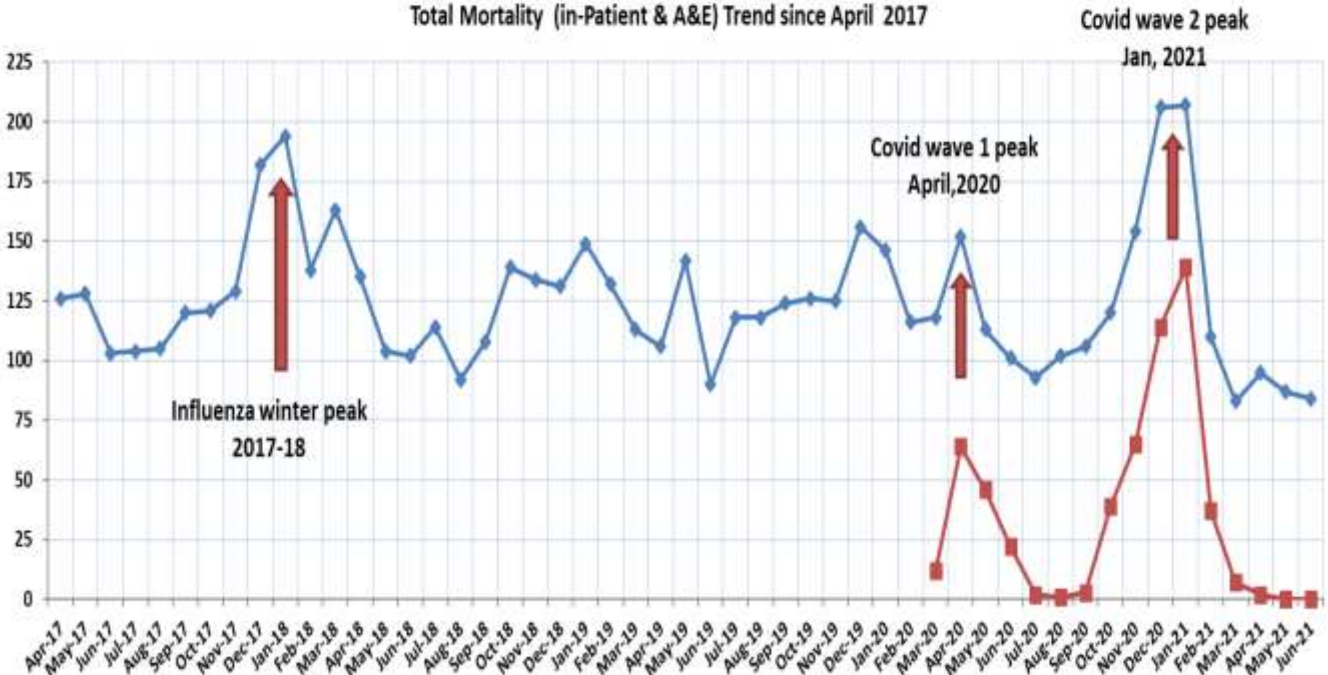
Case record review is undertaken routinely to learn and improve in the absence of any concerns, with all directorates undertaking their own specialty based mortality and morbidity meetings. This is because it can help identify issues where there are no initial concerns. It is also used where concerns exist, such as when bereaved families or members of staff raise issues about care.

3.2 The Trust policy currently identifies that all in-patient deaths and those in the Accident and Emergency department are included in the scope of the mortality reviews. The chart below shows the deaths since April 2017 to provide some comparison between the winter deaths in 2017-18 during the influenza epidemic; and the winter deaths in 2020-21 during the Covid Pandemic.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	126	128	103	104	105	120	121	129	182	194	138	163
2018/19	135	104	102	114	92	108	139	134	132	149	132	113
2019/20	106	142	90	118	117	124	126	125	157	146	116	118
2020/21	152	113	101	93	102	106	120	154	206	207	110	83
2021/22	95	87	84	0	0	0	0	0	0	0	0	0

3.3 The following chart shows the monthly trend and fluctuations in mortalities since April 2017 to June 2021; the markers represent key areas of peak deaths linked with influenza over the winter of 2017-18 and Covid-19 during 2020-21:



3.4 The Trust policy currently identifies specific cases where a compulsory review is required; these include:

- Where requests are made by families to undertake a case review.
- Where staff request a case review.
- All deaths in the Intensive Care Unit (ICU).
- All deaths linked to complaints about significant concerns in relation to clinical care.
- All deaths linked to Serious Incident investigations.
- All deaths where the patient was admitted for elective treatment.

Compulsory case reviews are also undertaken for the following cases, which are linked to specific national review processes:

- All deaths where a patient has a registered Learning Disability (LD) – in conjunction with the Learning Disability Mortality Review Programme (LeDER).
- All maternal deaths – in conjunction with M-BRRACE-UK.
- All deaths where the patient has a severe mental illness – in conjunction with local Mental Health Trusts as required.
- All child deaths (up to 18th birthday) – in conjunction with the Child Death Overview Panel (CDOP) process.
- All stillbirths – in conjunction with nationally agreed Perinatal Mortality Review tool.

3.5 The current Trust “Learning from deaths” policy is being reviewed by the Trust Mortality Lead and the Lead Medical Examiner to ensure it reflects the scrutiny being applied to in-patient deaths following the introduction of the Medical Examiners team. The Trusts team of Medical Examiners (ME) have been in post for the last year, covering 6 clinical sessions each week; the service has been extended to all in-patient areas following the appointment of two Medical

Examiner Officers (MEOs) wards. This programme has been agreed with the Regional Medical Examiner with an aim for the team to scrutinise all in-patient deaths end of 2021-22.

3.6 Where a patient's death immediately raises concern, this is reported and escalated through the Trusts incident reporting and investigation process, implementing Duty of Candour procedures as required. The details of the case will then be considered in line with the national Serious Incident framework to ensure any lessons learned are identified and reported to the Trusts commissioners. A case record review is completed as part of the investigation process. In all cases investigated as serious incidents Duty of Candour has been considered and applied appropriately.

During 2020-21, there have been 19 mortality cases reported and investigated as serious incidents, all were identified prior to mortality reviews being completed. One of these remains under investigation and seven remain under investigation with the Coroner, the overall outcome will be reported in future reports. The Coroner has recently commenced inquests using virtual technology.

During 2021-22, to the end of quarter 1, there have been no mortality cases reported and investigated as serious incidents.

3.7 The data presented in the appendix provides detail of all case reviews undertaken since April 2019. There are cases that may not have been identified immediately but have come to light as a result of the receipt of complaints and family requests through the Trust Bereavement survey; as a result, there are some reviews pending completion and details may change slightly for each report.

3.8 The following table provides a summary of the data, by financial quarters, for 2020-21. The numbers of mortality cases given scrutiny by the Medical Examiners team, during this latest quarter, has been included in the chart below to demonstrate the integration of the two approaches to reviewing care given. The ME team can refer any cases into the overall mortality review system for further interrogation of clinical care, as necessary utilising the established governance structures.

2020-21	**Q1**	**Q2**	**Q3**	**Q4**	**Total**
Total deaths in scope	366	301	480	395	**1542**
Deaths in compulsory criteria	42	46	54	39	**181**
Compulsory case reviews completed (no.)	18	9	14	7	**48**
Compulsory case reviews completed (%)	44%	20%	32%	18%	**27%**
Compulsory reviews pending	23	37	40	32	**132**
Additional reviews & ME scrutiny completed	15	0	86	70	**171**
Total completed (no.)	33	9	100	77	**219**
Total completed (%)	9%	3%	21%	19%	**14%**
Reviewed Deaths considered avoidable (no.)	0	0	0	0	**0**
Reviewed Deaths considered avoidable (%)	0%	0%	0%	0%	**0%**
Reviewed Deaths considered not preventable (no.)	33	9	100	77	**219**
Reviewed Deaths considered not preventable (%)	100%	100%	100%	100%	**100%**

3.9 The following table provides a summary of the data, by financial quarters, for 2021-22.

2021-22	Q1	Q2	Q3	Q4	Total
Total deaths in scope	252				**252**
Deaths in compulsory criteria	27				**27**
Compulsory case reviews completed (no.)	4				**4**
Compulsory case reviews completed (%)	15%				**15%**
Compulsory reviews pending	23				**23**
Additional reviews & ME scrutiny completed	152				**152**
Total completed (no.)	156				**156**
Total completed (%)	62%				**62%**
Reviewed Deaths considered avoidable (no.)	0				**0**
Reviewed Deaths considered avoidable (%)	0%				**0%**
Reviewed Deaths considered not preventable (no.)	156				**156**
Reviewed Deaths considered not preventable (%)	100%				**100%**

3.10 The numbers of mortality reviews undertaken by the Trust has been reduced during the Covid-19 pandemic; the capacity of clinical staff to undertake required mortality reviews has been significantly restricted. There are currently additional sessions planned to ensure relevant cases are reviewed and the required learning for improvement identified.

3.12 From March 2020 to the June 2021, the Trust has notified 526 deaths where patients were recorded as testing positive for Covid-19. A significant amount of this information continues to be provided for national data collection. The Trust contuse to work with other organisations, through the North East Quality Observatory (NEQOS) as part of the Regional Mortality Group, to collate data to assist in examining risks related to mortality across the region and how this has developed over the pandemic.

A key area of this is to understand the transmission of Covid in the local population; but also to examine cases where patients may have developed Covid whilst being cared for as an in-patient, this is known as "nosocomial" infection. The Trust is continuing to apply national guidance and taking stringent measures to protect patients, visitors and staff in the hospital. These are being updated via central government and NHS England as the pandemic is progressing, the Trust is examining and implementing to ensure safety.

As the numbers of Covid in the community increased during wave 2; it became increasingly difficult to manage. To date there have been 61 deaths linked to possible nosocomial infection' these are cases with Covid recorded on their death certificate. There have also been a further 12 patients who died following a positive Covid Swab where Covid was not included on their death certificate. Details have been collated for the 61 potential cases, and, following analysis of the data a summary will be provided to the Trust Board.

4. Medical Examiners (ME)

As outlined earlier in the report, the Trust ME team continues to progress their implementation plan within an aim to full scrutiny of all in hospital deaths by the end of this financial year. All of the ME and MEOs have now been accredited by the Royal College of Pathologists. The Trust ME office continues to have support from the Regional ME and MEO; this is reinforcing strong links with ME colleagues serving the hospitals south of the Tees.

The Trust works to national standards in the timeliness of issuing medical certificates of death and registering deaths. Additional training sessions in relation to the MEs role and death certification, have continued; these are virtual and open to doctors in training as well as final year medical students. These have been extended to include Coronial interactions and Cremation legislation with training for junior doctors also being included in the education programme within Medicine.

At this time there are difficulties recognised in relation to the implementation of the ME; the medical staff providing this service have a wealth of clinical expertise and experience; this means they are required to support the increasing activity required during the Covid pandemic. These are similar to the reduction in capacity, due to Covid, for clinical staff to undertake the mandated reviews of cases.

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

5. Maternity Stillbirth update

The Trusts Maternity department helps delivery around 2,500 babies each year; in the majority of cases, there are happy outcomes. However unfortunately there are some tragic circumstances where a baby dies before birth, and are "silently born" being classed as stillbirths. 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 from 22 completed week's gestation (excluding terminations) to 28 days after birth; as well as babies who die after 28 days following neonatal care.

The information obtained through using 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.

The PMRT is a web-based tool requires information to respond to a series of questions about care from pre-conception to bereavement and follow-up care. The information is then used to identify local and national learning with action plans being generated, implemented and monitored. In order to support this work the Trust has set up a Perinatal Mortality Review Group, which are attended by a multi-professional, cross-organisational group of staff. The value of discussions within this group has been central to good reviews of care; the use of external reviewers provides objectivity and undoubtedly has a role to play in quality assuring processes whilst also demonstrating transparency to families and the wider public. Relevant

clinical staff have also benefited from the multidisciplinary, cross boundary working when participating in reviews at other Trusts.

The learning obtained from the reviews is shared nationally but also allows the Trust to identify and understand any factors that may have impacted on the overall tragic outcome. The team have provided some information in relation to actions being taken, however they acknowledge that further improvement work is required and this is ongoing.

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 see her 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, multiple miscarriages or a history of premature birth. To promote this early contact with the midwives the Trust has 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.

The introduction of the risk assessment being completed at booking; has shown that women with 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 team are currently exploring how the digital maternity system can be used to support and strengthen the antenatal risk assessment processes.

At the latest review groups meetings, it was reported that the Covid-19 pandemic might have possibly adversely affected how the woman access maternity care. It was noted in the latest reviews that in all cases smoking during pregnancy was identified as an issue. Reducing smoking during pregnancy and smoking by parents with young families, has been for a long time, and remains a high priority area of impact for the Trust. The Trust continues to support the training and the use of the North East England Tabaco Dependency in Pregnancy Script to guide the conversations on the effect of smoking in pregnancy and promotes the Smoke free App from the National Centre for smoking Cessation (SSS).

Carbon monoxide testing was suspended nationally since spring 2020 due to Covid-19. This has now been re-introduced in April 2021. All women and partners who consent, are monitored and referred as appropriate for smoking cessation advice. The referral to smoking cessation has continued throughout Covid pandemic but the take up of referrals may have been impacted by the pandemic.

The Trust are also currently engaged with the Mat-Neo-Sip project; this has an aim to reduce the 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 2021/22 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.

The maternity team will be providing updates in relation to these agreed actions in future reports; at this time the learning from reviews has been shared with the midwifery and obstetric team. It is noted that these findings also reflect one of the immediate actions outlined in the national Ockenden Report further improvement work has been developed by the service in response to this report that will support the ongoing evaluation of the impact of these changes in practice.
(https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf)

6. Learning Disability Reviews (LeDeR)

The Trust undertakes reviews for all patients with a Learning Disability (LD) who die in our care; these deaths are thankfully low with an average of less than one per month since 2019, however, this makes it even more important to take every opportunity to learn. Information from the reviews is shared with the Teeswide LeDeR team who then collate the information for shared learning across all health and social care services. If necessary individual this can lead to a full multiagency review meeting to assist in identifying any shared learning.

Over the last few months, following on from any LeDeR the Nurse Advisor for Learning Disability has been providing feedback to staff in relevant departments involved in a case. This feedback has been in the form of a summary letter explaining what LeDeR is, a short description of the patient and the care received; the details of the scoring from the LeDeR, any lessons learned and actions taken as a result. This has been welcomed by the teams 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 the Trust reviews of cases, a standard operating procedure (SOP) was developed to guide staff making a referral and to also outline what actions will be taken following a referral. Alongside this, an online referral system is now in place to ensure there is a clear record of referrals which allows the Nurse Advisor for Learning Disability to hold an recorded audit trail in relation to all referrals. The SOP and electronic referrals are now in use across the Trust and supporting staff when caring for patients with learning disabilities.

The Trust is part of a regional 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. 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

The is supported by the Learning Disability Diamond Acute Care Workforce Education Package which developed to support all staff with learning disability awareness training. The training has been designed to be delivered face to face or via an e-learning package. The training focuses on:

- Communication
- Reasonable adjustments
- Mental Capacity Act and Best Interest Decision making
- Hospital Passports
- Learning Disability Diamond Standard Acute Care Pathways
- Case studies

As a result of learning from previous LeDeR reviews, the pre-assessment staff have nearly all now completed the Diamond training. This has resulted in an increase of referrals being received from that department to support planning for attendance at appointments or for admissions; which in turn provides appropriate support for patients and their families / carers during difficult situations.

Over the last couple of years, following LeDeR review and a serious incident investigation; the Trust enhanced the training provision for Learning Disability Awareness, and also added information to support staff awareness of the needs of patients with Autism. The Trust is pleased to advise that the training levels for this are now over 95% of all staff.

The Trust had identified a target of achieving 100% compliance for people with learning disability have hospital passports; this will be supported by the actions already being implemented as described earlier. The team will be auditing this and will be reporting progress through the Trusts Vulnerability Group, but this will also be included in future reports.

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

7. Deteriorating patient

Over the last 2 years, the Trust had identified various learning opportunities, including mortality reviews, incident investigations, and more recently, Medical Examiners scrutiny that there needed to be additional focus on the sharing of learning across all services within the Trust. This was emphasised more during the Covid pandemic as it became more imperative that teams link closely with others and provide mutual support. As a result it was agreed to initiate a new Trust group to look at these areas, the first meeting was held in July 2020, and despite the additional pressures the group has become well established, initially meeting every 2 months but has since increased to monthly.

The overarching function of the Deteriorating patient working group is to get together key stakeholders and clinicians in order to have a collaborative trust-wide approach to the care of the deteriorating patient. The group will gradually review and combine relevant policies/guidelines/protocols in order to ensure these are updated as needed and support local, regional and national recommendations relating to the deteriorating patient. The group will escalate issues pertaining to the deteriorating patient to the Trusts Excellence As Our Standard Group, also identifying from each meeting key areas for consideration, which will include areas for improvement and areas for celebration.

This group is attended by a broad range of professionals across all specialities; and covers a wide range of potential aspects of care relating to the deteriorating patient, these include but are not limited to:

- National Early Warning Scores (NEWS2)
- Paediatric Early Warning Scores (PEWS)
- Maternity Early Warning Scores (MEWS)
- Sepsis management / Sepsis 6
- Acute kidney Injury (AKI)
- Fluid balance
- Electrolyte imbalance
- Transfer of patients within and outwith of the Trust
- Treatment Escalation plans, including links to Palliative care and the Amber Care Bundle
- Training requirements
- Audit findings.

The group has also been identifying and agreeing actions for additional “task to finish groups” to enable the creation of sustainable actions and advise on steps forward to improve patient care and patient safety.

One of the key areas of focus for the group is to ensure there is appropriate support to enable the Trusts overall transition to electronic records; there is already a system for e-observations in place for most specialities, however, there are some services where the complexity is greater in relation to the requirements, for example ITU and obstetrics. Having awareness of the issues in relation to this will allow the group to consider what support is required to get implementation completed; an example of this has been the addition of the Sepsis Screening tool into the system, which will not only support communication of a patient’s condition but also assist with future audits of compliance. The move to electronic records overall is also being considered by the group; one key area of focus is currently the move towards having “Do Not Resuscitate” documentation electronically so that it is always available to staff wherever they are in the Trust.

The members of the Critical Care Outreach Team (CCOT) are key to supporting staff across the organisation with deteriorating and acutely ill patients, the team is represented at the Deteriorating Patient group and has already initiated to changes in practice. The team have set up a shared email that allows them and the Clinical Sight Managers, to all have access to receive alerts in relation to abnormal blood results that identify AKI; this supports them proactively attending the patient and providing support or advice. The CCOT representatives are also attending the regional Deteriorating Patient Forum in order to share and obtain learning from other Trusts.

Following case reviews and investigations linked to deterioration in a small number of patients who were requiring non-invasive ventilation; there was a decision made to set up a small project group to look at the specific aspects of the cases. Phase one of the project has been completed and examined the overall issues identified through learning; this was split into several work streams to look staffing requirements, training needs, governance, IT and other infrastructure / equipment. Phase two of the project has been the handing over of the project to the Care Group as a business case for a new Respiratory Support Unit has been agreed by the Executive Team, which has given a significant amount of funding into making the relevant changes to support the management of patients with respiratory problems. This has been a great achievement and not only provides support as the pandemic developed but also looking to the future for respiratory patients who are within one of the Trusts highest admission, and mortality diagnosis groups.

The information given here outlines only some of the key areas of work being undertaken across many areas of the Trust in relation identification and management of patients. Further details in relation to the points covered and the evaluation of impact will be shared in future; however, there will also be additional information obtained as part of a rolling programme from the group in future.

8. Conclusion/Summary

8.1 The Trust HSMR value is now **95.54** (April 2020 to March 2021), this has decreased from the previously reported **101.19** (February 2020 to January 2021). The latest SHMI value is now this has decreased slightly to **99.7** (February 2020 to January 2021) from the previously reported value of **100.18** (January 2020 to December 2020). Both are "within expected" ranges; the HSMR rates have been rebased once the end of financial year data was available.

8.2 The successful implementation of the Medical Examiners role has prompted a review of the Trusts policies; the Trust Mortality Lead and the Lead ME are reviewing the overall strategy and policy in relation to learning from deaths.

8.3 There is ongoing data collection in relation to Covid-19 deaths, not only for research studies but to also understand how Covid is being transmitted in the community and what can be learned, this will be examined further in future reports.

8.4 There is summary information in the report relating to actions initiated as a result of learning from maternity, Learning Disabilities and also the deteriorating patient groups work.

8.5 There were 19 mortality cases investigated as serious incidents during 2020-21, 1 remains under investigation and a further 7 are awaiting Coroners inquests to complete the reviews effectively. In all cases investigated as serious incidents Duty of Candour has been considered and applied appropriately.

During 2021-22, to the end of quarter 1, there have been no mortality cases reported and investigated as serious incidents.

8.6 During the Covid-19 pandemic clinical teams have not been able to provide all of the information that would generally be included in this report; updates are being obtained flexibly as the teams are able to supply the information.

9. Recommendations

9.1 The Board of Directors are asked to note the content of this report and the information provided in relation to the identification of trends to assist in learning lessons from the mortality reviews in order to maintain the reduction in the Trusts mortality rates.

9.2 The Board are asked to note the on-going work programme to maintain the mortality rates within the expected range for the organisation; but to also continue to be aware of the impact of the changes to Covid coding as future statistics are published.

9.3 The Trust Board are asked to note the details of some of the current quality improvement developments from various teams and groups across the Trust.

Dr D Dwarakanath

Medical Director / Deputy Chief Executive

Board of Directors

Title of report:	Appraisal and Revalidation, Report of the Medical Director
Date:	29 July 2021
Prepared by:	Dr Basant Chaudhury / Alison Cavanagh
Executive Sponsor:	Dr Deepak Dwarakanath, Medical Director
Purpose of the report	To provide the Board of DIrectors with an update on doctors appraisals and revalidation.

Action required:	Approve		Assurance	X	Discuss		Information	X
Strategic Objectives supported by this paper:	Putting our Population First		Valuing our People		Transforming our Services	X	Health and Wellbeing	X

Which CQC Standards apply to this report	Safe	X	Caring		Effective		Responsive		Well Led	X

Executive Summary and the key issues for consideration/ decision:
The report is presented to the Trust Board for assurance that the statutory functions of t Appraisal / Revalidation processes are being appropriately discharged. The report provides a summary of Medical Appraisal and Revalidation activity within the Trust in the period 1 April 2020 to 31March 2021 . Quality Improvement on Appraisals Improvement of the Starters and Leavers monthly updates overseas doctors and doctors staying within the trust once they have received their ARCP these doctors do not appear on the trusts starter list if they are not picked up they could miss out on having an annual appraisal.

How this report impacts on current risks or highlights new risks:
The prescribed format of this report has been retained for continuity but it should be noted h the information is presented against the backdrop of the Covid19 pandemic which markedly affected the ability to deliver appraisal and revalidation.

Committees/groups where this item has been discussed	Ps & Qs Medical Directors & Deputy Responsible officers meeting Medical Appraiser Update sessions
Recommendation	The Board of Directors is asked to note the content of the report and assurance on the processes in place in the Trust.

North Tees and Hartlepool NHS Foundation Trust

Appraisal and Revalidation

Report of the Medical Director

1 April 2020 – 31 March 2021

1. Executive Summary

Medical Revalidation was introduced in December 2012 and is now well established within the Trust. The Medical Director (Responsible Officer) has delegated the role to the Deputy Responsible Officer .The RO has a statutory duty to ensure that the requirements of revalidation are met. To be revalidated a doctor has to demonstrate that they have been participating in annual appraisal (assessed against the requirements of the GMC's Good Medical Practice) and have undertaken at least one patient and colleague multisource feedback exercise prior to their revalidation date and that there be no concerns about their conduct and practice.

The report provides a summary of Medical Appraisal and Revalidation activity within the Trust in the period 1st April 2020 to 31st March 2021. It includes information on the number of doctors that the Trust has on its GMC designated body.

The report sets out the governance arrangements around revalidation, provides details on how the performance of doctors is monitored and how concerns with doctors are responded to. Updates on the progress regarding medical appraisal and revalidation development plans will be included in the quarterly, HR and Educational Board Report as well as the Non-Executive Directors report when required

The report seeks to assure the Board that the Trust is compliant with requirements of Medical Revalidation.

2. Background

Medical Revalidation was launched in 2012 and is a legal requirement which applies to all licenced doctors listed on the GMC register in both the public and independent sectors. It is a way that the doctors are regulated, with the aim of improving the quality of care provided to patients, ensuring patient safety and increasing public trust and confidence in the healthcare. All practising doctors in the UK are required to be connected to a Designated Body (DB), usually a NHS organisation.

The Trust also acts as the Designated Body (DB) for both the Butterwick Hospice and Alice House Hospice, Hartlepool the Medical Director also presents an Annual Report to both organisations.

Trusts has a statutory duty to support and resource their Responsible Officers (RO) in discharging their duties under the Responsible Officer Regulations (The Medical

Profession) Responsible Officer Regulations 2010 as amended in 2013 and The General medical Council (Licence to Practise and Revalidation) and it is expected that Trust Boards will oversee compliance by:

- Monitoring the frequency and quality of medical appraisals in their organisation
- Checking there are effective systems in place for monitoring the conduct performance of doctors
- Confirming that feedback from patients is sought periodically so their views on their appraisal and revalidation process for the doctor

3. Governance Arrangements

Majority of doctors are now starting their second cycle and there is a continued requirement for the DBs to be able to provide assurance to patients and the public that appropriate systems and processes are in place to ensure that every licensed medical practitioner connected to the Trust as their Designated Body (DB) is safe to practice.

4. The Impact of Covid -19

On 17th March 2020 the GMC suspended the revalidation process for the period 17/03.2020 - 30/09/2020 to recognise the impact of the Covid-19 pandemic on doctors' ability to prepare for appraisal and revalidation. All doctors' under notice in this period has 12 months added to their due date. The suspension was extended again in early June to cover the period to 16th March 2021.

Shortly thereafter NHS England suspended the appraisal process for the same reason and for the same time frame. The Trust restarted appraisal period.

Doctors who were already overdue an appraisal as of 17th march 2020 were not given an approved miss or delay were not deemed to be Covid-19 related. However each doctor in this situation was followed up personally by the Revalidation Co-ordinator who worked with them to put a plan in place for completion of their appraisal in an achievable timescale.

All appraisals that continued to be conducted are being completed via Teams to comply with social distancing requirements.

Appraisal Network Meetings, Appraisal Update Training are being held online

5. Medical Appraisals Performance Data

As at 31st March 2021 the Trust had a prescribed connection with 267 doctors and the breakdown of appraisals are as table below

Directorate	Number to be Appraised	Number Appraised for 2020/21	Current number of outstanding appraisals	% Compliance
A&E	20	10	10	50.00%
Anaesthetics	44	44	0	100.00%
Palliative Care	5	4	1	80.00%
In Hospital Care	55	50	5	90.91%
Obstetrics & Gynaecology	17	15	2	88.24%
Occupational Health	1	0	1	0.00%
Orthopaedics	32	31	1	96.88%
Paediatrics	30	30	0	100.00%
Pathology	10	10	0	100.00%
Radiology	20	19	1	95.00%
Surgery	33	28	5	84.85%
Totals	**267**	**241**	**26**	**90.26%**

Appraisal compliance period for 2020 – 2021 was 90.26%. All of the 26 doctors with outstanding appraisals have been contacted and personalised action plan to assist them to get back on track with their appraisal most of the doctors are in the position of their appraisal being completed.

6. Appraisers

As at 31st March there are 53 active appraisers within the Trust, all whom have undertaken appraisal for revalidation training. This training is a one day training event held annually to maintain a ratio of 1:5 of appraisers to the connected doctors. All trained appraisers are invited to have annual refresher training.

The objectives of the Training include:

- Be familiar with the Trusts appraisal policy and process.
- Be up-to-date with the requirements of the GMC
- Understand the role of the appraisal in the revalidation process, based on the most current information from the GMC and NHS England
- Maintain the skills required to conduct an effective appraisal interview

7. Revalidation

During the period 1st June 2020 to 31st March 2021 there were 19 revalidation recommendations (when revalidation was suspended) made to the GMC by the Trust, 1 doctor has been deferred. The GMC suspended all revalidations in March 2020 due to Covid-19, writing to all doctors due to revalidate informing them their submission date had been postponed by 1 year. All recommendation were made before the doctors due date.

8. Access, Security and Confidentiality

The Appraisal Policy confirms that only the MD, Deputy RO and Revalidation Administrator have access to the appraisal documentation. All data is stored securely and in accordance with Data Protection legislation and must not contain any patient identifiable data.

9. Improvements

- Work has now been undertaken to address the issues highlighted in a gap analysis, including the updated version of a QA checklist prior to the doctors revalidation
- Close monitoring of appraiser attendance at annual update sessions.

- Updated Medical appraisal document, the documents is under constant review to reflect any changes that may be required in line with guidance from the GMC and effect of covid-19

10. Developments Required / Next Step

- Quality improvement activity to be more emphasised on the appraisal document and will be added to the appraiser update sessions

- Review of allocation of appraisers to ensure we have an even spread of numbers

- Regular newsletter to inform doctors of key information on medical appraisal / revalidation

- Improvement on communication on doctors coming from training into a fixed term contract / MTI doctors employed by the trust are currently not included on the monthly starter's lists.

11. Issues Highlighted

The team requires continued support of the trustees, executive board, HR and Medical Education Directorate to continue to achieve and maintain high standards in appraisal and revalidation of doctors.

Board of Directors

<table>
<tr><td>Title of report:</td><td colspan="10">Nursing and Midwifery Revalidation</td></tr>
<tr><td>Date:</td><td colspan="10">29 July 2021</td></tr>
<tr><td>Prepared by:</td><td colspan="10">Emma Roberts, Head of Nursing Workforce</td></tr>
<tr><td>Executive sponsor:</td><td colspan="10">Lindsey Robertson, Chief Nurse/Director of Patient Safety & Quality</td></tr>
<tr><td>Purpose of the report</td><td colspan="10">To provide assurance that there is robust governance in place to ensure nurses and midwives are compliant with Nursing & Midwifery Council professional revalidation requirements.</td></tr>
<tr><td>Action required:</td><td colspan="2">Approve</td><td></td><td colspan="2">Assurance</td><td>x</td><td colspan="2">Discuss</td><td></td><td>Information</td></tr>
<tr><td>Strategic Objectives supported by this paper:</td><td colspan="2">Putting our Population First</td><td>x</td><td colspan="2">Valuing People</td><td>x</td><td colspan="2">Transforming our Services</td><td></td><td>Health and Wellbeing x</td></tr>
<tr><td>Which CQC Standards apply to this report</td><td>Safe</td><td>x</td><td>Caring</td><td>x</td><td>Effective</td><td>x</td><td>Responsive</td><td>x</td><td>Well Led</td><td>x</td></tr>
<tr><td colspan="11">Executive Summary and the key issues for consideration/ decision:</td></tr>
<tr><td colspan="11">Revalidation is the process by which all NMC registrants maintain their registration with the Nursing and Midwifery Council (NMC) in the UK. The Code (NMC, 2018) advise that revalidation is the responsibility of the registrant and that it is the role of employers to provide support for registrants who wish to revalidate. All registrants are required to meet a number of minimum standards during the three years preceding the date of their application for renewal.

Individuals who fail to meet revalidation standards are not legally able to work in the United Kingdom within the profession.</td></tr>
<tr><td colspan="11">How this report impacts on current risks or highlights new risks:</td></tr>
<tr><td colspan="11">No impact/no new risks.</td></tr>
<tr><td>Committees/groups where this item has been discussed</td><td colspan="10">Patient Safety & Quality Committee</td></tr>
<tr><td>Recommendation</td><td colspan="10">The Board is asked to note the content of the report and the processes in place to ensure robust assurances for Nursing and Midwifery Revalidation compliance within the Trust.</td></tr>
</table>

North Tees & Hartlepool NHS Foundation Trust

Meeting of Board of Directors

29 July 2021

Nursing and Midwifery Revalidation

Report of the Chief Nurse/Director of Patient Safety and Quality

1 Introduction

Revalidation is the process by which all NMC registrants maintain their registration with the Nursing and Midwifery Council (NMC) in the UK. The Code (NMC, 2018) advise that revalidation is the responsibility of the registrant and that it is the role of employers to provide support for registrants who wish to revalidate. All registrants are required to meet a number of minimum standards during the three years preceding the date of their application for renewal.

2 Preparation and support for registrants

In order to revalidate the registrant must demonstrate that in the preceding three years they have achieved 450 practice hours within the scope of their role, evidence of 35 hours of Continuous Professional Development (CPD), completed five pieces of written reflective accounts and evidence of five records of feedback on their performance. This is supported by a reflective discussion with another registrant and written confirmation of the evidence collected.

Individuals who fail to meet revalidation standards are not legally able to work in the United Kingdom within the profession. The Head of Nursing Education and Placements and the Heads of Nursing and Midwifery for Healthy Lives, Responsive Care and Collaborative Care Groups identified as the operational leads for revalidation within the Trust on behalf of the Chief Nurse/Director of Patient Safety and Quality. Any individual queries from registrants relating to revalidation supported by the Head of Nursing Education and Placements and by the Care Group Heads of Nursing/Midwifery.

3 Monitoring compliance

Nursing and midwifery registration and revalidation is recorded in the Trust's Electronic Staff Records system (ESR) which automatically notifies line managers when their registrants are due to revalidate at 12, 6 and 4 months prior to revalidation taking place. The NMC also reminds staff via their recorded email address when their revalidation is due.

The Trusts nursing and revalidation policy has been expanded to include identified responsibility for generating reports for each of the Care Groups Heads of Nursing and Midwifery. The Business Intelligence team now run this report monthly and include the Deputy Chief Nurse, Heads of Nursing/Midwifery, workforce business partners, workforce advisor – resourcing & quality and employee relations manager. The BI report allows for robust monitoring and oversight of the registered nursing staff within each of the care groups in terms of their revalidation status and dates.

If a registrant fails to renew their registration or to revalidate, an alert will flag centrally and to the Employee Relations manager. This process is embedded and provides escalation to the Care Group Head of Nursing/Midwifery and the appropriate Senior Clinical Matron/Professional. Professional registration issues are escalated to the Deputy Chief Nurse & Chief Nurse by the Care Group Head of Nursing.

There has been a recent review of the process of how staff members' registration is documented within ESR to ensure that when new staff recruited into posts, ESR reflects the correct registration type.

Following the most recent AuditOne report, three staff required further actions relating to their NMC PIN/ registration status. Two of the staff have successfully revalidated and the ESR system reflects this position and the third staff member had an honorary contract now retired and removed from the system.

4 Recommendation

The Board is asked to note the content of the report and the processes in place to ensure robust assurances are in place for the Nursing and Midwifery Revalidation within the Trust.

Lindsey Robertson
Chief Nurse, Director of Patient Safety and Quality

Board of Directors

Title:	Workforce Race Equality Scheme (WRES) 2021
Date:	29 July 2021
Prepared by:	Nicola Hogarth, Employee Relations Advisor
Executive Sponsor:	Alan Sheppard, Chief People Officer
Purpose of the report	The WRES requires NHS Trusts to undertake an assessment against nine core indicators. The indicators are split across four workforce metrics, four staff survey findings and one Trust Board level information. In order to meet the requirement for 2021, the Trust is required to publish data (as at 31 March 2021), no later than 31 August 2021 to NHS England via the NHS Digital Strategic Data Collection Service (SDCS). In addition to this, the Trust must publish the WRES data on the corporate website by 31 October 2021.

Action required:	Approve	X	Assurance	X	Discuss		Information	X
Strategic Objectives supported by this paper:	Putting our Population First	X	Valuing People	X	Transforming our Services		Health and Wellbeing	X

Which CQC Standards apply to this report	Safe	X	Caring		Effective		Responsive		Well Led	X

Executive Summary and the key issues for consideration/ decision:

The Workforce Race Equality Standard (WRES) was introduced as part of the NHS Standard Contract in 2015 to ensure that employees from BME backgrounds have equal access to career opportunities and receive fair treatment in the workplace. Extensive research has been undertaken which has proven that there exists an inherent link between the experience of BME staff and the standard of patient care delivered.

The WRES consists of nine metrics which considers the fairness of how BME staff are treated and NHS organisations are required to report on the metrics annually and implement an action plan to address any disparities in an attempt to close the gap between the experience of BME staff and white staff.

The report contains detailed information regarding the nine metrics, however the highlights are summarised as:

- The overall percentage of BME Staff in the workforce has remained static at 11%.

- The overall BME staff figures highlight that the Trust is fairly well represented in comparison to the Government's Office for National Statistics which reports a 4.7% BME population in the North East of England.

- Analysis of the Trust's data has shown:

  - There is a higher likelihood of white staff being appointed from shortlisting;
  - BME staff are less likely than white staff to enter formal disciplinary processes;
  - White staff are more likely to access non-mandatory training and CPD opportunities;
  - A reduction in the % of BME staff experiencing harassment, bullying/abuse from the public;
  - A reduction in the % of BME staff experiencing harassment, bullying/abuse from staff;
  - An increase in the % of BME staff reporting that the Trust has equal opportunities for career progression and promotion;
  - An increase in the % of staff who have experienced discrimination at work.

An action plan is being developed to improve the experience of BME colleagues.

The Board of Directors is requested to note the content of this report and confirm approval for the submission to be made online to the NHS Digital Strategic Data Collection Service (SDCS).

This report identifies areas of action which will form part of the Trust action plan.

	Not applicable.
	It is recommended that the report is approved by the Board of Directors.
	Presentation to the following committee's: • BME Staff Network • Workforce Committee • Culture Group The WRES report requires submission to the NHS Digital Strategic Data Collection Service (SDCS) no later than 31 August 2021. The report also requires publication on the Trust's corporate website.

North Tees & Hartlepool NHS Foundation Trust

Trust Board of Directors

29 July 2021

NHS Workforce Race Equality Standard 2021

1. Introduction

As set out in the NHS Long Term Plan, respect, equality and diversity are central to changing culture and are at the heart of the NHS workforce implementation plan.

The Workforce Race Equality Standard (WRES) was introduced as part of the NHS Standard Contract in 2015 and seeks to tackle one particular aspect of equality – the consistently less favourable treatment of those who identify themselves as Black, Asian or from a Minority Ethnic background.

National research shows that those individuals who are from a Black, Asian or Minority Ethnic background are:

- less likely to be appointed for jobs once shortlisted;
- less likely to be selected for training and development programmes;
- more likely to experience harassment, bullying or abuse;
- more likely to be disciplined and dismissed.

The WRES consists of nine metrics which consider the fairness of how BME staff are treated. Trusts must report on the metrics annually and implement an action plan to address any disparities highlighted by the information, in an attempt to try and close the gap between the experience of BME staff as compared to White staff.

We are now entering the seventh year of WRES reporting and the importance of workforce equality remains as critical as ever. The NHS People Plan places Equality, Diversity and Inclusion as one of the nine headings, with defined actions aimed at improving the experience for everyone working in the NHS.

This report sets out the Trust requirements for 2021 and presents the nine WRES metrics and key findings.

2. Trust Requirements

In order to meet the requirements for 2021, the Trust is required to publish data (as at 31 March 2021) no later than 31 August 2021 to NHS England via the NHS Digital Strategic Data Collection Service (SDCS). In addition to this, the Trust must publish the WRES data on the Trust's corporate website no later than 31 October 2021.

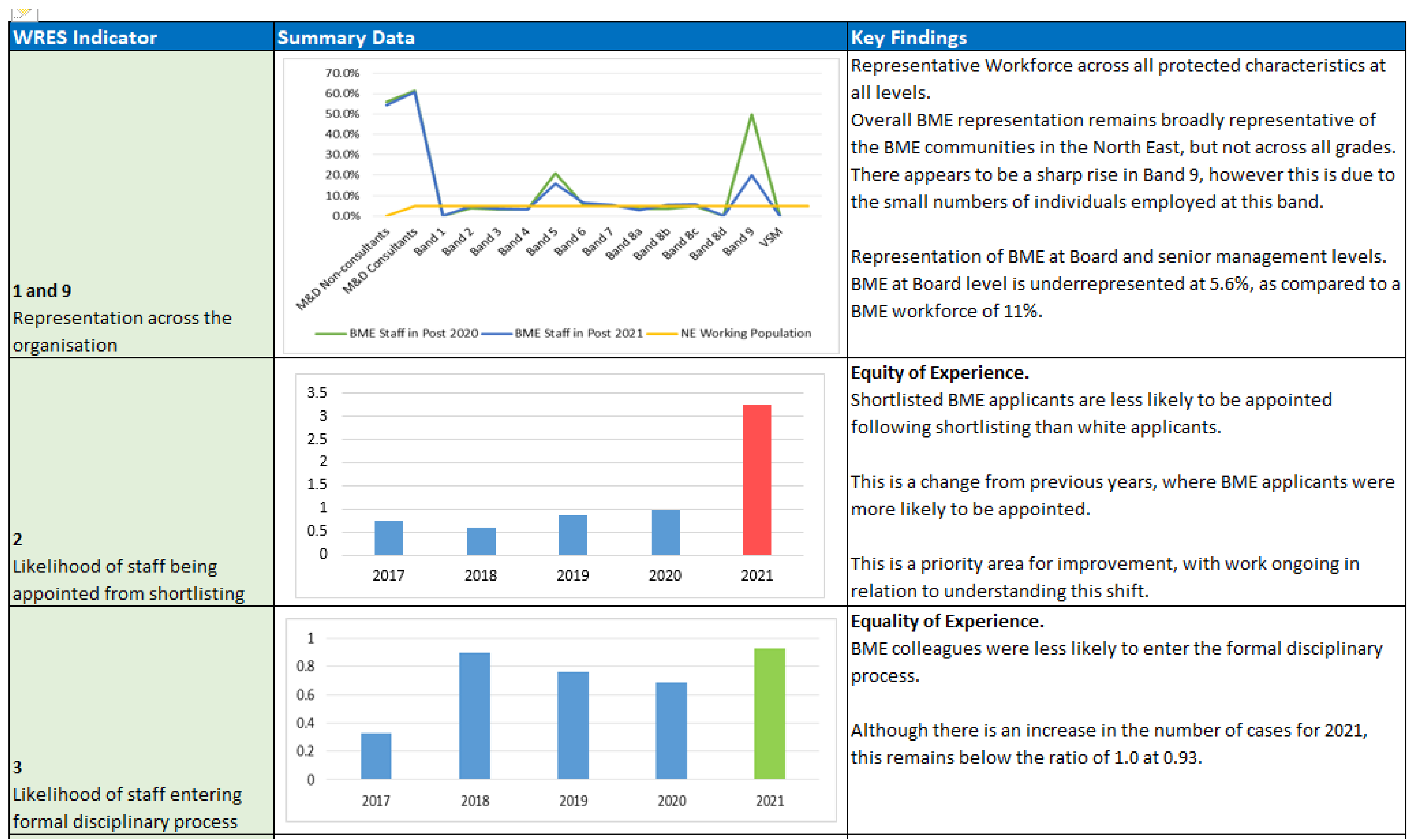
3. WRES Indicators 2021

A summary of the results for North Tees and Hartlepool NHS Foundation Trust is shown in the table below. The baseline data has been extracted and calculated to determine a response to each of the nine WRES indicators. This includes comparison of the Trust's results covering a five-year period: 2017 to 2021.

WRES Indicators for North Tees and Hartlepool NHS Foundation Trust: 2017-2021

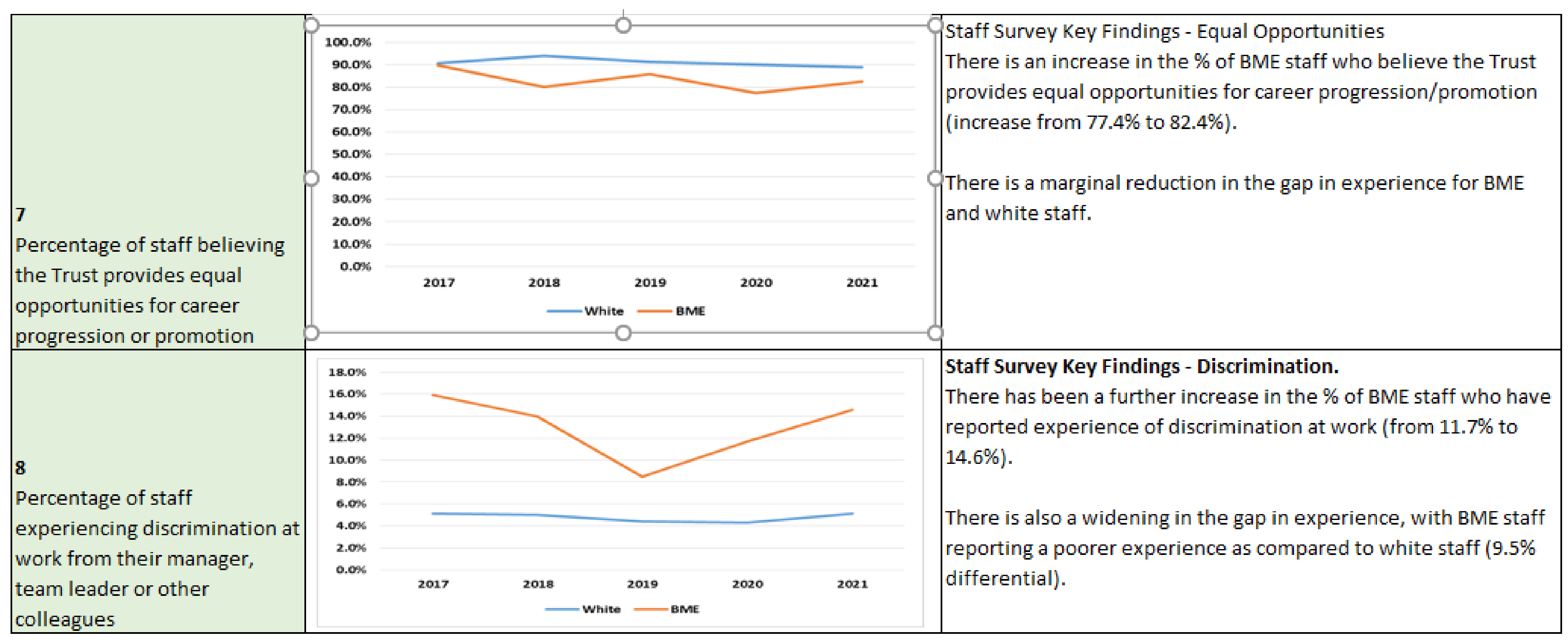
Wres Indicator			2017	2018	2019	2020	2021
1	Percentage of BME staff	**Overall**	9.0%	10.0%	11.0%	11.0%	**11.0%**
		VSM	0.0%	0.0%	0.0%	0.0%	**0.0%**
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants		0.74	0.58	0.86	0.99	**3.24**
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff		0.33	0.9	0.76	0.69	**0.93**
4	Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff		0.6	0.89	0.67	0.77	**1.16**
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	**BME**	39.1%	36.0%	37.5%	42.3%	**28.1%**
		White	26.6%	29.2%	26.9%	28.0%	**24.8%**
6	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	**BME**	20.0%	28.0%	31.3%	33.8%	**29.2%**
		White	19.8%	22.5%	18.3%	18.4%	**20.4%**
7	Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion	**BME**	89.9%	80.0%	85.7%	77.4%	**82.4%**
		White	90.8%	94.0%	91.4%	90.2%	**88.9%**
8	Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues	**BME**	15.9%	14.0%	8.5%	11.7%	**14.6%**
		White	5.1%	5.0%	4.4%	4.3%	**5.1%**
9	BME Board membership		7.1%	6.7%	6.7%	5.3%	**5.6%**

4. Key Findings for 2021



WRES Indicator	Summary Data	Key Findings
1 and 9 Representation across the organisation		Representative Workforce across all protected characteristics at all levels. Overall BME representation remains broadly representative of the BME communities in the North East, but not across all grades. There appears to be a sharp rise in Band 9, however this is due to the small numbers of individuals employed at this band. Representation of BME at Board and senior management levels. BME at Board level is underrepresented at 5.6%, as compared to a BME workforce of 11%.
2 Likelihood of staff being appointed from shortlisting		**Equity of Experience.** Shortlisted BME applicants are less likely to be appointed following shortlisting than white applicants. This is a change from previous years, where BME applicants were more likely to be appointed. This is a priority area for improvement, with work ongoing in relation to understanding this shift.
3 Likelihood of staff entering formal disciplinary process		**Equality of Experience.** BME colleagues were less likely to enter the formal disciplinary process. Although there is an increase in the number of cases for 2021, this remains below the ratio of 1.0 at 0.93.

4 Likelihood of staff accessing non-mandatory training and continuous personal development		**Belief in Equal Opportunities.** White staff are more likely to access non-mandatory training and continuous personal development compared to BME staff. This is a change to previous years where the ratio had remained below 1.0. The actual number of BME staff accessing training is broadly similar (157 staff in 2021, compared to 154 staff in 2020), however the number of white staff accessing training has increased significantly from 920 to 1431 staff which has increased the ratio.
5 Perecentage of staff experiencing harassment, bullying/abuse from patients, relatives/public		**Staff Survey Key Findings - B&H Public** Staff survey results show a decrease in the number of BME staff experiencing harassment, bullying and abuse from patients, relatives/public (28.1% compared to 42.3% last year). BME staff continue to be more likely to experience harassment, bullying/abuse from patients than white staff although the gap has narrowed for 2021.
6 Percentage of staff experiencing harrassment, bullying/abuse from staff		**Staff Survey Key Findings - B&H Staff** Staff survey results show a decrease in the number of BME staff experiencing harassment, bullying and abuse from staff (29.2% compared to 33.8% last year). BME staff continue to be more likely to experience harassment, bullying/abuse from staff than white staff although the gap is starting to narrow.



7 Percentage of staff believing the Trust provides equal opportunities for career progression or promotion	100.0% 90.0% 80.0% 70.0% 60.0% 50.0% 40.0% 30.0% 20.0% 10.0% 0.0% 2017 2018 2019 2020 2021 White BME	Staff Survey Key Findings - Equal Opportunities There is an increase in the % of BME staff who believe the Trust provides equal opportunities for career progression/promotion (increase from 77.4% to 82.4%). There is a marginal reduction in the gap in experience for BME and white staff.
8 Percentage of staff experiencing discrimination at work from their manager, team leader or other colleagues	18.0% 16.0% 14.0% 12.0% 10.0% 8.0% 6.0% 4.0% 2.0% 0.0% 2017 2018 2019 2020 2021 White BME	**Staff Survey Key Findings - Discrimination.** There has been a further increase in the % of BME staff who have reported experience of discrimination at work (from 11.7% to 14.6%). There is also a widening in the gap in experience, with BME staff reporting a poorer experience as compared to white staff (9.5% differential).

5. Action Planning

The Trust is committed to meeting the requirements of the Workforce Race Equality Standard for NHS Trusts and this is our seventh publication against this standard.

Having considered the 2021 data, alongside data from previous years, this year's action plan will link to the NHS People Plan and reflect the work being undertaken nationally in respect of the Overhauling Recruitment Practices pilot, which includes activities to improve/address disparity ratios.

A robust action plan will be developed with the purpose of bringing about positive change across the Trust resulting in an improvement in all WRES indicators. The Trusts' BME Staff Network will be instrumental in the development and ongoing monitoring of this action plan, with appropriate challenge from the Workforce Committee and Culture Group.

6. Conclusion

The WRES is important, because research shows that a motivated, included and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved patient safety.

The implementation of the WRES helps us to better understand the experiences of our BME staff and supports positive change for existing employees, with a more inclusive environment for BME staff working in the NHS.

There are a number of positive trends in relation to the WRES, for example, staff from a BME ethnicity continue to be less likely to enter formal disciplinary processes, when compared to colleagues from a White ethnicity; however we need to work towards achieving a more equal ratio where staff experience is the same regardless of an individual's ethnicity.

The data in relation to the staff survey metrics shows positive improvements for the 2020 survey (2021 WRES report), and we are starting to narrow the gap in relation to bullying/harassment from the public and staff; and staffs belief in equal opportunities.

It is important that we engage with our BME colleagues and seek to understand their views at an individual level. The BME staff network is an essential tool to enhance our engagement with staff and therefore our primary focus will be to continuously promote the network and recruit new members to ensure that we have a mechanism for BME colleagues to share their collective voice within the organisation.

The information contained within the WRES standard and progress made within the metrics and the resulting action plan for 2021 will be monitored through the Trust's BME staff Network, the Culture Group and the Workforce Committee.

7. Recommendation

The Board of Directors is requested to acknowledge the results of the Workforce Race Equality Standard (2021) and to confirm approval for the results to be submitted to NHS Digital Strategic Data Collections Service (SDCS) by the deadline of 31 August 2021.

Board of Directors

Title:	Workforce Disability Equality Scheme (WDES) 2021
Date:	29 July 2021
Prepared by:	Nicola Hogarth, Employee Relations Advisor
Executive Sponsor:	Alan Sheppard, Chief People Officer
Purpose of the report	To meet the requirements of the Workforce Disability Equality Standard (WDES) by comparing the experiences of disabled and non-disabled staff. To ensure that employees with disabilities have equal access to career opportunities and receive fair treatment in the workplace. In order to meet the requirement for 2021, the Trust is required to publish data (as at 31 March 2021), no later than 31 August 2021 to NHS England via the NHS Digital Strategic Data Collection Service (SDCS). In addition to this, the Trust must publish the WDES data on the corporate website by 31 October 2021.

Action required:	Approve	X	Assurance	X	Discuss		Information	X
Strategic Objectives supported by this paper:	Putting our Population First	X	Valuing People	X	Transforming our Services		Health and Wellbeing	X

Which CQC Standards apply to this report	Safe	X	Caring		Effective		Responsive		Well Led	X

Executive Summary and the key issues for consideration/ decision:

The Workforce Disability Equality Standard (WDES) came into force on 1 April 2019 as part of the NHS Standard Contract to compare the experiences of disabled and non-disabled staff and to ensure that employees with disabilities have equal access to career opportunities and receive fair treatment in the workplace.

The WDES consists of ten specific metrics, which consider the fairness of how disabled staff are treated.

Trusts are required to report on the metrics annually and the information obtained used to implement local action plans to address any disparities in the metrics and to demonstrate progress against the indicators of disability equality.

The report contains detailed information regarding the ten metrics, however the highlights are summarised as:

- The overall percentage of staff in the workforce who have informed the Trust that they have a disability or long term health condition has remained static at 2%.

- Analysis of the Trust's data has shown:

  - There is an increased likelihood of disabled applicants being appointed from shortlisting;
  - There have been no formal cases involving capability for disabled staff;

- A reduction in the % of disabled staff experiencing harassment, bullying/abuse from the public;
- An increase in the % of disabled staff experiencing harassment, bullying/abuse from managers and colleagues;
- An increase in the % of disabled staff reporting harassment, bullying/abuse;
- A reduction in the % of disabled staff reporting that the Trust has equal opportunities for career progression and promotion;
- An increase in the % of disabled staff who have felt pressured to come to work whilst unwell;
- A reduction in the % of disabled staff who feel valued by the organisation;
- A slight reduction in the % of disabled staff who reported that the Trust had made adequate reasonable adjustments to enable them to carry out their work;
- No change to the staff engagement score for disabled staff.

An action plan is being developed to improve the experience of disabled colleagues.

The Board of Directors is requested to note the content of this report and confirm approval for the submission to be made online to the NHS Digital Strategic Data Collection Service (SDCS).

This report identifies areas of action which will form part of the Trust action plan.

Committees/groups where this item has been discussed	Not applicable.
Recommendation	It is recommended that the report is approved by the Board of Directors.
Next steps for presentation e.g. Board Committee/Board meeting	Presentation to the following committee's: • Ability Staff Network • Workforce Committee • Culture Group The WDES report requires submission to the NHS Digital Strategic Data Collection Service (SDCS) no later than 31 August 2021. The report also requires publication on the Trust's corporate website.

North Tees & Hartlepool NHS Foundation Trust

Trust Board of Directors

29 July 2021

NHS Workforce Disability Equality Standard 2021

1. Introduction

As set out in the NHS Long Term Plan, respect, equality and diversity are central to changing culture and are at the heart of the NHS People Plan.

The NHS Workforce Disability Equality Standard (WDES) is designed to improve workplace experience and career opportunities for disabled people working, or seeking employment, in the National Health Service (NHS). The WDES follows the NHS Workforce Race Equality Standard (WRES) as a tool and an enabler of change.

The WDES first came into force on 1 April 2019 as part of the NHS Standard Contract and consists of ten specific metrics which consider the fairness of how disabled staff feel they are treated by the organisation. NHS Organisations are required to report on the metrics annually and the information obtained is used to implement local action plans to address any disparities in the metrics and to demonstrate progress against the indicators of disability equality.

This is the third year of WDES reporting and the importance of workforce equality remains as critical as ever. The NHS People Plan places Equality, Diversity and Inclusion as one of the nine headings, with defined actions aimed at improving the experience for everyone working in the NHS.

This report sets out the Trust requirements for 2021 and presents the ten WDES metrics and key findings.

2. Trust Requirements

In order to meet the requirements for 2021, the Trust is required to publish data (as at 31 March 2021) no later than 31 August 2021 to NHS England via the NHS Digital Strategic Data Collection Service (SDCS). In addition to this, the Trust must publish the WDES data on the Trust's corporate website no later than 31 October 2021.

3. WDES Indicators 2021

A summary of the results for North Tees and Hartlepool NHS Foundation Trust is shown in the table below. The baseline data has been extracted and calculated to determine a response to each of the ten WDES indicators. This includes comparison of the Trust's results covering a three-year period: 2019 to 2021.

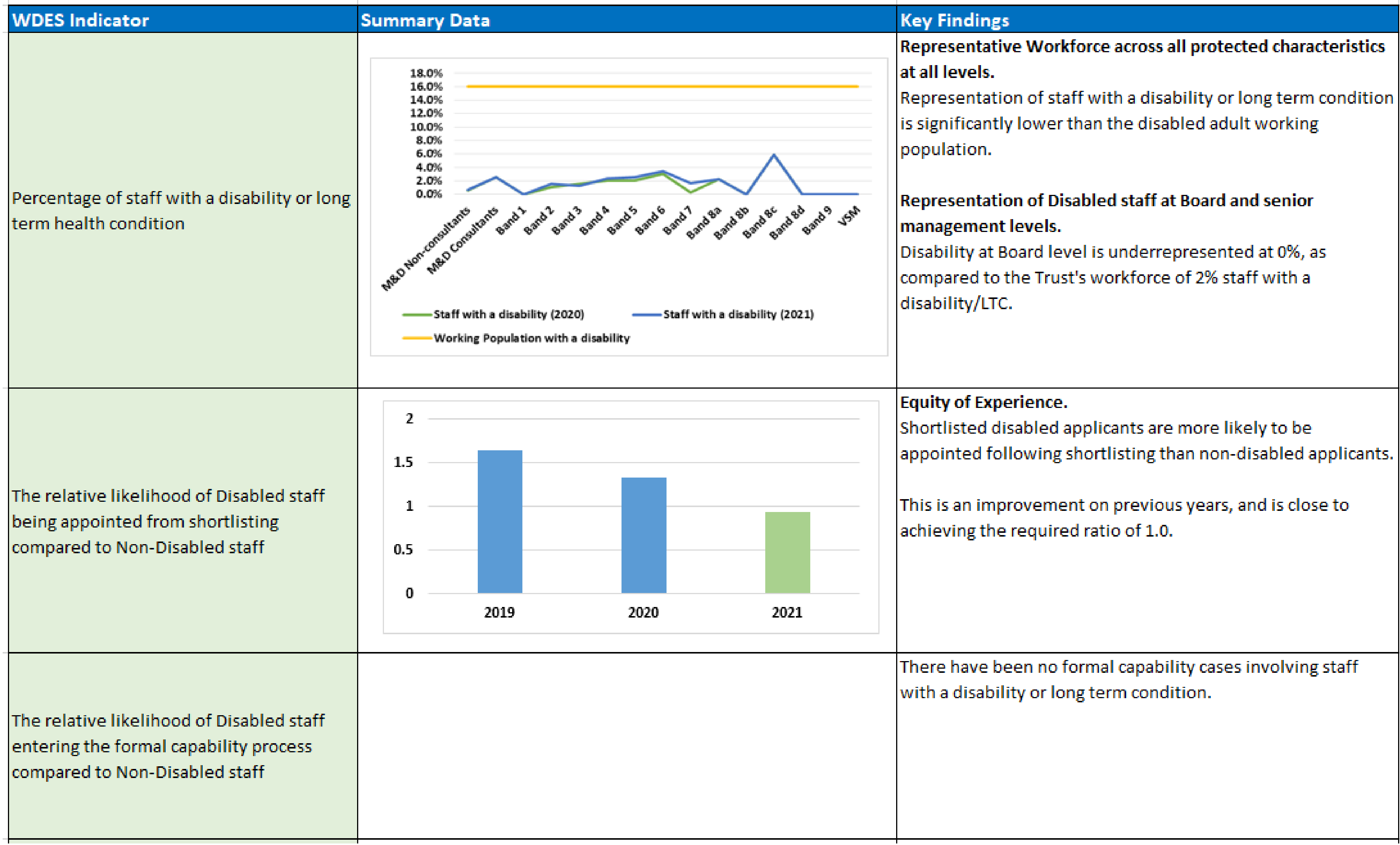
It is important to note that the majority of these indicators (4 to 12) are produced from the Trust annual NHS staff survey results where the definition used is staff identifying themselves as having a 'long lasting health condition or illness'. Approximately 50% of staff completed the survey in 2020 (2,097 staff) and of those, 415 individuals responded that they had.

Data used for the remaining indicators (1 to 3 and 13) is produced from ESR, where only 2% of staff have declared having a disability (82 individuals).

WDES Indicators for North Tees and Hartlepool NHS Foundation Trust: 2019-2021

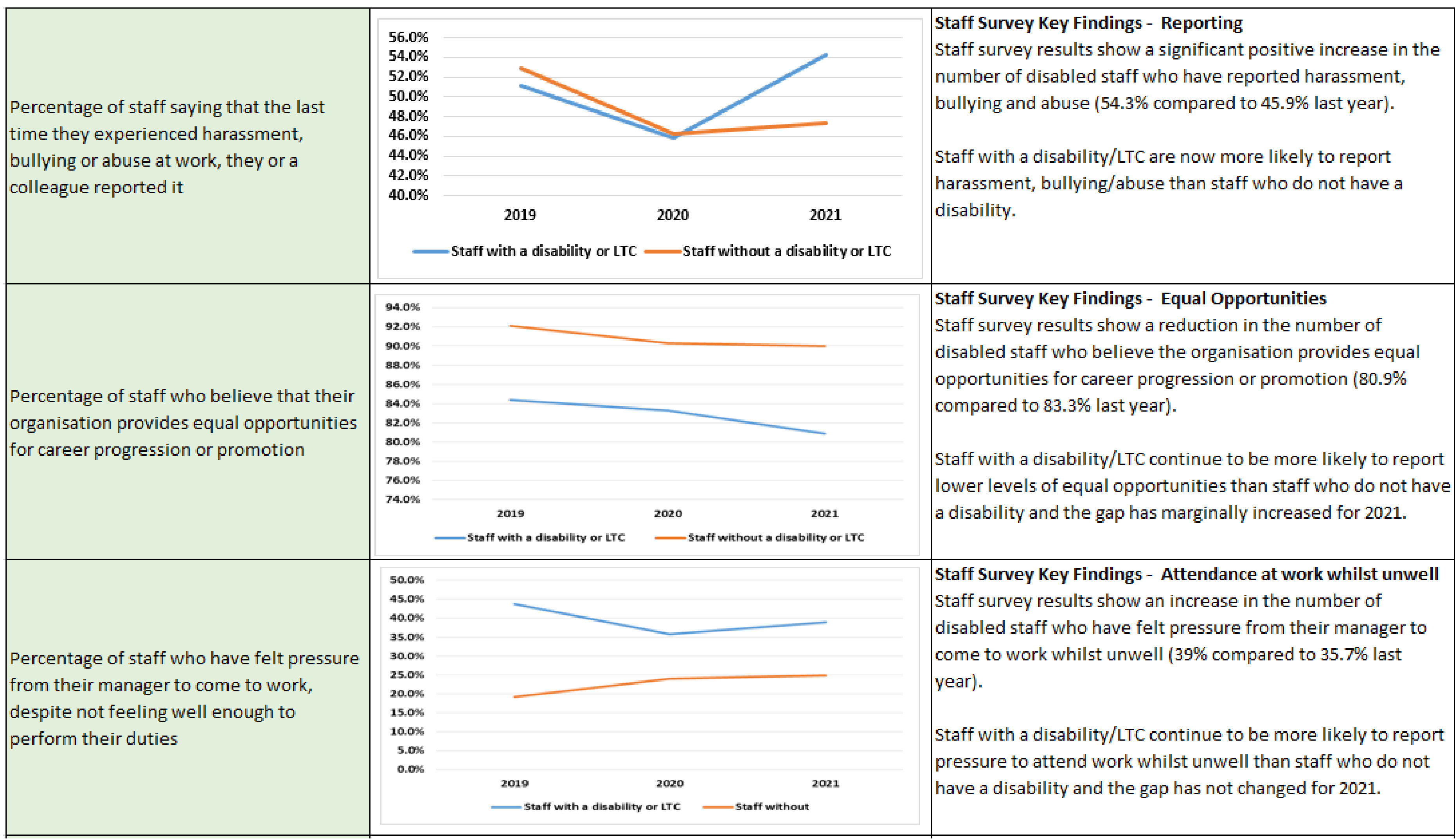
Wdes Indicator			2019	2020	2021
1	Percentage of staff with a disability or long term health condition	**Overall**	2.0%	2.0%	**2.0%**
		Non-clinical	2.0%	2.0%	**2.0%**
		Clinical	2.0%	2.0%	**2.0%**
2	The relative likelihood of Disabled staff being appointed from shortlisting compared to Non-Disabled staff		1.64	1.34	**0.94**
3	The relative likelihood of Disabled staff entering the formal capability process compared to Non-Disabled staff		0	0	**0**
4	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	**Staff with a disability or LTC**	35.4%	35.5%	**29.6%**
		Staff without	26.7%	27.8%	**24.1%**
5	Percentage of staff experiencing harassment, bullying or abuse from manager in last 12 months	**Staff with a disability or LTC**	16.3%	14.2%	**18.3%**
		Staff without	5.8%	7.3%	**7.5%**
6	Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months	**Staff with a disability or LTC**	33.7%	21.5%	**23.4%**
		Staff without	12.4%	14.7%	**13.8%**
7	Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	**Staff with a disability or LTC**	51.2%	45.9%	**54.3%**
		Staff without	52.9%	46.3%	**47.3%**
8	Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion	**Staff with a disability or LTC**	84.4%	83.3%	**80.9%**
		Staff without	92.1%	90.3%	**90.0%**
9	Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	**Staff with a disability or LTC**	43.8%	35.7%	**39.0%**
		Staff without	19.2%	24.0%	**24.9%**
10	Percentage of staff satisfied with the extent to which their organisation values their work	**Staff with a disability or LTC**	36.7%	40.7%	**36.9%**
		Staff without	53.4%	54.1%	**53.3%**
11	Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work	**Staff with a disability or LTC**	66.7%	77.4%	**74.2%**
12	Staff engagement score (0-10)	**Staff with a disability or LTC**	6.50	6.7	**6.7**
		Staff without	7.2	7.3	**7.3**
		Overall	7.1	7.2	**7.1**
13	Disabled/LTC Board membership		0.0%	0.0%	**0.0%**

4. Key Findings for 2021

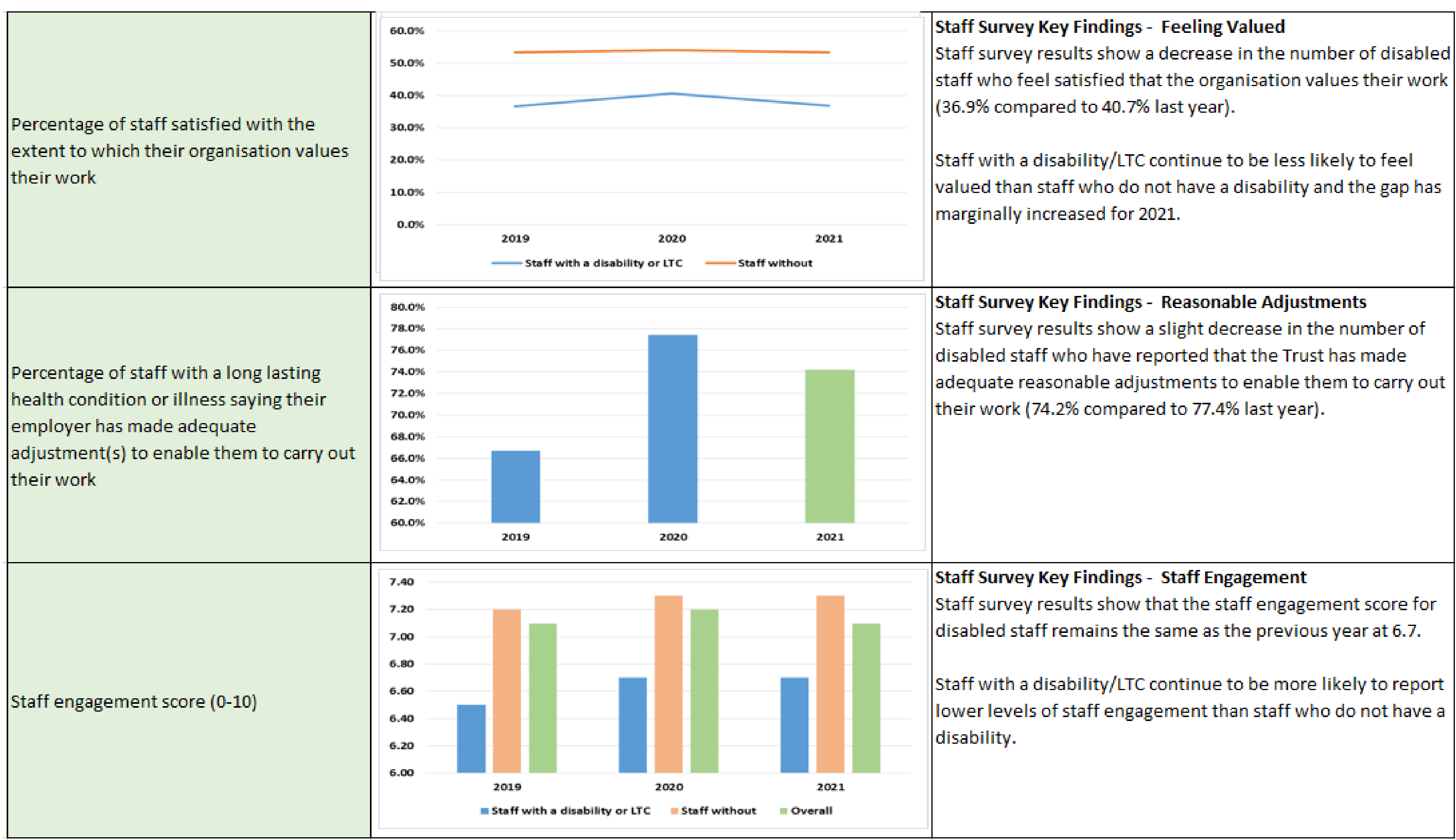


WDES Indicator	Summary Data	Key Findings
Percentage of staff with a disability or long term health condition		**Representative Workforce across all protected characteristics at all levels.** Representation of staff with a disability or long term condition is significantly lower than the disabled adult working population. **Representation of Disabled staff at Board and senior management levels.** Disability at Board level is underrepresented at 0%, as compared to the Trust's workforce of 2% staff with a disability/LTC.
The relative likelihood of Disabled staff being appointed from shortlisting compared to Non-Disabled staff		**Equity of Experience.** Shortlisted disabled applicants are more likely to be appointed following shortlisting than non-disabled applicants. This is an improvement on previous years, and is close to achieving the required ratio of 1.0.
The relative likelihood of Disabled staff entering the formal capability process compared to Non-Disabled staff		There have been no formal capability cases involving staff with a disability or long term condition.

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months		**Staff Survey Key Findings - B&H Public** Staff survey results show a decrease in the number of disabled staff experiencing harassment, bullying and abuse from patients, relatives/public (29.6% compared to 35.5% last year). Staff with a disability/LTC continue to be more likely to experience harassment, bullying/abuse from patients than staff who do not have a disability although the gap has narrowed for 2021.
Percentage of staff experiencing harassment, bullying or abuse from manager in last 12 months		**Staff Survey Key Findings - B&H Manager** Staff survey results show an increase in the number of disabled staff experiencing harassment, bullying and abuse from a manager (18.3% compared to 14.2% last year). Staff with a disability/LTC continue to be more likely to experience harassment, bullying/abuse from a manager than staff who do not have a disability and the gap has widened for 2021. Focus continues in relation to fostering an open and 'speaking up' culture which may have an impact on this increase. It is important that individuals feel able to raise such concerns and are supported in reporting those concerns.
Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months		**Staff Survey Key Findings - B&H Colleagues** Staff survey results show a marginal increase in the number of disabled staff experiencing harassment, bullying and abuse from a colleague (23.4% compared to 21.5% last year). Staff with a disability/LTC continue to be more likely to experience harassment, bullying/abuse from a colleague than staff who do not have a disability and the gap has marginally increased for 2021.



Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it		**Staff Survey Key Findings - Reporting** Staff survey results show a significant positive increase in the number of disabled staff who have reported harassment, bullying and abuse (54.3% compared to 45.9% last year). Staff with a disability/LTC are now more likely to report harassment, bullying/abuse than staff who do not have a disability.
Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion		**Staff Survey Key Findings - Equal Opportunities** Staff survey results show a reduction in the number of disabled staff who believe the organisation provides equal opportunities for career progression or promotion (80.9% compared to 83.3% last year). Staff with a disability/LTC continue to be more likely to report lower levels of equal opportunities than staff who do not have a disability and the gap has marginally increased for 2021.
Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties		**Staff Survey Key Findings - Attendance at work whilst unwell** Staff survey results show an increase in the number of disabled staff who have felt pressure from their manager to come to work whilst unwell (39% compared to 35.7% last year). Staff with a disability/LTC continue to be more likely to report pressure to attend work whilst unwell than staff who do not have a disability and the gap has not changed for 2021.



Measure	Chart	Key Findings
Percentage of staff satisfied with the extent to which their organisation values their work		**Staff Survey Key Findings - Feeling Valued** Staff survey results show a decrease in the number of disabled staff who feel satisfied that the organisation values their work (36.9% compared to 40.7% last year). Staff with a disability/LTC continue to be less likely to feel valued than staff who do not have a disability and the gap has marginally increased for 2021.
Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work		**Staff Survey Key Findings - Reasonable Adjustments** Staff survey results show a slight decrease in the number of disabled staff who have reported that the Trust has made adequate reasonable adjustments to enable them to carry out their work (74.2% compared to 77.4% last year).
Staff engagement score (0-10)		**Staff Survey Key Findings - Staff Engagement** Staff survey results show that the staff engagement score for disabled staff remains the same as the previous year at 6.7. Staff with a disability/LTC continue to be more likely to report lower levels of staff engagement than staff who do not have a disability.

5. Action Planning

The Trust is committed to meeting the requirements of the Workforce Disability Equality Standard for NHS Trusts and this is our third publication against this standard.

This years' action plan will link to the NHS People Plan and reflect the work being undertaken nationally in respect of the Overhauling Recruitment Practices pilot, which includes activities to improve/address disparity ratios.

The action plan is currently being developed and aims to bring about positive change across the Trust resulting in an improvement in all WDES indicators. The Trust's Ability Staff Network will be instrumental in the development and ongoing monitoring of this action plan, with appropriate challenge from the Workforce Committee and Culture Group.

Benchmarking for 2021 will be undertaken when the data is released from NHS England.

6. Conclusion

The WDES is important, because research shows that a motivated, included and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved patient safety.

The implementation of the WDES helps us to better understand the experiences of our staff who have a disability or long term health condition. It supports positive change for existing employees, with a more inclusive environment for disabled people working in the NHS.

It is encouraging to see that the report includes a number of positive indicators, in particular the statistic that no disabled employees have entered into a formal capability process in the previous three years. It is also positive to note that the likelihood of disabled applicants being appointed from the shortlisting stage has increased and this is at an equal level when compared to applicants who do not have a disability or LTC. We are also pleased that the percentage of disabled staff experiencing harassment, bullying/abuse has reduced for the 2020 staff survey (2021 WDES report) and also the number of disabled staff who have reported this has increased.

It is important that we engage with our colleagues who have a disability or long term health condition to understand their views at an individual level. The ability staff network is an essential tool to enhance our engagement with staff and therefore our primary focus will be to continuously promote the network and recruit new members to ensure that we have a mechanism for disabled colleagues to share their collective voice within the organisation.

The information contained within the WDES standard and progress made within the metrics and the resulting action plan for 2021 will be monitored through the Trusts' Ability Staff Network, the Culture Group and the Workforce Committee.

7. Recommendation

The Trust's Board of Directors is requested to acknowledge the results of the Workforce Disability Equality Standard (2021) and to confirm approval for the results to be submitted to NHS Digital Strategic Data Collections Service (SDCS) by the deadline of 31 August 2021.

Board of Directors

<table>
<tr><td>Title of report:</td><td colspan="10">Freedom to Speak Up Guardian Annual Report 2020-21</td></tr>
<tr><td>Date:</td><td colspan="10">29 July 2021</td></tr>
<tr><td>Prepared by:</td><td colspan="10">Debbie Elliott, Freedom to Speak Up Guardian</td></tr>
<tr><td>Executive sponsor:</td><td colspan="10">Lindsey Robertson, Chief Nurse, Director of Quality and Patient Safety</td></tr>
<tr><td>Purpose of the report</td><td colspan="10">To provide an overview of freedom to speak up activity and themes, both nationally and for the Trust</td></tr>
<tr><td>Action required:</td><td colspan="2">Approve</td><td>✓</td><td colspan="2">Assurance</td><td></td><td>Discuss</td><td>✓</td><td>Information</td><td></td></tr>
<tr><td>Strategic Objectives supported by this paper:</td><td colspan="2">Putting our Population First</td><td>✓</td><td colspan="2">Valuing People</td><td>✓</td><td>Transforming our Services</td><td></td><td>Health and Wellbeing</td><td>✓</td></tr>
<tr><td>Which CQC Standards apply to this report</td><td>Safe</td><td>✓</td><td>Caring</td><td></td><td>Effective</td><td></td><td>Responsive</td><td></td><td>Well Led</td><td>✓</td></tr>
<tr><td colspan="11">Executive Summary and the key issues for consideration/ decision:</td></tr>
<tr><td colspan="11">This report provides an overview of the work carried out by the Freedom to Speak Up Guardian (FTSUG) during 2020-21. Although some activities had to be paused due to the COVID-19 pandemic the Guardian has continued to promote the service and has provided support for 10 cases. All Trust data has been entered nationally as required by the National Guardian's Office.

Themes from 20-21 are around bullying and harassment and patient safety concerns which are the same as national themes. The number of concerns remains low.

Four cases remained ongoing in April 2021 and have been carried over to the new reporting year.

The Guardian has been supported by a group of FTSU Champions and recruitment of further champions is ongoing.</td></tr>
<tr><td colspan="11">How this report impacts on current risks or highlights new risks:</td></tr>
<tr><td colspan="11">None</td></tr>
<tr><td>Committees/groups where this item has been discussed</td><td colspan="10">None</td></tr>
<tr><td>Recommendation</td><td colspan="10">The Board is asked to note the content of the report, approve it and support the work to further develop this service.</td></tr>
</table>

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

29 July 2021

Freedom to Speak Up Guardian

Annual Report

1. Introduction

Over the last 12 months the role of the Freedom to Speak Up Guardian (FTSUG) has continued to evolve and be embedded within the organisation with a focus on raising awareness of the role, encouraging and enabling staff to access the Guardian and Champions, dealing with issues and concerns raised by staff, supporting staff, especially during the Covid-19 pandemic. Another main focus of the FTSUG is providing feedback, learning and actions to staff to show the commitment of the Trust in investigating concerns raised.

This report seeks to provide an update on the service and on-going developments as a means of enhancing the service provision over the next year and beyond.

The FTSUG was appointed in May 2018 initially for a period of one day per week which was subsequently increased to two. In line with recommendation from the National Guardians Office a full time FTSUG role is being implemented and the post has been appointed to.

The FTSUG is supported in the role by the National Guardians Office, Regional Guardians, the senior independent Non-Executive Director within the Trust and seven Champions [formerly First Stop Contact Officers, (FSCO)]

Progress to date

One of the main priorities of the FTSUG is to continually promote the profile of the Guardian and Champions, which is achieved through displaying posters on all wards and departments, screensavers, communications, Facebook, business cards, pens and keyrings and through a FTSU Sharepoint site. To enable staff easy access to contact details the guardian distributes pens, key rings and business cards across the organisation at Trust inductions, meetings, walkabouts and through promotions such as, Speak Up Month in October.

The FTSU Sharepoint site incorporates an online tool to submit a confidential email to the FTSUG. The page also has links to the amended Freedom to Speak Up policy, RM36v1, a video link showing NHS staff sharing their experiences speaking up, information relating to raising concerns, presentations, links to the National Guardians Office and information on the guardian role, champions role and the history surrounding the role (Mid Staffordshire public enquiry/Francis report) and information on Speak Up month. Updates/feedback and information of interest will be added to the site on a regular basis.

The guardian has recruited two further Champions, this includes representation from hard to reach groups (BAME/LGBTQ+) and future champion recruitment will be aimed at incorporating champions from all Care Groups and Community Services to continue to promote the role across the Trust.

In the past 12 months the guardian has attended various forums to promote the role, which includes Excellence as Our Standard to share case reviews from the National Guardians Office, Culture Group, workforce meetings, doctors in practice, LGBTQ+, surgical governance meeting, BAME forum and F1 doctors forum. Walking around wards and departments has been paused due to COVID-19 but was on going previous to this. The regular walk around for the promotion of Speak Up Month in October 2020, with a theme of the A-Z of Speaking Up was instead promoted via the Communications team, Education, Development and Learning Team, Sharepoint site and posters for all wards and departments.

The guardian presents the role for new members of staff at the Corporate Trust Induction, Student Nurse Induction, Preceptorship Induction, Volunteer Induction and provides training for non-clinical staff through online induction.

The National Guardians Office are producing e-learning modules which have been developed in association with Health Education England and are for everyone wherever they work in health. They explain in a clear and consistent way what speaking up is and its importance in creating an environment in which people are supported to deliver their best. The first module – Speak Up – is for everybody. The second module, Listen Up, for managers, builds upon the first and focuses on listening and understanding the barriers to speaking up. A final module – Follow Up – for senior leaders, will be launched later in the year to support the development of Freedom to Speak Up as part of the strategic vision for organisations and systems the modules will be added to staff mandatory training.

FTSU Index

Working with NHS England, the National Guardian's Office has brought together four questions from the NHS Staff Survey into a 'Freedom to Speak Up (FTSU) Index'. These questions relate to whether staff feel knowledgeable, secure and encouraged to speak up and whether they would be treated fairly after an incident.

The FTSU Index seeks to allow Trusts to see how an aspect of their FTSU culture compares with other organisations so learning can be shared, and improvements made. This is the third year that the FTSU Index has been published.

Since the introduction of Freedom to Speak Up Guardians in 2015, the FTSU Index has improved and risen 3.7 percentage points nationally from 75.5% in 2015 to 79.2%. Although there is a continued disparity between the highest performing organisations and the lowest, with a 21 percentage point difference between the highest and lowest. More concerning is that this disparity has increased this year. The National highest performing Trust's Index score is 87.6% and the lowest is 66.6%.

This year a new question was included in the NHS Staff Survey asking if workers feel safe to speak up about anything that concerns them in their organisation.

The answers to this question show a very strong positive correlation with the FTSU Index, with 66% of staff "agreeing" or "strongly agreeing" that they feel safe to speak up about anything that concerns them in their organisation. The National Guardian's Office will be looking in more depth into the details of the responses to this question in a future report.

This question has not been included in the FTSU Index scores to enable comparability to previous years. However, the answers to this question again showed a positive correlation between higher index scores and ratings received by the Care Quality Commission (CQC). Trusts with higher index scores were more likely to be rated 'good' or 'outstanding' by the CQC.

The Freedom to Speak Up Index 2020 for North Tees and Hartlepool NHS Trust is 81.2% which has an increase of 0.1% from 2020 which was 81.1%, the score for the new question (Q18f) is 66.4%.

The regional position across North East and Cumbria is as follows:

Q18f	2020/2021	2019/20	2018/19	Organisation
71.5%	83.0%	81%	81%	Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
77.6%	82.8%	83.3%	82%	Northumbria Healthcare NHS Foundation Trust
66.4%	81.4%	82.8%	83%	Gateshead Health NHS Foundation Trust
66.4%	**81.2%**	81.1%	81%	North Tees and Hartlepool NHS Trust
69.4%	80.2%	79.1%	81%	Tees, Esk and Wear Valley NHS Foundation Trust
68.7%	80.2%	80.6%	81%	The Newcastle upon Tyne Hospitals NHS Foundation Trust
61.7%	80.0%	80.5%	75%	County Durham and Darlington NHS Foundation Trust

63.8%	77.9%	73.1%	73%	South Tees Hospitals NHS Foundation Trust
57.4%	75.4%	68.5%	71%	North Cumbria University Hospitals NHS Trust
57.6%	75.3%	72.9%	76%	North East Ambulance Service NHS Foundation Trust

2. Concerns Raised

Since the appointment of the guardian in May 2018 there have been 37 cases to date raised under the Freedom to Speak Up. The data for May 2019 to March 2020 was reported in the previous annual report.

Concerns:

2020/2021

Q1	Apr – Jun	3 cases	3 Patient Safety
Q2	Jul – Sep	2 cases	1 Staff safety 1 Bullying and Harassment
Q3	Oct – Dec	1 case	1 Bullying and Harassment
Q4	Jan – Mar	4 cases	2 Bullying and Harassment 2 Patient Safety

Total: **10 cases**

The main themes being raised in the Trust:

- Bullying and Harassment
- Patient and Staff Safety

This correlates with the national themes being raised.

Outcome of allegations:

4 cases brought forward from 2019/20

10 cases resolved

4 cases still open

National Data 2019/2020 (2020-21 report not yet published).

.

Cases raised	Staff Groups reporting in 2019/20	Themes 2019/20
• 2018/19 = 12,244 • 2019/20 = 16,199 • Increase of 32%	• 28% nurses (↓ 1%) • 19% A&C (↑ 3%)	• Bullying & Harrassment = 36% (↓5%) • Patient Safety/Quality = 23% (↓6%) • Detriment as a result of speaking up = 3% (↓2%) • Anonymous reporting = 13%

The number of cases raised each quarter nationally increased:

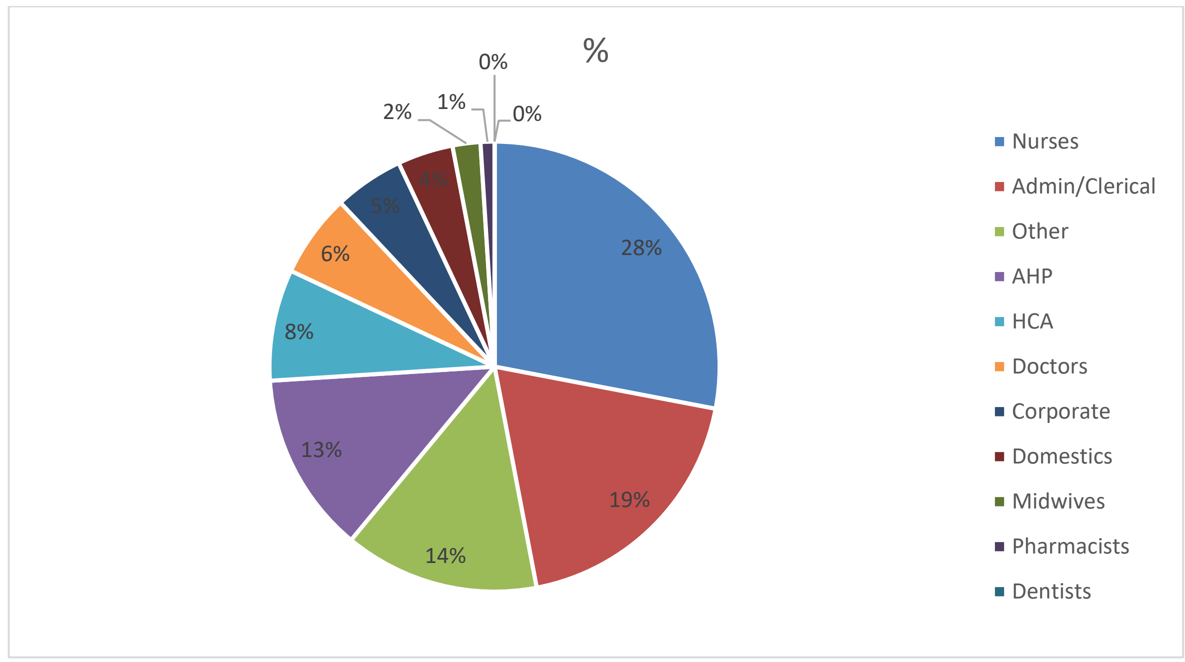
Quarter	2018/19	2019/20
Q1	2,550	3,531
Q2	2,651	3,764
Q3	3,634	4,486
Q4	3,459	4,418
Total	**12,244**	**16,199**

Regional Data 2019/2020

Trust	Q1 2020	Q2 2020	Q3 2020	Q4 2020/2021
North Tees and Hartlepool	**3**	**2**	**1**	**4**
Trust 1	15	20	6	2
Trust 2	14	9	18	17
Trust 3	11	12	11	9
Trust 4	3	4	4	5
Trust 5	35	54	50	54
Trust 6	6	11	30	23
Trust 7	12	15	6	14
Trust 8	7	7	13	16

FTSUG are now in other areas of business including GP practices, Dental practices, Parliamentary and Health Service Ombudsman and NHS Blood and Transplant.

Who is Speaking Up – national figures



3. Support for the FTSUG

The Freedom to Speak Up Guardian is supported by the National Guardians Office, Regional Guardians, Employee Relations, Senior Independent Non-Executive Director and the Champion's.

4. Review of the Service

Review of the service is on-going and an action plan is updated regularly, including development of resources, recruitment of additional champions and opportunities to promote the service to staff.

Actions identified from a review by AuditOne were delayed by the COVID-19 pandemic but revised dates have been agreed and all will be completed by target dates.

5. Next Steps

In order to further facilitate embedding of the FTSUG role the guardian will focus over the next year on:

- Continuing to increase awareness across the organisation by walkabouts, joining staff meetings, visiting community settings.
- Promote Sharepoint site and online reporting tool for staff to complete to disclose concerns which incorporates a trigger system to the guardian following submission.
- Complete the development of Standard Documentation to be designed to acknowledge receipt of open and confidential cases and on completion of cases to close.
- Regular meetings with Champions for updates and supervision.
- Delivering feedback to staff on themes of concerns raised and actions/learning following investigations.
- Progressing with the 4 remaining open cases
- Working collaboratively with senior managers, staff side, workforce, PET, Survey Lead, Education, Development and Learning, Workforce Independent Investigator.
- Resilience for the FTSUG role.
- Monitor process and timeframes.

- Including this question in surveys of the workforce following the NGO recommendation. ‘The promoters and barriers to speaking up are common to all settings and organisations. Is it safe to speak up? Will I be listened to? Will action be taken?’.
- Recruiting Champions across community settings and Care Groups to increase awareness.

6. Recommendations

The Board of Directors are asked to note the content of the report and the progress to date in embedding and developing the FTSUG role.

Author
Deborah Elliott
Freedom to Speak Up Guardian

Executive Sponsor
Lindsay Robertson
Chief Nurse/Director of Patient Safety & Quality

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title:	Quality Accounts 2020/21
Date:	29 July 2021
Prepared by:	Keith Wheldon, Safety & Quality Performance Manager
Executive Sponsor:	Lindsey Robertson, Chief Nurse/ Director of Patient Safety and Quality
Purpose	The Quality Accounts are an important way for the Trust to report on quality and show improvements in the services they deliver to local communities and stakeholders. The report attached provides the Quality Accounts for 2020/21, which have been prepared in line with national requirements as set out in the Health Act 2009 and updated in the Health and Social Care Act 2012.

Action required:	Approve		Assurance	x	Discuss	x	Information	x
Strategic Objectives supported by this paper:	Putting our population First	x	Valuing our People	x	Transforming our Services		Health and Wellbeing	x

Which CQC Standards apply to this report	Safe	x	Caring	x	Effective	x	Responsive	x	Well Led	x

Executive Summary and the key issues for consideration/ decision:

All NHS providers are required to produce an annual 'Quality Account', which summarises the quality of services provided, including the quality indicators set the previous year. The Quality Account provides information and assurance to patients, service users, carers, family members, commissioner, partner agencies and the public that the Trust is addressing quality issues and maintaining standards. This includes reporting on progress against the quality objectives identified in 2020/21 and identifying the objectives for 2021/22.

Initially NHS Trusts were informed that the national timescale for annual Quality Accounts had been delayed due to COVID-19, however on 4 May 2021 the requirements and timescale were confirmed, that Quality Accounts should be published by 30 June 2021 or as close to this date as possible. The changes to the requirements for this year's Account include:

- no requirement to externally audit the document
- no quality report is required within the annual report for 2020/21
- the Quality Account needs to be sent to NHS England and NHS Improvement to be added to their individual pages
- There were no specific new requests to be added into this year's Quality Account.

The Quality Account summarises progress against the priorities and quality metrics that were agreed with external stakeholders in 2019-20. It demonstrates some significant achievements during the course of the year and shows improvements in the services delivered to local communities and stakeholders.

The pandemic has inevitably affected how the Trust can deliver against a number of quality standards. Regardless of pressures, delivery on quality metrics has continued to be monitored closely through the established internal governance structures and is comparable to national and regional positions where benchmarking allows.

In respect to the Quality Account 2020/21 there is no requirement for an external audit assurance review, however, there has been full involvement of governors and third parties in production and review of the report. Third party declarations are received from the CCGs, Healthwatch in Hartlepool and Stockton, Stockton Adult Services and Health Select Committee, Hartlepool Borough Council Audit and Governance Committee, Council of Governors and the Healthcare User group	
How this report impacts on current risks or highlights new risks:	
Continuous and sustainable achievement of key quality standards alongside a number of variables outside of the control of the Trust within the context of pressures, managing Covid-19 pressures, winter and staffing resource.	
Committees/groups where this item has been discussed	NA
Recommendation	The Board of Directors is asked to note: • the performance against the quality standards within the document; • acknowledge the on-going excellent work undertaken by Trust staff in maintaining performance through what has been a very challenging time; and • the completion of the Quality Account within the required timescales and submission to NHS England and NHS Improvement.

Quality Accounts 2020-21

Contents

Part 1		
	Statement on quality from the Chief Executive	Page 2
Part 2		
2a	2020-21 quality improvement priorities	Page 5
2b	2021-22 quality improvement priorities	Page 68
2c	Statements of assurance from the Board	Page 76
2d	Core set of Quality Indicators	Page 97
Part 3		
3a	Additional quality performance during 2020-21	Page 109
3b	Performance from key national priorities from the Department of Health Operating Framework, Appendix B of the Compliance Framework	Page 122
Annex's		
Annex A	Third party declarations	Page 126
Annex B	Statement of Directors' responsibilities in respect of the Quality Account	Page 139
Annex C	Independent Auditors Limited Assurance Report to the Council of Governors of North Tees and Hartlepool NHS Foundation Trust on the Annual Quality Account.	Page 140
Annex D	Quality Accounts Feedback Form	Page 141
Glossary		
Glossary	Definition of some of the terms used within this document	Page 142

Part 1: Statement on quality from the Chief Executive

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

I am delighted to introduce the North Tees and Hartlepool NHS Foundation Trust Quality Accounts for 2020-21, which highlights the excellent work we are doing to ensure we provide the very best safe, quality care for our patients.

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

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

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

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

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

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

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

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

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

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

Julie Gillon
Chief Executive
Date: 31 May 2021

What is a Quality Report/Accounts?

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

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

The Board of Directors seek assurance on the Trust's performance at all times and recognise that there is no better way to do this than by talking to patients and staff at every opportunity.

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

Unconditional CQC Registration - During 2020-21 the Trust met all standards required for successful and unconditional registration with the Care Quality Commission (CQC) for services across all of our community and hospital services.

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

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

CQC Rating - The most recent CQC visit took place 2017 utilising revised inspection format, with the well-led element taking place during the week commencing 18 December 2017. The Trust has been rated as **'Good'**, for all domains additional detail regarding the recent visit is located in the CQC section on page 95.

Part 2a: 2019-20 Quality Improvement Priorities

Part 2 of the Quality Account provides an opportunity for the Trust to report on progress against quality priorities that were agreed with external stakeholders in 2019-20. We are very pleased to report some significant achievements during the course of the year.

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

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

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

Stakeholder priorities 2020-21

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

Patient Safety

- Mortality
- Dementia
- Mental Health
- Safeguarding (Adult & Children s)
- Infections

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

Priority 1: Patient Safety

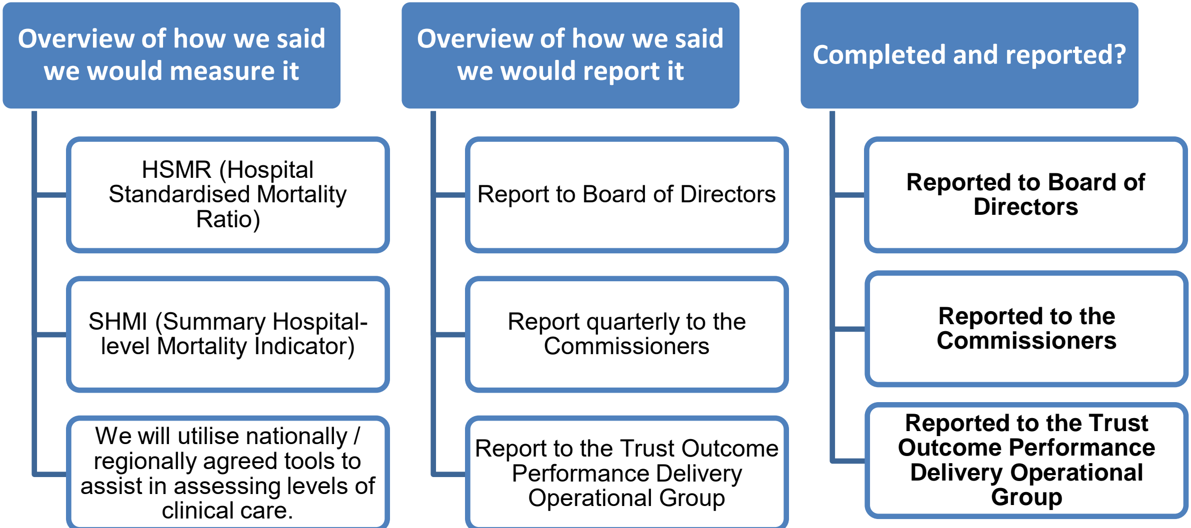
Mortality

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

Overview of how we said we would do it

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

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



The Trust Board of Directors continues to understand the values of both Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI). The Trust has achieved reductions for both metrics, to such an extent they are now consistently in the **'as expected'** range.

The Trust, while using national mortality measures as a warning sign, is investigating more broadly and deeply the quality of care and treatment provided. The Trust established a clinical link between consultants and the Trusts Coding Department, this work throughout 2020-21 continues to reap great rewards in respect of depth of coding. This increase in the number of co-morbidities being captured and documented per patient to over seven, from the lows of just over three, has had a profound effect on the HSMR and SHMI values, as well as giving a more accurate reflection of the patient's true level of sickness.

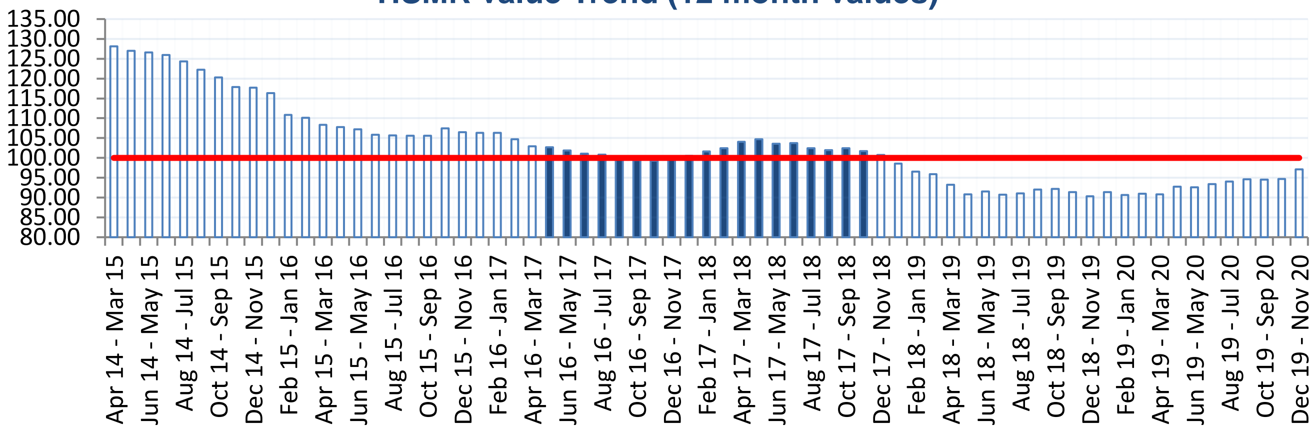
The following data is from the two nationally recognised mortality indicators of Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI).

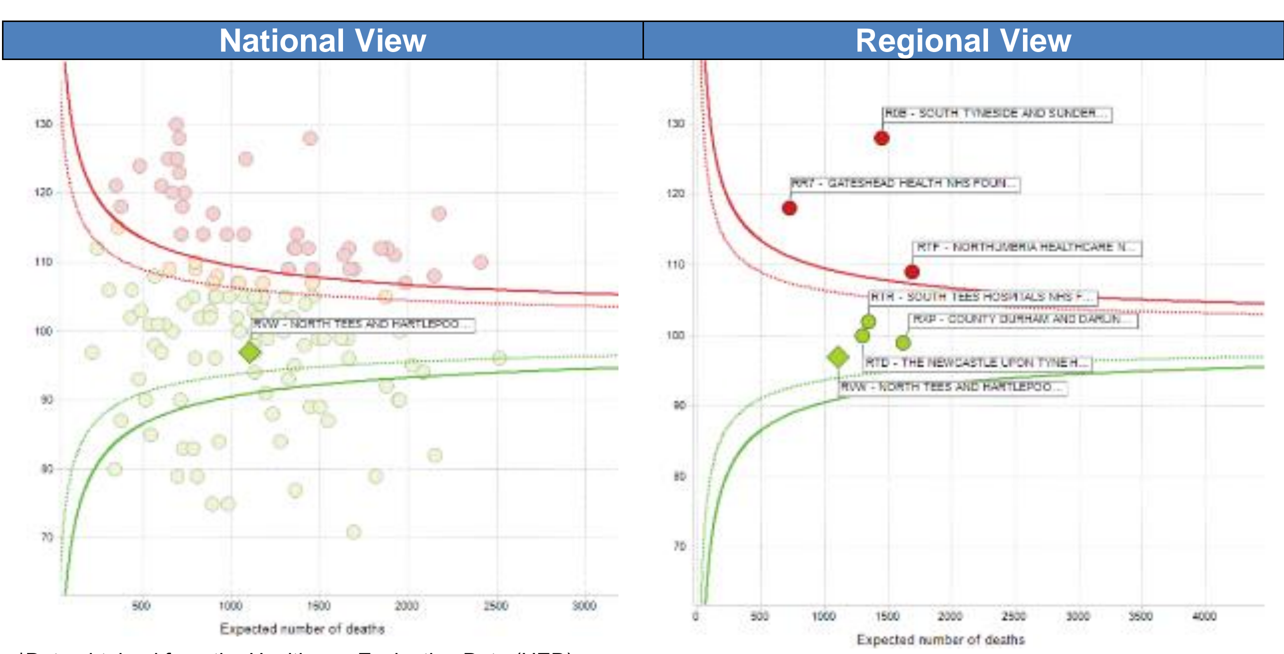
Hospital Standardised Mortality Ratio (HSMR)
December 2019 to November 2020

The Trust **HSMR** value is **97.12** for the reporting period from **December 2019 to November 2020**; this value continues to place the Trust in the **'as expected'** range. The National Mean is 100, which denotes the same number of people dying as expected by the calculations, any value higher means more people dying than expected.

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

*Crude Mortality Rate (CMR)





*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.

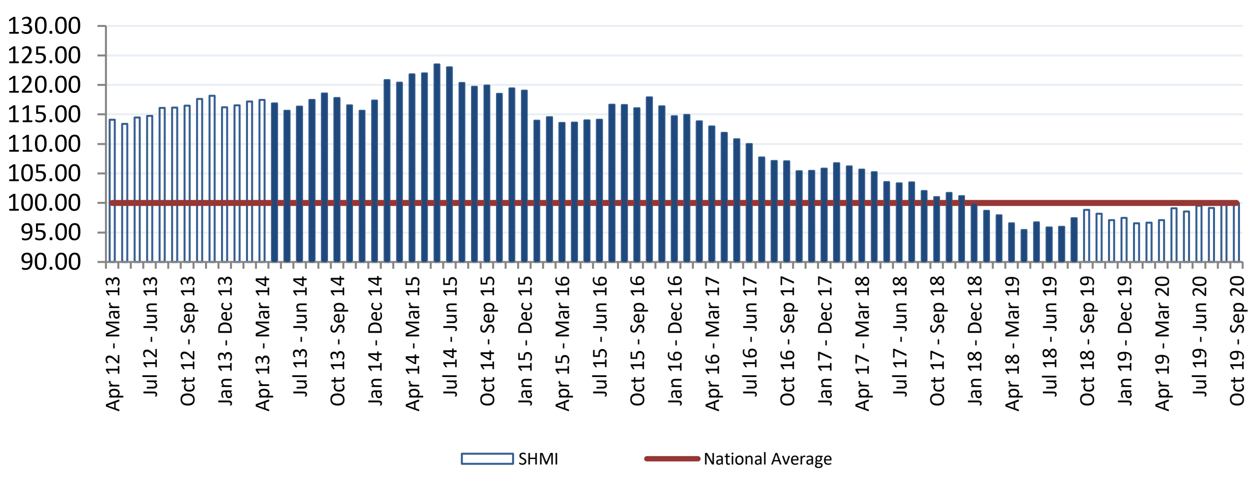
SHMI includes *deaths up to 30 days after discharge and does not take into consideration palliative care.*

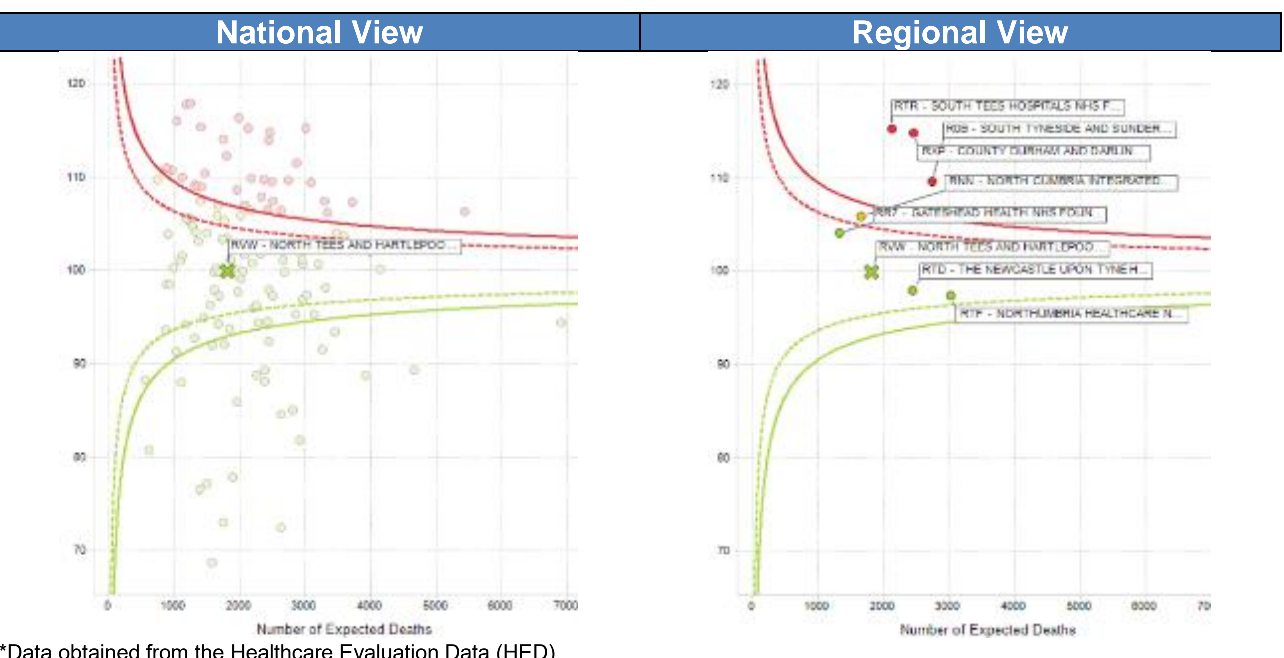
The following graphic demonstrates the Trust (red) National position with a SHMI value of **99.94 (October 2019 to September 2020)**, this value continues to reside in the **'as expected'** range.

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

*Crude Mortality Rate (CMR)

SHMI Trend Values (12 Month Values)





*Data obtained from the Healthcare Evaluation Data (HED)

Trust Raw Mortality

The following table and chart demonstrates the raw number of mortalites the Trust has experienced since 2016-17. For the latest financial year of 2020-21, the Trust experienced **1,547** mortalities, this is **62** more mortalities than experienced in 2019-20.

	Cumulative Totals											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016-17	142	273	396	515	622	719	851	970	1114	1269	1405	1541
2017-18	126	254	357	461	566	686	807	936	1118	1312	1450	1613
2018-19	135	239	341	455	547	655	794	928	1060	1209	1341	1454
2019-20	106	248	338	456	573	697	823	948	1105	1251	1367	1485
2020 21	**152**	**265**	**366**	**459**	**561**	**667**	**787**	**941**	**1147**	**1354**	**1464**	**1547**

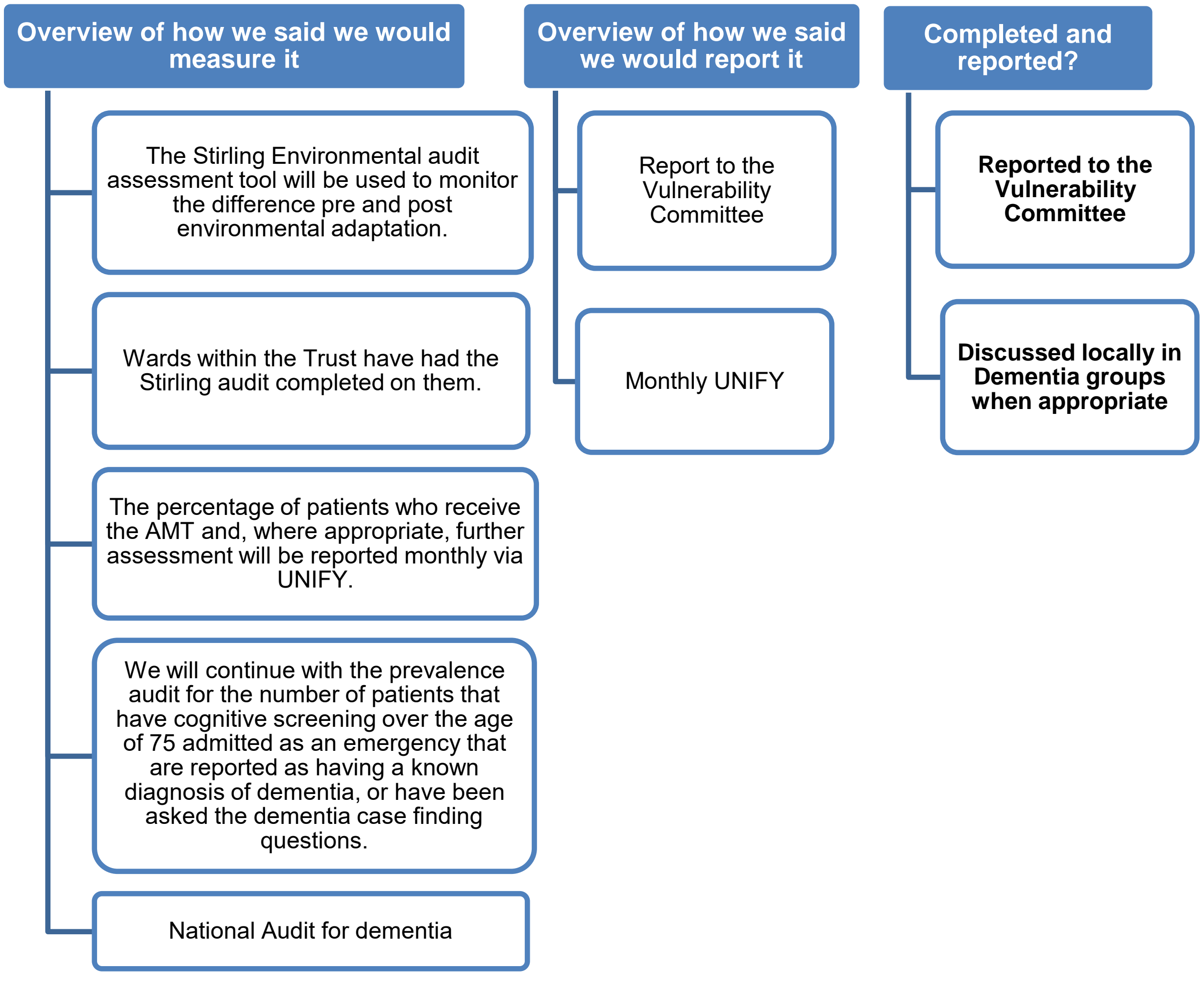
Priority 1: Patient safety

Dementia

Rationale: There are currently approximately 14,000 (last report 2014) people with a diagnosis of dementia across County Durham & Darlington and Tees. NHS Hartlepool/Stockton on Tees has the highest projected increase of dementia across the North East by 2025. All stakeholders identified dementia as a key priority.

Overview of how we said we would do it

- Introduce the 4at delirium assessment tool into the new falls pathway in nursing notes, to identify and delirium sooner after admission
- We will use the Stirling Environmental Tool to adapt our hospital environment
- We will make it mandatory that all patients over 65 receive an Abbreviated Mental Test (AMT) and are, where appropriate, referred for further assessment.
- Patients with Dementia will be appropriately assessed and referred on to specialist services if needed.
- Creation of a separate room in Accident and Emergency where people with acute confusion or dementia can wait to be seen in a more private and less stimulating environment than the main waiting room.
- Cross referencing people regarding a dementia diagnosis on North Tees and Hartlepool Trust Trakcare and Datix systems with (Tees, Esk and Wear Valleys NHS Foundation Trust) TEWV Paris system (electronic care record system) to confirm if a clinical diagnosis has been given by mental health services. If the diagnosis of dementia is confirmed, then an alert will be added to Trakcare system. This alert will aid and assist a dementia champion that is available on every ward.



Carers Support

- Carers' information packs are reviewed and updated regularly.
- This aims to reduce risk of carer breakdown, and information on how they can access individual carer's assessment
- Informs carers what services they have access to
- Increases information on how they can access individual carer's assessment
- Both Local authorities gave detailed directory of services to support the low level interventions required for people in their own homes.
- If carers feel more supported, there is less risk of admission of the people they care for
- Supports financial and social benefit
- Continue to promote the John's Campaign (www.Johnscampaign.org.uk) with the trust lead. This supports carers to outline which elements of care/support they would prefer to do for the patient whilst in hospital, and which elements they would prefer staff to complete. It also outlines allowances for carers and family i.e. if family/carers are spending significant amounts of time visiting, allowing flexible visiting, ability to order from the hospital menu for themselves and the Trust now has an agreement with Parking Eye regarding parking allowances for eligible families and carers.
- We now have John's campaign as an alert on Trakcare for staff awareness. We have also negotiated a discount at Costa and staff discount in the canteen. We have produced a card that the carers can produce to get this discount.
- PET team are doing follow ups questions for families and carers that have used John's campaign, so we can evaluate data and improve the service further.
- University Hospital of North Tees has become part of Dementia Friendly Stockton. The aim is to continue to develop close and consistent links with relevant local agencies. University hospital of Hartlepool is part of Dementia friendly Hartlepool.

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

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

Financial Year	Patients admitted to the Trust with a diagnosis of Dementia/Delirium	Increase or Decrease from Previous Year
2016-17	3,298	+587
2017-18	3,614	+316
2018-19	4,218	+604
2019-20	3,784	-434
2020 21	3,253	-531

*Data from Information Management Department

Dementia Training Levels

Tier 1 - Dementia Awareness Raising

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

The team also provide a 1.5 hour face to face training session. This is constantly evaluated and updated. It is also delivered to all new recruits to the Trust- overseas nurses, newly qualified staff, students, return to practice nurses, trust induction and can be delivered on request for team days.

There has been an identified training need for the Trust volunteers in relation to dementia.

We are currently planning this, and this will be based around the development of increased knowledge and practical skills to equip our volunteers with extra awareness of dementia when supporting people with a dementia diagnosis.

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

This is the level of 'Trust Dementia Champions'

To support this level of training we have the Trust Dementia Champion programme which, following feedback, has been reviewed and now runs over two consecutive days on alternate months. The purpose of the Dementia Champions is to create an individual with a high level of knowledge of dementia. The 6 stages of 'Barbara's Story' is used and discussed. This training involves support from other multi-disciplinary teams as well as guest speakers. It is open to all staff, of any profession or grade, either inpatient or community. This new programme enables it to be carried out 6 times a year, as opposed to being carried out over 2 hour sessions monthly over 11 months.

We are also placing more emphasis on the role of the Dementia Champions and have compiled a list of expectations which outline their responsibilities following the course.

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

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

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

*Data obtained from the Trust dementia training

Priority 1: Patient safety

Mental Health

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

Overview of how will measure it

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

Overview of how we will report it

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

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

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

Will aim to:

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

To achieve the 3 aims the objective will be to:

- Foster positive attitudes towards integrated mental and physical health, combatting stigma
- Improve recognition and support for both the mental and physical health needs of patients
- Assist staff to access support and resources for working with mind and body
- Ensure that mind and body care is addressed at all levels of healthcare
- Engage local partners in improving mind and body training and subsequently care
- Through Treat as One, develop a 1 day, tier 2 course to ensure that appropriate staff has a more in-depth understanding of how mental health and physical health are linked.

2021 Update

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

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

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

An update around the work on **embedding integrated mind and body care as common practice, joining up and delivering excellent mental and physical health care, research and education** so that we treat the whole person (one of the stated aims within the *Mental Health* priority).

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

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

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

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

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

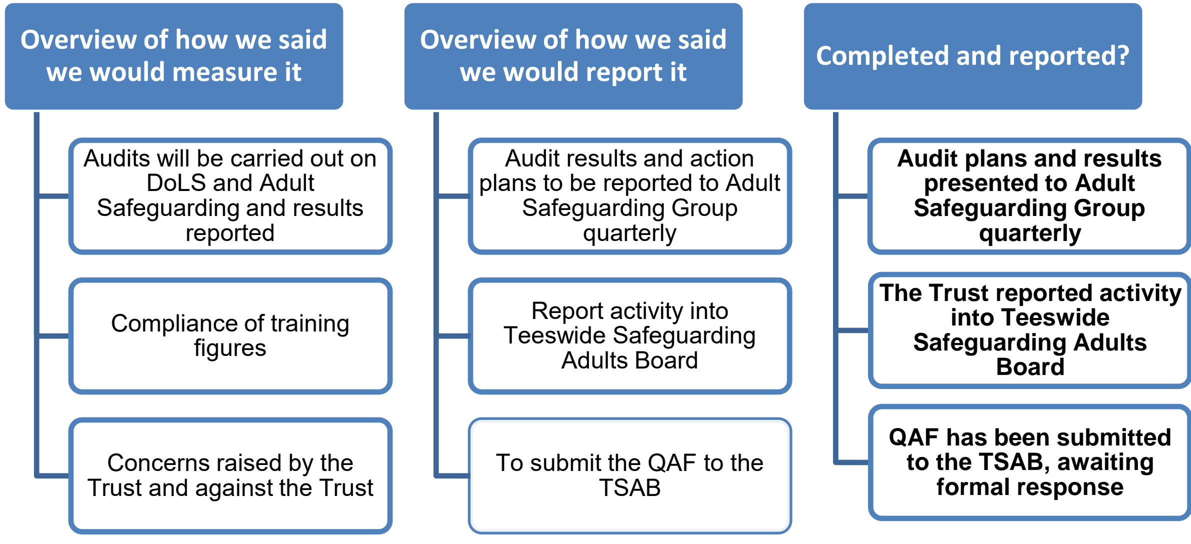
Priority 1: Patient safety

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

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

Overview of how we said we would do it

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



Safeguarding Adults

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

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

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

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

*Date provided by the Safeguarding team

Trust Reporting

For each quarter the Trust produces an Adult Safeguarding report. The purpose of this report is to provide the Trust Safeguarding Vulnerable Adults Steering Group members with an overview of safeguarding activity, with the objective that information relevant to their areas of representation may be disseminated.
Additionally, the importance of two way communications are recognised as vital to ensure safeguarding adult activity is embedded within practice across adult health and social care. Therefore, this report highlights areas of good practice within all service areas requiring development as well as providing actions agreed from discussion within the group.

The data contained in the reports includes:

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

Number of Concerns / Enquiries raised within the Trust

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

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

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

*Data as of 31 March 2021

Types of Concerns

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

Type of Concern	Q1	Q2	Q3	Q4	Total
Discriminatory	0	0	0	0	**0**
Domestic Abuse	16	15	14	18	**63**
Financial or Material	10	11	12	15	**48**
Modern Day Slavery	0	1	1	0	**2**
Neglect and Acts of Omission	58	81	71	46	**256**
Organisational	5	6	5	4	**20**
Physical	9	24	17	17	**67**
Psychological	7	6	10	10	**33**
Self-Neglect	45	40	46	43	**174**
Sexual Abuse	2	4	3	5	**14**
Sexual Exploitation	1	1	0	2	**4**
Total	**153**	**189**	**179**	**160**	**681**

*Data from the Trusts Adult Safeguarding database 31 March 2021

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

Alerting Care Group

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

Number of concerns against the Trust

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

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

*Data as of 31 March 2021

Themes of Alerts against the Trust

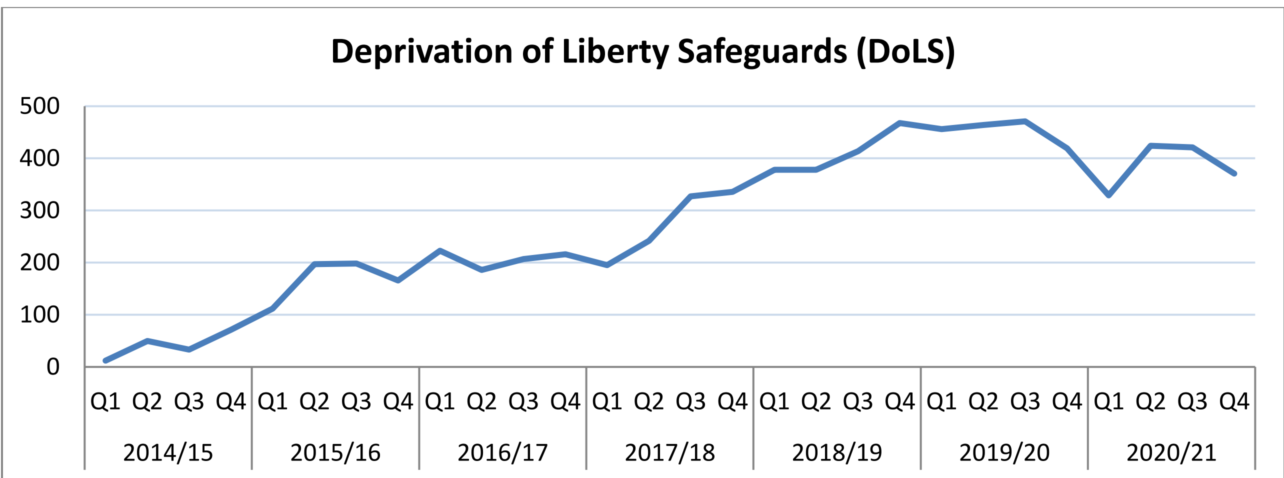
Themes of Alerts	Q1	Q2	Q3	Q4	Total
Assault	0	0	0	0	**0**
Communication	2	1	9	9	**21**
Dehydration	0	0	0	0	**0**
Discharge Issue	9	2	16	13	**40**
Documentation	0	0	3	0	**3**
Lack or Reasonable Adjustments	0	0	2	0	**2**
Malnourishment	0	0	0	0	**0**
Medication Error	3	3	4	5	**15**
Moving & Handling	0	1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

*To note: one concern can cover multiple themes

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

Deprivation of Liberty Safeguards (DoLS)

Provision of specialist advice relating to implementation of The Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS) and the Human Rights Act provides added assurance that the Trust remains compliant with legislation. The Trust continues to provide education regarding the awareness of DoLS; improvements have been made to the paperwork to assist staff in its completion.



The Trust has seen **1,545** applications during the first three quarters of 2020-21.

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

*Data as of 31 March 2021

Trust Adult Safeguarding Governance Arrangements

The Chief Nurse/Director of Patient Safety and Quality is the executive lead for safeguarding adults with the Deputy Chief Nurse holding operational responsibility.

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

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

The Trust is represented at the Tees-wide Adult Safeguarding Board, and its subgroups.

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

Adult Safeguarding - Prevent

Throughout 2020-21 Adult Safeguarding has continued to make positive strides towards its objectives.

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

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

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

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

Training Figures 2020-21	
PREVENT	84%
WRAP	85%

Children’s Safeguarding and Looked After Children (LAC)

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

North Tees and Hartlepool NHS Foundation Trust has a duty in accordance with the Children Act 1989 and Section 11 of the Children Act 2004 to ensure that its functions are discharged with regard to the need to safeguard and promote the welfare of children and young people. The Trust recognises the importance of partnership working between children/young people, parents/carers and other agencies to prevent child abuse, as outlined in Working Together to Safeguard Children and their Families, 2018. In addition, arrangements to safeguard and promote the welfare of children must also achieve recommendations set out by the CQC Review of Safeguarding: A review of arrangements in the NHS for safeguarding children, 2009 and give assurance as outlined in the National Service Framework for Children, Young People and Maternity Services, 2004 (Standard 5). The Trust continues to demonstrate robust arrangements for safeguarding and promoting the welfare of children.

Children & Young People Governance Arrangements

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

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

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

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

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

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

Children's Safeguarding Work Program

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

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

2. The safeguarding children annual audit and assurance program

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

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

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

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

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

Part 2 - Development Work

Children Not Brought for Appointments by Parents/Carers' Policy

The policy and assurance process is embedded across the Trust in response to a local serious case and learning lessons review, enabling practitioners to understand when a child has not been brought to appointments may be an early indicator of neglect and requires an appropriate response. The Trust can now also identify children whose appointments frequently rescheduled by parents/carers alongside those that do not attend.

Safeguarding Children's Policy

The Safeguarding Children's Policy ensures that Trust staff supported in understanding their responsibility under current legislation to safeguard and promote the welfare of children and to enable the Trust to meet its statutory duties in this regard. This policy was recently reviewed and agreed by members of the children's safeguarding Professionals and Steering group at the end of 2020.

Safeguarding Children Supervision

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

North of Tees Children's Hub

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

Child Sexual Exploitation (CSE)

CSE continues to be a growing concern. The Stockton and Hartlepool VEMT (Vulnerable, Exploited, Missing Trafficked) practitioners group and the Missing Exploited group (MEG) in County Durham identifies those children and young people at risk, allows for the sharing of information between practitioners and helps to put safety measures in place to attempt to reduce risk. A CSE risk assessment is completed on all LAC children over the age of 11 years and on all children who attend unscheduled care within the Trust if they fit within an agreed criteria of risk.

Domestic Violence & Abuse

The Trust is represented at Multi Agency Risk Assessment Conferences (MARAC) in Hartlepool and Stockton where high risk victims of domestic abuse are identified and safety plans put in place and the Trust also contribute to Multi Agency Tasking and Coordination (MATAC).

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

Local Authority Designated Officer (LADO)

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

Voice of the Child

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

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

Bruising in Immobile Babies Policy

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

Joint working with Adult Safeguarding

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

Audit

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

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

Key Achievements 2020/2021

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

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

Key Priorities 2021/2022

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

Safeguarding Children Training Programme

Throughout 2020 the Trust's in-house Safeguarding Children Training Programme has continued to provide mandatory foundation and update single agency training for all staff employed within the organisation. The training is in-line with the requirements of Safeguarding Children and Young people: roles and competences for health care staff, Intercollegiate Document (2019) and the Trust's Safeguarding Children Training Policy. This includes:

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

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

Level 3 Safeguarding training content has been refreshed and now includes scenario based training with the elements of effective referrals and information sharing.

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

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

Overall Trust Compliance for Safeguarding Children Training

Training compliance is monitored by the Safeguarding Steering Group and an action plan has been developed to address the reduced compliance. ESR competency reporting covers compliance for 12 months.

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

*Data obtained from the Trust safeguarding training

Looked After Children (LAC)

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

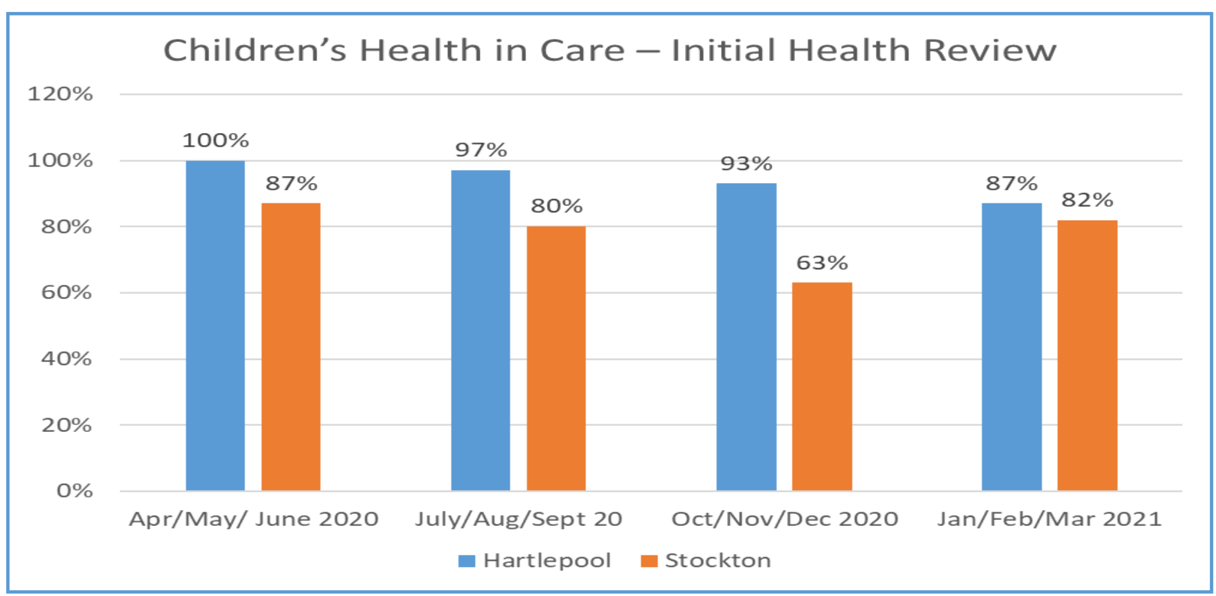
- LAC health provision is an integral part of the Trust Safeguarding and LAC Steering Group work programme which reports to the Trusts Children's Safeguarding Steering Group and Patient Safety Committee.

- The Trust continues to be represented and is an active member of the Children in Our Care Council in Stockton and Corporate Parenting Group in Hartlepool.

Looked After Arrangements and Provision

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

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



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

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

- Cancellations by carers continue to affect the rates of compliance. These issues are addressed with partner agencies and carers at the time

Review Health Assessments

Review Health Assessments must be undertaken at six monthly intervals for children under five years and annually for those over five up until they turn 18 years old.

Reviews are designed to identify and monitor health needs of LAC and are a statutory obligation. In Stockton the service model includes Health Visitors and dedicated School Nurses who undertake the RHA for those LAC accessing universal services. Health Visiting and School Nursing are a Public Health commissioned service. In Hartlepool the RHA's are undertaken by the Trust's Children's Health in Care (CHiC) team. To support this activity additional staff nurses have been recruited

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

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

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

Key Achievements 2020 - 2021

- Ongoing updates and improvements to the Electronic Health Care Record to improve the identification of health trends in the LAC population

- The sustained significant improvement in the completion of IHAs and RHAs within statutory timescales

- All new LAC are now flagged within the child's health care record, including Systmone and Trakcare enabling early identification of vulnerability

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

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

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

Key Priorities 2021 – 2022

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

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

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

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

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

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

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

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

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

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

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

LAC Key Priorities 2021 - 2022

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

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

Sensory Loss

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

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

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

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

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

The Trust set up a task and finish group to oversee implementation of the Standard and has worked with colleagues to meet the key milestones and to ensure compliance and achievement of the Standard within the Trust's sphere of control.

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

Identifying Patients with Sensory loss

Significant changes have been made to Core Admission Documentation to identify, more clearly, patients who have a sensory loss / impairment. The planning of care document has also been improved to include recording in relation to any reasonable adjustments required to support the patient during their hospital stay. This is followed by the provision and application of associated care plans; these are reviewed and evaluated as part of daily assessments and rounding by the Matrons. Work is also progressing to update current electronic systems used in acute and community settings to ensure inclusion of the requirements of the Accessibility Standards i.e. identifying, recording,

flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents where their needs relate to a disability, impairment or sensory loss.

Patient Experience

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

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

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

Specialist Equipment

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

Following the audit, the portable hearing loops were removed from the wards and stored in the medical equipment library so they are available to all when needed on a 24 hour basis. A Portable hearing loop is also kept in the resilience offices on both sites for emergency use. Over the coming year the Trust will be repeating the audit of hearing loops but also looking at what other specialist equipment is available for use.

Care Quality Commission Equality Objectives

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

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

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

Priority 1: Patient safety

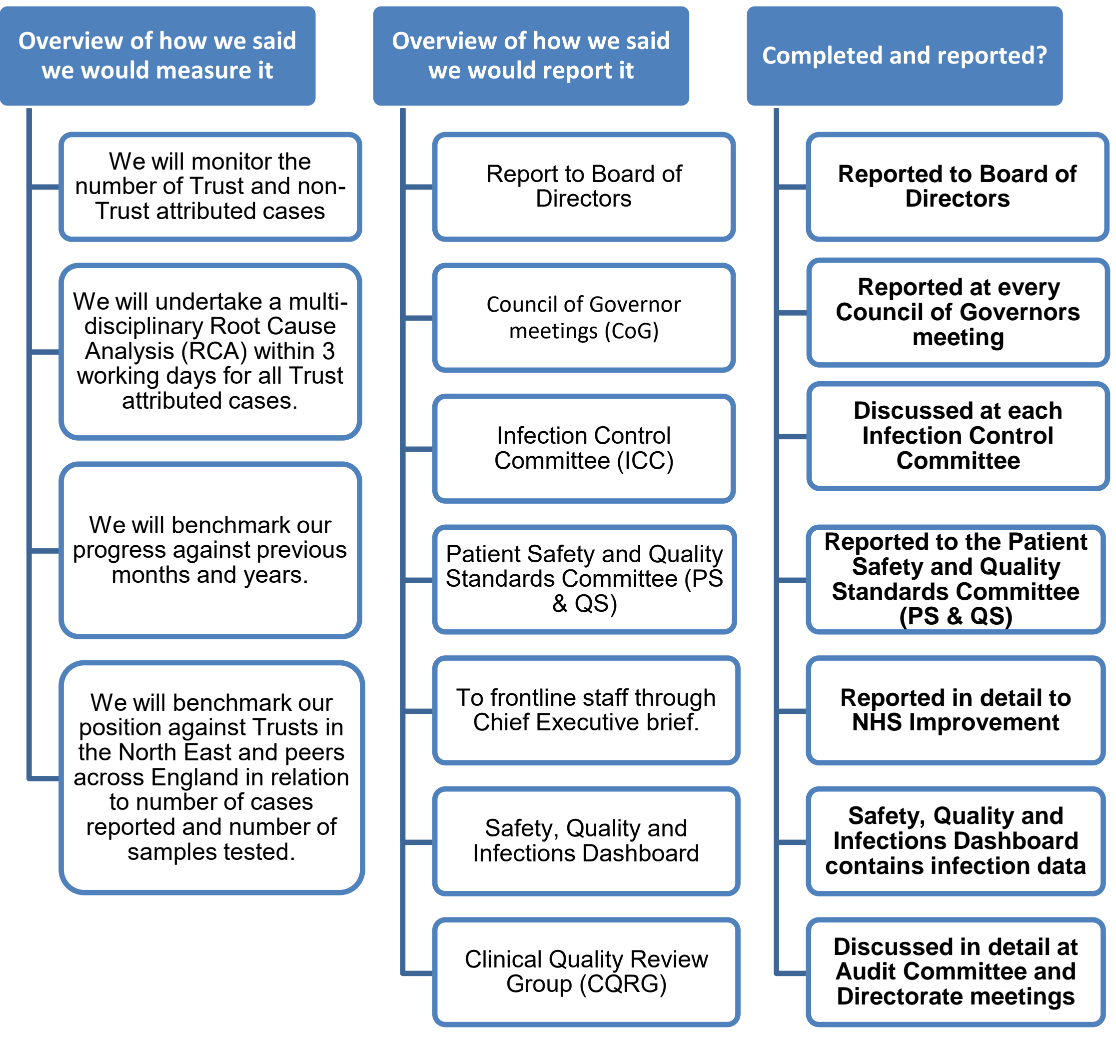
Infections

Rationale: The Trust continues to report on infections of:

- Clostridium difficile (C.diff),
- Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia;
- Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia; and
- Escherichia coli (E.coli)
- Klebsiella species (Kleb sp) bacteraemia; and
- Pseudomonas aeruginosa (Ps a) bacteraemia.
- Catheter-associated urinary tract infection (CAUTI)
- COVID-19

Overview of how we said we would do it

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



Clostridium difficile (C.difficile)

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

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

Our staff continue their efforts to control and reduce opportunities for infections to spread, whether we treat people in our clinical premises or in their own homes. The Trust has maintained a consistent approach to cleanliness across all areas of our environment including enhanced decontamination with hydrogen peroxide vapour, and the provision of a hygienist team to support additional cleaning. The focus on antimicrobial stewardship has continued and is led by a Consultant Microbiologist and Antimicrobial Pharmacist. The importance of adherence to high standards of hand hygiene has continued to be a core element of our strategy.

Actions to reduce C difficile are within an integrated HCAI improvement plan covering all infections and practices and is reviewed monthly. Progress against the plan is reported to the Healthcare Associated Infection Operational Group and Infection Control Committee and is regularly shared and discussed with commissioners.

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

Data reporting using the new requirements

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

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

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

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

Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia

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

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

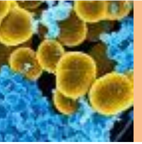
In 2020-21 our organisation reported **one** hospital onset cases of MRSA bloodstream infection, which is disappointing given the previous 2 years with no cases, and breaches with the national zero tolerance trajectory. Learning has been identified and shared across the Trust. Two community onset cases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

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

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

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

Methicillin-Sensitive Staphylococcus Aureus (MSSA)



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

In 2020-21 we reported **25** cases of hospital onset MSSA bacteraemia. This is a deterioration from the previous year. Each case is subject to a root cause analysis and the analysis of these investigations has shown that there are no apparent trends in terms of linked cases or frequently seen sources of infection. In many cases the source has been a chest or skin infection which would have been difficult to prevent.

However, the Trust recognises that further improvement can be achieved in this infection and increased emphasis on clinical practices continues to be a focus of our work to reduce the number of MSSA bacteraemia. A high number of community onset cases has continued to be seen this year. This may be due in part to an increased use of the sepsis screening protocol and an increase in the number of blood cultures sampled promptly in the emergency department and emergency assessment unit.

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

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

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

Escherichia coli (E.coli)

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

The numbers of E coli bacteraemia (blood stream infection) reported across by the Trust for the year are shown in the table below. As the majority of these cases are those that are identified within the first 48 hours of hospital admission, work is required across all healthcare settings to achieve improvements. A national objective to reduce gram negative blood stream infections (E coli, Klebsiella and Pseudomonas) by 50% by 2023 is in place and within this to reduce E coli bacteraemia by 10% each year.

Root cause analysis is completed for cases deemed to have been hospital onset and action plans are developed where actions are identified. In many cases these infections are related to urine infections and are thought to be not preventable with only a very small percentage of cases being in patients with a urinary catheter where there may be potential for improved practices.

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

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

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

Klebsiella species (Kleb sp) bacteraemia

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

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

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

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

In 2020-21 the Trust reported **10** Klebsiella species bloodstream infections which remained the same from the previous year. There is no reduction target associated with this infection currently. Enhanced data collection is carried out on each case to understand if there are any common themes to the infections. This allows us to target our efforts effectively to reduce the number of cases further.

Pseudomonas aeruginosa (Ps a) bacteraemia

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

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

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

In 2020-21 the Trust reported **3** Trust attributed cases of Pseudomonas aeruginosa bloodstream infections which has remained the same from the previous year. It is not possible to identify trends from such low numbers of cases. Many of these cases are considered to be unpreventable as with Klebsiella there is no reduction target assigned and enhanced data collection continues to better understand the sources of these infections.

Catheter-associated urinary tract infection (CAUTI)

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

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

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

Coronavirus disease (COVID 19)

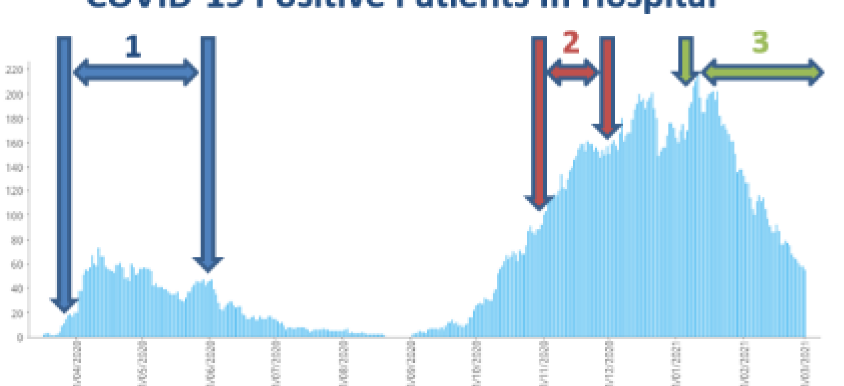
Coronavirus disease (COVID-19) is an infectious disease caused by a newly discovered coronavirus.

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

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

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

COVID-19 Positive Patients in the Trust



Lockdown **1** – 23rd March 2020 to 1st June 2020

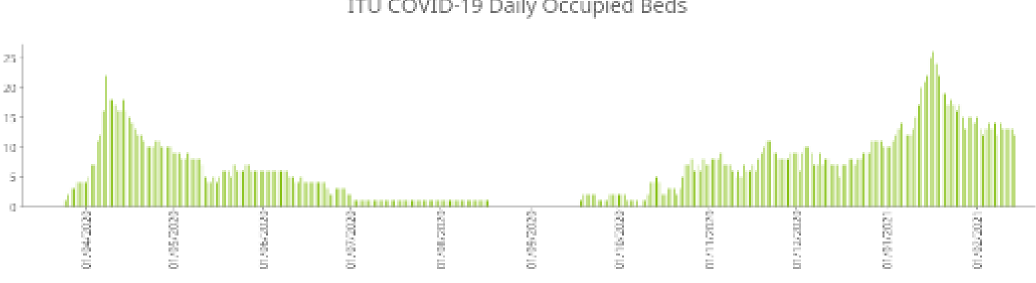
Lockdown **2** – 31st October to 16th December 2020

Lockdown **3** – 6th January to date

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

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

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



Priority 2: Effectiveness of Care

Learning from Deaths

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

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

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

During **April 2020 to March 2021**, **1,542** of North Tees and Hartlepool NHS Foundation Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

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

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

In **18** cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:
6 in the first quarter;
4 in the second quarter;
6 in the third quarter.
2 in the fourth quarter.

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

In relation to each quarter, this consisted of:
0 representing **0%** for the first quarter;
0 representing **0%** for the second quarter;
0 representing **0%** for the third quarter;
0 representing **0%** for the fourth quarter;

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

Medical Examiner

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

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

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

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

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

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

Learning Disabilities Mortality Reviews (LeDeR)

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

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

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

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

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

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

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

Bereavement surveys

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

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

Leading Improvements in Clinical Activity Recording and Coding

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

Education and Training

Multiprofessional regular training sessions:

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

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

Digital alignment

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

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

Improved coding practices

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

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

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

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

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

Surgical Mortality Reviews

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

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

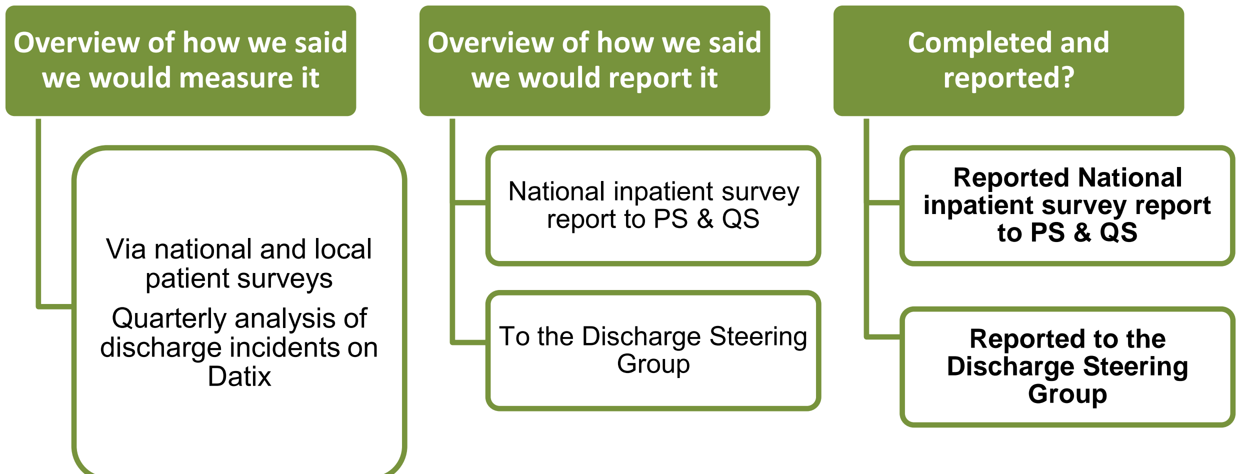
- In order to ensure consistency of review, any patients in the hospital that have been by the surgical team are now discussed at a daily meeting at 8am which are led by a consultant. This will ensure there all relevant patients have consultant input into their management, either by reviewing test results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

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

Priority 2: Effectiveness of Care

Discharge Processes

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



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

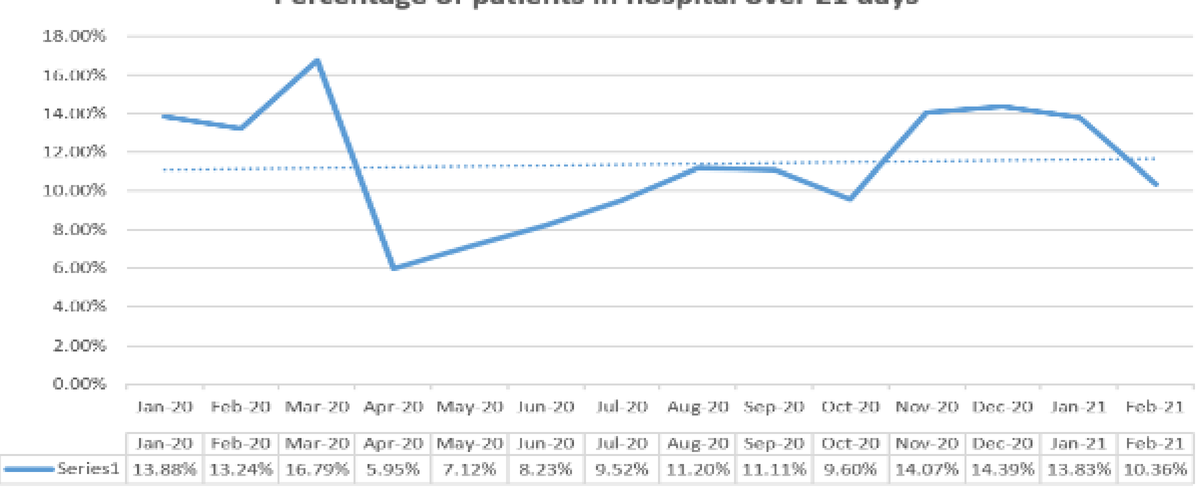
The Trust and our partners in social care have worked together to implement the discharge policy and continue to reduce delayed transfers of care.

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

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

Reduction length of stay in hospital

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



Help Force – Home but not alone scheme

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

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

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

7 day working focus on weekend discharges

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

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

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

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

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

Integrated single point of access pilot (ISPA)

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

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

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

District nursing in reach project

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

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

Frailty Coordinators

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

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

Home First Pilot

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

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

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

Priority 2: Effectiveness of Care

Accessibility

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

Aim

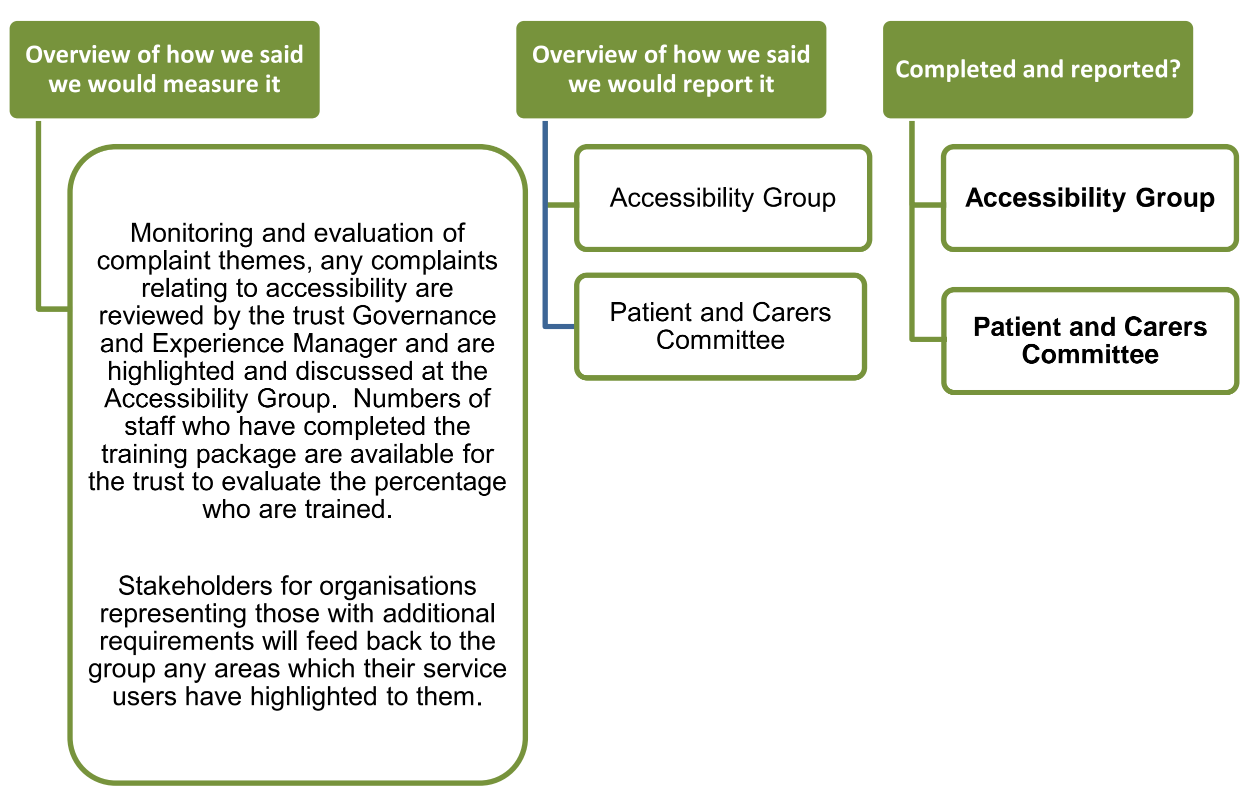
The aim is to develop a culture which learns from service user/stakeholder feedback. To provide a forum for service users/stakeholders to participate in accessibility projects and groups to ensure that their voices can be heard and that their views make a difference to the work in the trust. To ensure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

Overview of how we will do it

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

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

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



Developments and improvements 2020/2021:

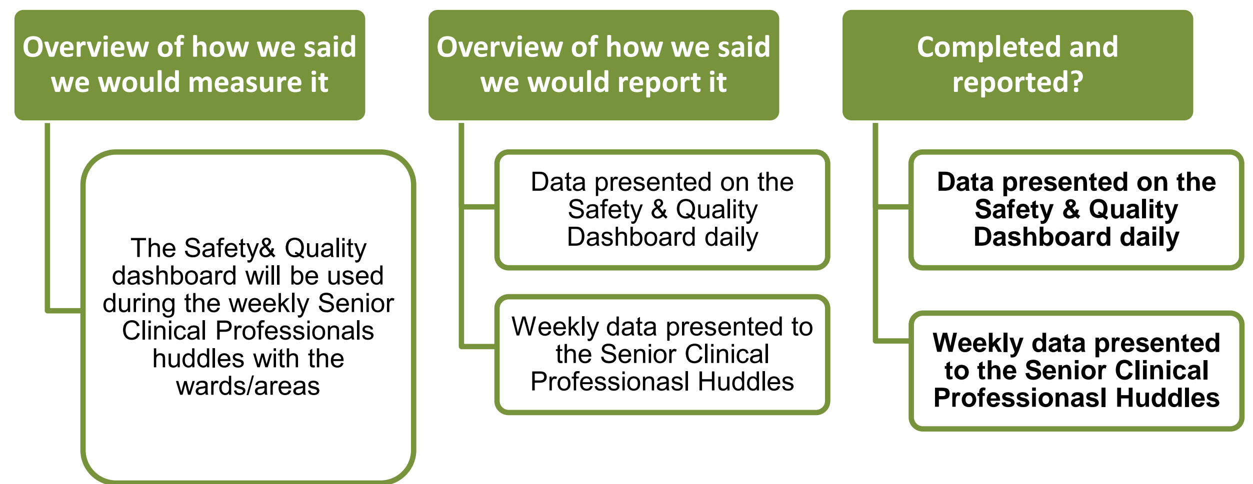
- E-learning sensory loss training package – included in the trust's dementia training
- 2 additional Task to Finish Groups have been set up and are in the initial stages groups to outline actions with deliverable aims – Guidance for staff - my colleague has autism and the second group Guidance for staff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

Priority 2: Effectiveness of Care

Violent Incidents

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

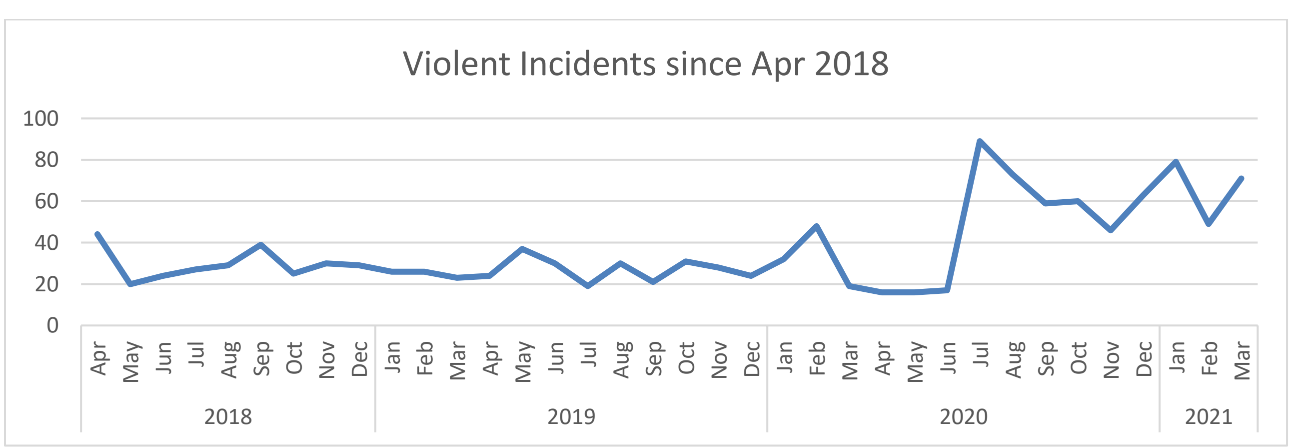
Overview of how we will do it
Utilise the Violent Incidents data held within the Trusts incidents reporting software (Datix).



Year Comparison

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

	Total Violent Incidents
2020 21	638
2019 20	343



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

*Data up to 31 March 2021

Priority 2: Effectiveness of Care

Safety and Quality Dashboard

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

Overview of how we said we would do it

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

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

The areas covered by the dashboard are:

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

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

Safety & Quality Dashboard

Patient Experience		Falls		Pressure Ulcers		Medication Errors	
Complaints	1,167	Total number of Falls	1,248	Total number of Pressure Ulcers	677	Total number of Medication Errors	540
Stage 1 - Informal	973	Fall No Injury	981	Category 1	150	Administration	305
Stage 2 - Formal Meeting	42	Fall Injury No Fracture	249	Category 3	78	Advice	7
Stage 3 - Formal Letter	152	Fall with Fracture	18	Category 2	431	Medication Error	141
Compliments	2,110			Category 4	18	Monitoring	33
						Pt Reaction	13
						Preparation	41
						Supply	0

Infections		Hand Hygiene		Friends & Family		Violent incidents	
Total number of Infections	324	Total Number of Audits (IPC Assessed)	68	Total Number of Responses	14,699	Total number of Violent Incidents	584
Cdif - HOHA	37	Nurse	95.55%	Very Good	11,454	Abuse etc of Staff by Patients	508
Cdiff - COHA	12	HCA	97.69%	Good	2,107	Abuse etc of Staff by Others	76
MRSA	1	Doctors	94.44%	Neither	484		
MSSA	25	Others	100.00%	Very Poor	348		
Ecoli	26	Compliance	96.38%	Poor	240		
Klebsiella	10			Don't Know	66		
Pseudomonas	3			Rated as: Very Good or Good	92.25%		
CAUTI	210						

Complaints

North Tees and Hartlepool NHS Foundation Trust

2020-21 Total Complaints	1,167
Stage 1 - Informal	973
Stage 2 - Formal Meeting	42
Stage 3 - Formal Letter	152

Complaints in the past 7 days	19
Stage 1 - Informal	18
Stage 2 - Formal Meet	0
Stage 3 - Formal Letter	1

Open Complaints	79
Stage 1 - Informal	31
Stage 2 - Formal Meet	17
Stage 3 - Formal Letter	31

Yearly Comparison

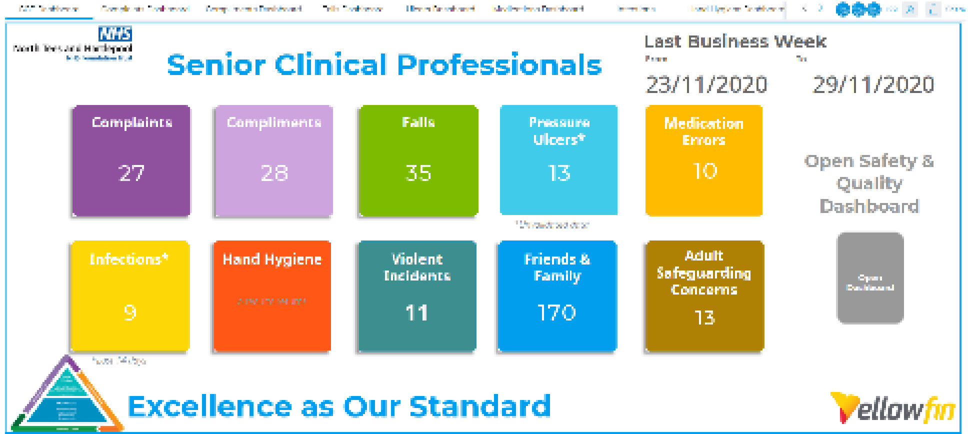
April to Current Month

Financial Years	
2018-19	1,191
2019-20	1,355
2020-21	1,167

Additional Reports: Theme by Fin Yr & Qtr — Open Report; Last Full Month - Report — Open Report; Specialty, Subject & Type Report — Open Report

Senior Clinical Professionals Weekly Huddle

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



Priority 3: Patient Experience

Palliative Care and Care For the Dying Patient

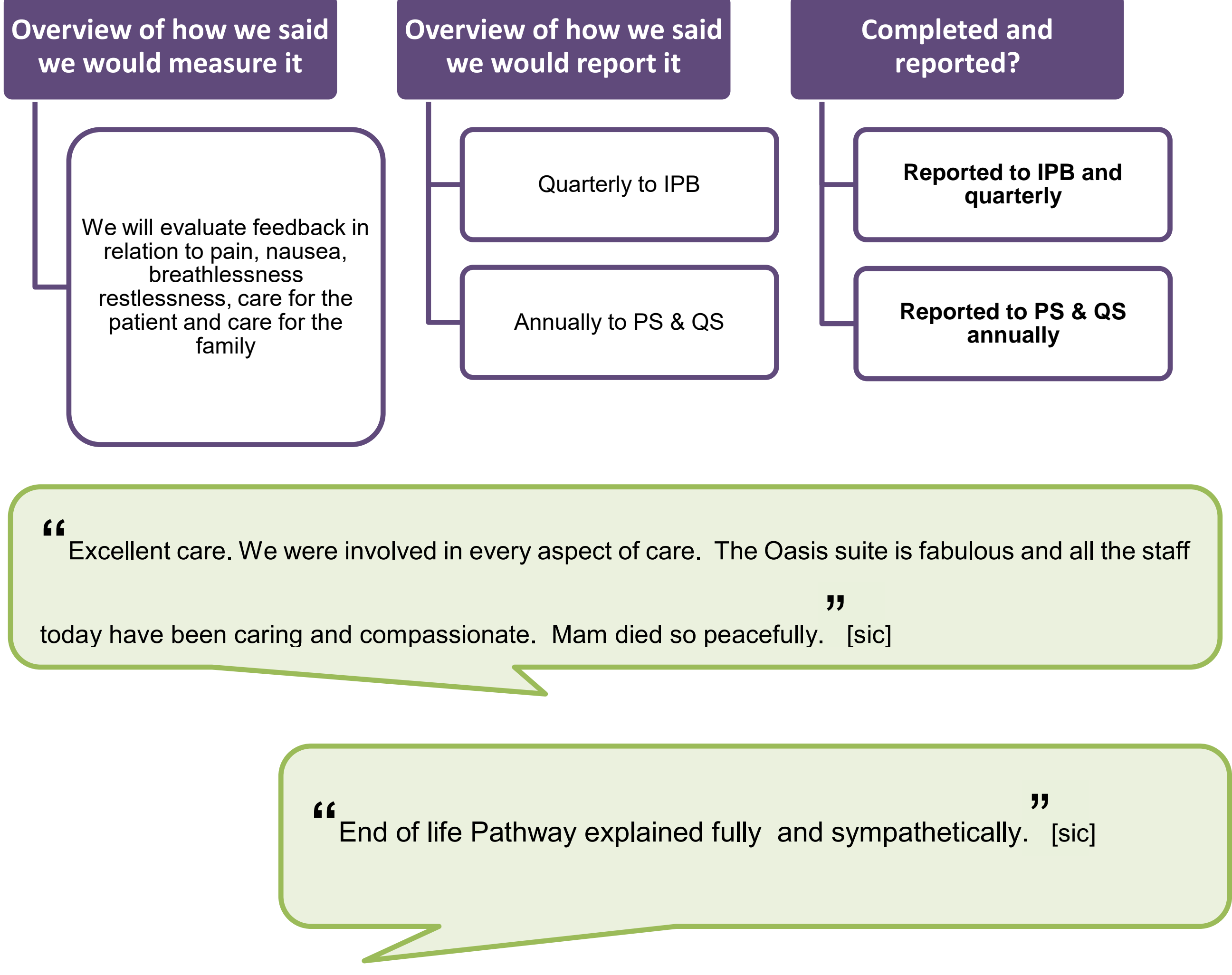
Rationale: The Trust used the Care For the Dying Patient (CFDP) and Family's Voice. Stakeholders and the Trust believe that this needs to remain a priority in 2019-20 both in hospital and in the community.

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

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

Overview of how we said we would do it

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



Specialist Palliative Care

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

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

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

*Data obtained from the Information Department

Band 5 & Band 3 Development

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

7 Day Specialist Level Clinical Support

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

End of Life Care Steering Group

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

Specialist Nurse Co ordinator

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

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

Locality wide Specialist Palliative Care MDT

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

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

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

Staff support Creative writing research project Covid19

The North Tees and Hartlepool Foundation Trust and The Open University joined forces on the Covid-19-Creative Writing with Health Care Workers Research Project to establish whether creative writing practice could reduce stress. This work was funded by the Open University rapid response Covid research funding scheme (see http://www.open.ac.uk/research/news/ou-funds-creative-writing-research-covid-19-frontline-healthcare-workers)

The project devised and facilitated eight workshops over three months, and this work developed a Creative Writing handbook for Health Care workers now set to be used in other Trusts. Facilitated by Dr Siobhan Campbell (OU), poet and social literary practitioner, with Mel McEvoy (Nurse Consultant in Cancer and Palliative Care) and Dr Donna Wakefield (Consultant in Palliative Medicine). Siobhan was Principal Investigator on a project in the use of creative writing in End of Life Care with Royal Trinity Hospice. Co-author of The Expressive Life Writing Handbook, her work in adapting writing pedagogies in communities led to projects with patients and clinicians as well as military veterans and rights activists. Mel worked on wards during Covid-19 and in providing psycho-social support to fellow staff. He is author of Listening to the family's voice: to improve symptom control and communication (2018), a project which used diaries as a method of supporting expression.

In questionnaires, all of the workshop participants noted that the workshops 'helped me to feel good about myself' and that the Creative Writing exercises 'helped me to express myself'. In an adapted Warwick-Edinburgh scale of psycho-social well-being, participants reported reductions in stress, and increased ability to cope. Participants were doctors, nurses, physiotherapists, occupational therapists and pharmacists who delivered care in C19. The writing shared powerful moments of personal experience:

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

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

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

The Family Voice Diary

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

End of Life Care Steering Group

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

NHSE / I work

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

Care For the Dying Patient (CFDP)

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

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

The Trust has endeavoured to improve the uptake of the CFDP with greater support from the chaplains who review every patient on the Care of the Dying Document. If the document has not been given out, it is pointed out and the next occasion they offer to accompany the staff in giving it out.

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

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

*Data obtained from the Trusts Family's Voice database

Quotes from family members/carers for the dying patient

"Nurses were amazing and so kind, helpful and compassionate." [sic]

"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]

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

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

In March 2015, the NHS England published NHS Chaplaincy Guidelines. The guidelines recognise the development of chaplaincy in a range of specialties including General Practice and in areas such as Paediatrics and Palliative care, describing the importance of spiritual and religious support to patients approaching end of life. The guidelines support and promote the approach that our Trust has taken since July 2009 to meet the needs of patients and families when faced with the knowledge that end of life is near.

Actions taken by the Trust:

The Trust has routinely referred patients on the end of life care pathway to the chaplaincy team. During 2020-21,**334** patients were referred by our staff to this pioneering service provided by the Trust chaplains. They provide **spiritual, pastoral and emotional support** to patients, families and staff. **1** patient declined support during the reporting year. **176** patients welcomed and received multiple visits. This service offers added value to the quality of overall care provided to patients and their loved ones and has highlighted the importance of this aspect of support to the dying patient.

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

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

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
Referrals	424	437	401	359	302	400	**334**
Received more than 1 visit	272	274	298	244	198	225	**176**
Declined Support	1	3	4	2	6	8	**1**

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

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

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

Multi Faith

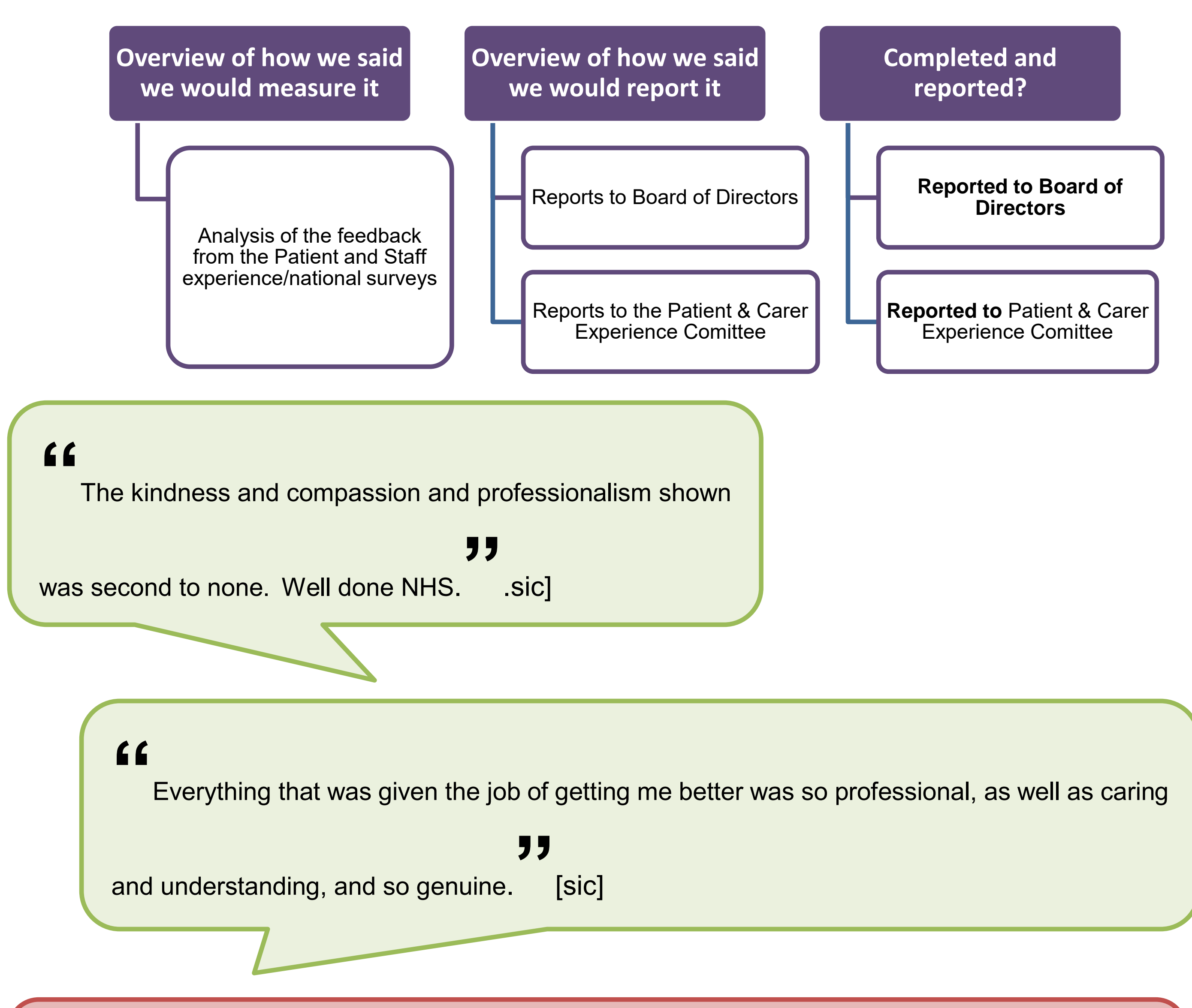
The Trust holds a directory of all the local faith groups in the area, if there is a request for the Imam (Muslim) or the Hindu Priest, Buddhist or any other faith, the chaplains would contact the Trust link person and arrange a visit.

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



Patient Experience Surveys

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

National Surveys

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

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

Local Surveys

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

National Surveys

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

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

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

CQC National Inpatient Data 2019 Key results

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

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

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

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

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

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

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

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

Action plans

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

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

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

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

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

Priority 3: Effectiveness of Care

Friends and Family Test

Friends and Family Test

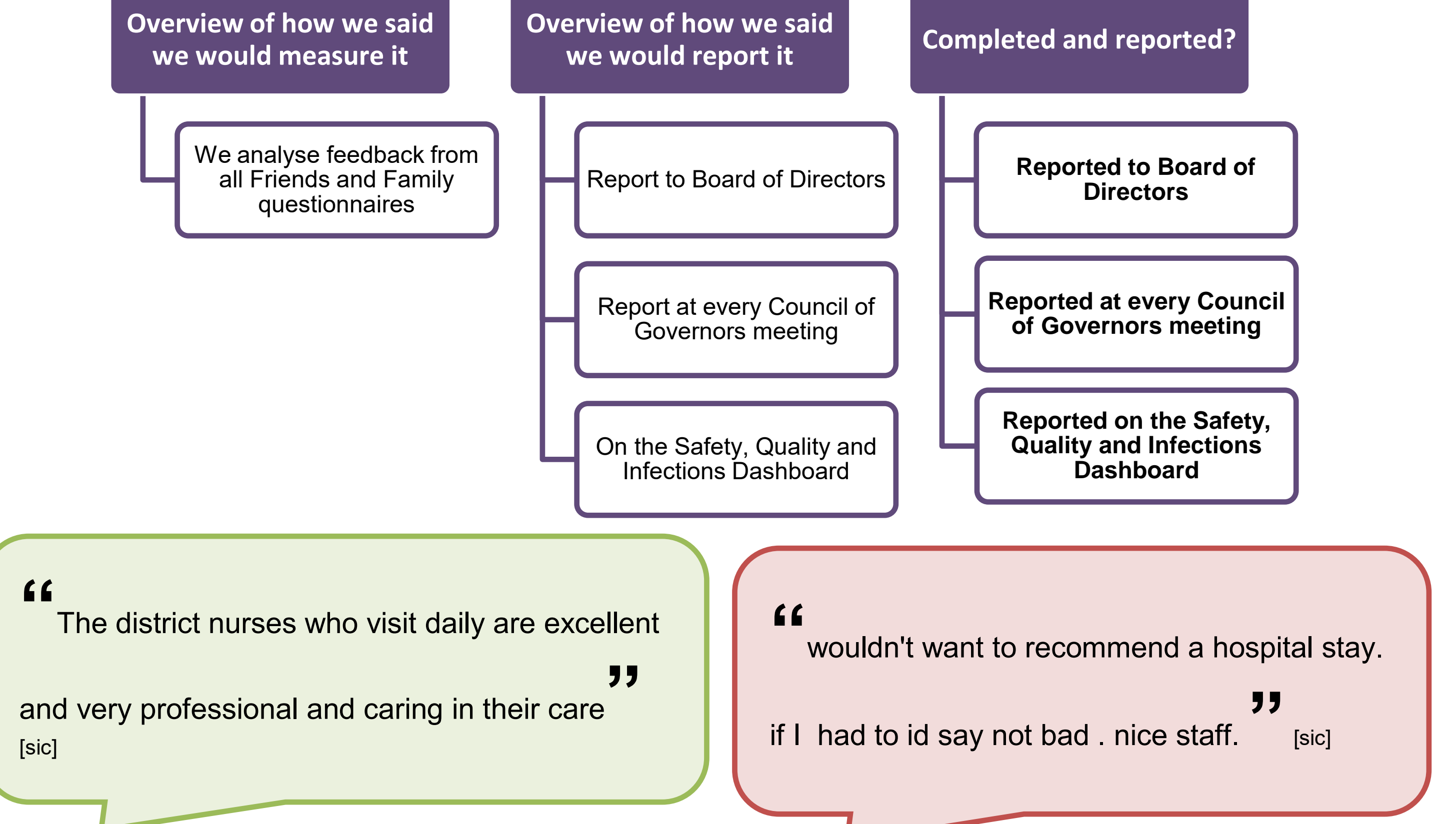
Tell us what you think about of the care or treatment you have received from us....

NHS
The Friends and Family Test

Rationale: The Department of Health require Trusts to ask the Friends and Family recommendation questions from April 2013. Stakeholders agreed that this continues to be reported in the 2020-21 Quality Accounts.

Overview of how we said we would do it

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



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

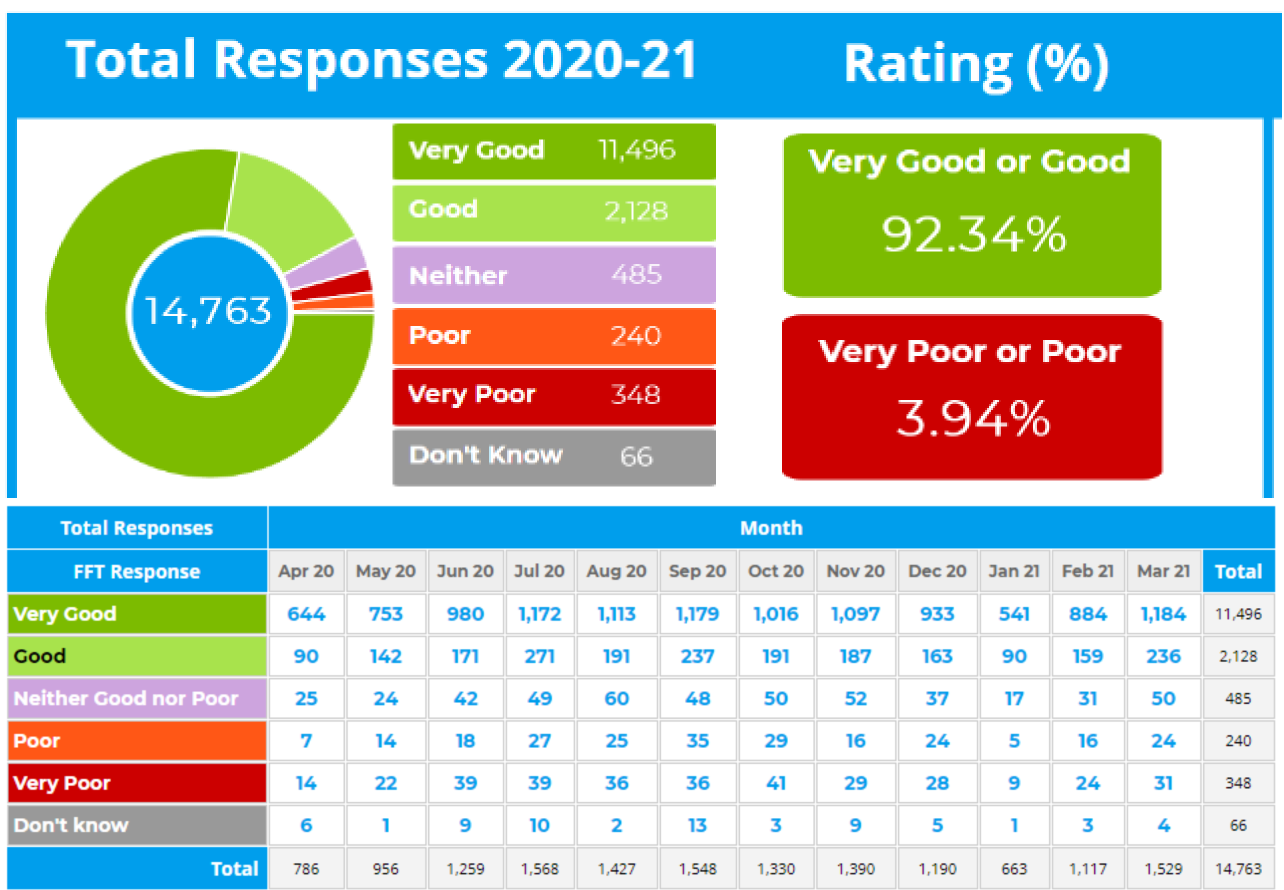
The Friends and family data can be found at:
https://www.england.nhs.uk/fft/friends-and-family-test-data/

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

North Tees and Hartlepool NHS Foundation Trust

Returns for April 2020 to 31 March 2021

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



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

*Data from Trusts Friends and Family database and Inhealthcare

“Always extremely helpful very efficient even though overloaded with patients.” [sic]

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

“Seen quite quick by very professional staff with patients.” [sic]

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

“I arrived 5 mins before my appointment at 11.40 and I wasnt seen until 2.10pm. No one informed me of the delay or spoke to me during my wait to inform me of how long the delay or an apology I would of made another appointment if I was aware as I had come out of work for my appointment.” [sic]

Staff - Friends and Family Test

The Trust continues to ask staff the Friends and Family Test, thus allowing staff feedback on NHS Services based on recent experience. Trust Staff are asked to respond to two questions.

Staff Friends and Family Test is conducted on a quarterly, the following data refers to the full 2020-21 financial year.

Breakdown of Responses Care

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

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

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

Breakdown of Responses Work

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

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

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

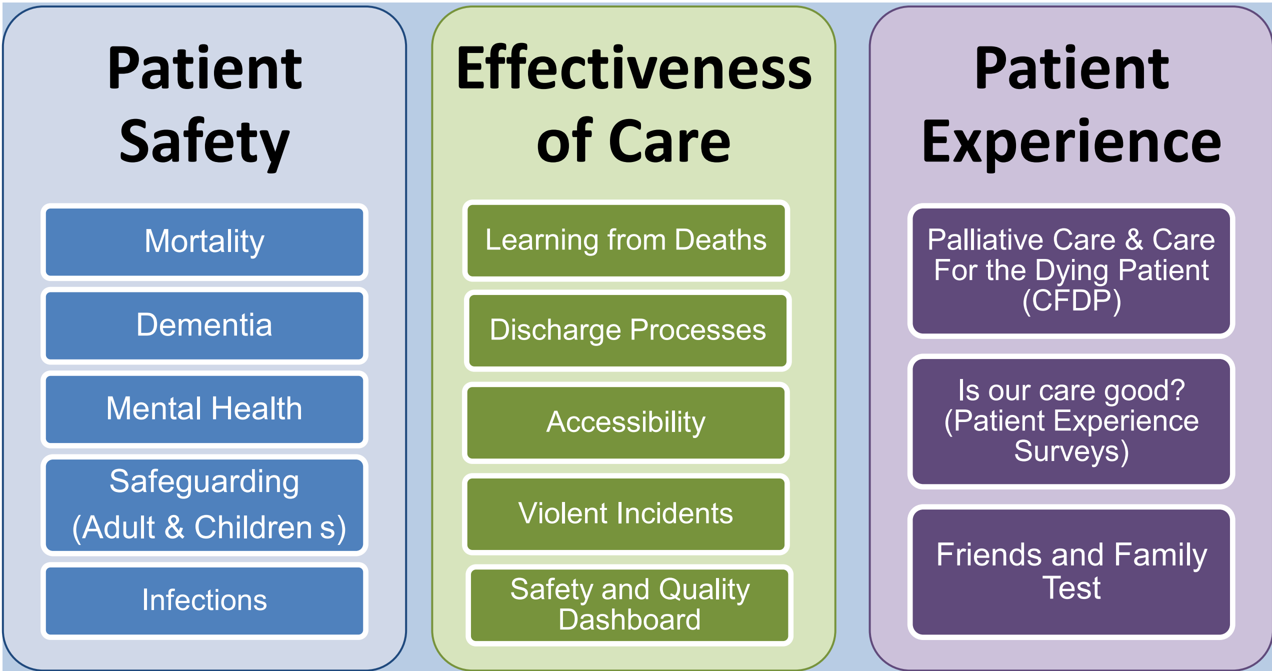
Part 2b: 2021-22 Quality Improvement Priorities

Introduction to 2021-22 Priorities

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

Stakeholder Priorities for 2021-22

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



Rationale for the selection of priorities for 2021-22

Through the Quality Accounts stakeholder meetings and other engagement events we provided an opportunity for stakeholders, staff and patients to suggest what they would like the Trust to prioritise in the 2021-22 Quality Accounts.

We then chose indicators from each of the key themes of Patient Safety, Effectiveness of Care and Patient Experience. The Trust will continuously monitor and report progress on each of the above indicators throughout the year by reporting to the Board.

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

Patient Safety

Priority 1 - Mortality

To reduce avoidable deaths within the Trust

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

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

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

Overview how we will monitor it
Monitored by the Mortality Dashboard

Overview of how we will report it
Report to Board of Directors meeting
Report to Council of Governors meeting
Report quarterly to the Commissioners

Priority 2 - Dementia

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

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

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

Patients with dementia will be appropriately assessed and referred on to specialist services if needed.

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

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

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

The percentage of patients who receive the Abbreviated Metal Test and, where appropriate, further assessment will be reported monthly via UNIFY.
We will continue with the prevalence audit for the number of patients that have cognitive screening over the age of 75 admitted as an emergency that are reported as having a known diagnosis of dementia, or have been asked the dementia case finding questions.

We will continue to undertake the National Audit for dementia.

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

Overview of how we will report it
Vulnerability Committee
Monthly UNIFY

Priority 3 – Mental Health

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

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

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

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

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

Priority 4 – Safeguarding

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

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

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

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

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

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

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

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

Priority 5 – Infections

Key stakeholders asked us to report on infections in 2020-21 due to the increase in Ecoli infections and scrutiny towards Cdifficile.

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

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

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

Overview of how we will report it
Board of Director Meetings, Council of Governor Meetings (CoG), Infection Control Committee (ICC), Patient Safety and Quality Standards Committee (PS & QS), To frontline staff through Chief Executive brief, Safety and Quality Dashboard and Clinical Quality Review Group (CQRG).

Effectiveness of Care

Priority 6 – Learning from Deaths

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

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

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

Overview how we will monitor it
Monitored by the Mortality Dashboard

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

Priority 7 – Discharge Processes

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

Overview of how we said we would do it

All patients should have a safe and timely discharge.
All concerns and/or incidents raised onto the Trust's Datix system.

Overview of how we said we would measure it

Via national and local patient surveys.
Quarterly analysis of discharge incidents on the Datix system.

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

Overview of how we said we would report it

National inpatient survey report to PS & QS.
To the Discharge Steering Group.

Priority 8 – Accessibility

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

Aim

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

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

Overview of how we will do it

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

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

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

Overview of how we will measure it

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

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

Overview how we will monitor it

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

Overview of how we will report it

Accessibility Group
Patient and Carers Committee

Priority 9 – Violent Incidents

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

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

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

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

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

Priority 10 – Safety and Quality Dashboard – Business Intelligence

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

Overview of how we will do it
Training will be undertaken and each department will evidence that their results have been disseminated and acted upon.

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

Overview of how we will measure it
The dashboard will be used during the weekly Quality Reference Group meetings with the wards/areas. Quarterly meetings with wards/areas will be held to ensure that data is up to date, accurate and displayed in public areas.

Overview how we will monitor it
Monthly dashboard analysis to the Chief Nurse/Director of Patient Safety and Quality

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

Patient Experience

Priority 9 – Palliative Care and Care For the Dying Patient (CFDP)

The Trust has continued to use the Care for the Dying Patient (CFDP) and Family's Voice. Stakeholders and the Trust believe that this still needs to remain a priority in 2020-21.

Overview of how we will do it
We will continue to embed the use of the Family's Voice in hospital and monitor use in community.

Overview of how we will measure it
We will evaluate feedback in relation to pain, nausea, breathlessness restlessness, care for the patient and care for the family.

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

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

Priority 10 – Is our care good? (Patient Experience Surveys)

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

Overview of how we will do it
We will ask every patient interviewed in the Patient and Staff Experience reviews. We will also ask the question in all Trust patient experience surveys, along with monitoring patient feedback from national surveys.

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

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

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

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 2020-21 the North Tees and Hartlepool NHS Foundation Trust provided and/or subcontracted **64** relevant health services. The majority of our services were provided on a direct basis, with a small number under sub-contracting or joint arrangements with others.

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

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

Participation in clinical audits

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

The Healthcare Quality Improvement Partnership (HQIP) provides a comprehensive list of national audits which collected audit data during 2020-21 and this can be found on the following link:

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

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

During 2020-21, North Tees and Hartlepool NHS Foundation Trust participated in **82%** of national clinical audits and **100%** of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

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

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

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

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

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

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

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

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

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

The national clinical audits and national confidential enquires that North Tees and Hartlepool NHS Foundation Trust participated in, and for which data collection was completed during 2019-20, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Mandatory National Clinical Audits	Participation	% cases submitted
British Spine Registry	Yes	100%
Case Mix Programme (CMP)	Yes	100%
Elective Surgery (National PROMs Programme)	Yes	100%
Emergency Medicine QIP: Fractured Neck of Femur	Yes	100%
Emergency Medicine QIP: Pain in Children	Yes	100%
Emergency Medicine QIP: Infection Control	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP)	Yes	100%
Learning Disabilities Mortality Review Programme (LeDeR)	Yes	100%
Mandatory Surveillance of HCAI	Yes	100%
Maternal and Newborn Infant Clinical Outcome Review Programme	Yes	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Adult COPD Audit	Yes	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Adult Asthma Audit	Yes	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Adult Pulmonary Rehabilitation Audit	Yes	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Paediatric Asthma Audit	Yes	100%
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	100%
National Audit of Cardiac Rehabilitation	Yes	100%
National Audit of Care at the End of Life (NACEL)	Yes	100%
National Audit of Dementia (NAD)	Yes	100%
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Yes	100%
National Bariatric Surgery Register	Yes	100%
National Cardiac Arrest Audit (NCAA)	Yes	100%

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

National Clinical Audits

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

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

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

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

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

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

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

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

National Confidential Enquiries (NCEPOD):

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

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

Local Clinical Audits

The reports of **47** local clinical audits were reviewed by the provider in 2020-21 and North Tees and Hartlepool NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

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

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

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

Commissioning for quality and innovation (CQUIN)

A proportion of North Tees and Hartlepool NHS Foundation Trust income in 2020-21 was conditional upon achieving quality improvement and innovation goals agreed between North Tees and Hartlepool NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

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

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

Care Quality Commission (CQC)

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

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

The Care Quality Commission (CQC) has not taken enforcement action against North Tees and Hartlepool NHS Foundation Trust during 2020-21. North Tees and Hartlepool NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

The Trust was inspected by the Care Quality Commission (CQC) under the new regime of inspection at the end of 2017. The new inspection includes an unannounced inspection which took place from 21 to the 23 November 2017 and a planned well-led inspection which took place from the 19 to the 21 December 2017.

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

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

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

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

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

2017-18 - Overall ratings for the Trust

Overall rating for this Trust	**Good**

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

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

Rating for Acute Services/Acute Trust

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

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

It is important to highlight the Trust has recently launched the Quality Improvement Strategy which is aligned to several key sub-strategies and the Trusts Vision, mission and values. It underpins continuous improvement in patient care and services by developing effective leaders, engaging

support and participation by all relevant staff with an emphasis on team work, innovation and sustainability. Fundamentally `Putting Patients First` is the Trust`s main objective and it is important as a Trust we create a person-centred approach across the organisation, embedding a culture which engages and enables staff to add value to patient experience and that can be demonstrated through patient safety, high quality and effective delivery of care.

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

CQC Contact and Communication

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

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

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

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

Seven Day Hospital Services

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

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

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

Duty of Candour

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

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

to be completed and stored in the patients records, full completion of this records sheet will ensure all of the necessary regulatory points are recorded.

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

There are continuing training and update sessions available to all staff in relation to Duty of Candour and details of any external seminars are shared to enhance wider knowledge of the regulations. From April 2018 Duty of Candour training has been mandated for all staff grade 6 and above; the training is provided monthly on a face to face basis but also available as e-learning. Training levels are monitored monthly through the Trusts mandatory training reports.

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

Commissioners Assurance

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

Freedom to Speak Up (FTSU)

Background to the Freedom to Speak Up Guardian

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

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

Philosophy

This role takes in the recommendations of Sir Robert Francis, following his review into whistleblowing in the NHS. It is intended that this will help normalise the raising of concerns for the benefit of all patients. Speaking up protects patient safety and improves the lives of workers. Freedom to Speak Up is about encouraging a positive culture where people feel they can speak up and their voices will be heard, and their suggestions acted upon.

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

- unsafe patient care
- unsafe working conditions
- inadequate induction or training for staff

- professional malpractice
- lack of, or poor, response to a reported patient safety incident
- suspicions of fraud (which can also be reported to our local counter-fraud team)
- a bullying culture (across a team or organisation rather than individual instances of bullying)
- suspicion that a bribe has been either offered, promised, agreed, requested or accepted
- conduct which is likely to damage the reputation of the Trust;
- breach of the Trust's policies and procedures
- a criminal offence has been, or is being committed, or is likely to be committed
- any misrepresentation of the true state of affairs of the Trust
- the environment has been, is being or is likely to be damaged
- the deliberate concealment of any of the above matters or information which has been or may be deliberately concealed.

Trust progress:

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

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

Themes from the 12 new cases are:

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

NHS number and general medical practice validity

North Tees and Hartlepool NHS Foundation Trust submitted records during 2020-21 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episodes Statistics (HES) which are included in the latest published data.

The percentage of records in the published data:

Which included the patient's valid NHS number was:	%	Which included the patient's valid general medical practice code was:	%
Percentage for admitted patient care**	**99.93%**	Percentage for admitted patient care	**100%**
Percentage for outpatient care	**99.97%**	Percentage for outpatient care	**100%**
Percentage for accident and emergency care	**99.61%**	Percentage for accident and emergency care	**100%**

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

Information governance (IG)

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

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

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

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

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

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

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

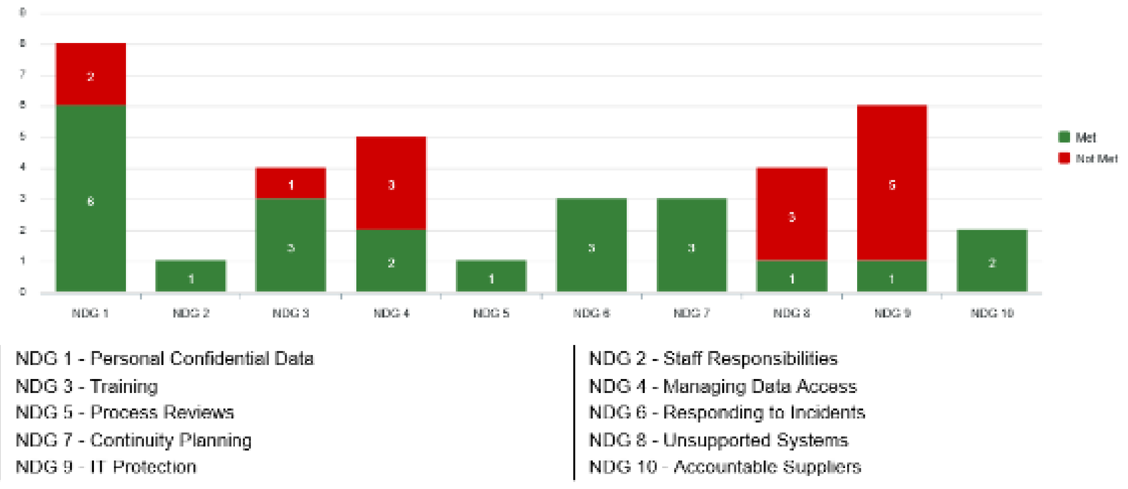
Assurance continues to be provided to the Board of Directors that systems and processes are being constantly assessed and improved to ensure that information is safe. The Data Security and Protection Standards for health and care are set out in the National Data Guardian's (NDG) ten standards and are measured though the completion of the Data Security Protection Toolkit (DSPT). All organisations that have access to NHS patient data and systems must use this toolkit

to provide assurance that they are practicing good data security and that personal information is handled correctly.

The DSPT sets out 111 mandatory evidence items in 42 assertions (37 Mandatory) which cover these 10 standards that the Trust must evidence compliance against in order to gain compliance.

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

The current position is reflected in the chart below:



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

Freedom of Information (FOI)

The Trust continues to respond to Freedom of Information requests from members of the public on a range of topics across all services and departments, complying with the 20 working day limit to do so. The act is regulated and enforced by the Information Commissioners Office (ICO). The ICO hold powers to enforce penalties against the Trust when it does not comply with the Act, including but not limited to monetary fines. For the year 2020-21 the Trust received 371 requests with a compliance level, as of 31 March 2021, of 96% with complete compliance data available after 30 April 2021. This was achieved despite Trust services experiencing significant pressure during the Covid-19.

Clinical coding error rate

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

North Tees and Hartlepool Foundation Trust was *not subject* to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

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

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

The services reviewed within the sample were 200 finished consultant episodes (FCEs) taken from the specialties of obstetrics and gynaecology. The results should not be extrapolated further than the actual sample audited.

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

Depth of coding and key metrics is monitored by the Trust in conjunction with mortality data. Targeted internal monthly coding audits are undertaken to provide assurance that coding reflects clinical management. Any issues are taken back to the coder or clinician depending on the error. The clinical coders are available to attend mortality review meetings to ensure the correct coding of deceased patients.

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

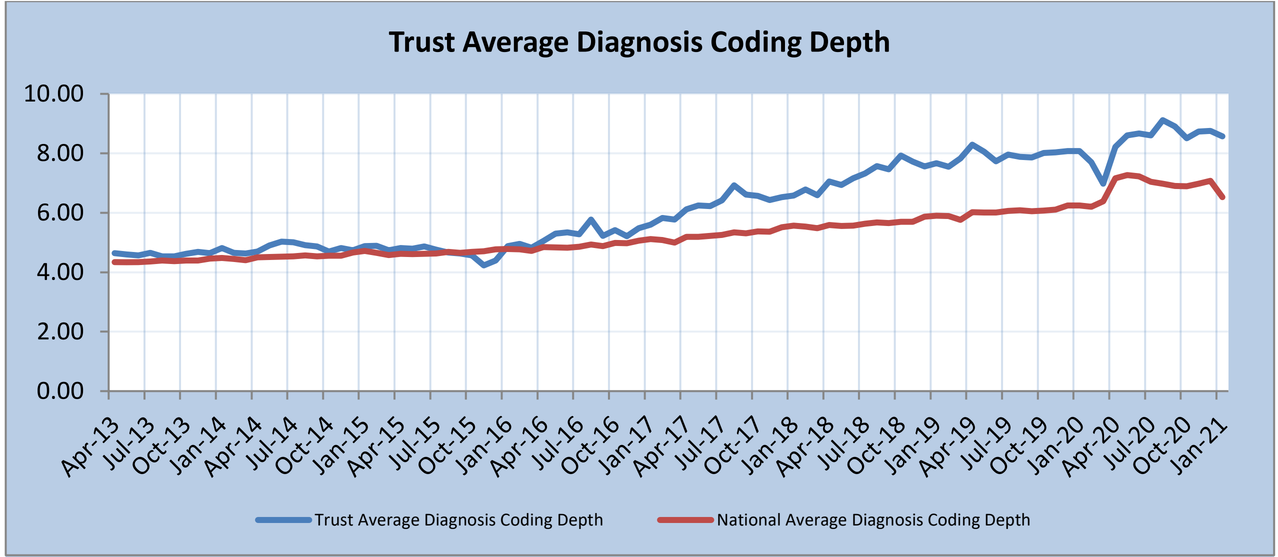
Specific issues highlighted within the audit have been fed back to individual coders and appropriate training planned where required. **North Tees and Hartlepool NHS Foundation Trust** will be taking the following actions to improve data quality. The coding department has undergone a re-structure in order to facilitate coding medical episodes from case notes.

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

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

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

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



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

Part 2d: Core set of Quality Indicators

Measure	Measure Description	Data Source
1a	The data made available to the trust by NHS Digital with regard to — the value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period **September 2019 – August 2020**.	NHS DIGITAL

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

Summary Hospital-level Mortality Indicator (SHMI) – Deaths associated with hospitalisation, England, **November 2019 – October 2020**

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

SHMI Regional – November 2019 – October 2020

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

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

The **North Tees and Hartlepool NHS Foundation Trust** has taken the following actions to improve this indicator and so the quality of its services. The Trust continues to undertake mortality reviews over two sessions each week, this is in line with the Secretary of State for health requirements for all Trusts to undertake mortality reviews; this continues to be supported by the CQC. This has been supported by the inclusion of the mortality reviews in the quality work

undertaken by all consultant staff as part of their annual appraisal. The information is input directly onto a dedicated database; this is then used to extract data for reporting.

The clinical reviews undertaken provide the organisation with the opportunity to assess the quality of care being provided as this will continue to be the priority over and above the statistical data. The Trust's review process is linked closely with the work being undertaken regionally and the Trust is working jointly with local Trusts to utilise a web based system to store mortality reviews that can be linked into the national system once this is agreed and in place. All Trusts in the region are undertaking reviews and Trust staff meet with them on a regular basis to share best practice and to also consider areas of focus across the region as well as locally.

The awareness, work and engagement has been delivered during 2019-20, this continues to make an impact on the HSMR and SHMI values, and have led to both of these statistics being reported as being "within expected" ranges. Whilst the Trust recognises that the values have maintained an excellent position over a number of months, the actions already initiated are being followed to completion and there are further areas being identified for review, and potential improvement work, from the analysis of a wide variety of data and information sources on a regular basis.

Measure	Measure Description	Data Source
1b	The data made available to the trust by NHS Digital with regard to — The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust - **Nov 2019 – Oct 2020**	NHS DIGITAL

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

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

Latest Time Period benchmarking position – November 2019 – October 2020

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

The **North Tees and Hartlepool NHS Foundation Trust** considers that this data is as described for the following reason. The use of palliative care codes within the Trust is now a fully embedded practice. The processes and procedures are continuously reviewed to ensure that the Specialist Palliative Care team are reviewing patients in a timely manner.

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

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

The Trust continues to work with commissioners to review pathways of care and support patient choice of residence at end of life wherever possible. Further work is also on-going with GPs to try and reduce inappropriate admissions to the Trust.

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

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

Apr 19 to Mar 20, Data from NHS Digital

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

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

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

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

Measure	Measure Description	Data Source
3	The data made available to the trust by NHS Digital with regard to the percentage of patients aged— (i) 0 to 15; and (ii) 16 or over. readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.	NHS DIGITAL

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

The **North Tees and Hartlepool NHS Foundation Trust** considers that this data is as described for the following reasons. The Trust monitors and reports readmission rates to the Board of Directors and Directorates on a monthly basis. The December 2019 position (latest available data) indicates the Trust has an overall readmission rate of 10.01% against the internal stretch target of 7.70%, indicating the Trust's readmission rates have slightly decreased by 0.95% from the same period in the previous year (10.96% - December 2018).

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

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

Period of Coverage	National Average	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST (out of 100)
2020 21	**Not Available**	**Not Available**
2019-20	67.10	62.60
2018-19	67.20	65.20
2017-18	68.60	68.70
2016-17	68.10	67.20
2015-16	69.60	67.70
2014-15	68.90	68.10

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

Benchmarked against over North East Trusts for 2019-20;

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

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

The scores are out of 100. A higher score indicates better performance: if patients reported all aspects of their care as "very good" we would expect a score of about 80, a score around 60 indicates "good" patient experience. The domain score is the average of the question scores within that domain; the overall score is the average of the domain scores. The Trust has worked hard in order to further enhance its culture of responsiveness to the personal needs of patients.

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

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

Measure	Measure Description	Data Source
5	The data made available to the trust by NHS Digital with regard to the percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	NHS DIGITAL

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

The aim of the test is to:

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

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

National NHS Staff Survey

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

	Survey Year			
Trust Name	**2017**	**2018**	**2019**	**2020**
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	77	83	88	87
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	58	59	61	66
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	**67**	**71**	**72**	**74**
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	89	90	91	91
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	69	71	64	76
GATESHEAD HEALTH NHS FOUNDATION TRUST	81	81	82	80
SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST			70	71
North East	72	74	75	78
England	70	70	71	74
National High	**86**	**95**	**-**	**92**
National Low	**47**	**41**	**-**	**48**

Friends and Family Test – Staff

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

	*Q1	*Q2	**Q3	*Q4
Percentage Recommended Care	N/A	N/A	74%	N/A

*Q1, Q2 and Q4 – Due to COVID-19 NHS Imprrovements stopped the data collection
**Q3 information taken from the NHS National Staff Survey

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

	*Q1	*Q2	**Q3	*Q4
Percentage Recommended Work	N/A	N/A	69%	N/A

*Q1, Q2 and Q4 – Due to COVID-19 NHS Imprrovements stopped the data collection
**Q3 information taken from the NHS National Staff Survey

More detail can be found for the Friends and Family Test in Part 3: Review of Quality Performance 2020-21, under Priority 3: Patient Experience – Friends and Family recommendation, point 3.

The **North Tees and Hartlepool NHS Foundation Trust** considers that this data is as described for the following reasons. The Trust continue to actively engage with and encourage staff to complete and return the Staff Survey along with the quarterly Staff Friends and Family Test. It is important that the results of these surveys are communicated to our staff and we utilise a 'you said, we did' approach to facilitate this. A new approach to action planning has been identified for 2019, with a specific focus on improving staff engagement. We are also incorporating staff survey action plans into the directorate performance reviews, which will improve accountability for action plans and ensure that actions are monitored going forward.

The **North Tees and Hartlepool NHS Foundation Trust** has taken the following actions to further improve this percentage, and so the quality of its services, by involving the views of the staff in developing a strategy for care. Understanding the views of staff is an important indicator of the culture of care within the organisation and the Workforce directorate is carrying out projects to understand the culture of the organisation. We have now commenced Phase 2 of the Culture and Leadership programme, which involves developing a collective leadership strategy for high quality, continuously improving, and compassionate care. The Culture Dashboard reports on a number of key staff survey metrics which can then be shared with the directorates for consideration and action where required.

National Staff Survey

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

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

*2020 released In March 2021

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

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

*2020 released In March 2021

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

Two year reporting trend

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

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

North East Trust benchmarking 2019-20

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

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

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

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

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

The Trust ensures that each Directorate clinical lead is responsible for monitoring and audit of compliance of NICE VTE guidelines and this is presented yearly to the Audit and Clinical Effectiveness (ACE) Committee.

Venous thromboembolism (VTE) mandatory training 2020 21	92%

*Data obtained from the Trust training department

Measure	Measure Description	Data Source
7	The data made available to the trust by NHS Digital with regard to the rate per 100,000 bed days of cases of C difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.	NHS DIGITAL

	Rate per 100,000 bed-days for specimens taken from patients aged 2 years and over				
Reporting Period	Trust C difficile cases	*Trust Rate	*National Average	*Highest National rate	*Lowest National rate
Apr 2020 Mar 2021	43	Not Available	Not Available	Not Available	Not Available
Apr 2019 – Mar 2020	53	13.20	Not Available	Not Available	Not Available
Apr 2018 – Mar 2019	31	16.40	12.20	79.97	0.00
Apr 2017 – Mar 2018	35	17.90	13.70	91.00	0.00
Apr 2016 – Mar 2017	39	18.80	13.20	82.70	0.00

* 2020-21 numbers as of 30 March 2021, additional detail not available at the time of print

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

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

- Enhanced ward cleaning and decontamination of patient equipment, including the use of steam, hydrogen peroxide and Ultraviolet (UV) light.
- Exploration of new patient products such as commodes to ensure they are easy to clean and fit for purpose.
- The continued use of the mattress decontamination service to reduce the risk of infection and improve quality of service to patients.
- Raised awareness and audit of antimicrobial prescribing and stewardship including the identification of antibiotic champions for each directorate and the introduction of competency assessments for prescribers. The Trust again participated in European Antibiotic Awareness day with displays for staff around prudent prescribing. Awareness has also been raised via the CQUIN scheme to reduce overall antibiotic consumption and ensure that prompt review of antibiotics takes place.
- Continued emphasis on high standards of hand hygiene for staff and patients, utilising hand hygiene champions and a monthly RAG report.
- Monitoring of the management of affected patients to support ward staff and ensure guidance is being adhered to.
- The continuation of annual update training in infection prevention and control for all clinical staff.
- Review of all hospital onset cases by an independent panel to ascertain whether the infection was avoidable and to ensure all learning has been identified.
- Collaborative working with partner organisations to standardise guidance and promote seamless care for patients who move between care providers.

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

Measure	Measure Description%	Data Source
8	The data made available to the trust by NHS Digital with regard to the number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	NHS DIGITAL

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

Provider: Acute (Non Specialist) – Organisational incident data by organisation in 6-month period, **October 2019 – March 2020**

	Based on occurring dataset (Degree of Harm – All)		National			Our Trust	
			Degree of harm Severe or Death			Degree of harm Severe or Death	
Report period	**Number of incidents occurring**	**Rate per 1000 Bed Days**	**Average %**	**Highest %**	**Lowest %**	**Number of incidents**	**%**
Oct 19 Mar 20	**3,820**	**41.60**	**0.16**	**0.49**	**0.01**	**26**	**0.30**
Oct 18 – Mar 19	1,580	16.90	0.16	0.49	0.01	15	0.16
Oct 17 – Mar 18	4,582	44.80	0.15	0.55	0.00	18	0.18
Oct 16 – Mar 17	3,087	29.80	0.15	0.53	0.01	5	0.05

Regional Benchmarking

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

*Data for Oct 18 – Mar 19

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

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

positive safety culture is associated with increased reporting and as such, the Trust continuously monitors the frequency of incident reporting and strives to increase reporting in all areas. The Trust is targeting the reporting of no and low harm incidents, which can provide valuable insights into preventing future incidents of patient harm. In relation to frequently occurring incidents such as falls and pressure damage, the Trust have developed templates within the incident reporting system to identify contributory factors of incidents, identify trends, develop improvements and evaluate the impact of these.

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

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

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

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

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

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

Part 3a:

Additional Quality Performance measures during 2020-21

This section is an overview of the quality of care based on performance in 2020-21. In addition to the three local priorities outlined in Section 2, the indicators below further demonstrate that the quality of the services provided by the Trust over 2020-21 has been positive overall.

The following data is a representation of the data presented to the Board of Directors on a monthly basis in consultation with relevant stakeholders for the year 2020-21. The indicators were selected because of the adverse implications for patient safety and quality of care should there be any reduction in compliance with the individual elements.

Patient Safety

Falls

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

A post falls checklist is completed and is used to help categorise the fall into the classification of Fracture, Fall No Injury or Fall Injury No Fracture.

Falls with Fracture

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

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

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

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

Falls Injury, No Fracture

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

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

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

Falls with No Injury

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

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

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

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

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

Never Events

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

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

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

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

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

The NHS England report can be accessed via:

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

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

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

Effectiveness of Care

Medication Errors

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

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

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

* Data from the Trusts Datix system

Safe Medication Practices Group (SMPG)

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

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

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

Electronic prescribing and medicines administration continues to be developed further and rolled out in the Trust. This system has the potential to reduce medicines errors through:

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

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

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

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

Ward based pharmacy services have now been rolled out to two further wards. This service provides wards with a designated pharmacist and supporting technicians to improve the safe supply of medications for patients and increase accurate and speedier supply of medication at the point of discharge.

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

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

“Waiting times unfair, general care disappointing and available medication poor. Triage Nurse had lack of understanding no empathy or care very disappointed.” [sic]

Clinical Effectiveness Indicators

These indicators for Clinical Effectiveness are covered under the section of Effectiveness of Care. The Trust has decided to include more detail around some of the Clinical Effectiveness indicators; this will be built on year on year, including more detailed data around the Monitor Compliance Framework.

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

The following table demonstrates the quarter on quarter performance with a benchmark position against 2019-20 data and against the 2020-21 performance target.

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

*Data from Trust Clinical Effectiveness Team

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

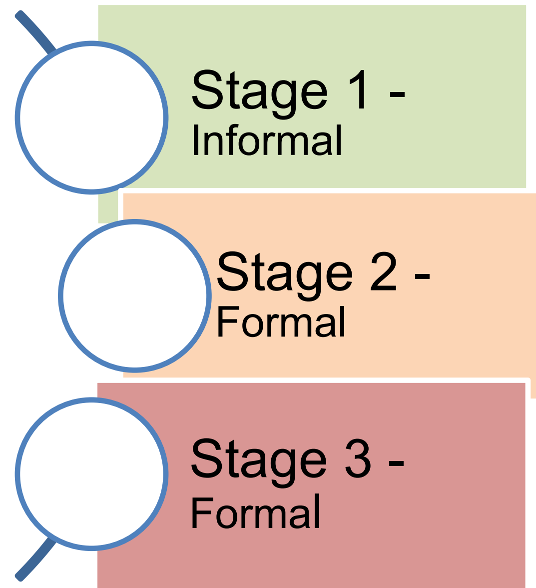
“ 3 members of staff, whom attended to my mam who could not speak due to having strokes, treat her with dignity, care and compassion. I could not thank them enough for taking the time needed to care for her, to communicate in a way my mam could answer for herself and be understood. Yes i told them what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

Patient Experience

Complaints

The Trust continues to work hard to improve customer satisfaction through patient experience.

We do recognise that we don't always get things right and this is why we have a dedicated **patient experience team** to listen to and investigate any concerns or complaints.



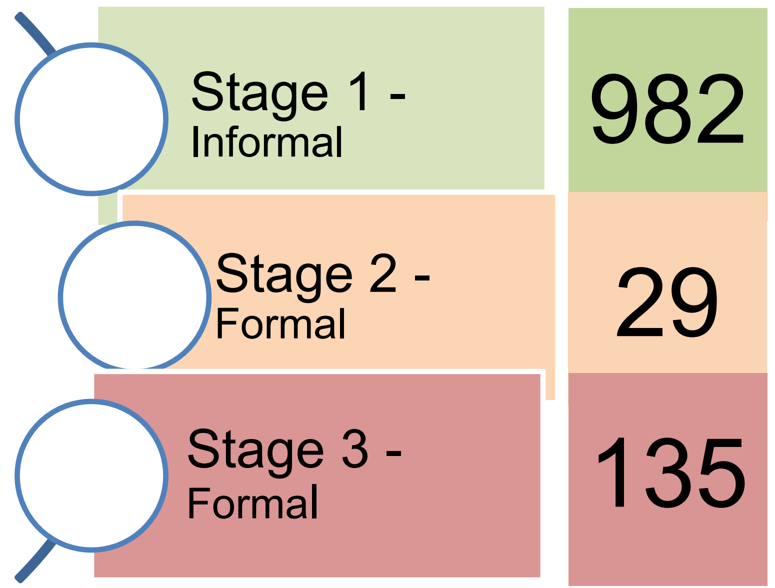
Dealt with at the time of complaint at ward level/ or by the Patient Experience Team (PET) to resolve.

A meeting arranged with the complainant to discuss the complaint with the Senior Clinical Matron, consultant and relevant personnel involved in the complaint with hopefully a resolution at this stage.

If Stage 1 or Stage 2 did not resolve the issue or the complainant did not want to go through those routes, a formal Stage 3 is then raised.

Number of Complaints – 2020-21

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



Total

1,146

*Data for 2020-21 obtained from Datix

2020-21 Complaints by complaint type:

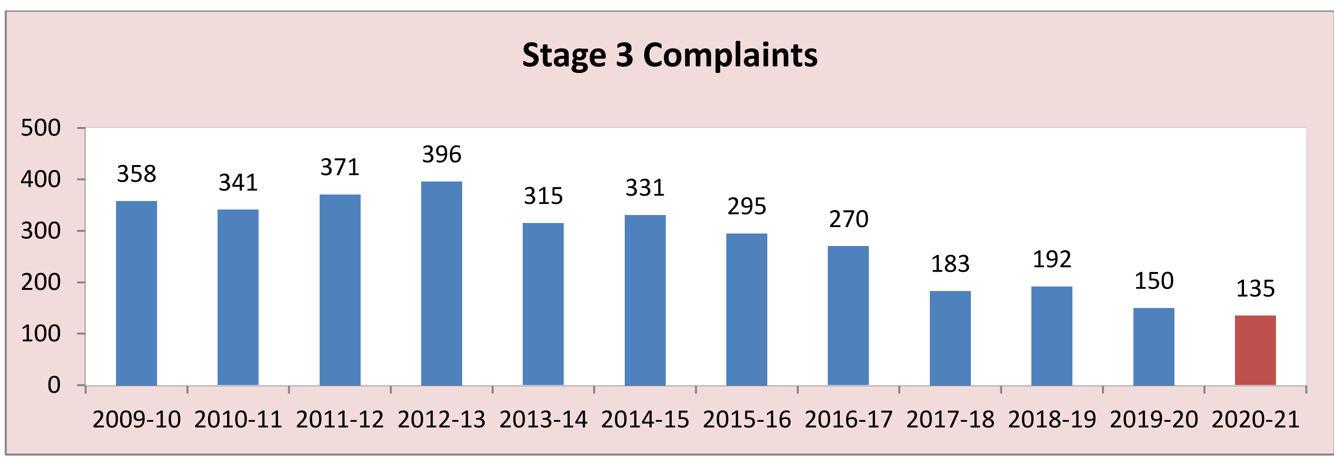
Please see the following breakdown for the Top 10 complaints from the **135 Stage 3** complaints in 2020-21

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

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

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

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



*Data obtained from Trust complaints dept. up to Feb 2021

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

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

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

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

*Data obtained from Trust complaints dept

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

Number of complaints

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

Referred to PHSO

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

Complaints upheld

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

Action taken to improve services

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

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

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

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

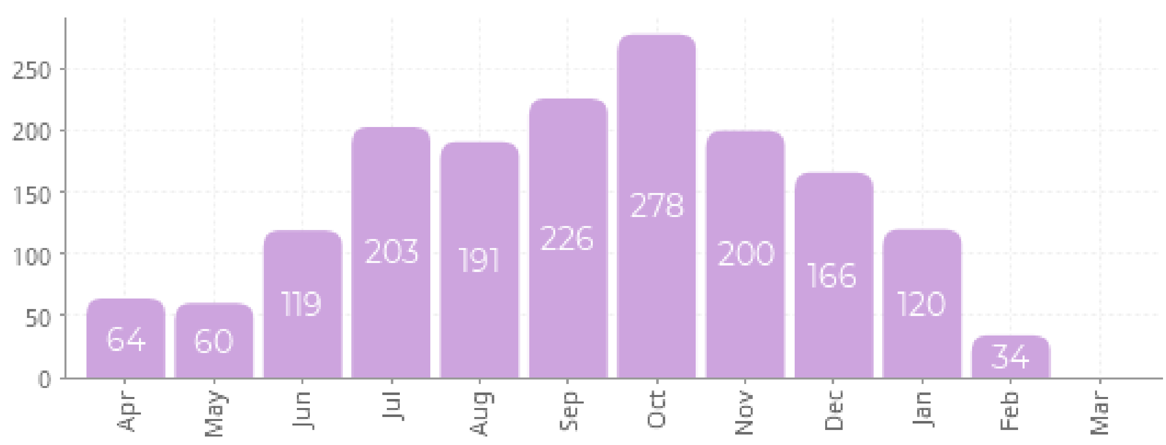
Workshops have been completed with staff to encourage local resolution of complaints, identifying and dealing with complaints locally is beneficially for both patients and staff as it allows for fast resolution of issues and appropriate escalation at the time of any issues.

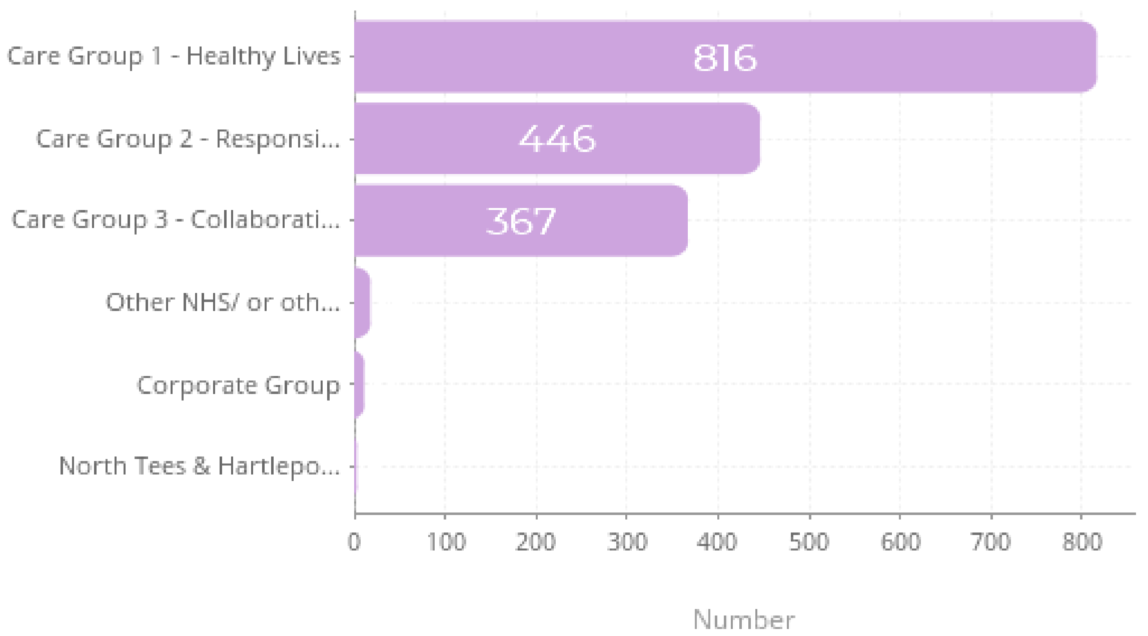
All staff involved in complaints are informed so they are able to reflect on their practice.

Compliments

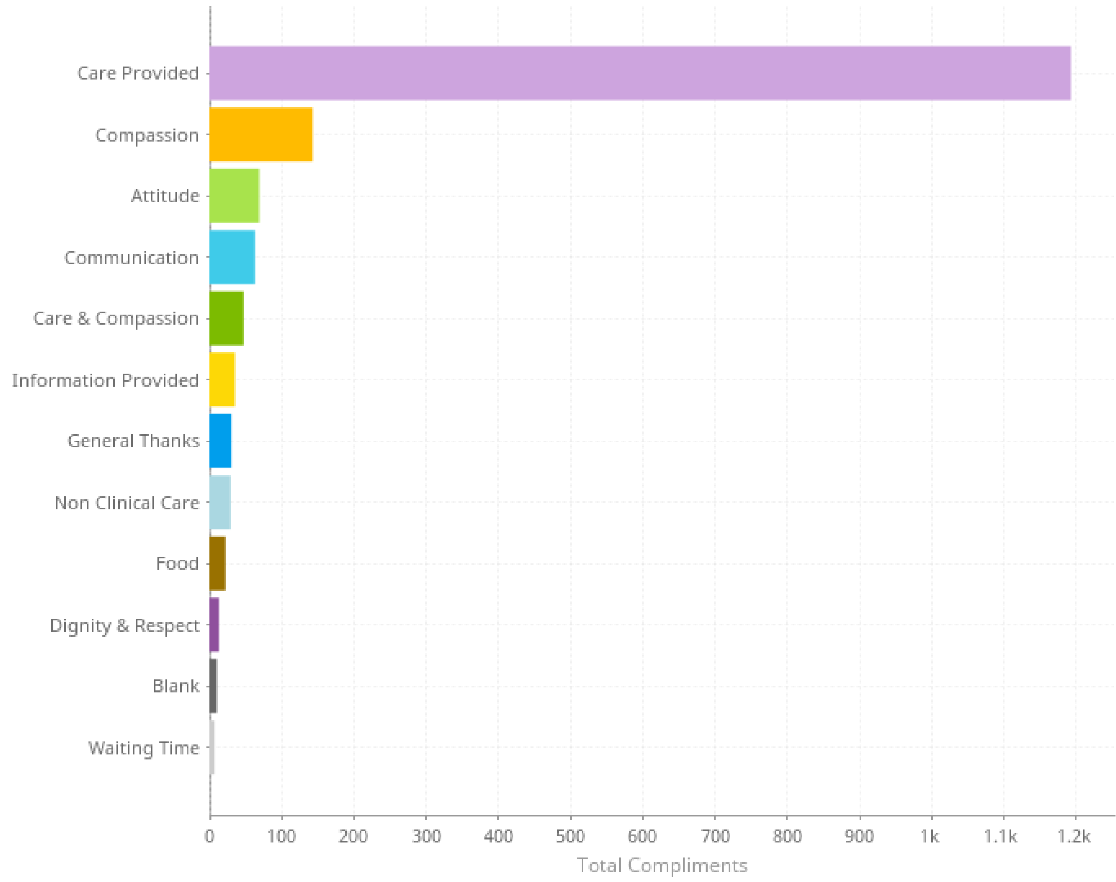
The Trust records the number of **compliments** received within each area. The trends in the number of compliments received can be seen in the following table and chart.

Total Compliments 2020-21 1,661





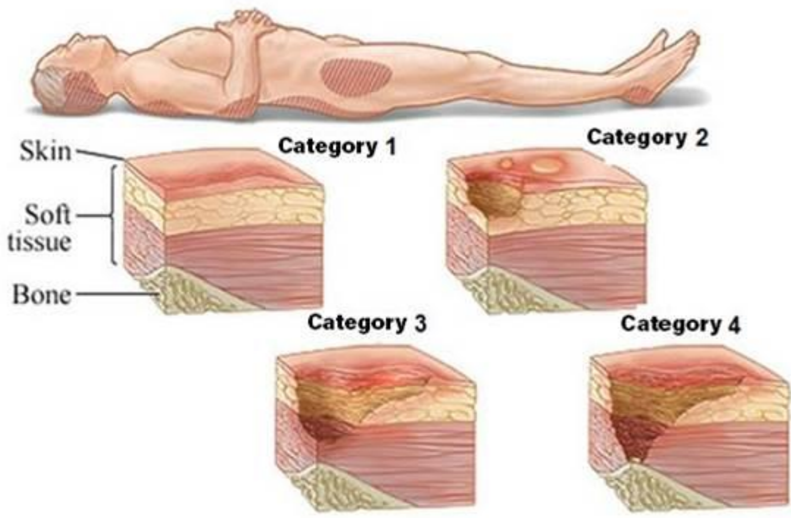
*Data obtained via the Trusts Compliments (PALS) module within Datix.



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

Pressure Ulcers

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



Year on Year Comparison – In-*Hospital Acquired*

Reporting Period	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Category 1	78	39	38	54	92	64
Category 2	258	128	189	198	299	233
Category 3	12	9	20	35	34	14
Category 4	1	1	2	2	3	3
Total	**349**	**177**	**249**	**289**	**428**	**314**

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

Year on Year Comparison – Out of Hospital *Acquired*

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

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

Actions taken by the Trust:

Pressure damage is one of the top five reported incidents within the Trust; with risk assessment, prevention and management being guided through the application of NICE guidelines and quality standards. The incidents are reported via datix and the Trust has developed a checklist within the system to capture the overall data in relation to pressure ulcer incident reporting. The checklist also supports colleagues reviewing such incidents by providing a consistent approach towards decision making in relation to the level of investigation required. All incidents are quality checked, after reporting, by the Tissue Viability Nurses. The numbers of pressure ulcer incidents are discussed at the Senior Clinical Professionals Huddle each week and monitored through the Tissue Viability Operational Group, Quality Reference Group which informs the integrated professional Board meeting.

The Tissue Viability Operational Group has the remit of reviewing the Trust's functioning programs of improvement, Trust policies and guidelines. Quarterly quality audits by the directorates are undertaken. An annual pressure ulcer prevalence audit is also undertaken for patients on the community nurse caseload and patients in hospital in-patient beds. Following the moderation of results, an improvement plan is negotiated with the Directorate Leads to provide assurance that there is evidence of continuous improvement and performance. The Trust continues with "Our Journey to Outstanding" and the Quality Improvement Strategy aims to place quality improvement at the heart of everything the Trust does, with a focus on the needs of our patients, families and carers. Therefore, as part of this journey the Trust has developed a Pressure Ulcer Assurance Framework which aims to give assertion of progression of excellent practice within pressure ulcer prevention as well as identifying any areas of improvement needed. During the COVID-19 pandemic staff have continued to be educated and empowered through ongoing support to reduce unwarranted variation and provide the very best care to every patients, every day. The agenda for pressure ulcer prevention is underpinned by evidence, research and best practice with measurable outcomes ensuring we do the right thing at the right time. A successful and inclusive collaborative pilot is planned to be widened across clinical areas with a focus on improving risk assessments and reducing potential for patient harm.

Education remains a key focus for the Tissue Viability Team so working with the departmental staff and managers is critical in the maintenance of a network of Tissue Viability Champions who meet for updates on wound care and all matters related to tissue viability. This meeting is well attended and the training topics at the meeting are chosen by the Champions themselves and delivered by either the Tissue Viability team or colleagues from the wound care industry. The annual Tissue Viability champions day is a full day of study and is planned for July 2021. Last year's event went ahead despite the problems with the pandemic and was well evaluated. The annual "Stop the Pressure" event was again very successful in November 2020 with a well circulated social media campaign. The "Stop the Pressure" event will be repeated in 2021.

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

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

Communication between services continues to be promoted in order to provide seamless holistic care for our patients moving between hospital and community. A key element of this is ensuring wound care information is passed onto the next care provider. The Tissue Viability service have developed their SystmOne functionality to allow those that are able to access the patients health care record to see the input of the TVN team regardless of which clinical

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

Section 3b:

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

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

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

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

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

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

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

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

Additional Assurance:

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

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

Annex A: Third party declarations

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

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

NHS Tees Valley CCG commissions healthcare services for the population of Darlington, Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton-On-Tees. The CCG take seriously their responsibility to ensure that the needs of patients are met by the provision of safe, high quality services and therefore welcome the opportunity to submit a statement on the Annual Quality Account for North Tees and Hartlepool NHS Foundation Trust (NTHFT).

The quality of services delivered and associated performance measures are the subject of discussion and challenge at the Clinical Quality Review Group (CQRG) meetings. The meetings are well attended and provide an opportunity to gain assurance that there are robust systems in place to support the delivery of safe, effective and high-quality care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Yours sincerely

Jean Golightly
Director of Nursing & Quality
NHS Tees Valley CCG

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

Hartlepool Healthwatch – 21 April 2021

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

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

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

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

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

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

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

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

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

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

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

Yours Sincerely,

Christopher Akers-Belcher

Chief Executive - Healthwatch Hartlepool

Stockton Healthwatch – 08 June 2021

Healthwatch Stockton 3rd Party Declaration

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Trusts Council of Governors – 03 June 2021

Council of Governors

(third party declaration)

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

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

The schedule of reports for the Council of Governor meetings and the Sub-Committees continue to be regularly reviewed to make sure that topical matters are shared in a timely manner. The Council of Governor meetings provide a valuable opportunity for the Governors to review performance and seek assurance on actions, raising any concerns with the Board of Directors present and it is anticipated that these opportunities will resume fully during 2021/22.

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

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

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

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

Audit and Governance Committee – Third Party Declaration

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

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

Patient Safety;
Effectiveness of care; and
Patient Experience.

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

Yours faithfully

COUNCILLOR GERARD HALL

Healthcare User Group (HUG) – 24 May 2021

Third Party Statement from the Healthcare User Group (HUG)

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

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

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

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

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

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

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

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

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

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

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

Healthcare User Group
May 2021

Annex B: Quality Report Statement

Statement of Directors' Responsibilities in Respect of the Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust boards should put in place to support data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2019-20* and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2020 to April 2021
    - papers relating to Quality reported to the Board over the period April 2020 to April 2021
    - feedback from commissioners dated xx *June 2021*
    - feedback from governors dated 03 *June 2021*
    - feedback from local Healthwatch organisations dated 21 April *2021 & 08 June 2021*
    - feedback from the Adult Services and Health Select Committee and Audit and Governance Committee dated 26 May *2021* & 04 *June 2021*
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated *Q4 2020-21*
    - the latest national patient survey *2019*
    - the latest national staff survey *2020*
    - the Head of Internal Audit's annual opinion over the Trust's control environment dated 16 *May 2019*
    - CQC Quality Report – Inspection Report 14 March 2018

    - the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered;
    - the performance information in the Quality Report is reliable and accurate;
    - there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
    - the data underpinning the measures of performance in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
    - the Quality Report has been prepared in accordance with NHS Improvements annual reporting guidance (which incorporates the Quality Accounts Regulations) as well as the standards to support data quality for the preparation of the quality report

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board

Date 31 May 2021

J Gillan

Chief Executive

Date 31 May 2021

Chairman

Annex C: Independent Auditors' Limited Assurance Report

Independent Auditors' Limited Assurance Report to the Council of Governors of North Tees and Hartlepool NHS Foundation Trust on the Annual Quality Report

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

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

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

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

Patient Experience Team

North Tees & Hartlepool NHS Foundation Trust

Hardwick Road

Stockton-on-Tees

Cleveland

TS19 8PE

....

Thank you for your time.

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

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

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

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

....
....
....
....
....
....
....

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

....
....
....
....
....
....
....
....

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

Glossary

A&E	Accident and Emergency
ACE Committee	Audit and Clinical Effectiveness Committee – the committee that oversees both clinical audit (i.e. monitoring compliance with agreed standards of care) and clinical effectiveness (i.e. ensuring clinical services implement the most up-to-date clinical guidelines)
ACL	Anterior Cruciate Ligament – one of the four major ligaments of the knee
AKI	Acute Kidney Injury
AHP	Allied Health Professional
AMT	Abbreviated Mental Test
AquA	Advancing Quality Alliance
BI	Business Intelligence
CAB	Citizens Advice Bureau
CABG	Coronary Artery Bypass Graft (or "heart bypass")
CAUTI	Catheter-associated urinary tract infection
CFDP	Care For the Dying Patient
CCG	Clinical Commissioning Group
CCOT	Critical Care Outreach Team
CDI	Clostridium difficile Infection
CHKS	Comparative Health Knowledge System
CIAT	Community integrated assessment team (CIAT)
Clostridium Difficile (infection)	An infection sometimes caused as a result of taking certain antibiotics for other health conditions. It is easily spread and can be acquired in the community and in hospital
CLRN	Comprehensive Local Research Network
CMR	Crude Mortality Rate
CNS	Clinical Nurse Specialist
COHA	Community onset Healthcare Associated
COPD	Chronic Obstructive Pulmonary Disease
CLIP	Complaints Litigation Incidents Performance
CPIS	Child Protection Information System
CPMS	Central Portfolio Management System
CSE	Child Sexual Exploitation
CSP	Co-ordinated System for gaining NHS Permission
CQC	The Care Quality Commission – the independent safety and quality regulator of all health and social care services in England

CQRG	Clinical Quality Review Group
CQUIN	Commissioning for Quality and Innovation – a payment framework introduced in 2009 to make a proportion of providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care
DAHNO	Data for Head and Neck Oncology (Head and Neck Cancer)
DARs	Data Analysis Reports
Datix	Datix is the Trust incident reporting system
DH	Department of Health
DLT	Discharge Liaison Team
DNA	Did Not Arrive
DNACPR	Do Not Attempt Cardio Pulmonary Resuscitation
DoLS	Deprivation of Liberty Safeguards
DSCP	Durham Safeguarding Children Partnership
DSPT	Data Security Protection Toolkit
DToC	Delayed Transfer of Care
DVLA	Driver and Vehicle Licensing Agency
EAU	Emergency Assessment Unit
E coli (infection)	Escherichia coli – An infection sometimes caused as a result of poor hygiene or hand-washing
ED	Emergency Department
EMSA	Eliminating mixed sex accommodation
EPMA	Electronic Prescribing and Medication Administration
EPR	Electronic Patient Record
EOL	End of Life
ESR	Electronic Staff Record
EWS	Early Warning Score – a tool used to assess a patient's health and warn of any deterioration
FCE	Finished Consultant Episode – the complete period of time a patient has spent under the continuous care of one consultant
FGM	Female Genital Mutilation
FICM	Faculty of Intensive Care Medicine
FOI (act)	The Freedom of Information Act – gives you the right to ask any public body for information they have on a particular subject
FFT	Friends and Family Test
FSCO	First Stop Contact officer

FTSU	Freedom To Speak Up
FTSUG	Freedom To Speak Up Guardian
Global trigger tool (GTT)	Used to assess rate and level of potential harm. Use of the GTT is led by a medical consultant and involves members of the multi-professional team. The tool enables clinical teams to identify events through triggers which may have caused, or have potential to cause varying levels of harm and take action to reduce the risk
GCP	Good Clinical Practice
GM	General Manager
HCAI	Health Care Acquired Infection
HED	Healthcare Evaluation Data (A major provider of healthcare information and benchmarking)
HEE	Health Education England
HENE	Health Education North East
HES	Hospital Episode Statistics
HLSCB	Hartlepool Local Safeguarding Children Board
HMB	Heavy Menstrual Bleeding
HOHA	Hospital Onset Healthcare Associated
HQIP	Healthcare Quality Improvement Partnership
HRG	Healthcare Resource Group – a group of clinically similar treatments and care that require similar levels of healthcare resource
HSCB	Hartlepool Safeguarding Children Boards
HSMR	Hospital Standardised Mortality Ratio – an indicator of healthcare quality that measures whether the death rate in a hospital is higher or lower than you would expect
HSSCP	Hartlepool and Stockton Safeguarding Children Partnership
HUG	Healthcare User Group
IBD	Inflammatory Bowel Disease
ICC	Infection Control Committee
ICE	
ICNARC	Intensive Care National Audit and Research Centre
ICO	Information Commissioners Office
ICS	Intensive Care Society
IG	Information Governance
IHA	Initial Health Assessment
IMR	Intelligent Monitoring Report tool for monitoring compliance with essential standards of quality and safety that helps to identify where risks lie within an organisation

LD	Learning Difficulties
ICE	Integrated Clinical Environment
IG	Information Governance
Intentional rounding	A formal review of patient satisfaction used in wards at regular points throughout the day
IPB	Integrated Professional Board
IPC	Infection Prevention and Control
ISPA	Integrated Single Point of Access
Kardex (prescribing 145ardex)	A standard document used by healthcare professionals for recording details of what has been prescribed for a patient during their stay
KEOGH	Sir Bruce Keogh
Kleb sp	Klebsiella Species (type of infection)
KPI	Key Performance Indicator
LAC	Looked After Children
LADO	Local Authority Designated Officer
LAR	Looked After Review
LD	Learning disabilities
LeDeR	Learning Disabilities Mortality Review
Liverpool End of Life Care Pathway	Used at the bedside to drive up sustained quality of care of the dying patient in the last hours and days of life
LMS	Local Maternity System
LPMS	Local Portfolio Management Systems
LPS	Liberty Protection Systems
LQR	Local Quality Requirements
LSCB	Local Safeguarding Children's Board
MARAC	Multi Agency Risk Assessment Conferences
MATAC	Multi Agency Tasking and Co-ordination
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK
MCA	Mental Capacity Act
MDT	Multidisciplinary Team
ME	Medical Examiner
MEG	Missing Exploited Group
MHA	Mental Health Act
MHRA	Medicines and Healthcare products Regulatory Agency
MIU	Minor Injuries Unit

MINAP	The Myocardial Ischaemia National Audit Project
MRSA	Methicillin-Resistant Staphylococcus Aureus – a type of bacterial infection that is resistant to a number of widely used antibiotics
MSSA	Methicillin-Sensitive Staphylococcus Aureus
MUST	Malnutrition Universal Screening Tool
NCEPOD	The National Confidential Enquiry into Patient Outcome and Death
NCPES	National Cancer Patient Experience Survey
NCRN	National Cancer Research Network
NDG	National Data Guardian
NEAS	North East Ambulance Service
NEEP	North East Escalation Plan
NEPHO	North East Public Health Observatory
NEQOS	North East Quality Observatory System
NEWS	National Early Warning Score
NHS Improvements	The independent regulator of NHS foundation Trusts
NICE	The National Institute of Health and Clinical Excellence
NICOR	The National Institute for Cardiovascular Outcomes Research
NIHR	National Institute for Health Research
NNAP	National Neonatal Audit Programme
NQB	National Quality Board
NRLS	National Learning and Reporting System
NTHFT	North Tees and Hartlepool Foundation Trust
OD Banding	Overdispersion (statistical indicators)
OFSTED	The Office for Standards in Education
PALS	Patient Advice and Liaison Service
PAS	Patient Administration System
Patient Safety and Quality Standards (Ps&Qs) Committee	The committee responsible for ensuring provision of high quality care and identifying areas of risk requiring corrective action
PET	Patient Experience Team
PHE	Public Health England
PIC	Patient Identification Centre
PICANet	Paediatric Intensive Care Audit Network
PMRT	Perinatal Mortality Review Tool
PREVENT	the government's counter-terrorism strategy
PROMs	Patient Reported Outcome Measures
Psa	Pseudomonas Aeruginosa (Type of Infection)
Pseudonymisation	A process where patient identifiable information is removed from data held by the Trust

QAF	Quality Assessment Framework
Quality Improvement	
R&D	Research and Development
RA	Recruitment Activity
RAG	Red, Amber, Green chart denoting level of severity
RCA	Root Cause Analysis
RCOG	The Royal College of Obstetricians and Gynaecologists
RCPCH	The Royal College of Paediatric and Child Health
REPORT-HF	International Registry to assess Medical Practice with longitudinal observation for Treatment of Heart Failure
RESPECT	"Responsive, Equipped, Safe and secure, Person centered, Evidence based, Care and compassion and Timely" – a nursing and midwifery strategy developed with patients and governors aimed at promoting the importance of involving patients and carers in all aspects of healthcare
RHA	Review Health Assessments
RMSO	Regional Maternity Survey Office
SBAR	Situation, Background, Assessment and Recommendation – a tool for promoting consistent and effective communication in relation to patient care
SCM	Senior Clinical Matron
SCMOoH	Senior Clinical Matron Out-of-Hours
SCR	Serious Case Review
SEPSIS	Life-threatening reaction to an infection
SHA	Strategic Health Authority
SHMI	Summary Hospital Mortality-level Indicator – a hospital-level indicator which reports inpatient deaths and deaths within 30-days of discharge at Trust level across the NHS
sic	The Latin adverb ***sic*** ("thus"; in full: *sic erat scriptum*, "thus was it written"), inserted immediately after a quoted word or passage, indicates that the quoted matter has been transcribed exactly as found in the source text, complete with any erroneous or archaic spelling, surprising assertion, faulty reasoning, or other matter that might otherwise be taken as an error of transcription.
SINAP	Stroke Improvement National Audit Programme
SLSCB	Stockton Local Safeguarding Children Board
SMPG	Safety Medical Practices Group
SOF	Single Oversight Framework
SOP	Standard Operating Procedures
SPA	Single Point of Access
SPC	Specialist Palliative Care
SPCT	Specialist Palliative Care Team
SPEQS	Staff, Patient Experience and Quality Standards
SPICT	Supportive & Palliative Care Indicator Tools

SPOC	Single point of contact
SSKIN	Surface inspection, skin inspection, keep moving, incontinence and nutrition
SSU	Short Stay Unit
STAMP	Screening Tool for the Assessment of Malnutrition in Paediatrics
STEIS	Strategic Executive Information System
STERLING	Environmental Audit Assessment Tool
SUS	Secondary User Service
TEWV	Tees, Esk and Wear Valleys NHS Foundation Trust
TIA	Transient Ischemic Attack
TNA	Training Needs Analysis
Tough-books	Mobile computers aim to ensure that community staff has access to up-to-date clinical information, enabling them to make speedy and appropriate clinical decisions
TRAKCARE	Electronic Patient Record System
TSAB	Tees-Wide Safeguarding Board
UCC	Urgent Care Centre
UHH	University Hospital of Hartlepool
UHNT	University Hospital of North Tees
UKST	UK Sepsis Trust
UNIFY	Unify2 is an online collection system used for collating, sharing and reporting NHS and social care data.
UTI	Urinary Tract Infection
UV	Ultra Violet
VEMT	Vulnerable, exploited, missing, trafficked
VSGBI	The Vascular Society of Great Britain and Ireland
VTE	Venous Thromboembolism
WRAP	Workshop to Raise Awareness of PREVENT
WTE	Whole Time Equivalent - is a unit that indicates the workload of an employed person in a way that makes workloads or class loads comparable
4at delirium assessment tool	Bedside medical scale used to help determine if a person has positive signs for delirium

Board of Directors

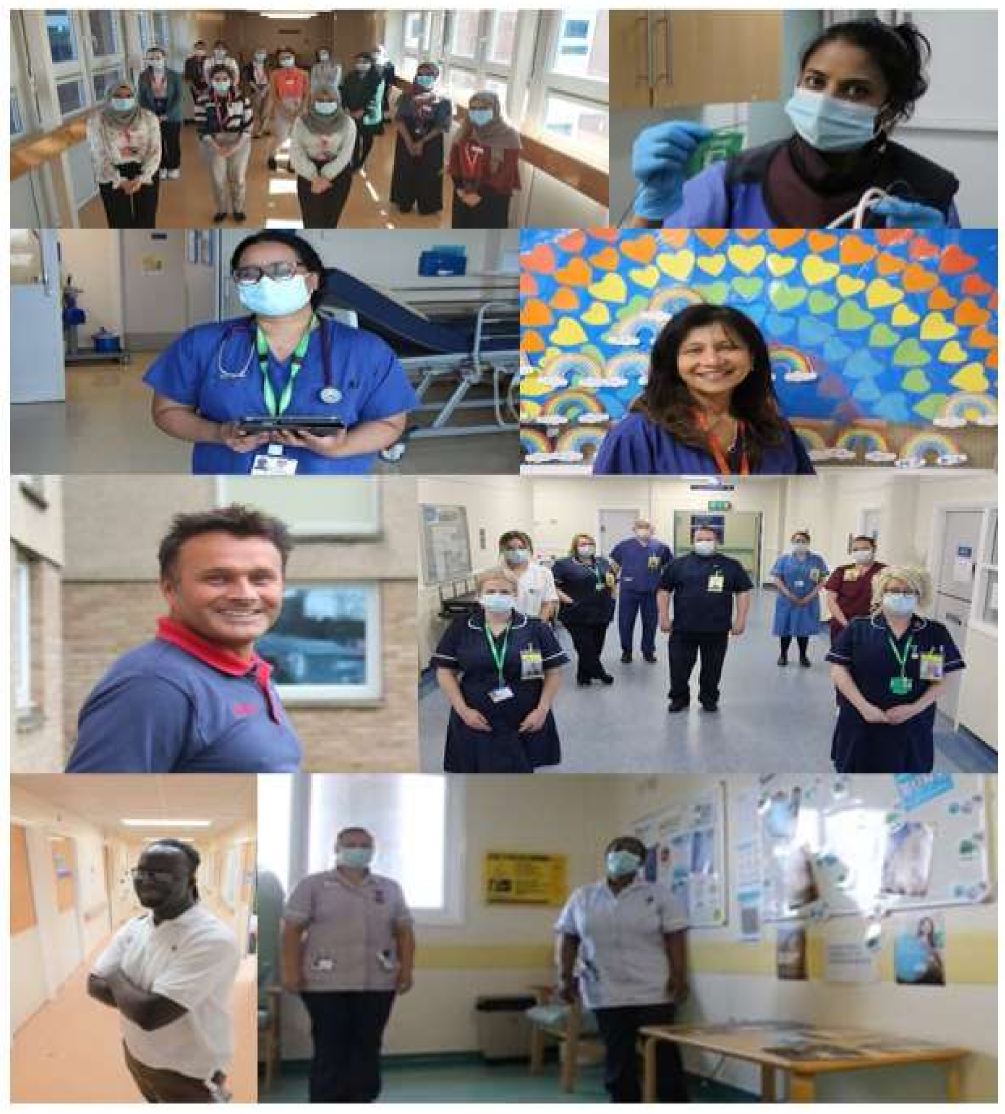
Title:	Annual Equality and Diversity Report 2020/2021
Date:	29 July 2021
Prepared by:	Nicola Hogarth, Employee Relations Advisor
Executive Sponsor:	Alan Sheppard, Chief People Officer
Purpose of the report	In line with requirements outlined within the Public Sector Equality Duty (General Duty), as a public body, we are required to, and are committed to; eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Under the Public Sector Equality Duty (Specific Duty), as a Trust we are required to publish information in compliance with the General Duty and publish our equality objectives.

Action required:	Approve	X	Assurance	X	Discuss		Information	X
Strategic Objectives supported by this paper:	Putting our Population First	X	Valuing People	X	Transforming our Services		Health and Wellbeing	X

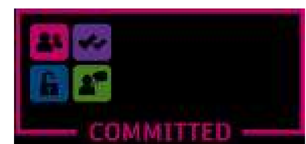
Which CQC Standards apply to this report	Safe	X	Caring		Effective		Responsive		Well Led	X

Executive Summary and the key issues for consideration/ decision:
The Trust is committed to ensuring the equality and diversity agenda is embedded across the Trust for all patients, service users and staff. Over the last 12 months the Trust has continued to strengthen the equality and diversity agenda and the attached report pulls this work together to highlight the achievements of the previous year. The report also provides detail of workforce information by protected characteristic. The Trust's Equality and Diversity Report 2020/2021 will be published on the Trust website and will go some way in demonstrating to staff and the public how committed the Trust is to equality and diversity. In addition to this, the annual report will also play a part in the Trust meeting the specific duties included within the Public Sector Equality Duty. The Board of Directors is requested to note the content of this report and confirm approval for publication on the Trusts corporate website.
How this report impacts on current risks or highlights new risks:
The report is for information only.

Committees/groups where this item has been discussed	Not applicable.
Recommendation	The Board of Directors is recommended to approve the Equality and Diversity Annual Report for 2020/2021 and approve its publication



Equality and Diversity Annual Report 2020-21



Contents

1. Introduction	**3**
2. Equality, Diversity and Inclusion - Strategic Overview	**4**
- Equality, Diversity and Inclusion Champions	
3. Staff Networks	**6**
4. Public Sector Equality Duty	**7**
5. Equality Delivery System 2	**8**
6. Workforce Race Equality Standard (WRES)	**9**
7. Workforce Disability Equality Standard (WDES)	**11**
8. Gender Pay Gap Report	**13**
9. Staff Survey	**15**
10. Equality, Diversity and Inclusion in Practice	**17**

- BME community targeted in organ donation video appeal
- Health care trust pledges to end mental health discrimination
- New support group for BME staff – as trust joins regional promise
- Special LGBT network helping NHS staff share experiences
- COVID-19 vaccines during Ramadan
- Support for people with dementia and their families.
- Improving care for people with a learning disability.
- Urging all of our communities across Teesside to stay at home.
- Falls campaign warning frail and elderly – “don’t fall down after lockdown”.
- More than 4,000 women register pregnancy online.

11. Contacts for Further Information	**26**
12. Workforce Equality Factsheets	**27**

- Gender
- Ethnicity
- Age
- Disability
- Sexual Orientation
- Marital Status
- Religion and Belief
- Pregnancy and Maternity
- Gender Reassignment

1. Introduction

As set out in the NHS Long Term Plan, respect, equality and diversity are central to changing culture and are at the heart of the NHS workforce implementation plan.

At North Tees and Hartlepool NHS Foundation Trust, we continue to work towards meeting our legal requirements as set out by the Public Sector Equality Duty (PSED). This report is compiled from information provided by different departments across the organisation and seeks to highlight the good practice, numerous initiatives and key achievements for the period 1 April 2020 to 31 March 2021.

The Trust acknowledges all protected characteristics to be of equal importance, including age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. We are committed to challenging discrimination and promoting equality both as an employer and a provider of health care services. We aim to make sure that equality and diversity is at the centre of our work, and is embedded into our core business activities.

As a provider of health care services, we aim to meet the changing needs of diverse communities and provide access for all in an environment where individuality is respected and promoted. As an employer we will continue to focus on creating an organisational culture in which staff feel able to challenge unlawful discrimination and promote equality.

Alan Sheppard
Chief People Officer

2. Strategic Overview

Equality and Diversity – The Continued Vision

The Workforce Committee provides the strategic direction for equality and diversity within the organisation, with operational support from the Trust's Culture Group. One of the main responsibilities of the Workforce Committee is to ensure that the Trust strives to achieve best practice across the organisation in a fair and equitable manner, ranging from employment practices through to service delivery and redesign.

The Workforce Committee is chaired by a Non-Executive Director of the Trust and has representation from across the organisation including, representatives from Executive Directors, Workforce, Senior Medical Staff, Senior Nursing Staff and Care Group leads.

The Trust is represented at an ICS level through membership of the Equality and Diversity Delivery Group and the regional Equality, Diversity and Human Rights Group, where representatives from local Trusts meet to share ideas and best practice with the aim of ensuring that various Trusts across the system work together to achieve a consistent and high level approach to implementing local and national equality and diversity practices.

The Trust holds the Disability Confident employer status, which recognises our commitment to removing inequality and ensuring fairness and equity in relation to recruitment and employment processes. This is reflected further within Trust policies and practices, all of which are assessed from an equality perspective.

Our Equality, Diversity and Inclusion Champions/Network Chairs

Michelle Taylor
Workforce Lead

Elizabeth Morrell
Employee Relations

Nicola Hogarth
Employee Relations

Michael Swinbourne
Age (Older) Network
Chair /Champion

Kristopher Bell
Ability Network
Chair/Champion

Stuart Harper-Reynolds
LGBTQ Staff Network
Chair/Champion

Sushil Munakhya
BME Network
Chair/Champion

Shooey Dar
Multi-faith Network
Chair/Champion

Samantha Eaton
Women's Network
Chair/Champion

3. Staff Networks

At North Tees and Hartlepool NHS Foundation Trust, we are proud of our strong reputation within the Equality, Diversity and Inclusion (EDI) agenda and we are committed to creating a more diverse and inclusive culture, where our staff can come to work in a supportive working environment, which is strengthened by a framework of comprehensive workforce policies.

It is important that, as a caring and compassionate employer, we understand how it feels to work for this Trust and particularly, how an individual's lived experience may be influenced by one or more protected characteristic(s) and to allow our leadership teams to learn about the real impact of policy and practice.

One way of understanding this is through the development of staff networks and we have committed to develop a network for each of the following groups:

Black and Minority Ethnicity (BME)
Lesbian, Gay, Bi-sexual and Transgender (LGBT+)
Disability
Age (Older)
Age (Younger)
Multi-faith
Women
Men

It is intended that our networks will offer a place for staff to come together, share experiences and facilitate learning and development. Networks can also assist in the shaping and delivery of organisational strategy and policy, working with us to improve staff experience on specific issues relating to each network.

We recognise that some individuals may identify with more than one characteristic and therefore it is both right and important that our networks allow the opportunity for intersectionality. To this aim, we aim to bring together all networks on an annual basis, and we have scheduled quarterly meetings for the network chairs as a means of peer support and to discuss any shared objectives/actions.

Our Network Chairs are also members of our strategic Workforce Committee. By adopting a collective approach, we will ensure greater equity and impact, which is underpinned by a strong commitment to listen, understand, support and improve the experience of our staff, acknowledging the different needs of protected characteristics.

4. Public Sector Equality Duty (PSED)

The principles of equality and diversity have been incorporated throughout the Trust, with inclusion of EDI considerations within business plans, ensuring that equality impact assessments are completed to a consistent standard, and that these are considered when implementing new and amended services, and workforce practices and policies.

As a Trust, we continue to seek to:

- Eliminate unlawful discrimination, harassment and victimisation;
- Advance equality of opportunity between different groups;
- Foster good relations between different groups;
- Seek to improve existing practices, embed new initiatives and enhance our equality and diversity activity.

We are continuing to work towards achieving the objectives identified in line with the specific duties of PSED.

Our current objectives are:

- To engage with our patients, the local community and various stakeholders, in line with the requirements of EDS2, to ensure the effective provision of services;

- To enable our staff to work alongside patients and carers to determine realistic, reasonable adjustments to deliver safe, effective care to people with literacy problems, learning difficulties and dementia.

- To promote equality, diversity and inclusion across the trust.

- To explore and reduce the discrimination experienced by our staff, as identified by the NHS annual staff survey, through the development of proactive measures and support mechanisms to be implemented trust-wide.

We aim to review our equality objectives for 2021/22, ensuring that focus is given on issues that are of particular importance to the organisation, based on feedback from our stakeholders.

5. Equality Delivery System 2

The Department of Health reviewed and revised the Equality Delivery System (EDS) with a view to make it smarter and simpler to use. The review brought about the launch of EDS2, which retains much of the original framework however encourages local adaptation with a focus on local issues. It also prompts learning and sharing of good practice throughout the trust.

We have worked closely with our stakeholders, both internal and external to the Trust, in relation to the implementation of the Equality Delivery System (EDS2).

EDS2 enables us to provide focus for areas requiring further attention, to ensure all identified equality issues are addressed for all protected characteristics, as recognised by the Equality Act 2010.

We are not complacent and we know there is still much work to do. We will continue to work with service users, carers, staff, other organisations and members of the public to ensure that we are consistently fair and that our services meet the needs of our diverse communities.

This can only be achieved by working together to eliminate inequality wherever it exists and to promote fairness and inclusion in everything we do. This includes:

- Access to Trust services;
- The provision of Trust services;
- The delivery of Trust services, and;
- Employment.

6. Workforce Race Equality Standard (WRES)

The Workforce Race Equality Standard (WRES) was introduced as part of the NHS Standard Contract in 2015 and seeks to tackle one particular aspect of equality – the consistently less favourable treatment of those who identify themselves as Black, Asian or from a Minority Ethnic background.

The WRES consists of nine metrics which consider the fairness of how BME staff are treated. Trusts must report on the metrics annually and implement an action plan to address any disparities highlighted by the information, in an attempt to try and close the gap between the experience of BME staff as compared to White staff.

The Trust's WRES report for 2020 is available on our website and can be found here:

https://www.nth.nhs.uk/about/equality-diversity

A summary of the results for 2020 is shown in the table overleaf. The baseline data has been extracted and calculated to determine a response to each of the nine WRES indicators.

WRES Indicators for North Tees and Hartlepool NHS Foundation Trust: 2017-2021

Wres Indicator			2017	2018	2019	2020	2021
1	Percentage of BME staff	**Overall**	9.0%	10.0%	11.0%	11.0%	**11.0%**
		VSM	0.0%	0.0%	0.0%	0.0%	**0.0%**
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants		0.74	0.58	0.86	0.99	**3.24**
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff		0.33	0.9	0.76	0.69	**0.93**
4	Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff		0.6	0.89	0.67	0.77	**1.16**
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	**BME**	39.1%	36.0%	37.5%	42.3%	**28.1%**
		White	26.6%	29.2%	26.9%	28.0%	**24.8%**
6	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	**BME**	20.0%	28.0%	31.3%	33.8%	**29.2%**
		White	19.8%	22.5%	18.3%	18.4%	**20.4%**
7	Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion	**BME**	89.9%	80.0%	85.7%	77.4%	**82.4%**
		White	90.8%	94.0%	91.4%	90.2%	**88.9%**
8	Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues	**BME**	15.9%	14.0%	8.5%	11.7%	**14.6%**
		White	5.1%	5.0%	4.4%	4.3%	**5.1%**
9	BME Board membership		7.1%	6.7%	6.7%	5.3%	**5.6%**

7. Workforce Disability Equality Standard (WDES)

The NHS Workforce Disability Equality Standard (WDES) is designed to improve workplace experience and career opportunities for Disabled people working, or seeking employment, in the National Health Service (NHS). The WDES follows the NHS Workforce Race Equality Standard (WRES) as a tool and an enabler of change.

The WDES first came into force on 1 April 2019 as part of the NHS Standard Contract and consists of ten specific metrics which consider the fairness of how disabled staff feel they are treated by the organisation. NHS Organisations are required to report on the metrics annually and the information obtained is used to implement local action plans to address any disparities in the metrics and to demonstrate progress against the indicators of disability equality.

The Trust's WDES report for 2020 is available on our website and can be found here:

https://www.nth.nhs.uk/about/equality-diversity/

A summary of the results for North Tees and Hartlepool NHS Foundation Trust is shown in the table overleaf. The baseline data has been extracted and calculated to determine a response to each of the ten WDES indicators.

WDES Indicators for North Tees and Hartlepool NHS Foundation Trust: 2019-2021

Wdes Indicator			2019	2020	2021
1	Percentage of staff with a disability or long term health condition	**Overall**	2.0%	2.0%	**2.0%**
		Non-clinical	2.0%	2.0%	**2.0%**
		Clinical	2.0%	2.0%	**2.0%**
2	The relative likelihood of Disabled staff being appointed from shortlisting compared to Non-Disabled staff		1.64	1.34	**0.94**
3	The relative likelihood of Disabled staff entering the formal capability process compared to Non-Disabled staff		0	0	**0**
4	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	**Staff with a disability or LTC**	35.4%	35.5%	**29.6%**
		Staff without	26.7%	27.8%	**24.1%**
5	Percentage of staff experiencing harassment, bullying or abuse from manager in last 12 months	**Staff with a disability or LTC**	16.3%	14.2%	**18.3%**
		Staff without	5.8%	7.3%	**7.5%**
6	Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months	**Staff with a disability or LTC**	33.7%	21.5%	**23.4%**
		Staff without	12.4%	14.7%	**13.8%**
7	Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	**Staff with a disability or LTC**	51.2%	45.9%	**54.3%**
		Staff without	52.9%	46.3%	**47.3%**
8	Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion	**Staff with a disability or LTC**	84.4%	83.3%	**80.9%**
		Staff without	92.1%	90.3%	**90.0%**
9	Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	**Staff with a disability or LTC**	43.8%	35.7%	**39.0%**
		Staff without	19.2%	24.0%	**24.9%**
10	Percentage of staff satisfied with the extent to which their organisation values their work	**Staff with a disability or LTC**	36.7%	40.7%	**36.9%**
		Staff without	53.4%	54.1%	**53.3%**
11	Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work	**Staff with a disability or LTC**	66.7%	77.4%	**74.2%**
12	Staff engagement score (0-10)	**Staff with a disability or LTC**	6.50	6.7	**6.7**
		Staff without	7.2	7.3	**7.3**
		Overall	7.1	7.2	**7.1**
13	Disabled/LTC Board membership		0.0%	0.0%	**0.0%**

8. Gender Pay Gap

The Trust complies with the **Equality Act 2010** (Gender Pay Gap Information) Regulations 2017**.**

Our gender pay gap report as of 31 March 2020 (the snap shot date) shows the Trust has an average pay gap of 35.67%, and a median pay gap of 22.34%. A further breakdown of results shows that the average pay gap is slightly higher amongst the non-medical workforce in comparison to medical staffing. This is because the proportion of male senior managers employed by the Trust is higher than the number of female senior managers. It is therefore reasonable to conclude that male workers earn a higher rate of average pay than female workers.

The median pay gap is higher amongst the medical workforce compared to non-medical staff. Men account for 65% of all Trust medical staff compared to 35% female. There has been an increase in female medical staff commencing employment with the Trust in recent years. If this trend continues this is likely to have a positive impact on our gender pay gap results.

Gender	Average Hourly Rate (Mean)	Median Hourly Rate (Median)
Male	24.32	18.25
Female	15.65	14.18
Difference	8.68	4.08
Pay Gap %	35.67%	22.34%

The mean gender pay gap for the Trust is that female staff are paid 35.67% less than male staff. The median gender pay gap for the Trust is that female staff are paid 22.34% less than male staff.

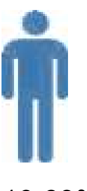
Gender	Average Bonus Pay (Mean)	Median Bonus Pay (Median)
Male	£10,673.23	£6,032.04
Female	£8,859.00	£6,032.04
Difference	£1,814.23	0.00
Pay Gap %	17.00%	0.00%

The Trust does not operate a bonus scheme, however consultant medical staff are eligible to apply for clinical excellence awards, which are considered to be a bonus payment and form part of the gender pay gap calculations. As our consultant medical workforce are predominantly male, the results show that male consultants earn a higher average rate of bonus pay (CEAs) than female consultants.

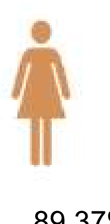
It is positive to note that the median bonus pay reports that there is a 0% pay gap between male and female employees.

Pay Quartiles by Gender:

Lower Quartile

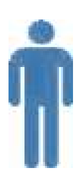


10.63%

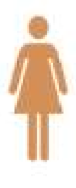


89.37%

Lower Middle Quartile



11.07%



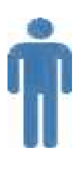
88.93%

Upper Middle Quartile

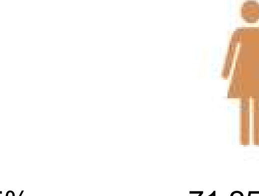
12.32%

87.68%

Upper Quartile



28.75%



71.25%

The data above shows the male to female split of our workforce for each quartile.

The lower quartile represents the lowest salaries in the Trust and the upper quartile represents the highest salaries. The Trust employs more women than men in every quartile.

9. Staff Survey

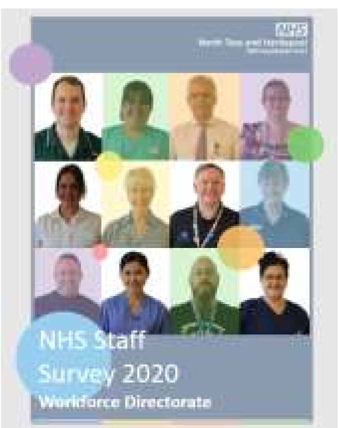
The national staff survey is an annual review of all organisations within the National Health Service and seeks to understand just how staff feel about their employer.

2020 was one of the most testing years we have ever faced as a health service and the world health pandemic has impacted on many of our colleagues, both on a personal and a professional level. We were therefore delighted to see that, amongst the category of community and acute trusts (around 140 of them) we came 16th in terms of satisfaction. Drilling that down a little deeper, we placed second across the North East and North Cumbria Integrated Care System (NENC ICS).

All employees were invited to participate in the survey and the personal characteristics of the respondents are reported as similar to the overall profile of our workforce.

We achieved a repose rate of 48%, where 2,097 of our colleagues took the time to tell us about their experiences of working for the Trust.

The results showed that for 10/10 themes, the Trust scored higher than the regional average.



You said, we did

These are the actions which we identified as being important in response to the 2019 staff survey, and which we believe have directly contributed to our high scores for 2020:

- Provision of unconscious bias training
- Development of our Staff Networks
- Introduced Values Based Recruitment
- Refreshed our Practical Skills Training for Managers
- Included Talent Management in appraisal training
- Enhanced our flexible working offer to staff
- Creation of a staff support hub
- Delivered training on Mental Health First Aid
- Creation of our Rainbow Rooms for staff to relax in
- Introduced the Customer Care Charter
- QI Leads located in each Care Group
- Provided opportunities such as difficult conversations, leadership training and apprenticeships

Staff Support

Responses to the staff survey are anonymous therefore it is not possible for us to directly address any concerns raised through the survey on an individual basis. However, we continue to ensure that all staff are informed of the numerous options in place where they are able to raise concerns in confidence, and this includes details of the various support systems that are available for staff to access.

There are both formal and informal measures to assist staff who may be experiencing any form of discrimination, bullying or harassment. In addition to our Workforce policies for raising a request for resolution or raising concerns of bullying and harassment, there are also additional routes for staff to seek support. This includes direct access to and support from the Trust's Freedom to Speak Up Guardian and Champions; referral to our internal mediation service, and; self-referral to occupational health support which includes access to counselling services.

We are keen to ensure that staff feel empowered to raise concerns and that, as a responsive employer, we clearly communicate the cultures and values we expect from our employees, including those in relation to behaviour and attitude and ensuring these are instilled within all staff at all times.

10. Equality, Diversity and Inclusion in Practice

Equality and diversity is about inclusion, respect and removing barriers, whether this be in relation to the health care services we provide, or the employment of our staff.

There are numerous ways in which this is illustrated throughout the organisation, through specific initiatives as well as in everyday practices. The following section of the report highlights some examples of good practice and the case studies which reflect this.

BME community targeted in organ donation video appeal.

North Tees and Hartlepool NHS Foundation Trust issued an appeal to bilingual- BME staff to film short videos encouraging members of the BME community to become organ donors.

Ruksana Salim, Lead Nurse, Quality and Professional Standards, filmed a video in Urdu.

Ruksana said: “It’s a sad reality that members of the Asian community are living with illnesses that could be resolved with organ or tissue transplants. Some are even dying earlier than they should.

“It’s a sensitive subject for sure and there are additional cultural issues that we need to be aware of, but we are asking everyone, from every community, to consider organ donation.”

Anchal Dhaliwal works for the Trust’s Patient Experience Team and filmed two appeals – one in Hindi and another in Punjabi.

Anchal commented: “I was happy to be part of filming the videos.

“It breaks down the language barriers to reach members of the community who may not have English as their first language. It’s a complicated subject, so explaining it in a language they’re more comfortable with will help get the message through.”

Specialist Organ Donation Nurse Clare Fletcher said: “While the new presumed consent organ donation law automatically puts every eligible adult on the donor list, consent from the next of kin is still required.

“We want everyone to discuss their decision about organ donation with their family and friends so that should the worst happen, they know what their loved one would want.

“We need more BME donors and Ruksana and Anchal’s videos will be a huge help in getting the message out to the BME community.”

Health care trust pledges to end mental health discrimination.

On Friday 4 September 2020 North Tees and Hartlepool NHS Foundation Trust committed to supporting the plight to end mental health discrimination.

Colleagues from across the organisation gathered in a socially distanced signing ceremony, attended virtually by some delegates to witness Julie Gillon, Chief Executive and Alan Sheppard, Chief People Officer sign the pledge.

Alan spoke of the importance of the Trust's involvement 'the Time to Change employer pledge is our way of demonstrating a commitment to changing the way we all think and act surrounding mental health in the workplace. We want to ensure that our 5,500 strong employees feel supported about opening up and talking about their own experiences and journeys'.

The event held at the University of North Tees hospital site invited staff to talk about their individual experiences. Colleagues shared personal stories in a bid to start positive conversation surrounding the matter.

Julie Gillon, Chief Executive commented 'the importance of our health must never be underestimated. The last six months have tested us all, we must now take action and position mental wellbeing of equal importance with our physical health. Our staff have, and indeed always do demonstrate great resilience, but we should always be cognisant of the challenges colleagues have faced and will continue to face.

This pledge is our own personal dedication to our teams, as one of over 1,500 other employers that we will support them, we will listen and we will end the stigma'.

Approximately one in four people and one in eight young people will experience mental health problems annually.

North Tees and Hartlepool join employers such as Sky News, Middlesbrough College and the London Fire Brigade – as well as other NHS providers.

You can find out more about the pledge by visiting: https://www.time-to-change.org.uk/

New support group for BME staff – as trust joins regional promise.

As it marks Black History Month, North Tees and Hartlepool NHS Foundation Trust has joined forces with neighbouring trusts in signing a promise aimed at ensuring fairness for all black, Asian and minority (BME) groups.

The promise aims to ensure fairness for all and embed a culture where people can thrive no matter what their race, background or personal experience.

The leaders are committed to ensuring that no one person's experience is influenced by prejudice – either as a staff member or patient accessing health and care services.

As part of the Trust's commitment, a new BME staff network group was launched earlier this year aimed at supporting members in their working lives and promoting equality, diversity and inclusion.

Michael Chivhunga, clinical team leader and senior occupational therapist, is a member of the new group.

He said: "This group is there to provide a safe environment to raise issues and share experiences. "It is also there to help signpost and support people, offer information and guidance and contribute to staff development and awareness activities.

"It's a fantastic idea and one which we hope many BME staff will benefit from. It represents the organisation's clear commitment to continuing it support of ethnic minority groups."

Yvonne Ormston MBE, Chief Executive of Gateshead Health NHS Foundation Trust and regional BME lead said "Black History Month has given us all an opportunity to celebrate our diverse staff groups and learn something about the different cultures that contribute to our success.

"As employers and leaders of important local organisations we've come together to make this promise which not only celebrates the contribution that our BME staff and communities make to the region, but also marks a promise to them about our collective way of working.

"We recognise that there have been additional pressures placed on our BME colleagues both as a result of the adverse effect of Covid19 and because of recent international events that have placed a focus on inequalities for these communities. We are proud that our all our staff have been able to continue to provide the best service despite these pressures.

"However as leaders it's also important that we make sure staff are aware that our organisations do not accept discrimination of any kind towards our BME colleagues or patients and that we will act to address any instances of discrimination."

Special LGBT network helping NHS staff share experiences

As a health trust marks a special LGBT month, staff have spoken about their own personal experiences and being involved in a new staff support group. North Tees and Hartlepool NHS Foundation Trust recently set up its own internal network for any member of staff who identifies as lesbian, gay, bisexual or transgender staff.

As the organisation joins the NHS in supporting LGBT History Month, staff are sharing their own stories and raising awareness of the staff support group.

Two staff network members are chief operating officer Levi Buckley and named nurse for adult safeguarding Stuart Harper-Reynolds

Levi said: "I am proud to work in the NHS – to be making a difference to the lives and health outcomes of people across Teesside.

.

"I am proud of who we are as an organisation, inclusive to people from all sexual identifies, all genders, as well as all ethnicities and all backgrounds.

"I am lucky to have always felt comfortable about being exactly who I am in the workplace. As a society, we have come so far over recent years but we still need to take more action to avoid prejudice and discrimination for both our staff and patients. But let's also be proud of how far we have already come and what we have achieved.

Stuart has worked across the organisation for a number years – including a nurse ward matron in the accident and emergency team – and is also one of the Trust's freedom to speak up champion

He is also the chair of the LGBT support network.

He said: "As someone who has worked in the organisation for most of my career, I have seen and experienced dramatic changes in how LGBT people are perceived.

"As a gay man, I was once afraid to speak about and be who I am. I don't feel that way at all anymore and haven't done so for many years. "I am so proud of how far we have come. The staff network is the latest step in this progress we are making.

"It has been a pleasure to be a part of the group, to allow staff to share experiences and support each other and know that they have other staff to turn to should they have any difficulties .

COVID-19 vaccines during Ramadan

We're reassuring the local Muslim community that receiving a COVID-19 vaccination during the Islamic holy month of Ramadan does not contravene the requirement to fast.

Ramadan begins on Monday 12/Tuesday 13 April (depending on moon sightings) and will see observant Muslims not eat or drink during daylight hours. There is concern that some people may believe receiving a vaccine during Ramadan may inadvertently break the fast.

Dr Ijaz Anwar, a consultant with the Trust and practising Muslim, said: "I would urge everyone to get their COVID-19 jab, even if it's during Ramadan. It will not affect your fast. You can even check this with your Imam at your local mosque."

The Trust has recorded a series of short videos featuring the multi-lingual Dr Anwar appealing for fasting Muslims to accept their vaccination appointments during Ramadan. The videos, which were shared on the Trust's social media feeds throughout April, have been recorded in English, Urdu and Punjabi.

The British Medical Journal offers the following advice: "People from some ethnic minority backgrounds, such as black, Bangladeshi and Pakistani, may be more hesitant to receive a covid vaccination because they don't want to compromise their fast. It is important for these groups to know that having vaccines intramuscularly during fasting time (dawn to dusk) does not nullify one's fast and vaccination should not be delayed."

Trust staff who encounter vaccine hesitancy from Muslim patients will sensitively advise that, as the British Medical Journal suggests, injections do not invalidate the fast and are not in contradiction with the teachings of Islam.

Support for people with dementia and their families

The impact of the pandemic has stretched far and wide – and that includes for people with dementia and their carers and family members.

Our dementia specialist nurse Stephen Nicholson is raising awareness that the same help and support is still out there. As part of Dementia Action Week, Stephen is reminding and informing people about some of the fantastic organisations we can call on in the area.

This includes the Green Links gardening and crafting group from Groundwork, the Clevearc dementia charity, The Bridge in Hartlepool and the LiveWell Dementia Hub in Stockton. The Trust also supports the John's Campaign for the right of people with dementia to be supported by their family carers.

Other initiatives include the All About Me document in hospitals which provides professionals with information about a patient with dementia to help enhance and support their care.
Stephen said: "As for so many other people with health issues and for loved ones, the pandemic has had an impact.

"What I want to stress this Dementia Action Week is just how much support is out there.
"I am encouraging people that if they have a loved one with dementia and want more help and support, please contact these fantastic organisations. "And if you have a loved one receiving care in our organisation, there is also so much we can do to support you."

https://www.groundwork.org.uk/hubs/north-east-and-yorkshire/projects/green-links-in-tees-valley/
https://clevelandalzheimers.co.uk/
http://www.hospitalofgod.org.uk/page/the-bridge
https://www.stocktoninformationdirectory.org/kb5/stockton/directory/service.page?id=0t4sTa8dXqo

Improving care for people with a learning disability

Care for patients with a learning disability is improving all the time – with a new set of standards now in place across the region.

The safeguarding team at North Tees and Hartlepool NHS Foundation Trust is supporting new 'diamond pathways' to deliver high quality, reasonably adjusted care for people with a learning disability.

The new standards, developed by the North East and Cumbria Learning Disability Network and Access to Acute Network, are about planned admission, emergency admission and discharge which are then underpinned by a core set of values and principles.

As part of Learning Disability Week last week, the safeguarding team visited clinical areas to highlight the new standards and deliver information and free goodies.

Carley Ogden, nurse advisor for adult safeguarding and learning disability, said: "These new standards will provide the standard of care that people with learning disability require and to which they are entitled. "They can be easily adopted and localised to each acute trust – meaning the region will become a leader in care for people with learning disabilities.

"The aim of the pathway and workforce education package is to help people with a learning disability by improving communication, experiences of health care, quality of life for people with learning disability, promoting seamless care and reducing premature mortality.

"The education package focuses on communication, reasonable adjustments, the Mental Capacity Act, the diamond standard and pathways and any relevant case studies."

The team also used the week to raise awareness of hospital passports – a document for patients about them and their health needs.

Carley added: "These passports are so important for people with a learning disability – it's an opportunity to include useful information for staff including interests, likes and dislikes and any details to help staff make these patients feel more comfortable.

"We encourage all loved ones of people with a learning disability to fill these in if a stay in hospital is expected."

Urging all of our communities across Teesside to stay at home

We launched an online appeal asking people from all communities across Teesside to remain home and practice physical distancing.

Focused on targeting potentially hard-to-reach groups, bilingual staff from the Trust have recorded video appeals reminding people in a number of languages that the threat from COVID-19 remains present and to stay at home and save lives.

Nurse Alexandru Andrei works at University Hospital of North Tees. Originally, from Romania, Alexandru was the first to record an appeal, stating he was “happy to help get the message out to the local Romanian community and across the country.”

The Trust posted Alexandru’s Romanian messages, plus videos in Arabic, Mandarin, Cantonese, Urdu, Punjabi and Filipino across its social media feeds.

Falls campaign warning frail and elderly – “don’t fall down after lockdown”

Senior clinical practitioner Carol Bowler, who is the Trust’s falls lead nurse, is calling on everyone to be careful.

She said: “Our campaign – Don’t Fall Down After Lockdown – is clear.

“Because people – particularly the frail and elderly – have spent an extended period in their homes and are now moving around outside more, they are more vulnerable to falls. “People may have deconditioned as they have been at home. They are likely to have lost muscle tone and balance and elderly people may have lost confidence moving around.”

Carol has some simple advice and support which can help people avoid a fall.

This includes using a walking aid if needed, doing simple exercises, wearing suitable footwear, being mindful of tripping hazards, staying hydrated and eating well and taking medication when appropriate. She said: “There are simple steps people can take to make sure they are safe.

“Regular exercise to help strengthen up is important, as is making sure hazards are removed at home. Being conscious of the surface we are walking on when we are outside is also so important.”

Kath Duncan, occupational therapist and discharge co-ordinator, said: “We have had an increase in falls from hip fractures.

“Please be aware of things in the home you may slip on and ensuring you have the right footwear on.

More than 4,000 women register pregnancy online

North Tees and Hartlepool NHS Foundation Trust launched its online pregnancy registration system just one year ago. In that time, more than 4,000 women have completed the user-friendly form to quickly upload their details and medical history.

The Trust’s maternity team uses the information to allocate the best care package for each mum-to-be.

Anita Scott, specialist lead midwife for the Trust, said: “The online registration form has been really well received by the mums we care for. “In fact it’s so successful, we’ve even had women from outside our area accidentally complete the form!

“Even as we all battle through the COVID-19 pandemic, our community and hospital midwives are here for all pregnant women in our area, providing safe, effective care.”

The online registration process is also a key tool to ensure Continuity of Carer, a Trust-commitment to providing the same community midwife throughout pregnancy.

11. Contacts for Further Information

If you would like any further information about Equality, Diversity and Inclusion within North Tees and Hartlepool NHS Foundation Trust, please contact our Workforce Equality and Diversity lead:

Michelle Taylor, Head of Workforce
University Hospital of North Tees
Tel: 01642 624025

Feedback

We actively seek feedback on our annual reports from stakeholders and service users so that we can continue to meet our commitment to improve service delivery. We would welcome any feedback and comments on this document which should be directed to:

The Employee Relations Team, University Hospital of North Tees, Hardwick Road, Stockton on Tees, TS19 8PE or by email at nicola.hogarth1@nhs.net

The information contained within this report is also available in alternative formats, which can be obtained by contacting, Cordelia Wilson, Clinical Governance Lead on 01642 383576.

12. Workforce Equality Factsheets

Workforce Profile of the Trust

This section on the report contains a number of factsheets in relation to the workforce profile of the Trust, reporting on each protected characteristic for the period 1 April 2020 to 31 March 2021.

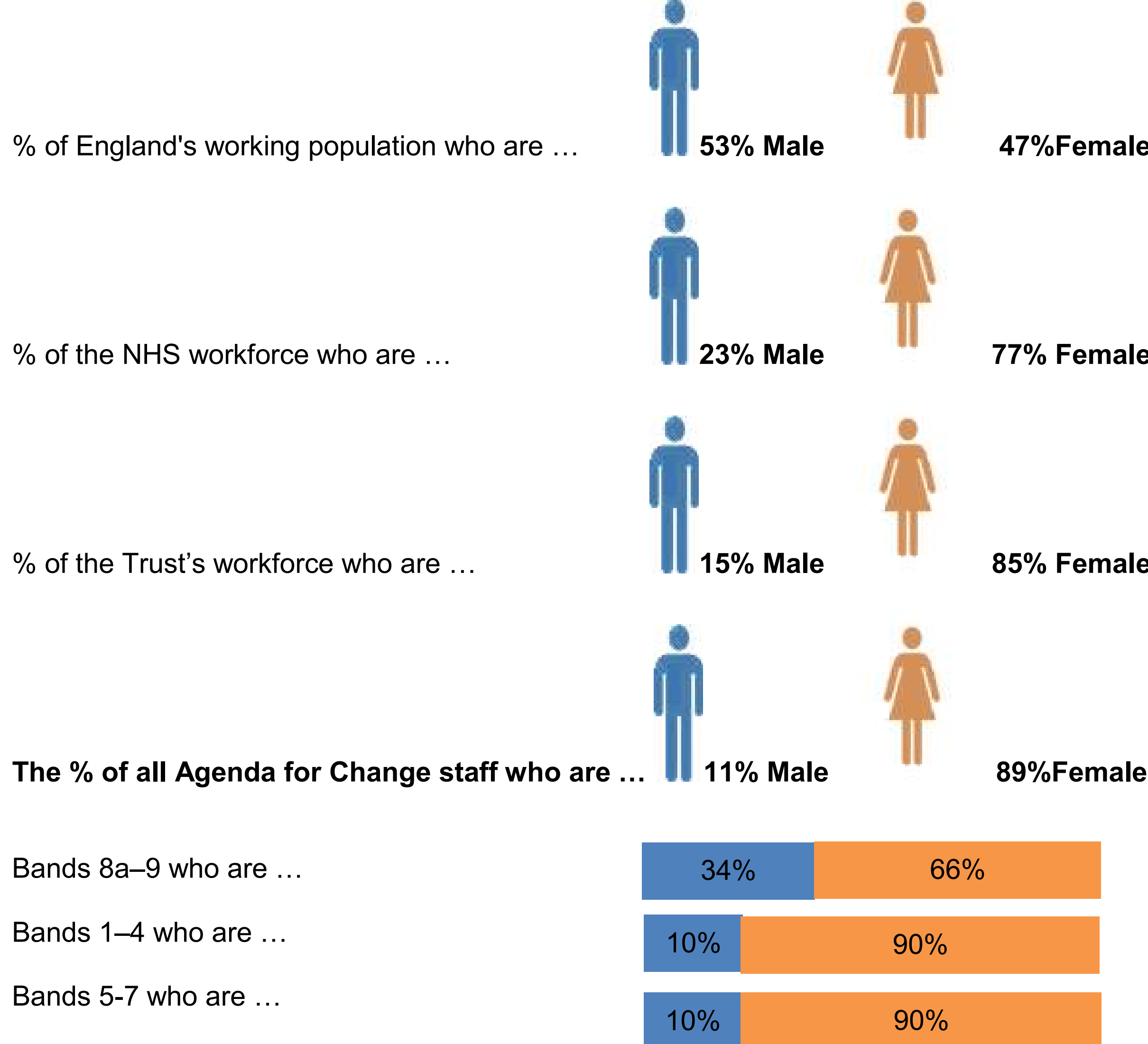
As at 31 March 2021, there were 4,719 members of staff employed by the Trust.

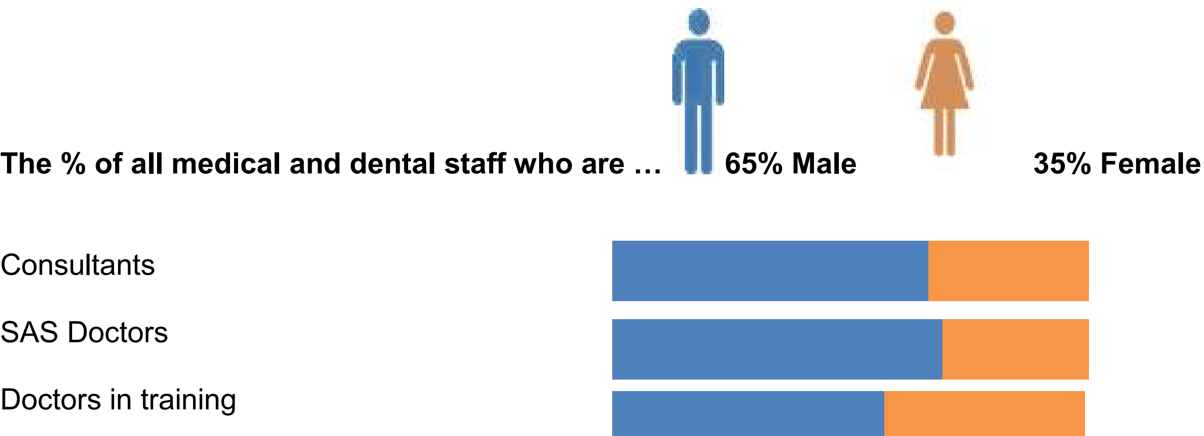
This section outlines the profile of the workforce of the Trust in relation to each protected characteristic, for the period 1 April 2020 to 31 March 2021.

Of the total staff employed by the Trust, 2,493 employees (53%) work on a full time basis and 2,254 employees (47%) work part time.

Section 1 – Gender

The Trust employs 4,014 female members of staff and 705 male members of staff.

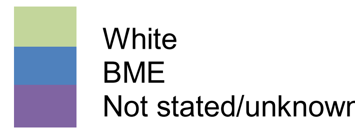


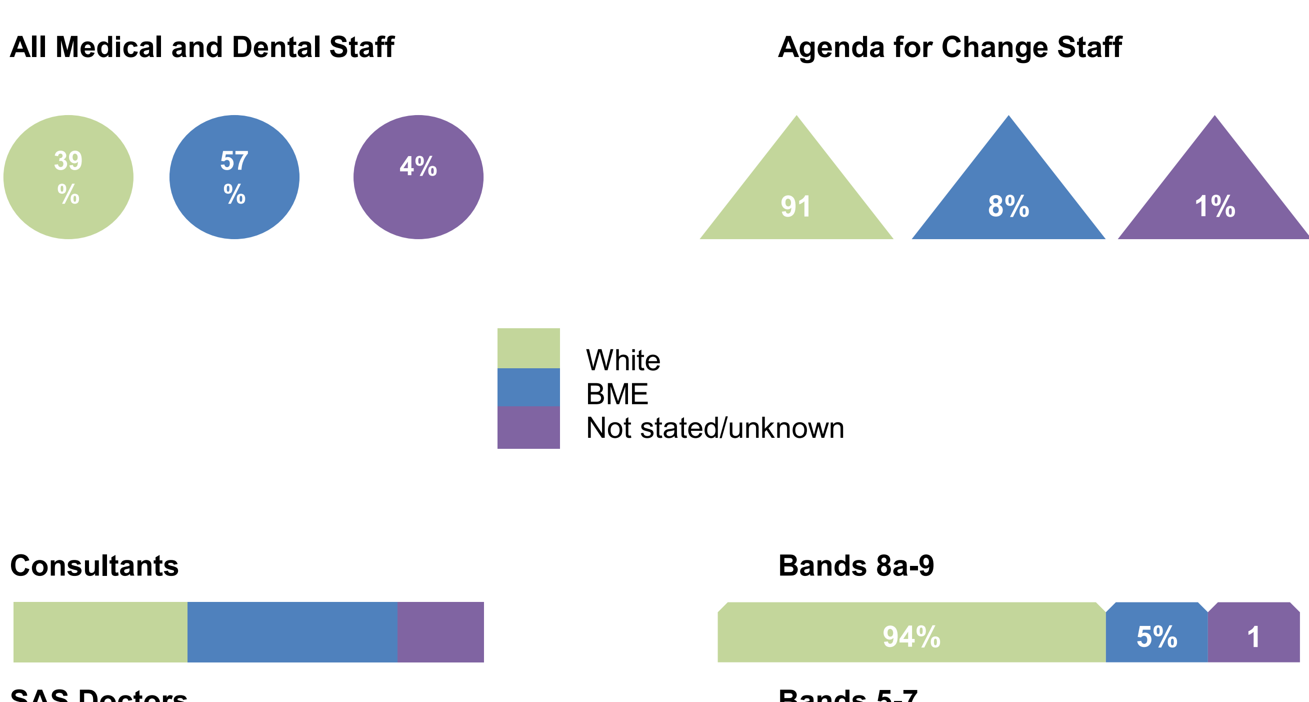


Section 2 – Ethnicity

The Trust employs 4,123 White employees and 526 BME employees. A further 70 employees have chosen not to declare their ethnicity.

% Ethnic breakdown of England's working population		% Ethnic breakdown of the NHS Workforce		% Ethnic breakdown of the Trust's Workforce	
•White	86%	•White	76%	•White	87%
•Black or Black British	3%	•Black or Black British	6%	•Black or Black British	1%
•Asian or Asian British	7%	•Asian or Asian British	9%	•Asian or Asian British	7%
•Mixed	1%	•Mixed	2%	•Mixed	1%
•Chinese	1%	•Chinese	1%	•Chinese	0%
•Any other ethnic group	1%	•Any other ethnic group	2%	•Any other ethnic group	2%
•Not stated/unknown	0%	•Not stated/unknown	5%	•Not stated/unknown	2%





SAS Doctors

Bands 5-7

88% 11% 1

Doctors in Training

Bands 1-4

95% 4% 1

Section 3 – Age

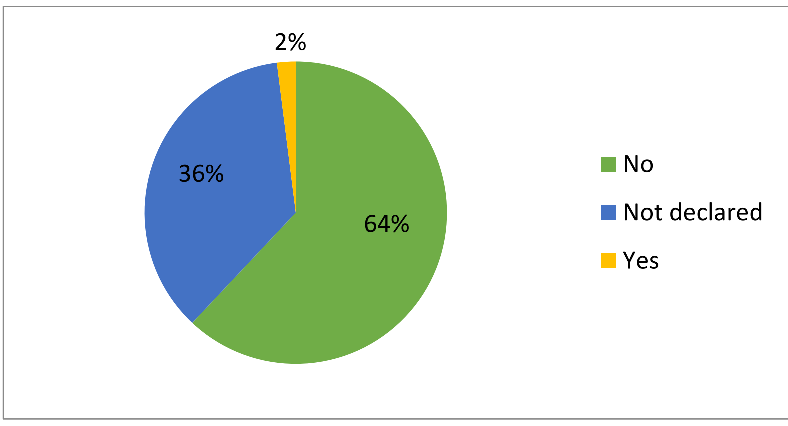
Of the 4,719 individuals employed by the Trust, the majority of staff are aged 45 to 54, followed by age 35-44 and then 25-34.

Age breakdown of England's working population		Age breakdown of the NHS Workforce		Age breakdown of the Trust's Workforce	
•Under 25	12%	•Under 25	6%	•Under 25	6%
•25 to 34	23%	•25 to 34	23%	•25 to 34	22%
•35 to 44	22%	•35 to 44	24%	•35 to 44	23%
•45 to 54	21%	•45 to 54	28%	•45 to 54	27%
•55 to 64	18%	•55 to 64	18%	•55 to 64	20%
•65 and over	4%	•65 and over	2%	•65 and over	2%

Section 4 – Disability

Our data indicates that the majority of our employees (64%) have declared that they do not have a disability, as compared to 2% of employees who have declared that they do have a disability.

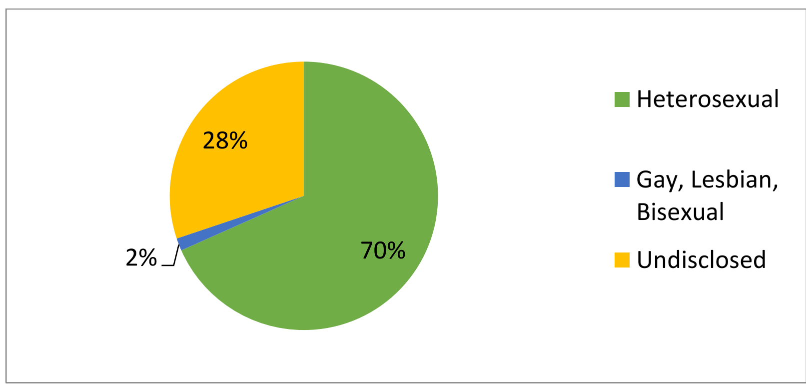
The information we hold relating to staff and disability continues to improve as there has been a reduction in the number of staff who have not declared their disability status from 40% in 2018/19 to 36% in 2019/20 to 34% in 2020/21



Section 5 – Sexual Orientation

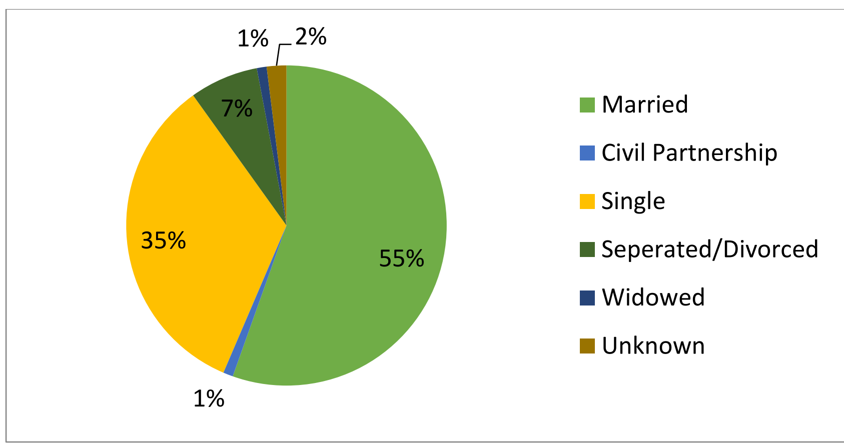
72% of our employees have declared their sexual orientation, whereas 28% have chosen not to declare their status. The number of staff choosing not to declare their status has reduced by 5% since 2018/19.

Of those employees who have chosen to declare their status, 70% of our employees have declared their sexuality as heterosexual, with a further 2% employees who have declared their status as gay, lesbian or bisexual.



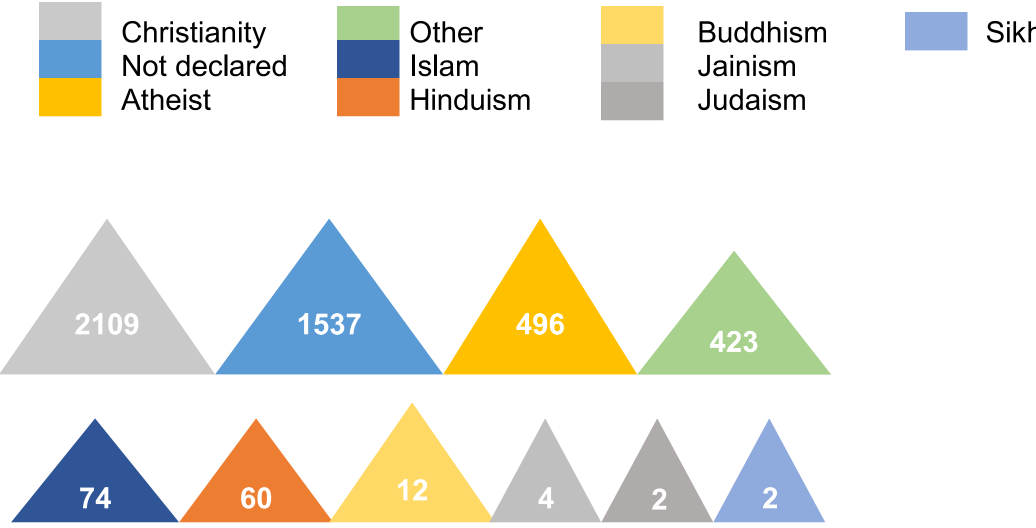
Section 6 – Marital Status

The marital status of our workforce profile indicates that 55% of our employees are married, with a further 1% who have indicated that they are in a civil partnership and 35% of our employees are recorded as single.



Section 7 – Religion and Belief

45% of our employees have recorded their religion as Christian, whereas 33% of staff have chosen not to declare their religion and 10% of staff have declared that they are Atheist.



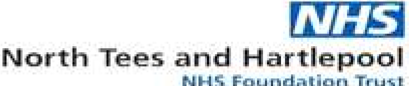
Section 8 – Pregnancy and Maternity

4.7% of our staff (223 employees) have taken maternity/adoption or paternity leave in the last year.

Section 9 – Gender Reassignment

At present we are not able to report on this equality strand as these details are not captured on the standard documents/application forms that are used to gather personal details.

However, any member of staff currently undergoing gender reassignment is supported throughout their transition by their manager and an employee relations advisor, in relation to employment matters and workplace considerations.



Board of Directors

Title of report:	Carbon Reduction Programme Performance Targets
Date:	29 July 2021
Prepared by:	Stuart Watkin and Steven Taylor
Executive sponsor:	Mike Worden
Purpose of the report	To provide an update on the on-going Carbon Management Programme with respect to reductions in the carbon footprint

Action required:	Approve		Assurance	x	Discuss		Information	x
Strategic Objectives supported by this paper:	Putting our Population First	x	Valuing People	x	Transforming our Services	x	Health and Wellbeing	x

Which CQC Standards apply to this report	Safe	x	Caring		Effective	x	Responsive		Well Led	x

Executive Summary and the key issues for consideration/ decision:

The NHS Sustainable Development Unit (SDU) has reported that the wider NHS community in England was responsible for more than 30 million tonnes of CO_2 in 2010. In recognition of the urgency of climate change, the UK Government introduced the Climate Change Act 2008 committing itself to take action and cut UK carbon emissions by 10% by 2015 (based on 2007 reference levels), 34% by 2020 and 80% by 2050.

Against a trend of increasing carbon emissions coupled with increased healthcare activity the SDU has reported that the NHS had achieved its 10% reduction in Carbon emissions by 2015, with schemes being devised, planned and funded to target 2030 and 2050 aspirations.

The Trust commenced its participation in the NHS Carbon Management Programme in May 2010 with the purpose of reducing carbon emissions, making energy savings and reducing costs, thereby demonstrating the organisation’s commitment to ‘good corporate citizenship’.

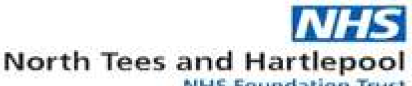
Entering the next phase of a drive to new-zero carbon, the government are now prioritising the decarbonisation of heating within public buildings. The Trust, in partnership with NTH Solutions, has established a Sustainability Development Management Group to plan for this and other sustainability projects.

Key Achievements

The initial period of the Carbon Management Plan (CMP) was completed successfully in 2016, achieving the ambitious CO_2 emissions reduction target of 20% against the government benchmark year of 2007/08. A further reduction target of 2% per year was then set, which has now seen the Carbon Footprint reduced by **over 34%** by FY20/21 against the initial government benchmark.

In 2020/21, the Trust’s Carbon Footprint was reduced **by 5.7% (**10,292 tonnes CO2 for 2020/21 against 10,961 tonnes CO2 for 2019/20), due in part to the impact of the COVID-19 pandemic, but noticeably through further improvements in Combined Heat and Power (CHP) availability and significant Capital investment in:-

- LED lighting (now 75% of all lighting within the Trust is by LED).
- Further installation of modern energy efficient and compliant air conditioning plant.
- Improvements to insulation, energy management controls and optimisation of the CHP waste heat recovery that currently heats 87% of the Trust’s hot water needs.



Also, the solar PV generation from the 2 arrays on Podium and Energy Centre roofs, that was installed in 2019, has to date generated over 567,000 Kwh of electricity on the UHNT site (enough to power 157 domestic houses for a year). This has also saved the Trust circa £85,000 off its electricity bill to date.

The continued efforts of the extended programme have been a success and made very real and identifiable savings, most notably in terms of cost avoidance (£12M over 10 years) due to site rationalisation, tax exemptions, driving down energy consumption and promoting investment in the infrastructure to secure future savings. This will continue forward into the next phase with the establishment of the Sustainable Development Management Group.

NTH Solutions spent £1.57m on Gas & Electric during 2020/21 on behalf of the Trust. This is a reduction on 2019/20 (£1.61m); undoubtedly due to the COVID-19 pandemic and the initial lockdown in April/May 2020. Exemption from a significant element of the ever increasing Climate Change Levy has realised avoidance of some £60,000 of additional charges.

During 2020/21, the Total Steam Demand increased by 1.8% following a colder winter (increase was limited by in year improvements), while the Total Electric Demand reduced by some 4.5%.

From 1 April 2020, the Trust has purchased 100% green electricity for all imported electricity. This was mandated for all public bodies to be able to record zero-carbon for their electrical imports.

Electric Vehicle Charging: 48 vehicle charging positions have been installed on Trust premises for transport vehicles, staff and the public.

How this report impacts on current risks or highlights new risks:

- Control of financial expenditure on utilities.
- Reducing carbon footprint to support NHS and government targets.

Committees/groups where this item has been discussed	NTH Solutions Senior Management Team meeting 13.07.21
Recommendation	The Board is asked to receive this report and note the continued success and progress in achieving energy reduction targets and site optimisation, to drive down energy consumption, carbon emissions and costs in the support of government targets.

Meeting of the Board of Directors

29 July 2021

Carbon Reduction Programme Performance Targets

Report of the Managing Director of North Tees and Hartlepool Solutions LLP

1. Introduction/Background

1.1 To update the Board of Directors on the progress that has been made on energy saving measures which have been implemented as part of the ongoing Carbon Management Programme (CMP). To seek renewed Board support for an on-going programme of works and to demonstrate that a focus on behavioural changes of staff can drive down carbon usage across procurement, travel and the environment, and as a result make further contributions to cost avoidance.

1.2 The NHS Sustainable Development Unit (SDU) had reported that the wider NHS community in England was responsible for more than 30 million tonnes of CO_2 in 2010. In recognition of the urgency of climate change, the UK Government introduced the Climate Change Act 2008 and committed itself to take action and cut UK carbon emissions by 10% by 2015 (based on 2007 reference levels), 34% by 2020 and 80% by 2050.

1.3 Against a trend of increasing carbon emissions coupled with increased healthcare activity the SDU had reported that the NHS has achieved its 10% reduction in Carbon emissions by 2015, with schemes being devised, planned and hopefully funded to target 2050 and future aspirations (Appendix 1).

1.4 The Trust commenced its participation in the NHS Carbon Management Programme in May 2010 with the purpose of reducing carbon emissions, making energy savings and reducing costs, thereby demonstrating the organisation's commitment to 'good corporate citizenship'.

1.5 With the government entering its next phase of work towards a net-zero carbon economy, it is prioritising, amongst numerous themes, work on the decarbonisation of public buildings. The Trust, in partnership with NTH Solutions, has established a Sustainability Development Management Group to plan and implement these measures.

2. Carbon Management Programme

2.1 Commitment to the Programme

Acceptance into the initial CMP and progression through the scheme was dependant on top-level commitment from the Executive Directors. Projects were devised and supported by a multi-disciplinary cross-Directorate team. The Trust has, for over a decade, demonstrated the will to support and implement schemes to reduce energy expenditure. Trust support saw the construction of a new Energy Centre, which has already demonstrated savings through implementation of new technologies and incremental performance enhancements.

The continued support from Trust Capital funds and investment from NHSE/I has seen over £500,000 spent on LED lighting, with a return on investment of 3 years.

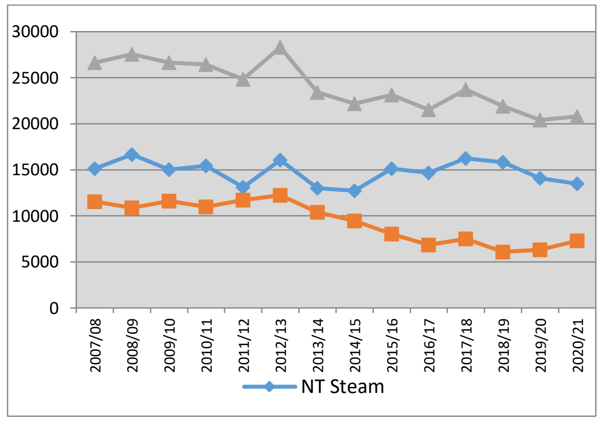
2.2 Carbon Implications

The implementation of the initial Carbon Management Programme made a significant impact on the Trust's Carbon Footprint; a reduction of 20% on the government benchmark year of 2007/8. This was achieved by implementing schemes to reduce heating, improve lighting, install electrical inverter drives and efficient air conditioning systems, but also through site rationalisation and closure of unwanted buildings.

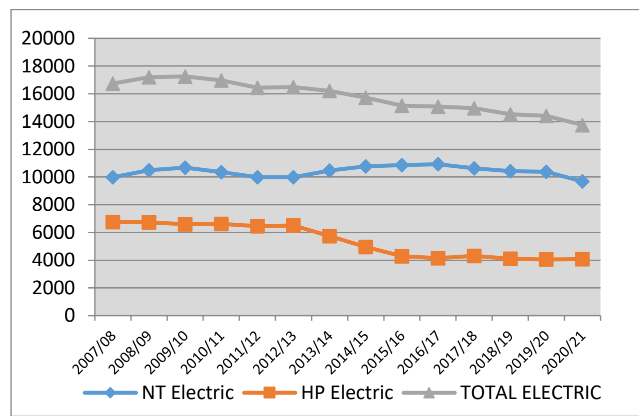
As of 2020, under new legislation of the Companies Act 2006 (Strategic Report and Directors' Report) Regulations 2013 and the Companies and LLP (Energy and Carbon Report) Regulations 2018, it is a requirement for NTH Solutions through the Streamlined Energy and Carbon Reporting (SECR) to present the energy use and associated greenhouse gas emissions as part of the energy report. It has been suggested by NHS Energy Groups that this report along with a tabulated report (Appendix 2) satisfying the requirements.

During 2020/21, the Total Steam Demand increased by 1.8% following a colder winter, while the Total Electric Demand reduced by some 4.5% through energy saving schemes such as LED lighting and energy efficient air conditioning units, but undoubtedly affected by the COVID-19 pandemic whereby general activity reduced.

TOTAL STEAM DEMAND (MWh)



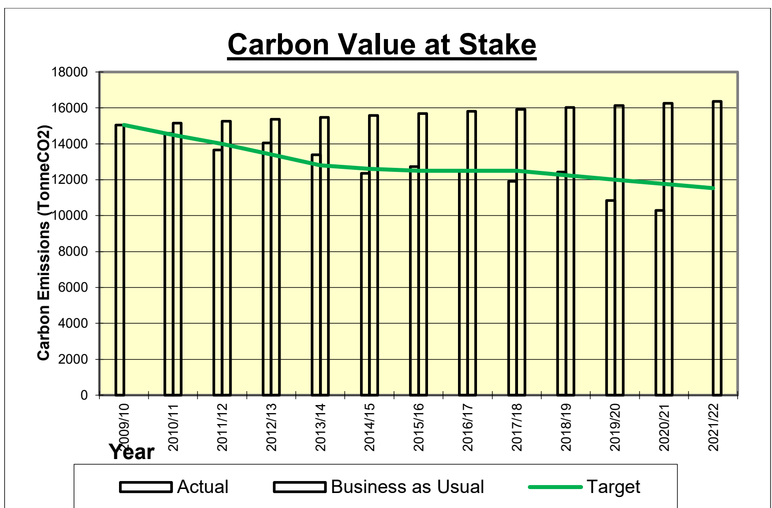
TOTAL ELECTRICAL DEMAND (MWh)



With good CHP availability throughout 2020/21 on both sites, the majority of our utility import is gas. In the past this would have been good to avoid carbon-heavy electricity from the grid, however from 1 April 2020, all public bodies have been mandated to purchase green tariff electricity to be able to record zero-carbon for their electrical imports.

Some trusts, which do not employ CHP, will show significant carbon reductions just through their procurement of green electric. While that might seem attractive, if the Trust were to remove CHP, our electricity bill would double the utility budget required and there would be no waste heat recovery – which accounted for 35% of Steam generation, 87% of Hot Water and 24% of Heating at North Tees in 2020/21.

Over the extended reporting period, the Trust's carbon footprint has been a continuous measure of the energy used in buildings, waste, water and business travel. The trend continues downward, and the Carbon Footprint is now over 34% down against the Government benchmark year of 2007/08.



It is clear that the Trust, working with NTH Solutions, has the ambition to sustain this downward trend and challenge itself with further carbon emissions reductions.

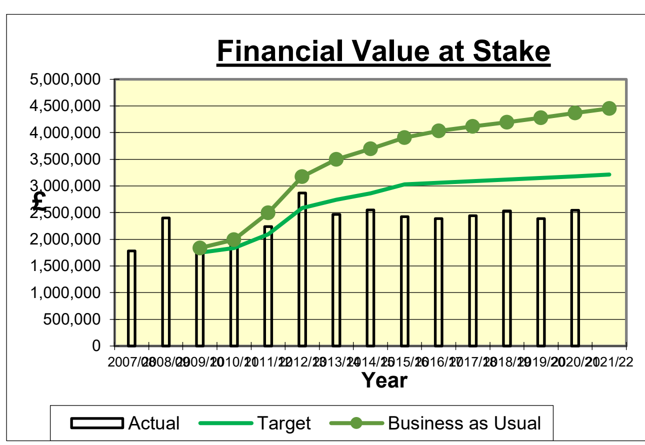
Implementing a Heat Decarbonisation Plan

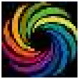
Working with NTH Solutions and Veolia Environmental Services the Trust will have an outline plan for the next 5-10 years. Indeed a full feasibility study into the large-scale decarbonisation of the Trust estate using ground source heat pumps and further PV solar arrays is planned during FY21/22. This will be the next key step change in the Trust's carbon footprint.

2.3 Financial Implications

The need to maintain budgetary control has never been more important, this is as important with utility purchases as any other service. The need to minimise expenditure through reduced energy consumption has been a key driver throughout the CMP and the need to reduce our future risk from an increasingly carbon-constrained economy.

The Trust's CMP provided cost savings on purchased utilities of £430,000 per year by 2015. Successful implementation of the scheme, combined with changing tax levy exemptions, have provided the Trust with cost avoidance of over £12 million since the start of the programme against the Carbon Trust's predicted Business as Usual costs.

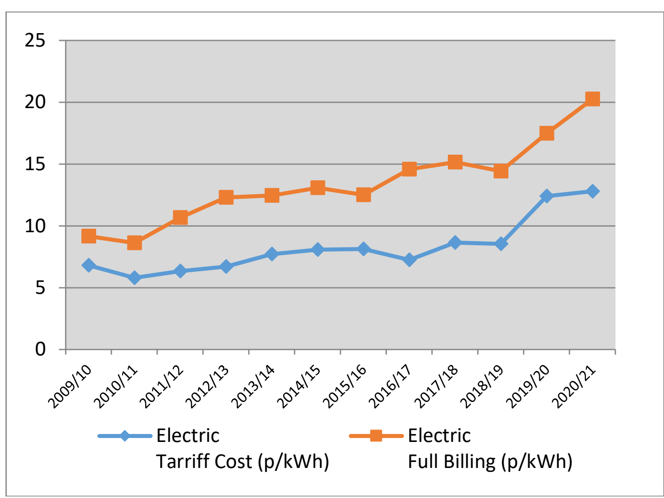




Despite tax exemptions and savings measures, North Tees and Hartlepool Solutions LLP spent £1.57m on Gas & Electric during 2020/21 on behalf of the Trust.
All bills are reconciled and queried as required; the account has benefited from a £8300 electrical rebate managed through NTH Solutions and INENCO.

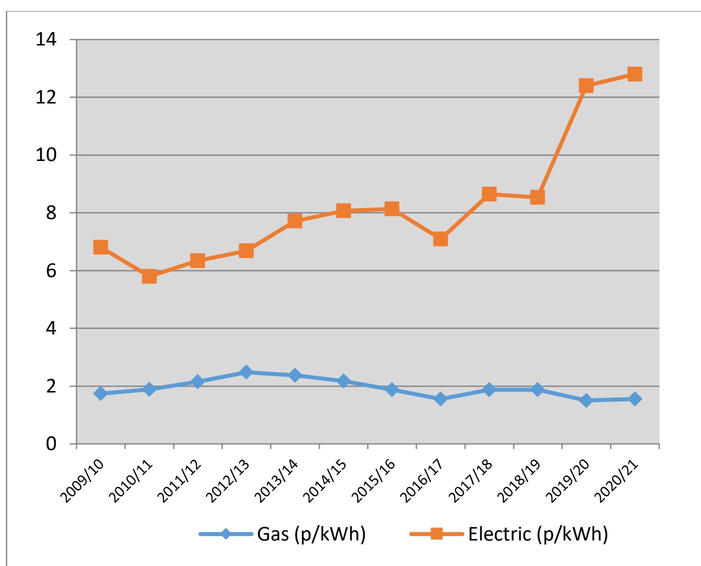
The Real Cost of Electricity

The non-commodity element of the electricity price through government taxes and levies has increased continually over the past 10 years.



Tariffs for the past 2 years now include green levies, which means that 60% of the rate is tax or levy.

While it would be ideal to move to electric for carbon-free utility, the financial impact would be prohibitive. Gas has remained virtually unchanged across the period, but is a carbon-based fuel. This raises important questions on where to direct the next phase of carbon reductions.



At present, our best financial model is to buy gas for our CHPs and generate our own electricity, but it is increasingly difficult balance with the carbon footprint, as electricity becomes greener but more expensive. The general direction of travel nationally is to reduce overall electrical demand through energy efficiency measures and then pursue large-scale decarbonisation of the Trust estate using ground source heat pumps and further PV solar arrays.

2.4 Tax Implications

Under the Climate Change Act 2008, the Government introduced the Carbon Reduction Commitment (CRC) – an additional tax burden for larger, 'energy heavy' organisations. The Trust was required to register as a participant for Phase 1 and paid costs of £140,000 in 2011/12. Due to CHP availability, the trust did not qualify for Phase 2, where costs would have risen to more than £200,000 per year.

A further benefit of having the CHPs on each site is that the Trust is virtually exempt from Climate Change Levy (CCL), which has now increased to 0.465p/kWh.

3. Conclusion/Summary

3.1 The Trust's involvement in the Carbon Management Programme has been very worthwhile. It has forced the Trust to look at its energy usage, its travel and its methods of procurement, to find savings and drive through the changes. The efforts of the original CMP team have undoubtedly made an impact on the way business is now completed and projects supported and as such procedures have been changed and enhanced.

3.2 The extended programme has been a success and made very real and identifiable savings, most notably in terms of cost avoidance due to site rationalisation, seeking ways to drive down energy consumption and promoting investment in the infrastructure to secure future savings. This will now be carried forward, into the next phase of the government's drive to become net-zero carbon by 2050, with the establishment of the Sustainable Development Management Group.

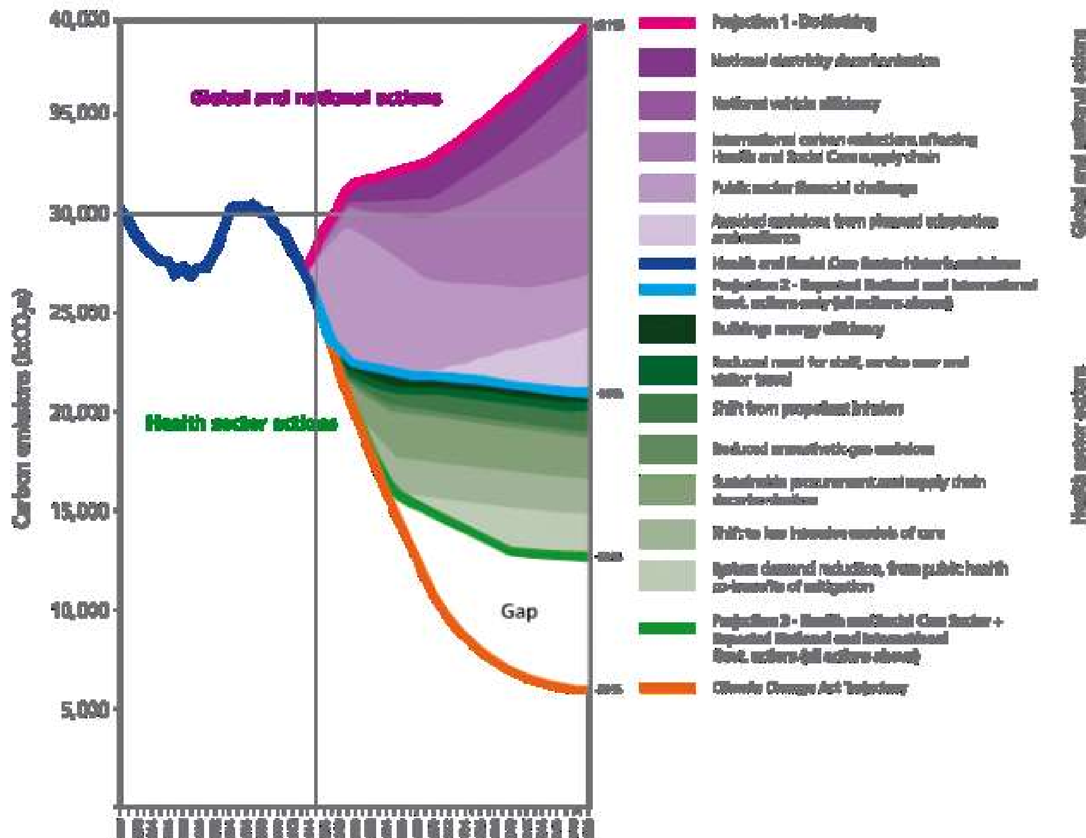
3.3 The new Energy Centre has been fully performance optimised and realised savings; a major milestone in the Trust's long term Carbon Management strategy. The next phase will be to seek innovation, investigate novel technologies and complete feasibility studies to help decarbonise the buildings.

4. Recommendation

The Board is requested to receive this report and note the continued success and progress in reducing energy consumption and carbon emissions in support of government targets.

Mike Worden
Managing Director
North Tees and Hartlepool Solutions LLP

Appendix 1



An NHS owned company

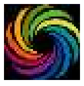
Appendix 2

Greenhouse Gas Emissions

Area							
		2018/19	2019/20	2020/21	2018/19	2019/20	2020/21
Finite Resources	Electricity	5277.2 MWh	1003.8 MWh	1595.8 MWh	£722,958	£441,846	£320,616
		1493.5 tCO2	278.1 tCO2	0 tCO2 (1)			
	Gas	51,252 MWh	56,551 MWh	56,027 MWh	£1,009,819	£1,169,273	£1,249,039
		9410.9 tCO2	10179.2 tCO2	10309 tCO2			
	Oil	65,061 kWh	239,069 kWh	102,924 kWh	£60,000	£58,000	£12,434
		17.2 tCO2	63.4 tCO2	27.3 tCO2			
Waste	Total Waste	1477 t	1567 t	1435 t	£560,334	£814,290	£372,431
Hazardous Waste	Clinical waste to alternative treatment of incineration	182 t	196 t	408 t			
		41.1 tCO2	44.3 tCO2	92.2 tCO2			
Non-hazardous Waste	Landfill	23 t	0 t	51 t			
		10.3 tCO2	0 tCO2	22.8 tCO2			
	Re-used / Recycled	414 t	360 t	285 t			
	Incinerated with Energy Recovery	859 t	951 t	681 t			
	Electrical Waste (WEEE)	6 t	5 t	10 t			
Travel	Commercial Vehicles Diesel	529,051 miles	541,574 miles	0 (2)	£95,869	£97,641	£0
		95.2 tCO2	97.5 tCO2	0 tCO2			
	Lease Vehicles Petrol	25,000 miles	23,971 miles	191234	£5,893	£4,576	£36,506
		4.5 tCO2	4.3 tCO2	34.4 tCO2			
	Lease Vehicles Diesel	2,323 miles	0	95519	£548	£0	£22,533
		0.42 tCO2	0 tCO2	17.2 tCO2			
	Business Miles	3,943,626	1,178,594	1,000,823	£714,622	£212,490	£180,440
		709.9 tCO2	212.1 tCO2	184.0 tCO2			
Water	Water Consumption	139908 m3	132944 m3	138894 m3	£377,798	£350,097	£362,736
		56.5 tCO2	53.7 tCO2	56.1 tCO2			

Notes:

1. Electricity is now from Green Tariff so no Carbon Footprint
2. Finance now report Business miles and lease mileage directly. Portering use Electric vans.



Board of Directors

Title of report:	Estates and Facilities Annual Report
Date:	29 July 2021
Prepared by:	Sharon Mee / Steve Taylor (Assistant Directors)
Executive sponsor:	Mike Worden (Managing Director)
Purpose of the report	This purpose of the report is to provide information to the Board of Directors on the Estates and Facilities annual performance for 2020/2021

Action required:	Approve		Assurance	X	Discuss		Information	X
Strategic Objectives supported by this paper:	Putting our Population First	X	Valuing our People		Transforming our Services	X	Health and Wellbeing	

Which CQC Standards apply to this report	Safe	X	Caring	X	Effective	X	Responsive	X	Well Led	X

Executive Summary and the key issues for consideration/ decision:

The report is for information and details performance over the financial year 2020-2021, it includes key achievements by service, information on Premises Assurance, Health, Safety, Security, Model Hospital metrics, Capital Programme and Design and Development Service, Estates Services, Carbon Reduction and Sustainability and key issues and planned actions for the FY 2021/22.

Key points:

- ERIC return 2019/2020 - within the Lowest quartile (good) for all Trusts and are ranked 50th nationally out of 223 Trusts compared to last year when we were ranked 54 out of 227 Trusts;

- MSA Compliance – Only 3 Performance Indicators out of 95 had 5 or more reds in the 12 month period (Unwanted (False Fire Alarms), Catering income and Sickness Absence) This was predominantly due to the Covid 19 Pandemic for 2 of them;

- Backlog Maintenance – costs across the whole estate was reduced by £2.65m from £37.85m to a revised total of £35.2m. Critical infrastructure risk backlog maintenance was reduced from £7.45m from £6.1m;

- Oxygen Ring main reinforcement - Improved the capacity and resilience of oxygen pipework system;

- A & E Front of House – Phase 1 (main A & E) delivered on time and brought into full operation on 7.12.20 – Phase 2 (remodelling Day Case) completed w/c 8.2.21 – Phase 3 (works to Paediatric Day Unit) completed w/c 22.2.21 – Phase 4 (major corridor and adult resuscitation area refurbishment) completed Q4;

- Fire alarm replacement UHNT – completed December 2020 – training to be completed before old system decommission and removed;
- Carbon Reduction & Sustainability - Carbon footprint reduced by a further 5%;
- Premises Assurance – 260 self-assessment questions scored either outstanding (13) or good (247) ratings out of 335 questions audited.

How this report impacts on current risks or highlights new risks:	
All the risks are identified on the LLP and the Trust risk register.	
Committees/groups where this item has been discussed	LLP Senior Management Team 13/07/20 LLP Management Board 22/7/21
Recommendation	The Board of Directors is asked to note the content of the annual report.

Estates and Facilities Annual Report

FINANCIAL YEAR 2020 / 2021

Presented: 22/07/2021

Reporting period:	FY2021/22
Agreed by:	Mike Worden: NTH Solutions Managing Director

Estates and facilities management in health and care

An NHS owned company

Executive Summary

This has been yet another exciting and challenging year, with the LLP continuing to mature and grow whilst endeavouring to meet the requirements and demands of its client and the ever-changing requirements of society and the NHS.

Throughout 2020/21 the key function of North Tees and Hartlepool LLP was to optimise the operational effectiveness of the services it provides, whilst ensuring compliance with key legislation and ensuring the services adapt to the changing requirements of the Trust. This provides assurances to the Board of Directors that services are delivered in a safe environment, employing safe practices and ensuring the safety of staff, patients and visitors. As well as ensuring all the services are delivered in accordance with best value principles, are of appropriate quality, efficient and on time.

In 2020/2021 the LLP updated its core purposes to reflect its trading maturity and growth objectives for the following financial year.

This year Professor Graeme Evans resigned on the 1st May 2020 and Mr Stuart Irvine, Deputy Director of Finance NTH&H NHS FT, was appointed as a new voting member to the LLP Management Board on 1st May 2020.

The efficiency of the Estates & Facilities services are annually benchmarked against the Lord Carter developed 'Model Hospital' metrics; these continue to indicate that services are delivered in the lowest cost quartile, which indicates cost efficiency again estate.

The procurement department are responsible for all third-party spend on behalf of North Tees and Hartlepool NHS Foundation Trust with the following exclusion; All Pharmacy spend is managed via the Pharmacy department, either through their own dedicated buyer or via regional Pharmacy arrangements.

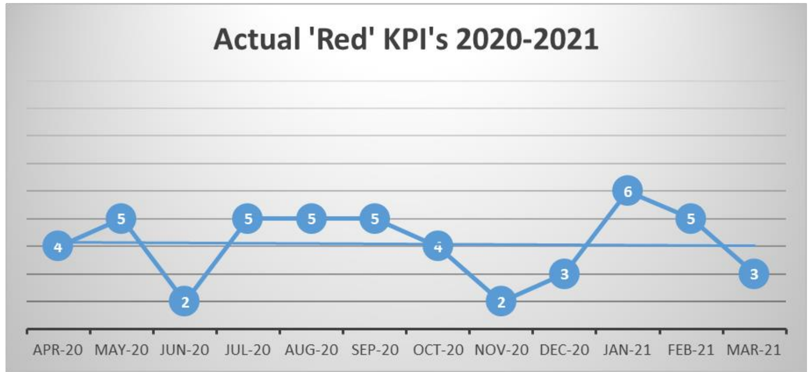
In addition, the Inventory Management Team provide a materials management service in a number of key areas within the Trust.

The businesses performance in delivering the Master Services Agreement (MSA) requirements is measured via Continuous Improvement Indicators and Key Performance Indicators. The MSA reports on performance to the Service Level Agreement (SLA) via the MSA Steering Group, which meets on a monthly basis and is represented by both Trust and NTHS key stakeholders.

Each month two monthly reports were presented to the Trust MSA Steering Group. These consist of a Performance and Assurance report which details the monthly Continuous Improvement Indicators (CII) and Key Performance Indicators (KPI) status and an Exception report which details exceptions (primarily those performance indicators' which have shown a red target rating for the month). Service failure notifications & implications and service pressure information is included in the exception report. In addition deep dive reports are included if applicable when a performance indicator is of concern.

The overall MSA contractual performance improved throughout the course of the year. With the LLP being able to demonstrate a downward, trend of reduction in significant (red) KPI breaches throughout the course of the year representing a clear indication of continual improvement. Six months of the year resulted in the red targets going above the trend line, this was due to a drop in

catering income due to the Covid Pandemic and Unwanted fire alarms in May, July, August September, January and February as well as Clinical Cleaning and Electric Demand falling below the expected targets in January and February of this year.



This was an excellent performance particularly when there have been many challenges whilst continuing to strive for growth and maintain compliance with relevant standards / legislation.

Summary FY20/21 KPI performance

Month	Number of Reportable KPI's Per Month	Number of KPI's Reported	Green		Amber		Red	
			KPI Count	% of Total	KPI Count	% of Total	KPI Count	% of Total
Apr-20	95	75	59	62%	12	13%	4	4%
May-20	95	83	69	87%	9	10%	5	5%
Jun-20	95	82	65	68%	15	16%	2	2%
Jul-20	95	81	66	70%	10	11%	5	5%
Aug-20	95	74	63	66%	6	6%	5	5%
Sep-20	95	73	57	60%	11	12%	5	5%
Oct-20	95	74	60	63%	10	11%	4	4%
Nov-20	95	73	63	66%	8	8%	2	2%
Dec-20	95	74	66	70%	5	5%	3	3%
Jan-21	95	73	57	60%	10	11%	6	6%
Feb-21	95	74	59	62%	10	11%	5	5%
Mar-21	95	72	61	64%	8	8%	3	5%

Out of a total of 95 Key Performance Indicators which are monitored by the Trust there have been 3 which have had 5 or more reds in a 12-month period:-

- Unwanted (False) Fire Alarm - NIL Brigade attendance;
- Catering income;
- Sickness Absence.

The performance achieved is excellent considering the many challenges, particularly whilst dealing with the Covid 19 pandemic, continuing to strive for growth and maintain compliance with relevant standards / legislation. In meeting these challenges, the LLP has continued to play its part and achieved its aim through the dedication and hard work of its entire staff.

Premises Assurance Model

The Premises Assurance Model (PAM) is a tool that allows NHS organisations to better understand the efficiency, effectiveness and level of safety with which they manage their estates and how that links to patient experience. As the LLP is a subsidiary of North Tees & Hartlepool NHS foundation Trust and is supplying Estates and Facilities Services under a Master Services Agreement to the Trust it is appropriate for the LLP to carry out this assessment.

The PAM Self-Assessment Questions (335 questions) are grouped into five Domains, which are broken down into individual self-assessment questions and further sub-questions known as prompt questions. The model is completed by scoring the prompt questions under each SAQ. The six domains are:

- Safety (Hard and Soft)
- Patient Experience
- Efficiency
- Effectiveness
- Organisational Governance

Areas in which the Trust Obtained a Rating of Outstanding

There were no domains, rated as outstanding however; some self-assessment questions did receive an outstanding score, as follows:

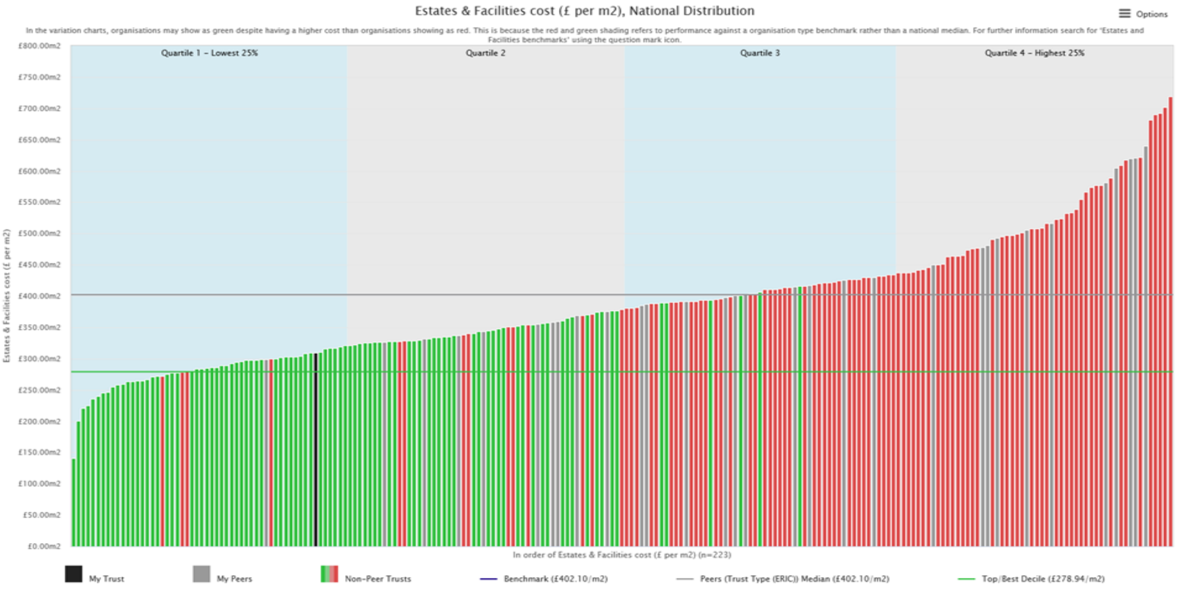
- Safety Soft (SS2) Decontamination x 6
- Safety Hard (SH5) Asbestos x 3
- Safety Hard (SH6) Medical Gases x 2
- Governance (G3) - Professional Advice x 1
- Governance (G3) – In-House Advisors x 1

The overall ratings following the assessment were:

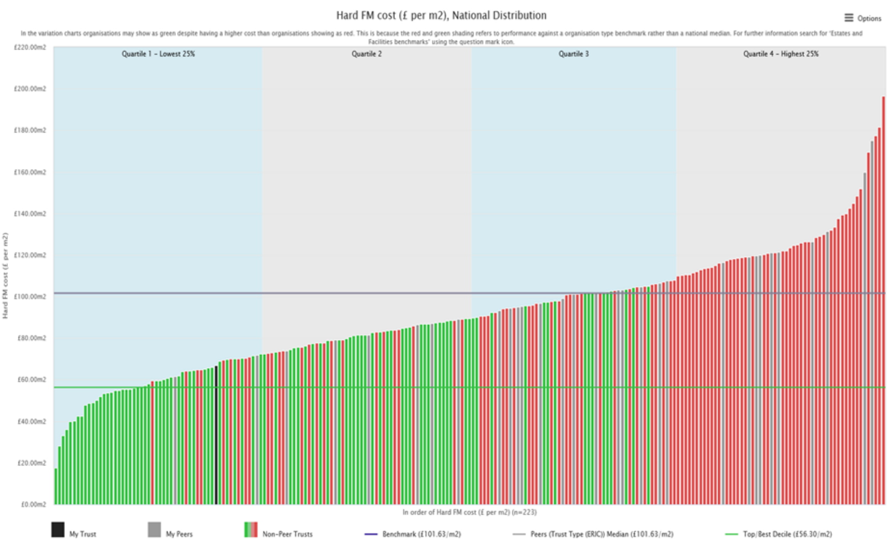
- Outstanding = 13
- Good = 247
- Requires minimal improvement = 33
- Requires moderate improvement = 15
- Inadequate = 1
- Not Applicable = 26

Model Hospital Metrics Estates & Facilities

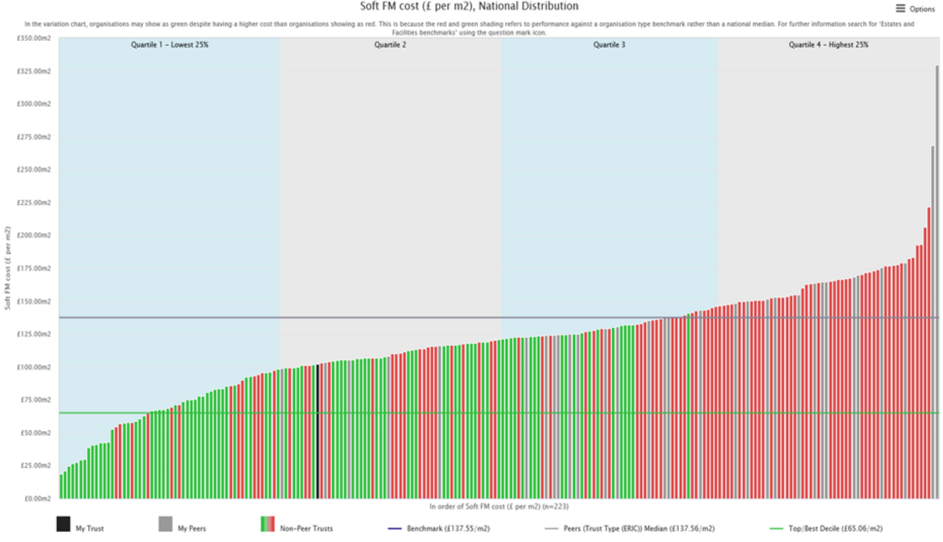
ERIC Return 2019/20 -2nd Lowest Cost from 32 (Peers) Medium Sized Acute Trusts Nationally: NHS Digital published the Model Hospital benchmarks for all Estates and Facilities services for each Trust nationally in September 2019. This is populated from 2019/20 Estates Return Information Collection (ERIC) information that was submitted by the LLP on behalf of the Trust in June 2020. After analysis of the results North Tees and Hartlepool NHS Foundation Trust is within the lowest quartile (good) for all Trusts (which includes community hospitals and ambulance Trusts) and are ranked as 50th place nationally out of 223 Trusts compared to last year which was 54th out of 227 for the estates and facilities services that are provided by the LLP. This is a significant indicator demonstrating that the LLP is delivering good value for money for the Trust.



The Trust performs very well in terms of estates and facilities cost per square metre – it is in the lowest 25% quartile for total occupied floor area in operational use. The Trust value with regard to running costs of the total occupied floor area is £309 compared to its peer median of £299.05 and benchmark value £402.10 this gives an indication of cost efficiency against the estate.



This metric compares the hard FM running costs to the occupied floor area and provides an indication of the cost efficiency of the hard FM function of the estate. The higher the cost per unit area, the lower the cost efficiency. Hard FM costs make up one component of the total running costs, which is made up of three parts: hard FM, soft and financing costs. Changes to this metric can be the result of movements in either of these elements year-on-year. The Trust value with regard to Hard FM Costs is £66.04 compared to its peer median of £61.47 and benchmark value £101.63 this gives an indication of cost efficiency against the estate.



This metric compares the soft FM running costs to the occupied floor area and provides an indication of the cost efficiency of the soft FM function of the estate. The higher the cost per unit of the areas the lower the cost efficiency. Soft FM costs make up one component of the total running costs, which is made up of three parts: hard FM, soft and financing costs. Changes to this metric can be the result of movements in either of these elements year-on-year. The Trust value with regard to Soft FM Costs is £102.41 compared to its peer median of £99.09 and benchmark value £137.55 this gives an indication of cost efficiency against the estate.

Capital Programme and Design and Development Service

Capital Programme Performance 2020/21: The long-term estates strategy continues to be to rationalise the existing old estate to centralising into core buildings and the disposal of surplus estate or to attract business developments which utilise the existing surplus estate. At all times ensuring the estate is maintained in a safe condition while achieving performance standards and patient expectations. The NHS Improvement Compliance Framework requires that a minimum of 85% and a maximum of 115% of the original capital allocation should be spent on a monthly basis. Only goods and services that have been received or invoiced may be counted as expenditure. At the end of Q4, expenditure (invoices and accruals) was £21.4m, against a budget of £23m, which is 93% of the Trust's planned spend for the year.

Reducing Backlog Maintenance Position: During the FY 2019/20 capital programme, and taking maturing risk into account, the Trust's backlog maintenance costs across the whole estate was reduced by £2.65m, from £37.85m to a revised total of £35.2m. Critical infrastructure risk backlog maintenance was reduced from £7.45m from £6.1m.

Oxygen Ring Main Reinforcement: Work commenced in April to convert the existing oxygen radial pipeworks system (with an initial max. capacity flow rate of 1000 l /m) to a ring main, improving the capacity and resilience of the oxygen pipework system**.** The pipework installation was completed in Q3. BOC (working under priority control of NHSI) carried out enhancements to the oxygen capacity of the UHNT VIE, increasing oxygen flow rate capacity from 1000l/m to 3000l/m with an additional 3000 l/m back up. BOC estimated the Trust required a larger vessel than initially planned, and approval was given in December for the additional cost associated. The final vessel was delivered on site and installed the last week of March.

A&E Front of House: The North East & North Cumbria ICS received a capital allocation of £22m, to be allocated to the 11 A&E sites across the ICS. The Trust submitted their scheme and funding was confirmed at £2.53m with an additional £450k to support NEAS, to be spent and the project completed in January 2021.

The creation of a 'one door' model for Urgent and Emergency Care to alleviate any confusion for patients and support getting patients to the right place and increase capacity.

Phase 1 (main A&E) was delivered on time and was brought into full operation on the 7 December 2020 in readiness for significant winter pressures (first Trust in the North East to achieve this). Positive feedback from both patients and staff has been received and this will be shared in the near future. The Communication team have shared the success of service changes in phase 1, including the benefits. The project team have managed to continue this critical piece of work despite the on-going operational challenges.

Phase 2 of the project, remodelling Day Case, completed w/c 8th February, and phase 3, which included works to the Paediatric Day Unit, completed w/c 22nd February.

The A&E majors corridor and the adult resus area has also undergone a refurbishment with the remaining small allocation of funding, to improve patient observation and the aesthetic, and was completed in Q4. The estates team worked closely with the department to ensure the area remained operational whilst the works took place.

Endoscopy: External funding of £901k has been secured to form an 8th endoscopy room. The estates enabling works are quoted at £300k. Project design work has been undertaken and agreed. Strip out work commenced and completed in March, along with construction of the dirty corridor to allow the department to operate normally. The project was part receipted in FY 20/21 (£200K) and the remaining planned for Q1 FY 21/22.

Staff Recharge Hub: Utilising donations from Captain Sir Thomas Moore, the Trust has created two staff wellbeing hubs, aptly named the Rainbow Rooms, at both UHNT and UHH. Works included a full refurbs of the rooms, new comfortable furniture, kitchen facilities, and shower facilities at UHNT. The outdoor spaces were further developed to create an outdoor seating area with heaters and a covered canopy, which can be used year-around.

Decarbonisation: The Trust was unsuccessful in an application for £300k for decarbonisation initiatives. However, utilising additional funding from capital underspends, elements of the initial plan, including progressing the changeover to LED Lighting and replacing end of life air conditioning units, were progressed in Q4.
This has contributed to a 5.7% reduction in carbon emissions in the FY2020/21. This is a carbon emissions reduction of 15.7% in the last 2 years.

Electric Vehicle Charging: Vehicle charging positions have been installed on Trust premises for transport vehicles in Q3, with 4 at the Energy Centre UHNT and 4 at UHH. In addition, charging stations for staff/public have been installed with 24 on the UHNT site, 14 on the UHH site and 2 on the PCH site (48 charging points on total). All installation has been completed by the end of March. The locations and number of charging points were agreed at the Sustainability Management Group.

Roofing Repairs: A multi-year programme was developed, awarded to Group Tegula Ltd following a mini-competition. The contract value is capped at £2m, and includes flexibility to address the high risks roofs and other roofs in dilapidated conditions. A proportion of the external Critical Infrastructure Risk (CIR) funding was utilised for additional roofing repairs. The project has delivered just under £1m of urgent roofing repairs within FY 2020/21 including Theatre roof, Middlefield Centre North Wing roof on the UHNT site and the OPD department roof on the UHH site.

Roofing repairs will remain a feature of the backlog capital 5 year programme over the remaining years programme.

Concrete Repair Works - Tower Block UHNT: The scope of works will repair the damaged concrete and apply a coloured protective coating guaranteed for 10 years. The total cost of the works is £455k, split over 2 years (£195K in year 1 and £260K in year 2). Overall, the project is 40% complete; Phase 1 of the programme completed prior to Christmas and phase 2 re-commenced in March to avoid poor weather conditions in January and February. The year 1 project was completed and the end of March with the year 2 continuing into FY 21/22.

Window Replacement: Replacement of the windows for x-ray consultants, wards 18 / 19 on the UHNT site and the OPD department on the UHH site has been completed in Q4.

Roads and Car Park Repairs 2020/21: A multi-year programme has been developed, awarded to AWG Civil Engineering Ltd following a mini-competition. The contract value is capped at £250K to allow flexibility to tackle other emergency conditions or provide flexibility if the overall programme needs to increase spend. Works were carried out on the UHNT and UHH main car parks and roads. These were progressed in a phased manner and completed on time and to budget by the end of Q4. A new programme of works will be put in place for FY 21/22 to tackle remaining repairs.

Fire Alarm Replacement UHNT: Installation was completed in December 2020. The testing /commissioning of the system was completed in Q4. The existing system continues to be fully operational until the changeover takes place. The changeover will take place once the training has been completed for the fire response team, to ensure staff are competent to use the new system. Once the changeover has been completed the old system will be decommissioned and removed. This is anticipated to be during Q1 FY21/22.

Fire Alarm Replacement UHH: The business case was approved in May 2020. Following an OJEU procurement tender, the project was awarded to TFS. The overall project cost is £1m, with £50K of spend in FY20/21 and the remaining spend in FY21/22. Funding has been identified within the 5-year capital backlog maintenance plan. The scheme commenced in February 2020 and will continue in FY21/22 with completion and changeover onto the new anticipated by

Lift Refurbishment UHNT: The overall project completion was expected in February 2021 (from October 2020 due to Covid 19). Lift 1, 2, 3, 4, 5 and 6 on Tower block have been refurbished and have now been synchronized to improve the efficiency of response to landing calls and reduce energy usage and carbon emissions. A proportion of the CIR funding has been allocated to replace/refurbish the UHNT theatre dirty/kitchen lift. The completion of the theatre lift replacement is expected to complete in Q1 21/22.

The North Wing lifts are planned for subsequent years of the capital programme.

Theatre Refurbishment UHNT: Theatre 7 refurbishment and the creation of additional recovery space has been postponed to Q1 FY 21/22 due to impact of Covid-19. Proposals have been developed in conjunction with the Elective Care Group and design work has taken place with Howarth. The funding for this scheme has been partly spent in FY 20/21 buying equipment and carrying out preparatory infrastructure works. The works within the theatre will commencing in Q1 21/22. The underspent funding in FY 20/21 has been reallocated to other high risk backlog items.

The risk associated with the shared plant for theatre 1,2 & 3 have been added to datix.

The 5-year backlog plan includes the refurbish of two theatres per year for the remaining years of the 5-year programme. Discussions are ongoing to agree the programme with the elective care group.

Building Management System Replacement (BMS): The BMS system that controls the hot / cold water legionella monitoring and heating systems across the Trust estate continues to be upgraded and modernised with end of life components being replaced.

Additional CIR funding has addressed the A&E air handler that was not linked to the BMS.

Accessibility Audit 2020/21: Accessibility audits are conducted in 5 yearly cycles by an independent external accredited consultant to audit the Trust's estate to validate compliance with relevant legislation, ensuring reasonable alternatives measures are in place for all users of the building (including those with mobility, sight and hearing disabilities). Availability for consultants is limited due to Covid-19. It is expected the audit will now take place in the FY21/22 and the accessibility allocation for FY20/21 was utilised on improving decoration and signage at main entrances of the Trust estate.

Medical Equipment Replacement Programme

The Capital Medical Equipment Replacement Programme had been prioritised against an initial allocation of £2.5m, with an additional £1.7m of 'Priority Additional Equipment' and £0.83m of 'Adopt and Adapt' funding received part way through the financial year.

Medical Equipment spent £3.07m between January and end of March. The following elements have been progressed in Q4.

Anaesthetic Machines: Sixteen Anaesthetic machines have been delivered and are being brought into operational use in UHNT Theatres week commencing 12th April and in UHH Theatres from week commencing 19th April. Four Induction room machines (used for anaesthetising patients before they move into Theatres) are being installed at North Tees and Five induction room machines at Hartlepool. Eight Main Theatre Machines, (used for life support during surgery), are being installed at UHNT

Ultrasound machines: Two 'Acusson S2000' Ultrasound diagnostic scanning machines have been received for UHH Main out patients and Peterlee hospital. Two further Siemens Acusson Juniper Ultrasound machines have been delivered for Women's Outpatients and Women's services at North Tees.

Syringe Drivers: One hundred Micrel 101+ syringe drivers, used for pain relief during palliative care have been received and commissioned to replace the obsolete fleet of McKinnley T34 units in the hospital and Community.

Thermometers: One Hundred Braun Tympanic Thermometers have been received for Community to replace the obsolete Medtronic Genius 3 type currently in use. This will standardise the community with the hospitals who already use the Braun Tympanic thermometers

Resuscitaires: Four resuscitaire baby resuscitation and warming units have been received for Maternity to replace existing machines that only have oxygen. (Current recommendations state that air and oxygen should be available on these units)

ECG Cart: A Welch Allyn ECG recorder, used for recording heart rhythm traces, was received for Ward 18

Image intensifier: A Philips BV Pulsera C arm X-ray was ordered and a vesting certificate issued as delivery was not possible before end of March

Bone Densitometer: A Vertec hologic Horizon DXA X ray was ordered. This is used to measure bone density and the Horizon DXA system also has features for a complete fracture risk assessment.

Fujifilm FDR Visionary Suite x-ray system: This will replace the obsolete EOS X-ray system in room 2 orthopaedic outpatients. A vesting certificate was received for this system as delivery and installation was not possible in Q4.

Patient trolley's: Four patient trolleys for Endoscopy were ordered and a document of bonding received as delivery before end of March was not possible.

Exercise Bike: An exercise bike was received for Hartlepool Hospital Gym.

Flexible Cryoscopes: have been delivered for Endoscopy. These are used for the removal of foreign objects, mucous plugs and blood clots.

Estates Services

2019/20 has seen a continuation of the challenge brought to the Estates team with the on-going improvements to the estate. The Estates team continues to provide a safe compliant and cost effective patient environment, delivering on budgetary targets for the year, underpinned by 13,616 reactive (reduction from previous year due to areas being out of use due to COVID-19) and 12,019 planned preventative maintenance tasks.

COVID-19 challenged the Estates team to ensure that the clinical teams had the services to deliver care, most importantly the high volumes of oxygen into ward areas. The Estates team were instrumental in increasing oxygen capacity from 1000l/ m to 3000l/m over the course of the year. Local o2 capacity was also doubled in the Respiratory wards and EAU in year. The estates team also installed a significant number of temporary protective COVID-19 screens in a number of ward and department areas sometimes on a hour by hour basis as the pandemic unfolded.

In addition to this, the Estates team supported development schemes, such as the A&E project throughout the year and lead on several further infrastructure projects including LED Lighting, drainage, Building Management system (BMS) that control the heating and hot water monitoring systems.

The Estates apprentice scheme (via the Northern and Yorkshire NHS Assessment Centre) has also successfully trained and retained a further 1 electrical candidate following 4 year apprenticeships. We have also appointed a further 3 apprentices during 2020/21 (1x electrical, 1x mechanical and 1x decorator). The apprentices played a key role during COVID-19 and as part of the wider team took vital o2 pressure readings around the site to ensure o2 supplies remained safe and operational.

Carbon Reduction and Sustainability

The initial period of the Carbon Management Plan (CMP) was completed successfully in 2016, achieving the ambitious CO_2 emissions reduction target of 20% against the government benchmark year of 2007/08. A further reduction target of 2% per year was then set, which has now seen the Carbon Footprint reduced by **over 34%** by FY20/21 against the initial government benchmark.

In 2020/21 the Trust has seen its carbon footprint reduced by a further **5%**, due in part to the impact of the COVID-19 pandemic, but noticeably through further improvements in Combined Heat and Power (CHP) availability and significant Capital investment in:-

- LED lighting (now 75% of all lighting within the Trust is by LED).
- Further installation of modern energy efficient and compliant air conditioning plant.
- Improvements to insulation, energy management controls and optimisation of the CHP waste heat recovery that currently heats 87% of the Trust’s hot water needs.

Also, the solar PV generation from the 2 arrays on Podium and Energy Centre roofs, that was installed in 2019, has to date generated over 567,000 Kwh of electricity on the UHNT site (enough to power 157 domestic houses for a year).

The continued efforts of the extended programme have been a success and made very real and identifiable savings, most notably in terms of cost avoidance (£12m over 10 years) due to site rationalisation, tax exemptions, driving down energy consumption and promoting investment in the infrastructure to secure future savings. This will continue forward into the next phase with the establishment of the Sustainable Development Management Group.

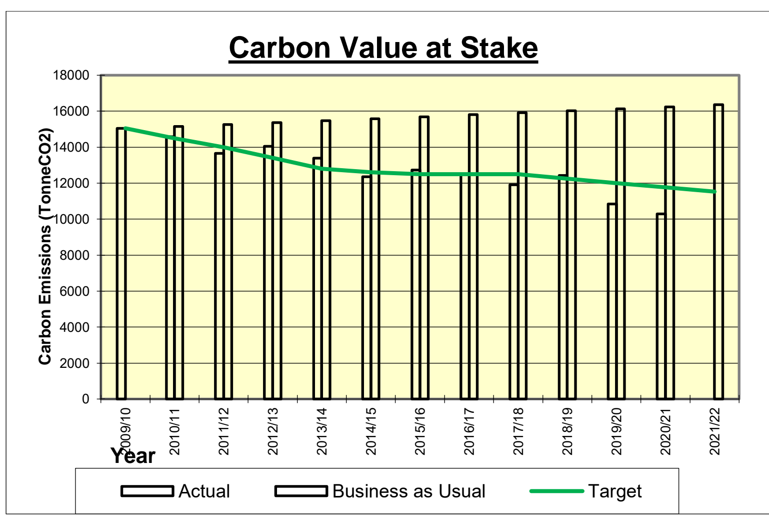
NTH Solutions spent £1.57m on Gas & Electric during 2020/21 on behalf of the Trust. This is a reduction on 2019/20 (£1.61m); undoubtedly due to the COVID-19 pandemic and the initial lockdown in Apr/May 2020. Exemption from a significant element of the ever increasing Climate Change Levy has realised avoidance of some £60,000 of additional charges.

During 2020/21, the Total Steam Demand increased by 1.8% following a colder winter (increase was limited by in year improvements), while the Total Electric Demand reduced by some 4.5%.

From 1 Apr 2020, the Trust has purchased 100% green electricity for all imported electricity. This was mandated for all public bodies to be able to record zero-carbon for their electrical imports.

Carbon Emissions (2020/21)

Carbon emissions overall have reduced from 10,961 tonnes of CO_2 in 2019/20 to 10,292 tonnes of CO_2.



Key Achievements

During 2020/21, North Tees and Hartlepool Solutions LLP have achieved the following:

Catering:

- As a result of COVID outbreaks in the department, we have had occasions when up to 28 staff have been off at any one time. The facilities team have all pulled together in order to safely manage the service and ensure patients nutrition and hydration are always satisfied at the frequencies and standards set out.
- A total of 35,890 patient meals were served during the month of December. This notes an increase of 6,284 meals when compared to the number served in November.
- Catering have continued to support the additional areas opened as being red-zones during the Covid 19 pandemic.

CSSD:

- Endoscopy model changed, adding lists that are additional to University Hospital of Hartlepool with additional transport, as well as supporting the endoscopy work carried out at the Nuffield of which Sterile Services provided a service of scope decontamination and delivery/collection to the site in order to support our endoscopy teams at North Tees.
- The COVID outbreak in the last year resulted in reduced operating lists across the trust. Due to this, the CSSD and Endoscope Decontamination Units supported other areas within NTH Solutions with staff returning to roles within Catering, Portering, Domestics and Ward Hostesses.
- Other staff completed touch point and department cleans, hand gel top ups, supplies deliveries, PPE recording, collecting and delivering.
- They also supported by transporting equipment to and from Nuffield and Hartlepool hospitals as the trust continuously changed strategy to cope with the implications of the virus.
- The reduced theatre activity/opening hours led to a dip, on occasions, in CSSD performance due to the inability to despatch processed items to the relevant departments.

Domestic & Linen Services

- The NHS Estates Team at NHS England and NHS Improvement (NHSE/I) shared some guidance in respect of the types of costs for which suppliers could seek to reclaim additional funding due to the Covid pandemic. One such cost was linen and laundry to support the COVID-19 guidance issued by the Finance Team at NHSE/I. NHS trusts were required to agree costs applicable to their organisation at a local level with suppliers. The methodology supplied suggests that Trusts consider agreeing costs in line with a schedule. They also indicate there are far lower costs for the period to September, which

can be agreed locally. Trusts were asked to note that Elis has agreed to withdraw the costs for additional costs on premises delivery and additional transport costs. They advised that Trusts would need to ensure that any amounts already invoiced and/or paid for relating to these two elements are credited unless site-specific costs can be identified. The LLP has facilitated the discussions with regard to this matter.

- Domestic services have continued to support the additional requests in opening and changing areas as required in line with red and green COVID-19 areas including ward moves/changes.

- The medical equipment team has supported ongoing pressures in relation to the appropriate and timely discharge of patients via Occupational Therapy team, beds, mattresses, seating and lifting equipment that has not been available from its current contract provider. The opportunity to provide this equipment has afforded the LLP the opportunity to review the requirements of the service and explore options of providing an improved service, which will better meet the needs of the service.

- It was escalated that the accommodation provided by the LLP on behalf of the trust is regularly completely full and the LLP are often having to turn away custom. The reason for the escalation was because, it is often junior doctors and occasionally consultants making the requests, therefore there was a risk that rotations may not be filled due to not having no accommodation available.

- The LLP managed the additional domestic support being provided to the wards to reduce risk of cross contamination. Providing touch point cleaning and additional toilet cleaning 1-2 hourly. The LLP continued to see significant pressures across Domestic Services due to the sheer volume of COVID environmental cleans required.

- Significant pressures in order to meet the KPI's set out in the SLA simply due to the COVID impact on workforce - in terms of depleting it. The additional agency staff brought in to provide the extra cleaning proved challenging but has been effective, the challenge was to maintain the standards and safely manage the additional staff required to bring on to site, safely and train them accordingly again we expect to continue to reap the benefits for patients now and in the future.

- Worked on a service review document in relation to adding permanent domestic cover to each ward, which will see an additional 6 hours minimum introduced to each ward. The expectation is that this will also significantly reduce risk of cross contamination and will increase the numbers of toilet cleans in all wards areas.

Environmental Services

Since recruiting to the Environmental Services Managers post, several improvements have been identified and implemented:

- The Trust have now terminated the clinical waste contract they had with Mitie as part of the North East and Cumbria Clinical Waste Consortium and are getting better value for money elsewhere.
- There has been an overall decrease in waste by 8% in 2020/21.

- An increase in clinical waste of 35% for 2020/2021 compared to the previous year, due to the Covid 19 pandemic.

- There has been a decrease in domestic waste, as waste was directed from domestic to clinical due to pandemic and we activity looked at what was going into the skips and who was putting it in order to reduce waste and reuse items.

- A decrease in overall recyclable waste of 2% for 2020 / 2021 compared to the previous year. The decrease is due to the reduction of confidential waste. (Although 14.08% of all domestic waste is recycled which nearly double the 7.98% figure of last year). There is a decrease in confidential waste from 231 to 175 tonnes (56 tonnes or 24%), possibly due to Covid 19, as this stream is recycled the decrease does reduce the overall recycling percentage.

- Offensive waste is included with the domestic figures, it is mixed with domestic for waste to energy incineration, so difficult to quantify. The use of tiger stripe bags have been introduced, with training sessions provided to support the changes.

Estates

- Construction Industry Scheme (CIS) – NTHS facilitated the completion and submission of the monthly CIS return to HMRC.

- Facilitated discussions with NHSI to provide new Vacuum Insulated Evaporator (VIE) for the University Hospital of Hartlepool to re-establish business as usual on this site.

- An external audit of estates control of contractors has been undertaken. The LLP currently used the RESET certification scheme, which has a number of key tools to help provide the Trust with the reassurance that all contractors who are working on this site are fully competent and safe to fulfil the work we require them to do. In order for a contractor to obtain a badge and be allowed on site, they firstly have to go through a strict vetting process, which both the LLP and RESET certification have to approve. Without this the contractor, is not allowed to work for the LLP / Trust. There are over 25 Trusts with 300 NHS sites that currently use Reset to help them check the competency of contractor companies and individuals coming to work on the Trust estates. The number of contractor log-ins show that the LLP/ Trust has risen from third to first in the league table. Even discounting the log-in activities through the UHNT A&E Covid Alterations Works Area (temporary) touchscreen the LLP/Trust still records, by some distance, the highest number (4,681) of contractor log-ins in this period.

- Grace Dental – A renewed licence agreement for Grace Dental came into effect on 1st June 2020, for a period of 8 years. The licence provides Grace Dental with an additional two exam rooms to their existing demise and secures an additional c£10k per annum for the Trust, to be reviewed each year and inflated in line with the retail price index.

- Hartlepool Borough Council – Hartlepool Borough Council increased their occupation on the UHH site, for further integration of the Single Point of Access services provided by the Trust and Local Authority. The lease came into effect from 24th January 2020, and secured an additional c£20k income for the Trust per annum from 1st September 2019.

- Former Rainbow Nursery, UHH, the Northern Education Trust approached the Trust to obtain a 12-month extension to their lease. The LLP have delayed issuing a longer lease, due to the Hartlepool GP scheme, which remains an aspiration. There has been no progress during the last year and the timescales to establish the scheme would exceed 12 months. We proposed that we offer a further 12 months lease on the same terms as the existing lease, with the ability to break the lease on 6 months' notice, save for a 3% uplift in rent, to £37,600 per annum.

- Radon Assessment at Peterlee Hospital: NTH Solutions worked closely with the Trust's Radiation Protection Advisor (RPA) and the Trust's Radiology Department to install radon monitors in March 2020. The radon monitor readings were reviewed by the RPA and a report was issued to the Trust Radiology Manager. The report summary confirmed that the results indicate that the Regulations are unlikely to apply in these areas with respect to radon. Consequently, there is no need for radon controls.

- The LLP secured circa £79k of savings against the Trust's business rates bills for Peterlee Community Health Centre, Lawson Street Health Centre and One Life Hartlepool, for the current ratings list, which covers April 2017 through to March 2023.

- Display Energy Certificates have been produced for both Trust sites. North Tees has stayed within the green C-band improving from C-75 to C-66 over the past 12 months. This will be in part due to the new Energy Centre coming online, but will also include the drop in resource used and reduced intensity of service during the first wave of COVID-19. Hartlepool Hospital has also stayed with green C-band but changed from C-58 up to C-67, affected by poor periods of CHP availability as the engine approaches the end of its service life. The Middlefield Centre has stayed within the yellow D-band classed as an office building, improving from D-83 to D-82. Peterlee CH has also stayed within the yellow D-band and is classed as a Health Centre, improving from D-95 to D-93.

- Phase 1 of the A&E development was handed over to the Trust on Monday 7 December 2020. The projects were developed quickly in close collaboration with the Trust A&E team and was completed to the planned programme and under budget. The whole project has been fast tracked to provide the Trust with an expanded A&E estate providing a single entrance for Urgent and Emergency Care as well as an additional 16 consult/examination rooms prior to winter pressures commencing. This project traditionally, should have taken 16 months to complete, but was completed in 6 months.

- A & E expanded by 700 Square metres, there was a requirement for additional domestic services 24/7 - contract variation raised.

- Highlighted situation whereby wards / departments were changing the use of a room, out of operational necessity, but without a full understanding of the potential resulting consequences. An example of this is ward 32 who were using its large disabled shower / WC situated to end of the ward, to store equipment. This poses an increased risk of legionella due to the taps not being able to be run. Together with the increased fire risk due to the room not being equipped with fire doors or smoke detectors. Request made that briefing be delivered at the Heads of Nursing meeting to explain the issues and agree how these risks can be better controlled / managed.

- The redecoration programme has made a significant impact on improving the image of the Trust estates over the first 3 quarters. However, the £150K funding for the additional decorators will end at the end of March and we will drop back down to 2 decorators. The concern is that all the wins achieved to improve the image of the estate, in high activity areas, will be undone in 3-6 months in our busy buildings. The Trust agreed to fund this permanently (£102k recurrently from 21/22).

Health and Safety / Fire

Health and Safety

- 95 PK6 Observational health and safety inspections for individual areas covering general health and safety and the production of summary reports for the Health, Safety and Security Committee;
- 86 PK3 Fire safety inspections for individual areas and the production of summary reports for the Health, Safety and Security Committee;
- 69 PK7 Waste compliance inspections for individual areas and the production of summary reports for the Health, Safety and Security Committee;
- 158 Covid Environmental Safety risk assessments. Conducted by the team, initially in all areas then continued in communal areas across the hospital sites;
- Audits for Containment level 3 pathogen processing in Pathology;
- Asbestos and Legionella safety management audits carried out;
- 6 Union walkabout inspections, continuing monthly;
- Communication of 124 CAS alerts with collation of responses and sign off where applicable;
- Production and monitoring of quarterly and bi-monthly non-clinical incident reports for Health, Safety and Security Committee and Health, Safety and Welfare Committee;
- Production and monitoring of quarterly risk reports for Health, Safety and Security Committee and Health, Safety and Welfare Committee;
- Production and monitoring quarterly safer sharps compliance reports for individual Care Groups and the Medical Devices Committee.
- Conflict resolution training continues to be delivered to front line staff to identify and de-escalate potential violent situations.
- Statutory / Mandatory training has been continued to be delivered for Fire and Waste’
- 16 fire warden sessions were delivered and 127 staff trained.

Fire Safety

In the recent Authorising Engineer annual report received, the following was noted:

- Good progress has been made across the North Tees & Hartlepool NHS Foundation Trust bearing in mind that the Trust has been under extremely trying circumstances due to the Covid$_{19}$ pandemic. However, there were areas within this report where improvement measures are recommended to enhance the current arrangements.

- The AE advised from the evidence assessed, it is clear that fire safety is taken seriously by the Trust and the LLP with appropriate actions taken when required. A number of recommendations from last year's report (May 2020) have been actioned, the 2021 report has now been received and an action plan is being developed to accommodate any outstanding actions and those identified from the 2021 report which is to go to the LLP Board.

- Strategically there remains an effective management structure in place and responsibilities have been assigned appropriately, together with appropriate governance arrangements. It is understood that, for Assurance and Governance purposes, the Chief Nurse is the Trust Board member responsible for Fire. All fire issues are reported through the Master Service Agreement Trust Steering Group and via the Health and Safety Committee meetings.

- Where possible the Trust and the LLP is striving to achieve standards as set out within HTM guides and where this is not possible, it aims to achieve a suitable compromise. This can prove challenging with ageing assets that do not fully comply with relevant HTM guides.

- Overall, the standard of the strategies, policies and procedures reviewed were of a good quality, albeit that some are under review.

- Significant investment continues to be allocated to fire safety systems in the form of replacement fire systems, Fire evacuation lifts and compartmentation. This demonstrates that the Trust and the LLP takes the responsibility of keeping staff and patients safe from fire seriously and is of a high priority.

- The report recommended additional Fire Safety Advisor resources be provided to support the current 0.6WTE resource currently in place. Trust agreed fixed term 15 hour post for 18 months.

- A Management of Fire Safety Policy has been produced covering all properties within the Trust and has recently been reviewed and is awaiting publication on to the trusts intra net site. The 'Fire Strategy University Hospital of North Tees' is a useful document but is in need of a review and at such time it is advised that this is expanded across all areas of the Trust

- Work continues to be carried out with regard to forward planning for reducing backlog maintenance with fire safety taking a significant role. This plan covers a five-year period and the Trust to date is in year 3. The replacement of the fire alarm system at Hartlepool has recently commenced and is expected to continue for the next year.

- A letter was received, from Cleveland Fire Brigade, indicating that with effect from 1 April 2021, a new charge of £340 plus VAT would be implemented, every time the Fire Brigade attended the Trust for an unwanted alarm. The charge will take effect following receipt of the fifth automatic fire alarm, in a 12-month rolling period. Once the new alarm system is up and running we will have

38 panels so technically they should be counting each panel separately as it is classed as a panel per site in normal circumstances, so this should also reduce the numbers and costs. As the installation progresses, there will be new detector heads in all rooms to meet a BS 5839 Pt 1, L1 standard, as well as those comprising the existing system. As has happened at UHNT, the new system detectors are likely to be provided with dust covers to distinguish them from those on the existing system; until such times that, the replacement system is tested and commissioned. The LLP have asked the Brigade if they could share this information with their colleagues, especially those on the Flexi – duty system, as we are keen to alleviate CFB needing to attend and check when an 'anonymous' source reports that our detector heads are covered up, as has happened twice during the project at UHNT.

- The LLP have informed the Fire Brigade that switchover to the replacement system at UHNT is imminent and that more information will follow, as there are some distinct differences from the existing system. The LLP have asked if it would be possible to have a period of grace extended to ourselves during the switchover period (up to 3 days) for a short time afterwards to allow for any teething issues. The Brigade have indicated they will certainly circulate the information with operational staff most likely through a fire alert, which will ensure the message gets across. With regards to the switchover of systems at UHNT, the Fire Brigade are happy to provide a period of grace, They have suggested a fortnight should be sufficient, however, if during that time we identify issues that may go unsolved beyond that timescale we can liaise further with the department. They have asked that we provide an accurate date of the commencement of switchover so the process can be managed appropriately.

Portering:

- The department continued to support the Trust with additional requests for patient discharges by way of providing drivers and vehicles due to the pressures on social distancing in ambulances etc. NTHS were also supported kindly with volunteers from Middlesbrough College, Redhouse School and the use of the Butterwick Hospice vehicle.
- Portering and Transport have continued to support the additional areas opened as being red-zones during the Covid 19 pandemic.

Security

- Issued safe Park-Mark Award this ensures continuous high standards are maintained in the car parks which are assessed every year;
- All incidents of physical assault on staff were investigated; this included providing support towards the staff and also established which of the assaults were intentional and required subsequent police involvement;
- Security information and advice is an item on the Health, Safety and Security Committee where security issues across the Trust are discussed;
- Continue to publicise the Trust's / LLP's approach to security management through displaying various posters in public areas around the Trust;
- Continue to send out letters to perpetrators of unacceptable behaviour;

- Security officers Issued with Body Worn Camera's (BWC). Eight Body Worn Cameras issued to the security officers the benefits being. Assisting security personnel in their duties concerning evidence gathering in the event of any security incident. Assisting in the prevention and detection of crime (and the fear of crime) against persons and property. Enabling the identification and subsequent apprehension (and prosecution) of offenders, in relation to any crimes actually committed. Helping to ensure the security of property belonging to the Trust or, their patient's employees and visitors;

- Seventeen new CCTV cameras installed around the hospital site at North Tees these included a camera in each lift;

- Proximity access control (PAC) and a time profile to engage and disengage during 6pm – 08:00 were fitted to floor 4 at Hartlepool to prevent access to the main corridor and ensure no unauthorised entry outside normal working hours leading to the SPA;

- All local alerts were disseminated where necessary to provide staff with important information regarding potentially violent patients and members of the public;

- Conflict resolution training continues to be delivered to front line staff to identify and de-escalate potential violent situations;

- All staff are encouraged to report all security related incidents via the Trusts/LLP's incident report system (DATIX). The analysis of incidents is presented to the Health, Safety and Security Committee to identify trends, develop preventative measures and share any lessons learned;

- Partnership working is continuing with the police, local authorities and neighbouring Trusts to share information about repeat and potential offenders.

Procurement

The Procurement department have introduced several new processes in order to achieve efficiencies within the Trust, including:

- Development of an electronic workflow based process for the approval of Single Tender Action (SFI Waiver) requests.

- Standards of Procurement Level 1 – reaccreditation. The team are about to undertake a Peer review for reaccreditation on the 21st July 2021. Once this has been successfully achieved the work will begin to gain Level 2, improving the Trust ranking within the Model Hospital league table and also providing greater assurance that the service is effective, efficient and following best practice within the industry.

Members of the Procurement department regularly attend regional NHS Heads of Procurement meetings, collaborating where possible to achieve cashable savings and/or process efficiencies.

Further to this, there is currently a considerable amount of work going into collaborative opportunities for procurement within the South ICP. Examples of on-going collaboration include the regional Pathology Network (Blood Sciences and Point of Care Testing), regional Trauma Contract, regional lower limb in conjunction with Category Towers, Enteral Feeds (NTHS Lead) and Sharps Disposal Bins (NTHS lead). The department are also undertaking a review of existing strategy, policy and operating procedures in line with the Chartered Institute of Procurement and Supply guidance and best practice, in order to make improvements and drive transformational change within the function. These Collaborative opportunities are still ongoing.

The department has completed a review of existing strategy, policy and operating procedures in line with the Chartered Institute of Procurement and Supply guidance and best practice, in order to make improvements and drive transformational change within the function. The revised documentation is awaiting approval via the MSA Steering Group.

Conclusion / Summary

The LLP has continued to provide a safe, patient-centred, efficient and effective estate, with a record of achievement and a culture that strives for and delivers continuous improvement. Benchmarking undertaken nationally on behalf of Lord Carter against all other small/medium size Trusts provides assurance that our Estate and Facilities services was ranked as 50th place nationally out of 223 Trusts compared to last year which was 54th out of 227 for the estates and facilities services that are provided by the LLP. This is a significant indicator demonstrating that the LLP is delivering good value for money for the Trust, meaning the service the Trust receives is one of the most cost efficient and safe estates and facilities service in the UK.

Recommendations

The Board is requested to receive this report and note the work undertaken in 2020/21 to support patient services across the Trust Estate.

Board of Directors

Title of report:	Health, Safety & Security Annual Report							
Date:	29 July 2021							
Prepared by:	Zara McCulloch, Health and Safety Manager							
Executive sponsor:	Sharon Mee, Assistant Director (Governance & Compliance)							
Purpose of the report	This purpose of the report is to provide information to the Board of Directors on Health, Safety and Security Annual Performance for 2020/21							
Action required:	Approve		Assurance	X	Discuss		Information	X
Strategic Objectives supported by this paper:	Putting our Population First	X	Valuing our People	X	Transforming our Services	X	Health and Wellbeing	X

Which CQC Standards apply to this report	Safe	X	Caring	X	Effective	X	Responsive	X	Well Led	X

Executive Summary and the key issues for consideration/ decision:

The report is for information and details performance over the financial year 2020/21 as well as key achievements, key issues / future activity for 2021/22.

Key Issues:

- 26 RIDDOR incidents reported;
- 141 physical assaults on staff – 12% involved the police;
- 62 fire alarm incidents reported – 2 actual fire and 60 unwanted alarms;
- 26% increase in clinical waste, 22% decrease in domestic waste and 2% decrease in recyclable waste;
- 124 safety alerts disseminated and reported via MHRA site;
- 411 Inspections covering a number of different disciplines carried out.
- 16 fire warden sessions delivered training 127 fire wardens

How this report impacts on current risks or highlights new risks:

This report does not raise any new risks that the Trust and LLP are not aware of.

Committees/groups where this item has been discussed	Health, Safety & Security Committee - 20/07/2021 LLP Management Board - 22/7/21
Recommendation	The Board of Directors is asked to note the content of the annual report.

Health, Safety & Security Annual Report

FINANCIAL YEAR 2020 / 2021

Presented: 05/07/2021

Reporting period:	FY2020/21
Author:	Zara McCulloch: Health & Safety Manager
Agreed by:	Sharon Mee: Assistant Director Governance & Compliance

The figures and % in this analysis report have been compiled from the data collated from the Trusts' DATIX incident reporting systems and are reflective of the number of actual incidents which occurred during the period: 01-04-2020 to 31-03-2021. It should be noted that the information recorded in Bimonthly and quarterly reports is compiled by incident reported date and not on actual date of incident and therefore discrepancies in reports is likely.

Contents: **Page:**

1.	Introduction	3
2.	Performance 2020/21	3
3.	Key Achievements 2020/2021	15
4.	Key Issues / Future Activity 2021/2022	16
5.	Recommendations	18

1. Introduction

The Health, Safety & Security remit covers the following areas:

- Non-Clinical Risk Management
- Health & Safety
- Fire Safety
- Waste Management
- Central Alerting System (CAS)
- Security Management (LSMS)

North Tees and Hartlepool Solutions LLP is a subsidiary of North Tees & Hartlepool NHS foundation Trust and supplies Health, Safety and Security advice and support under a Master Services Agreement to the Trust.

As with all support services the LLP's aim is to ensure that, our activities support the Trust's and the LLP's strategic aims and objectives,

To achieve this, the LLP aim to operate a lean, performance-focused organisation that thrives on change and provides:

- Good patient care through safe, modern high quality health services
- Efficient services, by recognising that waste in one area compromises patient care in another
- Good place to work, being a good employer working together and valuing people
- Education and training, to enable staff to deliver individual, professional, team and organisational objectives

It is essential that the aims and objectives to effectively manage health and safety and non-clinical risk are integrated into the Trust's and the LLP's day to day operational and annual planning processes. Effective risk management will minimise incidents, reducing sickness absence and litigation costs and the risk of potential prosecution. With this in mind, all Care Groups and departments should utilise this report and consider future health and safety performance information to inform their own planning processes to ensure this integration and demonstrate ownership and management of associated risks.

2. Performance 2020/21

The following key performance indicators are part of the Master Services Agreement with the Trust, the tables overleaf indicates performance through 2020-21.

2.1 Trust Master Service Agreement Indicators 2020-21

Key Performance Indicators

	Indicator	Performance Output Range			Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
		Green	Amber	Red	Actual											
1	Actual Fire Alarm - Fire Brigade attended per month < 1	<1	1-4	>5	1	0	0	0	0	0	0	0	0	0	1	0
2	Unwanted (False) Fire Alarm - Fire Brigade attended per month < 2	<2	3-4	>5	2	0	0	0	0	1	0	0	0	0	0	0
3	Unwanted (False) Fire Alarm - NIL Brigade attendance per month < 2	<2	3-4	>5	0	1	3	5	5	1	9	4	7	4	5	10
4	Number of Physical Assault (Malicious) on employees per month < 5	<5	6-8	>9	2	0	2	2	6	9	0	1	3	6	0	2
5	Number of Physical Assaults (Unintentional) on employees per month < 12	<12	13-20	>21	4	1	4	17	2	8	9	6	7	11	8	15
6	Number of RIDDOR incidents per month < 3	<3	3-5	>6	1	2	1	2	1	2	4	2	1	4	2	4
7.	Number of Enforcement Notices (All)	0	1	>2	0	0	0	0	0	0	0	0	0	0	0	0
8.	Number of Health and Safety Inspections (Internal)	>/=20	14-19	<13	0	0	115	10	14	16	53	73	48	36	41	43
9.	Number of High / Moderate risks with no action plan	0	1-2	>3	n/a	n/a	n/a	n/a	35	1	1	0	0	0	0	0
11.	Number of out of date risks	0	1-10	>11	n/a	n/a	n/a	n/a	54	15	13	0	0	0	0	0

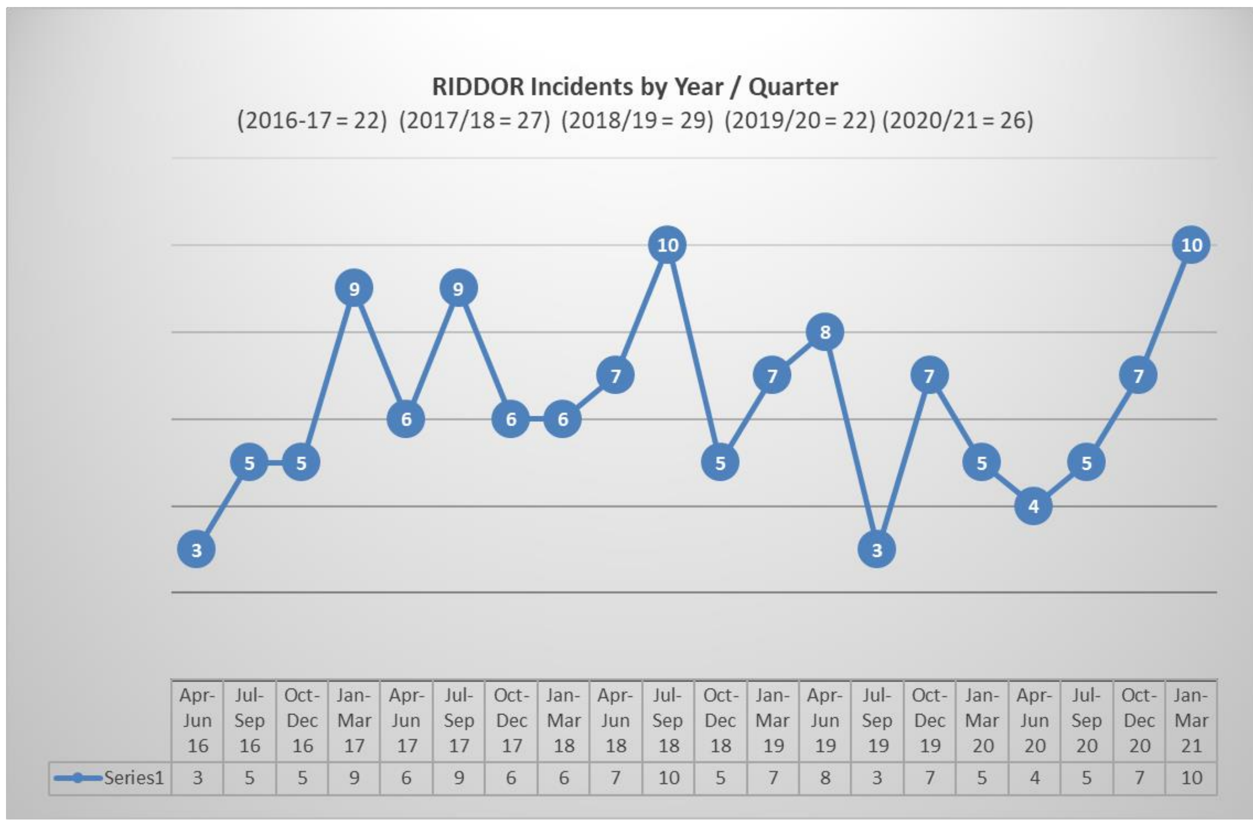
2.2 North Tees & Hartlepool Solutions Performance Indicators

Performance indicators have been developed for the Health and Safety service as a whole. Performance is shown in the below detailed key areas.
RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations)
Reportable incidents
Inspections
Enforcement Notices
Physical assault against staff incidents Malicious & unintentional
Fire : Actual Fire Alarm - Fire Brigade attended, Unwanted (False) Fire Alarm - Fire Brigade attended, Unwanted (False) Fire Alarm - NIL Brigade attendance
Waste
Sharps
Central Alerting System compliance statistics
Number of high/ moderate risks and number of out of date risks.

2.2.1 RIDDOR Reportable Incidents

A total of 26 RIDDOR reportable incidents occurred during 2020-21 compared to 22 reported in 2019/20 which is an 18% increase in RIDDOR reportable incidents since the previous year.

Table 1



	Apr-Jun 16	Jul-Sep 16	Oct-Dec 16	Jan-Mar 17	Apr-Jun 17	Jul-Sep 17	Oct-Dec 17	Jan-Mar 18	Apr-Jun 18	Jul-Sep 18	Oct-Dec 18	Jan-Mar 19	Apr-Jun 19	Jul-Sep 19	Oct-Dec 19	Jan-Mar 20	Apr-Jun 20	Jul-Sep 20	Oct-Dec 20	Jan-Mar 21
Series1	3	5	5	9	6	9	6	6	7	10	5	7	8	3	7	5	4	5	7	10

The key specific hazards and areas of risk causing concern are those that result in adverse incidents, particularly RIDDOR reportable incidents resulting in work related sickness absence, those being, slips trip and falls including collisions (8), lifting incidents (12), trap or struck incidents (3), scalding incidents (1), physical abuse incidents (1) and use of PPE incidents (1). Of the 26 reported incidents

20 were in the over 7-day category for reporting and the remanding 6 were in the specified injury category for reporting.

Cost of RIDDOR Accidents

Total Number of Employee Days Lost (Time off due to Incidents at Work)

There have been a total of 241 lost days due to RIDDOR accidents at work shared between 17 employees. This is **483** days less compared to the previous year of 2019-20 (724).

Total Cost to Trust of Injuries from Work
Formula = days lost x hours' x cost per hour
Total cost of days lost due to accidents = **£31,591.22**

A study undertaken by the HSE showed that indirect and hidden costs could be a minimum of 8 times or a maximum of 36 times greater than the direct cost of an accident or disease and that in reality the direct cost is represented by the tip of the Accident Iceberg compared to the overall cost, shown in the figure below.

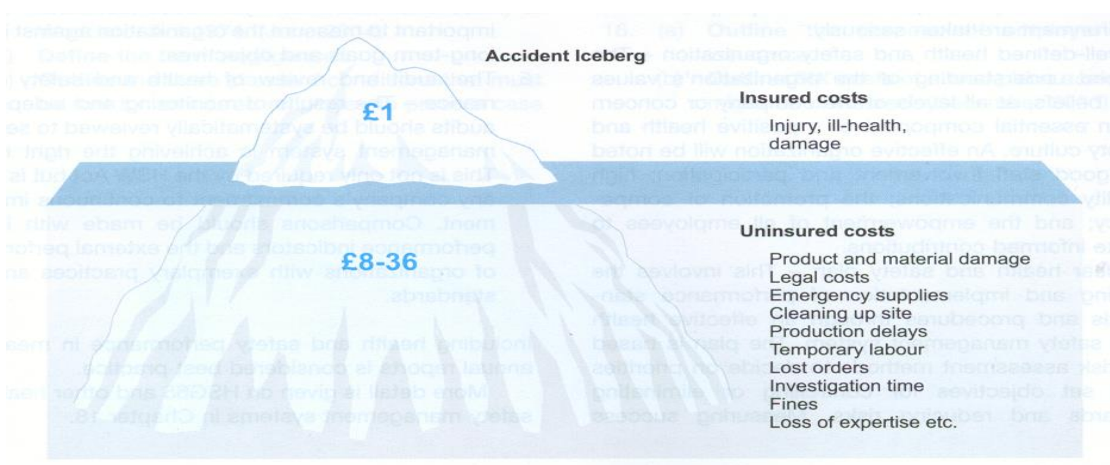


Figure 1 Iceberg model

Based on this equation, the calculated hidden cost accrued by the Trust for RIDDOR reportable accidents, equates to ***£252,729.76*** **(*as a minimum*) and *£1,137,283.92* (*as a maximum*).**

These figures are for accidents, which occurred within the financial year of 2020 – 21.

2.2.2 Security

The Accredited Local Security Management Specialist (ALSMS) works for North Tees and Hartlepool Solutions (LLP) and provides a service to North Tees and Hartlepool NHS Foundation Trust.

The LSMS is responsible for:

- Policy and operation matters to do with security and creating a standard framework across the NHS;

- Promoting the security culture within the organisation and ensuring that there are systems and processes in place for deterrence for example sending out letters to perpetrators of unacceptable behaviour as well as ensuring the prevention and detection of crime. If crime does occur then the LSMS also makes sure investigations are carried out and sanctions are taken against offenders. This involves partnership working with the police and via keeping people safe.

- Specific areas of work
  - Violence and Aggression;
  - Assets and damage to property (Crime Prevention Survey's and loss of assets);
  - Prescriptions and Hazardous materials (e.g. Controlled drug destruction in conjunction with Pharmacy);
  - Single point of contract between Multi-Agency Public Projection Arrangements (MAPPA) and Clinical Site Managers / Trust

2.2.3 Incidents of Physical Assault against Staff

North Tees and Hartlepool NHS Foundation Trust and North Tees and Hartlepool NHS Solutions continue to regard Violence and Aggression towards staff as a primary priority area for action. The LSMS reviews reported incidents of violence and aggression against staff and carries out an investigation to establish the cause, and where necessary, which sanctions, if any, should be considered.

Some of the incidents reported in these categories include assault towards others such as, patient on patient or visitor to patient. These incidents are reported to the police when deemed necessary.

A total of 141 physical assaults on staff by patients or visitors were reported onto Datix during the year April 2020 to March 2021, compared to 118 the previous year, an increase of 19%. Of the reported physical assaults 136 occurred within North Tees, and 5 in the community.

Of the reported incidents of physical assault 11 required medical treatment first aid/attendance at A&E/Urgent care and 129 resulted in no injury, minor pain/bruising/scratches. One assault was reported to the HSE as in accordance with RIDDOR regulation. The range of staff assaults are evidenced in Table 2 below.

Table 2

Type of Physical Assault on staff	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Punch / thump	3	15	3	15
Slap	2	2	1	0
Kick	2	7	4	8
Grab	2	3	8	10
Push	0	5	3	0
Weapon / Object	2	4	1	4
nip/pinch	0	0	0	0
Spit	2	3	0	1
Scratch	1	7	1	5
Head butt	0	0	2	0
Bite	0	1	2	4
Elbow / Knee	0	1	0	0
hair pulled	1	1	2	0
strangled	1	1	1	0
Total	**16**	**50**	**28**	**47**

The Care Group where these occurred is evidenced in Table 3. The exact location is evidenced in Table 4. The assaults affected both Trust and LLP staff.

Table 3

Care Group locations	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total
Care Group 1	1	2	0	4	7
Care Group 2	14	43	20	38	115
Care Group 3	1	5	**8**	5	19
Total	**16**	**50**	**28**	**47**	**141**

Table 4

Location	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL
Ward 27	3				1	7				8		5	**24**
A&E	2			3	1	2	2	1		1		6	**18**
Ward 40			3	5			3	1	2			2	**16**
Ward 26			2	2	1	3		1			2	2	**13**
Acute Cardiology Unit					7		2		1				**10**
ITU / Critical Care			1			3			2			1	**7**
EAU / Ambulatory Care (EAU)	1			2				1	1		2		**7**
Ward 41		1	1	5									**7**
Ward 24									1	5		1	**7**
Ward 36 - SSU short stay unit				1					2	3			**6**
Ward 33								3			2		**5**
Ward 32						2	1		2				**5**
Ward 42				2	1			1	1				**5**
patient own home			1		1							1	**3**
Ward 38			1									1	**2**
Paediatric OPD											1	1	**2**
Ward 28											2		**2**
Out of Hospital Care - Dentistry					1								**1**
Tithbarn house											1		**1**
MONTH TOTAL	**6**	**1**	**9**	**20**	**13**	**17**	**8**	**8**	**12**	**17**	**10**	**20**	**141**

It should be noted that the majority are non-intentional and are caused by the patient's medical condition. It is important to note that out of 141 assaults it was necessary to involve the police with 17 incidents of which 15 were in the malicious category and two in the unintentional category. (See Table 5).

Table 5

Physical Assaults on staff reported to Police	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total
Unintentional	12	34	**22**	40	108
Malicious Intention	4	16	**6**	7	33
Reported to Police	5	5	**3**	4	17
Total	**16**	**50**	**28**	**47**	**141**

Further analysis showed a high number of elderly patients responsible for the assaults throughout the hospital (28%), followed closely by those in the age range 40 – 59 (22%). (See Table 6)

Staff, are informed of their responsibility to report all violent incidents during their attendance at Trust induction, local induction and conflict resolution training. This year 22 patients have been responsible for 69 assaults; further analysis showed a 85-year-old male responsible for 7 assaults, two 88-year old male patients responsible for 4 assaults and one 70-year old patient responsible for 5 assaults. The upper age group 60 to 80+ were responsible for *49.28* % of all assaults towards staff.

Table 6

Physical Assaults on Staff by Age of Perpetrator

Qtr 1 Total = 16 Qtr 2 Total = 50 Qtr 3 Total = 28 Qtr 4 Total = 47

combined Annual Total = 141

	Age 80+	Age 70 to 79	Age 60 to 69	Age 40 to 59	Age 17 to 39	Age 2 to 16	No age submitted
Qtr 1	5	1		4	2		4
Qtr 2	14	1	5	24	3	0	3
Qtr 3	11	3	2	1	7	0	4
Qtr 4	9	15	3	3	2	2	13

The security officer's logbook reported 904 emergency responses throughout the year as detailed in Table 7 below.

Table 7

Security April-March log book Stats 2020-21

580
175
76
72
31
324

No of emergencey response bleeps
Restraint used
Police involvement
Physical Assaults (Unintentional) per month Datix
Physical Assaults (Malicious) per month Datix

2.2.4 Fire Safety

The Trust has a Service Level Agreement in place with an external Authorising Engineer (Fire) employed by Cleveland Fire Brigade Risk Management Services who acts as an independent professional adviser to the Trust & the LLP. The remit includes:

- assesses and makes recommendations for the appointment of authorised persons (Fire);
- monitors the performance of fire safety management;

- Provides an annual audit to the Board Level Director with fire safety responsibility as required by in Hospital Technical Memorandum (HTM) 05:01 Managing Healthcare Fire Safety who provides external fire safety assurance.

In the recent annual report received the following was noted. Good progress has been made across the North Tees & Hartlepool NHS Foundation Trust bearing in mind that the Trust has been under extremely trying circumstances due to the $Covid_{19}$ pandemic. However, there were areas within this report where improvement measures are recommended to enhance the current arrangements.

From the evidence assessed, it is clear that fire safety is taken seriously by the Trust and the LLP with appropriate actions taken when required. A number of recommendations from last year's report (May 2020) have been actioned, the 2021 report has now been received and an action plan is being developed to accommodate any outstanding actions and those identified from the 2021 report which is to go to the LLP Board.

Strategically there remains an effective management structure in place and responsibilities have been assigned appropriately, together with appropriate governance arrangements. It is understood that, for Assurance and Governance purposes, the Chief Nurse is the Trust Board member responsible for Fire. All fire issues are reported through the Master Service Agreement Trust Steering Group and via the Health and Safety Committee meetings.

Where possible the Trust and the LLP is striving to achieve standards as set out within HTM guides and where this is not possible, it aims to achieve a suitable compromise. This can prove challenging with ageing assets that do not fully comply with relevant HTM guides.

Overall, the standard of the strategies, policies and procedures reviewed were of a good quality, albeit that some are under review.

Significant investment continues to be allocated to fire safety systems in the form of replacement fire systems, Fire evacuation lifts and compartmentation. This demonstrates that the Trust and the LLP takes the responsibility of keeping staff and patients safe from fire seriously and is of a high priority.

A Management of Fire Safety Policy has been produced covering all properties within the Trust and has recently been reviewed and is awaiting publication on to the trusts intra net site. The 'Fire Strategy University Hospital of North Tees' is a useful document but is in need of a review and at such time it is advised that this is expanded across all areas of the Trust

Work continues to be carried out with regard to forward planning for reducing backlog maintenance with fire safety taking a significant role. This plan covers a five-year period and the Trust to date is in year 3. The replacement of the fire alarm system at Hartlepool has recently commenced and is expected to continue for the next year.

Fire Incidents

There were 62 fire alarm incidents reported during 2020/21 this is a decrease of 43% (46) incidents compared to 2019/20 (108). 66% (41) of incidents originated within the North Tees hospital site, 34% (21) at the Hartlepool site. There were 2 actual fires and 60 noted as unwanted alarms.

The Fire Service attended site on 5 occasions during this time. Table 8 below provides a comparison to previous years and the trend line of fire incidents

Table 8

2.2.5 Waste Management

Table 9 shows a breakdown of all wastes created within the Trust from 2016 to date. It shows an overall decrease in waste by 8% in 2020/21. An increase in clinical waste of 35% for 2020/2021 compared to the previous year, due to the Covid 19 pandemic.

There has been a decrease in domestic waste, as waste was directed from domestic to clinical due to pandemic and we activity looked at what was going into the skips and who was putting it in order to reduce waste and reuse items. A decrease in overall recyclable waste of 2% for 2020 / 2021 compared to the previous year.

The decrease is due to the reduction of confidential waste. (Although 14.08% of all domestic waste is recycled which nearly double the 7.98% figure of last year). There is a decrease in confidential waste from 231 to 175 tonnes (56 tonnes or 24%), possibly due to Covid 19, as this stream is recycled the decrease does reduce the overall recycling percentage.

Offensive waste is included with the domestic figures, it is mixed with domestic for waste to energy incineration, so difficult to quantify. The waste split produced by the Trust is 28% clinical waste and 72% domestic waste. 21% of domestic waste is recycled.

Table 9

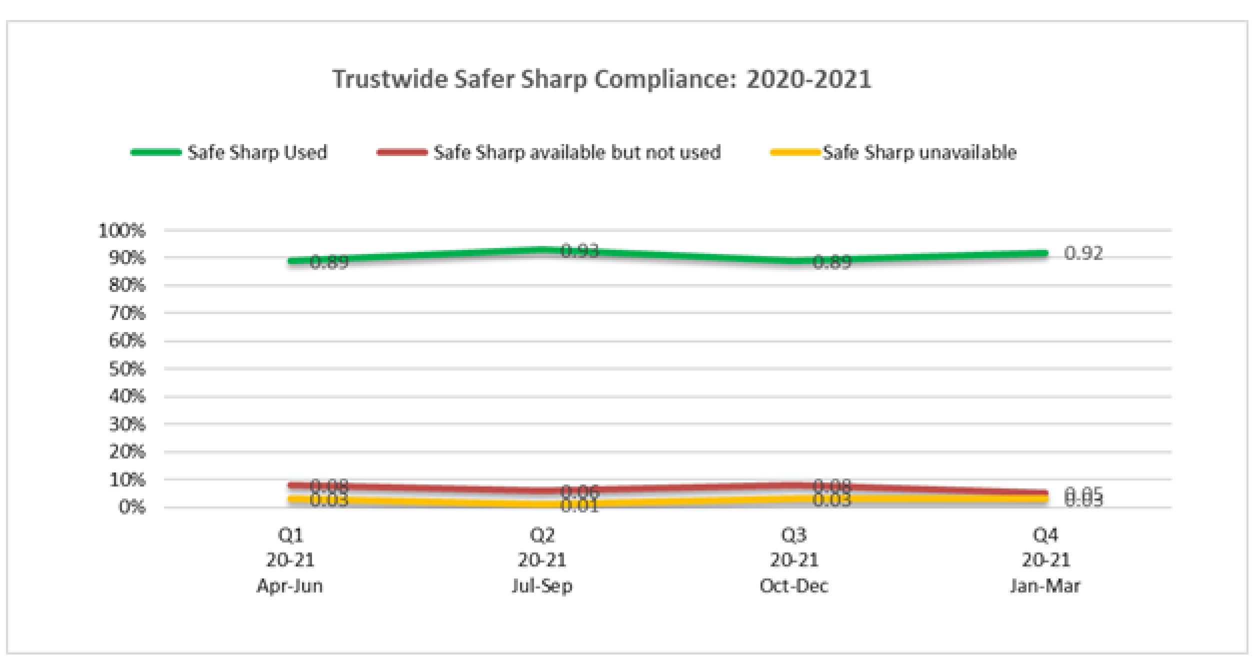
Period	Hazardous Clinical	Autoclave / waste to energy %	Inert Landfill	Waste to energy	Confidential Waste	Metal	Cardboard	Mixed Recycling	Garden Waste	WEE	Total Waste	Total % Recycling
2016/17	**378**	**76**	**64**	**819**	**275**	**12**	**51**	**0**	**0**	**39**	**1714**	**22%**
2017/18	**265**	**85**	**51**	**893**	**293**	**8**	**41**	**0**	**0**	**10**	**1646**	**21%**
2018/19												

	182	78	23	859	275	10	44	0	0	6	1477	28%
2019/20	196	107	0	951	231	14	32	18	13	5	1567	23%
2020/21	284	124	0	681	175	20	49	28	13	10	1435	21%

2.2.6 Sharps

Table 10 below gives trend analysis for sharps usage for the year, it looks at the percentage of safer sharps/unsafe sharps used. All Care Groups / areas are required to have in place an 'Unsafe Sharps Usage' Risk Assessment, if they are using unsafe sharps and are not able to follow the corporate risk assessment. The assessment identifies all / the non-compliant area(s) together with the types of unsafe sharps in use. It also clearly outlines the rational for the use of unsafe sharps.

Table 10



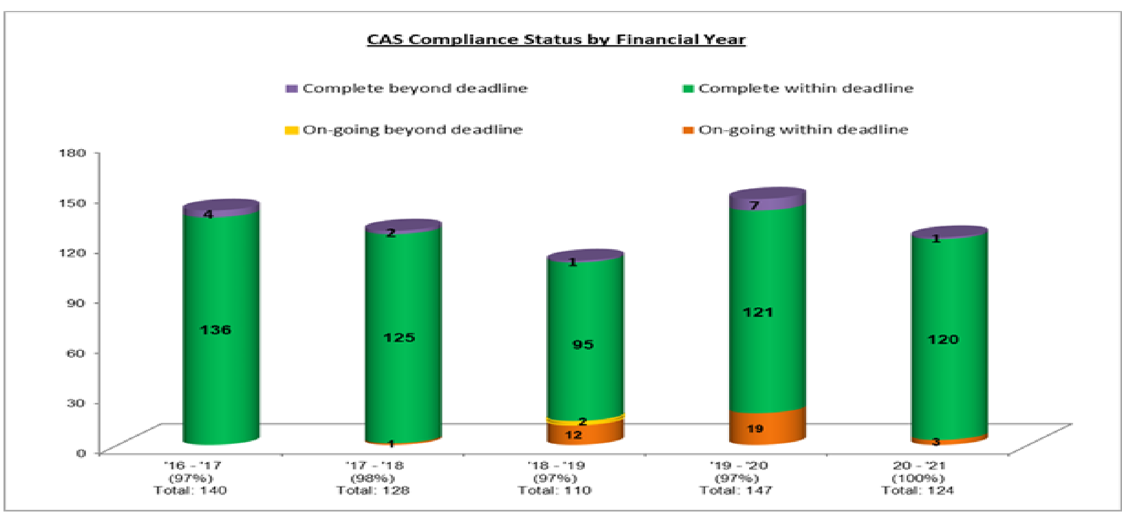
A total of 94 Sharp incidents were reported on the DATIX incident reporting system for the year. This is a 29% decrease of the previous year 2019-2020 (132).

2.2.7 Central Alerting System

The Central Alerting System (CAS) is a web based flexible IT system that creates a robust and suitable technology for distributing safety alerts and is held by the Medicines and Healthcare products Regulatory Agency which is a government site / function.

Compliance with specified action completion deadline dates for CAS alerts throughout the year is shown in Table 11.

Table 11



There were a total of 124 alerts received, 120 were completed within deadline, 3 are on-going within deadline and 1 alerts was signed off a day after the deadline but was complete on the deadline day. All information on alerts disseminated and responses received are forwarded to the relevant Committee on a monthly or quarterly basis depending on frequency of Committee. The Committee's receiving reports are:

- Patient Safety Committee
- Medical Devices Committee
- Health, Safety and Security Committee
- Health, Safety and Welfare Committee

3. Key Achievements 2020/21

Monitoring & Auditing Performance

- Premises Assurance Model audits undertaken with all relevant services to obtain assurances through self-assessment questions which support quality and safety compliance (37 audits covering 335 self-assessment criteria over 5 domains). One of the domains covers Safety and is split into Safety Hard and Safety Soft;

- 95 PK6 Observational health and safety inspections for individual areas covering general health and safety and the production of summary reports for the Health, Safety and Security Committee;

- 86 PK3 Fire safety inspections for individual areas and the production of summary reports for the Health, Safety and Security Committee;

- 69 PK7 Waste compliance inspections for individual areas and the production of summary reports for the Health, Safety and Security Committee;

- 158 Covid Environmental Safety risk assessments. Conducted by the team, initially in all areas then continued in communal areas across the hospital sites;

- Audits for Containment level 3 pathogen processing in Pathology;

- Asbestos and Legionella safety management audits carried out;

- 6 Union walkabout inspections, continuing monthly;

- Communication of 124 CAS alerts with collation of responses and sign off where applicable;

- Production and monitoring of quarterly and bi-monthly non-clinical incident reports for Health, Safety and Security Committee and Health, Safety and Welfare Committee;

- Production and monitoring of quarterly risk reports for Health, Safety and Security Committee and Health, Safety and Welfare Committee;

- Production and monitoring quarterly safer sharps compliance reports for individual Care Groups and the Medical Devices Committee;

- 16 fire warden sessions were delivered and 127 staff trained.

Security

- Issued safe Park-Mark Award this ensures continuous high standards are maintained in the car parks which are assessed every year;

- All incidents of physical assault on staff were investigated; this included providing support towards the staff and also established which of the assaults were intentional and required subsequent police involvement;

- Security information and advice is an item on the Health, Safety and Security Committee where security issues across the Trust are discussed;

- Continue to publicise the Trust's / LLP's approach to security management through displaying various posters in public areas around the Trust;

- Continue to send out letters to perpetrators of unacceptable behaviour;

- Security officers Issued with Body Worn Camera's (BWC). Eight Body Worn Cameras issued to the security officers the benefits being. Assisting security personnel in their duties concerning evidence gathering in the event of any security incident. Assisting in the prevention and detection of crime (and the fear of crime) against persons and property. Enabling the identification and subsequent apprehension (and prosecution) of offenders, in relation to any crimes actually committed. Helping to

ensure the security of property belonging to the Trust or, their patient's employees and visitors;

- Seventeen new CCTV cameras installed around the hospital site at North Tees these included a camera in each lift;

- Proximity access control (PAC) and a time profile to engage and disengage during 6pm – 08:00 were fitted to floor 4 at Hartlepool to prevent access to the main corridor and ensure no unauthorised entry outside normal working hours leading to the SPA;

- All local alerts were disseminated where necessary to provide staff with important information regarding potentially violent patients and members of the public;

- Conflict resolution training continues to be delivered to front line staff to identify and de-escalate potential violent situations;

- All staff are encouraged to report all security related incidents via the Trusts/LLP's incident report system (DATIX). The analysis of incidents is presented to the Health, Safety and Security Committee to identify trends, develop preventative measures and share any lessons learned;

- Partnership working is continuing with the police, local authorities and neighbouring Trusts to share information about repeat and potential offenders.

4. Key Issues/Future Activity

Continuous improvement in performance and service delivery is our aim and the following key issues will be progressed:

- Provide a Health and Safety Management Service to the Trust and LLP which consists of the following:
    - The provision of expert and specialist health and safety advice;
    - The provision of expert and specialist health and safety training where appropriate;
    - Implementing monitoring and measuring systems to ensure legislative compliance and progress e.g. inspections / audit;
    - Monitoring and advising on health and safety risk assessments;
    - Produce, review and develop relevant policies and procedures to ensure adequate information to staff and compliance with Regulatory Bodies, Standards requirements;
    - Develop and implement effective reporting and investigation systems for RIDDOR reportable incidents ensuring lessons are learnt and identified counter measures are effective. Participate in adverse incident investigations and assist in the monitoring of recommended outcomes where necessary;

- Monitor compliance with alert deadlines from DH Central Alerting System, overseeing the development and monitoring of systems to ensure effective reporting, cascading and feedback to the Department of Health Central Alerting System to demonstrate all required actions have been taken within deadlines;
- Provide advice and guidance to managers on risk assessment and develop processes / documentation to assist in the production of suitable and sufficient risk assessments;
- Develop and implement effective monitoring and auditing systems to measure health and safety performance at local and trust wide levels;

* The LSMS/Security Manager provides the ongoing work to ensure effective management of security issues ensuring patients, staff and visitors are safe and secure within our premises.

5. Recommendations

The Board is requested to receive this report and note the work undertaken in 2020/21 to support patient services across the Trust Estate.

Board of Directors

<table>
<tr><td>Title of report:</td><td colspan="10">Organ Donation Committee</td></tr>
<tr><td>Date:</td><td colspan="10">29 July 2021</td></tr>
<tr><td>Prepared by:</td><td colspan="10">Dr Tara Mane, Clinical Lead for Organ Donation</td></tr>
<tr><td>Executive sponsor:</td><td colspan="10">Kevin Robinson, Non-Executive Director/Chair of Organ Donation Committee</td></tr>
<tr><td>Purpose of the report</td><td colspan="10">To inform the Trust Board of Organ Donation activity April 2020 to March 2021</td></tr>
<tr><td>Action required:</td><td colspan="2">Approve</td><td>X</td><td colspan="2">Assurance</td><td>X</td><td colspan="2">Discuss</td><td></td><td>Information</td><td>X</td></tr>
<tr><td>Strategic Objectives supported by this paper:</td><td colspan="2">Putting our Population First</td><td>X</td><td colspan="2">Valuing People</td><td></td><td colspan="2">Transforming our Services</td><td></td><td>Health and Wellbeing</td><td></td></tr>
<tr><td>Which CQC Standards apply to this report</td><td>Safe</td><td>X</td><td>Caring</td><td>X</td><td>Effective</td><td>X</td><td>Responsive</td><td></td><td>Well Led</td><td></td></tr>
<tr><td colspan="11">Executive Summary and the key issues for consideration/ decision:</td></tr>
<tr><td colspan="11">Trust overall performance against standards and quality was good</td></tr>
<tr><td colspan="11">How this report impacts on current risks or highlights new risks:</td></tr>
<tr><td colspan="11">The impact of Covid will continue to have an impact on the capacity of available organs for transplantation that will save the lives of others</td></tr>
<tr><td>Committees/groups where this item has been discussed</td><td colspan="10">Quarterly reports are discussed at the Patient Safety and Quality Committee</td></tr>
<tr><td>Recommendation</td><td colspan="10">The Board of Directors is acked to note the content of the report and work will continue with the best practices for organ donation</td></tr>
</table>

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

29 July 2021

Executive Summary

Organ Donation Committee

Report of the Medical Director

1. Introduction

1.1 Detailed report attached shows the actual and potential deceased organ donation for the time period 1 April 2020 - 31 March 2021

2. Key Issues & Planned Actions

2.1 The COVID pandemic was the most difficult year for our Trust in delivering on the Organ Donation pathways

2.2 To continue with the best practices for organ donation and implement the Organ Donation and Transplantation Strategy 2030:- Meeting the Need.

2.3 To raise awareness of change of legislation from donor “opt out” to “opt in”

2.3 Create a permanent outside memorial at North Tees as a tribute to the selfless act of organ donation for donors, recipients and families.

3. Recommendations

3.2 Continue to develop and construct new and meaningful interventions with families and donors that removes barriers to successfully create a pathway of excellence that meets the needs of those donors and recipients.

Dr T Mana
Clinical Lead for Organ Donation
29 July 2021

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

29 July

Organ Donation Committee

Report of the Medical Director

1. Introduction/Background

1.1 Last year was the most challenging year for the Trust and the ITU due to the COVID 19 pandemic.

1.2 All services were affected, including organ donation and transplantation. Despite the challenges faced, our medical and nursing staff continued with their support for the organ donation pathway and to respect end of life decisions of patients and families.

1.3 The outcomes for donation were down a third overall and ITU overwhelmed at the peak of the pandemic but maintained referral rates during the most challenging of circumstances.

1.4 Credit to the staff who never lost focus for the quality of patient care and compassionate end of life pathways.

2. Report

2.1 From three consented donors, North Tees and Hartlepool NHS Foundation Trust facilitated 3 actual solid organ donors resulting in 11 patients receiving a transplant during the year.

2.2 A Specialist Nurse was present for 5 organ donation discussions with families of eligible donors. There were no occasions when a Specialist Nurse was absent for the donation discussion.

2.3 Our Trust referred 48 patients to NHSBT's Organ Donation Services Team; 24 met the referral criteria and were included in the UK Potential Donor Audit. (DBD -6, DCD-18)

2.4 There were a further 2 audited patients that were not referred as they were not identified as potential organ donors.

2.5 Neurological death testing was done on 6 patients.

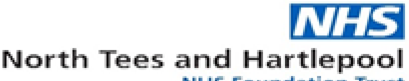
2.6 Introduction of new legislation for donor consent.

3. Conclusion/Summary

3.1 Overall performance and quality of Organ Donation Pathways were maintained throughout the most challenging year.

3.2 Staff showed resilience and compassion in the most challenging of circumstances and delivered an end of life care pathway for many that ultimately saved 11 lives.

4. Recommendation



4.1 Implement the Organ Donation and Transplantation Strategy 2030:- Meeting the Need.

4.2 Create a permanent outside memorial at North Tees as a tribute to the selfless act of organ donation for donors, recipients and families.

Kevin Robinson
Non Executive Director
29 July 2021

Detailed Report

Actual and Potential Deceased Organ Donation

1 April 2020 - 31 March 2021

North Tees and Hartlepool NHS Foundation Trust

Table of Contents

1. **Donor outcomes**

2. **Key numbers in potential for organ donation**

3. **Best quality of care in organ donation**

3.1 Neurological death testing
3.2 Referral to Organ Donation Service
3.3 Contraindications
3.4 SNOD presence
3.5 Consent
3.6 Solid organ donation

4. **PDA data by hospital and unit**

5. **Emergency Department data**

5.1 Referral to Organ Donation Service
5.2 Organ donation discussions

6. **Additional Data**

6.1 Supplementary Regional data
6.2 Trust/Board Level Benchmarking

Appendices

A.1 Definitions
A.2 Data description
A.3 Table and figure description

Further Information

- We acknowledge that the data presented includes the period most significantly impacted by COVID-19 and appreciate that the COVID-19 pandemic affected Trusts/Boards differently across the UK.
- Appendix A.1 contains definitions of terms and abbreviations used throughout this report and summarises the main changes made to the PDA over time.
- The latest Organ Donation and Transplantation Activity Report is available at https://www.organdonation.nhs.uk/supporting-my-decision/statistics-about-organ-donation/transplant-activity-report/
- The latest PDA Annual Report is available at http://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit/
- Please refer any queries or requests for further information to your local Specialist Nurse - Organ Donation (SNOD)

Source

NHS Blood and Transplant: UK Transplant Registry (UKTR), Potential Donor Audit (PDA) and Referral Record.
Issued May 2021 based on data meeting PDA criteria reported at 10 May 2021.

1. Donor Outcomes

A summary of the number of donors, patients transplanted, average number of organs donated per donor and organs donated.

Data in this section is obtained from the UK Transplant Registry

Between 1 April 2020 and 31 March 2021, North Tees and Hartlepool NHS Foundation Trust had 3 deceased solid organ donors, resulting in 11 patients receiving a transplant. Additional information is shown in Tables 1.1 and 1.2, along with comparison data for 2019/20. Figure 1.1 shows the number of donors and patients transplanted for the previous ten periods for comparison.

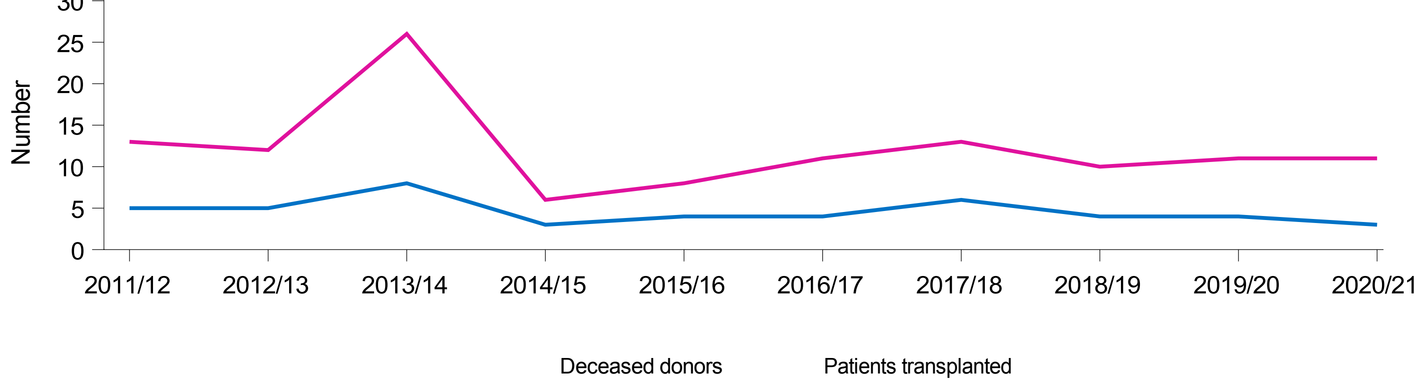
Table 1.1 Donors, patients transplanted and organs per donor, 1 April 2020 - 31 March 2021 (1 April 2019 - 31 March 2020 for comparison)

Donor type	Number of donors		Number of patients transplanted		Average number of organs donated per donor Trust		UK	
DBD	3	(4)	11	(11)	4.0	(3.0)	3.3	(3.5)
DCD	0	(0)	0	(0)	-	(-)	2.7	(2.7)
DBD and DCD	3	(4)	11	(11)	4.0	(3.0)	3.1	(3.2)

Table 1.2 Organs transplanted by type, 1 April 2020 - 31 March 2021 (1 April 2019 - 31 March 2020 for comparison)

	Number of organs transplanted by type											
Donor type	Kidney		Pancreas		Liver		Heart		Lung		Small bowel	
DBD	6	(8)	0	(0)	2	(3)	1	(0)	3	(0)	0	(0)
DCD	0	(0)	0	(0)	0	(0)	0	(0)	0	(0)	0	(0)
DBD and DCD	6	(8)	0	(0)	2	(3)	1	(0)	3	(0)	0	(0)

Figure 1.1 Number of donors and patients transplanted, 1 April 2011 - 31 March 2021



2. Key Numbers in Potential for Organ Donation

A summary of the key numbers on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section presents key numbers in potential donation activity for North Tees and Hartlepool NHS Foundation Trust. This data is presented in Table 2.1 along with UK comparison data. Your Trust has been categorised as a level 3 Trust and therefore percentages in this section are only presented on a national level. A comparison between different level Trusts is available in the Additional Data and Figures section.

It is acknowledged that the PDA does not capture all activity. In total there were 0 patients referred in 2020/21 who are not included in this section onwards because they were either over 80 years of age or did not die in a unit participating in the PDA. None of these are included in Section 1 because they did not become a solid organ donor.

Table 2.1 Key numbers comparison with national rates, 1 April 2020 - 31 March 2021

	DBD		DCD		Deceased donors	
	Trust	**UK**	**Trust**	**UK**	**Trust**	**UK**
Patients meeting organ donation referral criteria[1]	6	1810	20	6027	26	7551
Referred to Organ Donation Service	6	1777	18	4770	24	6282
Referral rate %		*98%*		*79%*		*83%*
Neurological death tested	6	1490				
Testing rate %		*82%*				
Eligible donors[2]	5	1353	7	2860	12	4207
Family approached	5	1210	0	1042	5	2248
Family approached and SNOD present	5	1168	0	925	5	2089
% of approaches where SNOD present		*97%*		*89%*		*93%*
Consent ascertained	3	891	0	665	3	1553
Consent rate %		*74%*		*64%*		*69%*
Actual donors (PDA data)	3	777	0	404	3	1180
% of consented donors that became actual donors		*87%*		*61%*		*76%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

3. Best quality of care in organ donation

Key stages in best quality of care in organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section provides information on the quality of care in your Trust at the key stages of organ donation. The ambition is that your Trust misses no opportunity to make a transplant happen and that opportunities are maximised at every stage.

3.1 Neurological death testing

Goal: neurological death tests are performed wherever possible.

Figure 3.1 Number of patients with suspected neurological death, 1 April 2016 - 31 March 2021

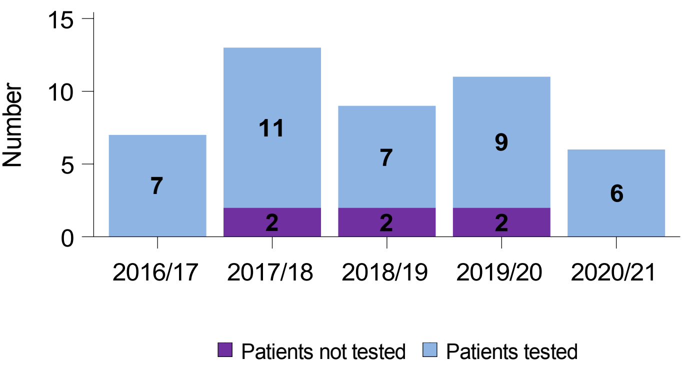


Table 3.1 Reasons given for neurological death tests not being performed, 1 April 2020 - 31 March 2021

	Trust	UK
Biochemical/endocrine abnormality	-	19
Clinical reason/Clinician's decision	-	42
Continuing effects of sedatives	-	13
Family declined donation	-	24
Family pressure not to test	-	15
Hypothermia	-	1
Inability to test all reflexes	-	20
Medical contraindication to donation	-	11
Other	-	30
Patient had previously expressed a wish not to donate	-	5
Patient haemodynamically unstable	-	100
Pressure of ICU beds	-	8
SN-OD advised that donor not suitable	-	7
Treatment withdrawn	-	18
Unknown	-	7
Total	**-**	**320**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.2 Referral to Organ Donation Service

Goal: Every patient who meets the referral criteria should be identified and referred to the Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].

Aim: There should be no purple on the following charts.

Note that patients who met the referral criteria for both DBD and DCD donation will appear in both bar charts and both columns of the reasons table.

Figure 3.2 Number of patients meeting referral criteria, 1 April 2016 - 31 March 2021

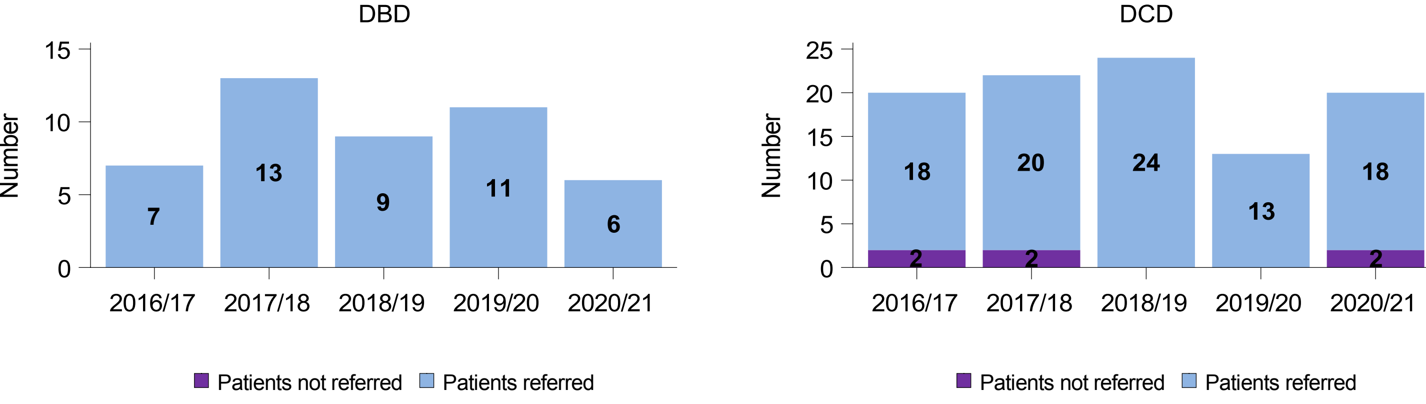


Table 3.2 Reasons given why patient not referred to SNOD, 1 April 2020 - 31 March 2021

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Clinician assessed that patient was unlikely to become asystolic within 4 hours	-	-	-	2
Coroner / Procurator Fiscal reason	-	-	-	1
Family declined donation following decision to remove treatment	-	-	-	10
Family declined donation prior to neurological testing	-	2	-	1
Medical contraindications	-	3	-	423
Not identified as potential donor/organ donation not considered	-	19	2	478
Other	-	3	-	86
Patient had previously expressed a wish not to donate	-	-	-	1
Pressure on ICU beds	-	-	-	17
Reluctance to approach family	-	-	-	1
Thought to be medically unsuitable	-	2	-	224
Thought to be outside age criteria	-	-	-	3
Uncontrolled death pre referral trigger	-	4	-	10
Total	**-**	**33**	**2**	**1257**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.3 Contraindications

In 2020/21 there were 13 potential donors in your Trust with an ACI reported, 1 DBD and 12 DCD donors. Please note, the number of potential DBD and DCD donors with an ACI reported may not equal the total stated as a patient can meet potential donor criteria for both DBD and DCD donation.

3.4 SNOD presence

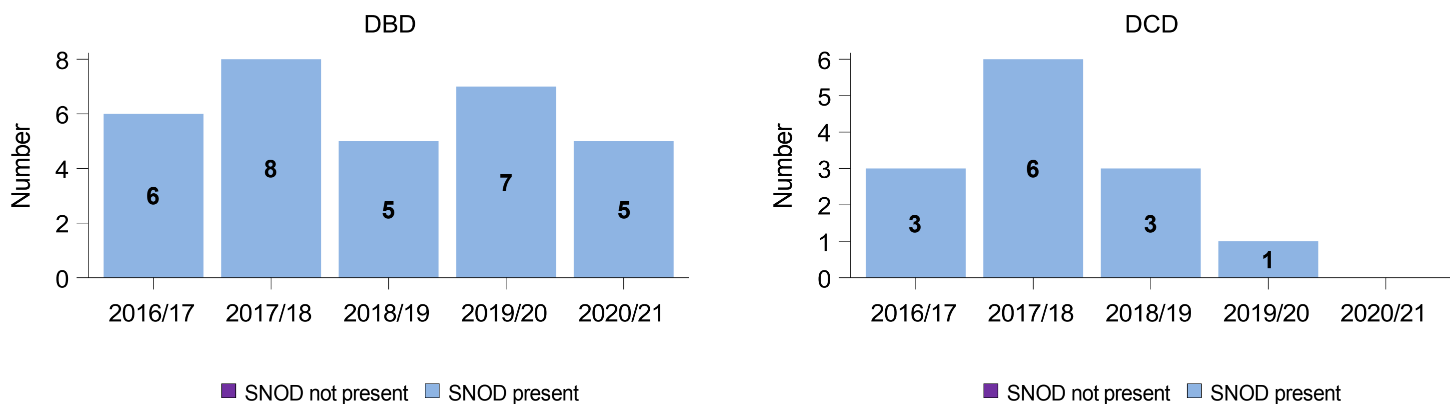
Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]

Aim: There should be no purple on the following charts.

In the UK, in 2020/21, when a SNOD was not present for the approach to the family to discuss organ donation, DBD and DCD consent/authorisation rates were 43% and 23%, respectively, compared with DBD and DCD consent/authorisation rates of 75% and 69%, respectively, when a SNOD was present.

Every approach to those close to the patient should be planned with the multidisciplinary team (MDT), should involve the SNOD and should be clearly planned taking into account the known wishes of the patient. The NHS Organ Donor Register (ODR) should be checked in all cases of potential donation and this information must be discussed with the family as it represents the eligible donor's legal consent to donation.

Figure 3.3 Number of families approached by SNOD presence, 1 April 2016 - 31 March 2021



[1] NICE, 2011.
NICE Clinical Guidelines - CG135
[accessed 10 May 2021]

[2] NHS Blood and Transplant, 2012.
Timely Identification and Referral of Potential Organ Donors - A Strategy for Implementation of Best Practice
[accessed 10 May 2021]

[3] NHS Blood and Transplant, 2013.
Approaching the Families of Potential Organ Donors – Best Practice Guidance
[accessed 10 May 2021]

3.5 Consent

In 2020/21 less than 10 families of eligible donors were approached to discuss organ donation in your Trust therefore consent rates are not presented.

Figure 3.4 Number of families approached, 1 April 2016 - 31 March 2021

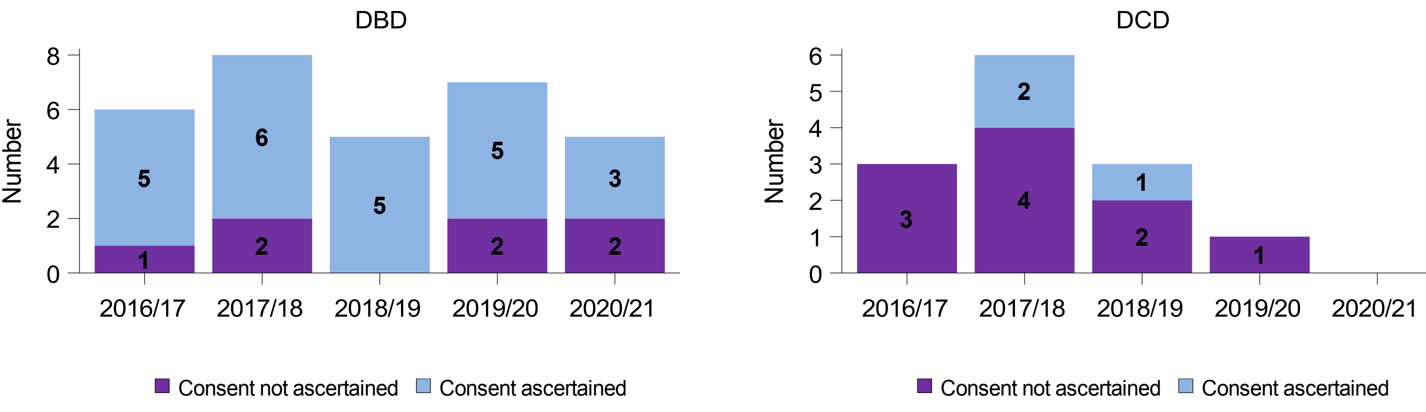


Table 3.3 Reasons given why consent was not ascertained, 1 April 2020 - 31 March 2021

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Family believe patient's treatment may have been limited to facilitate organ donation	-	1	-	-
Family concerned donation may delay the funeral	-	1	-	-
Family concerned other people may disapprove/be offended	-	3	-	2
Family concerned that organs may not be transplantable	-	1	-	1
Family did not believe in donation	-	10	-	13
Family did not want surgery to the body	-	29	-	35
Family divided over the decision	2	13	-	16
Family felt it was against their religious/cultural beliefs	-	38	-	13
Family felt patient had suffered enough	-	16	-	34
Family felt that the body should be buried whole (unrelated to religious/cultural reasons)	-	12	-	9
Family felt the length of time for the donation process was too long	-	9	-	48
Family had difficulty understanding/accepting neurological testing	-	2	-	-
Family wanted to stay with the patient after death	-	1	-	2
Family were not sure whether the patient would have agreed to donation	-	35	-	36
Other	-	22	-	34
Patient had previously expressed a wish not to donate	-	112	-	108
Patient had registered a decision to Opt Out	-	6	-	13
Strong refusal - probing not appropriate	-	8	-	11
Total	**2**	**319**	**-**	**375**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.6 Solid organ donation

Goal: NHSBT is committed to supporting transplant units to ensure as many organs as possible are safely transplanted.

Table 3.4 Reasons why solid organ donation did not occur, 1 April 2020 - 31 March 2021

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Clinical - Absolute contraindication to organ donation	-	8	-	3
Clinical - Considered high risk donor	-	5	-	2
Clinical - DCD clinical exclusion	-	-	-	1
Clinical - No transplantable organ	-	8	-	13
Clinical - Organs deemed medically unsuitable by recipient centres	-	35	-	73
Clinical - Organs deemed medically unsuitable on surgical inspection	-	15	-	1
Clinical - Other	-	8	-	3
Clinical - Outside of donation criteria at referral	-	-	-	3
Clinical - PTA post WLST	-	-	-	109
Clinical - Patient actively dying	-	4	-	5
Clinical - Patient asystolic	-	2	-	1
Clinical - Patient expected to die before donation could take place attendance not required	-	6	-	7
Clinical - Patient’s general medical condition	-	2	-	4
Clinical - Positive virology	-	4	-	1
Consent / Auth - Coroner/Procurator fiscal refusal	-	10	-	12
Consent / Auth - Family placed conditions on donation	-	1	-	-
Consent / Auth - NOK withdraw consent / authorisation	-	1	-	11
Logistical - No critical care bed available	-	-	-	1
Logistical - Other	-	5	-	10
Total	**-**	**114**	**-**	**260**

If 'other', please contact your local SNOD or CLOD for more information, if required.

4. PDA data by hospital and unit

A summary of key numbers and rates from the PDA by hospital and unit where patient died

Data in this section is obtained from the National Potential Donor Audit (PDA)

Tables 4.1 and 4.2 show the key numbers and rates for patients who met the DBD and/or DCD referral criteria, respectively. Percentages have been excluded where numbers are less than 10.

Table 4.1 Patients who met the DBD referral criteria - key numbers and rates, 1 April 2020 - 31 March 2021

Unit where patient died	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Stockton-On-Tees, University Hospital Of North Tees													
A & E	0	0	-	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	6	6	-	6	-	6	5	5	5	-	3	-	3

Table 4.2 Patients who met the DCD referral criteria - key numbers and rates, 1 April 2020 - 31 March 2021

Unit where patient died	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DBD donors
Stockton-On-Tees, University Hospital Of North Tees											
A & E	1	1	-	1	0	0	0	-	0	-	0
General ICU/HDU	19	17	89	19	7	0	0	-	0	-	0

Tables 4.1 and 4.2 show the unit where the patient died. However, it is acknowledged that there are some occasions where a patient is referred in an Emergency Department but moves to a critical care unit. In total for North Tees and Hartlepool NHS Foundation Trust in 2020/21 there were 1 such patients. For more information regarding the Emergency Department please see Section 5.

5. Emergency Department data

A summary of key numbers for Emergency Departments

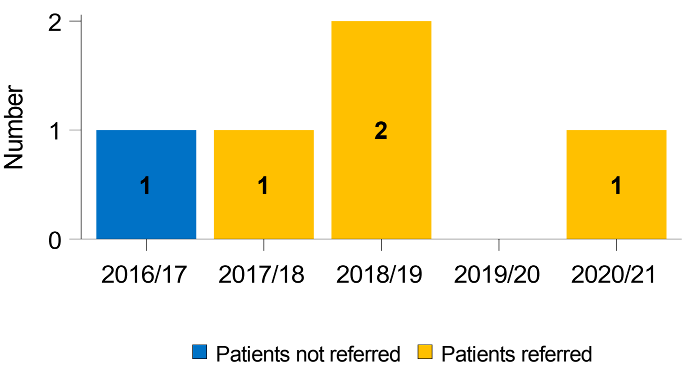
Data in this section is obtained from the National Potential Donor Audit (PDA)

Most patients who go on to become organ donors start their journey in the emergency department (ED). Deceased donation is important, not just for those people waiting on the transplant list, but also because many people in the UK have expressed a wish in life to become organ donors after their death. The overarching principle of the NHSBT Organ donation and Emergency Department strategy [4] is that best quality of care in organ donation should be followed irrespective of the location of the patient within the hospital at the time of death.

5.1 Referral to Organ Donation Service

Goal: No one dies in your ED meeting referral criteria and is not referred to NHSBT's Organ Donation Service.
Aim: There should be no blue on the following chart.

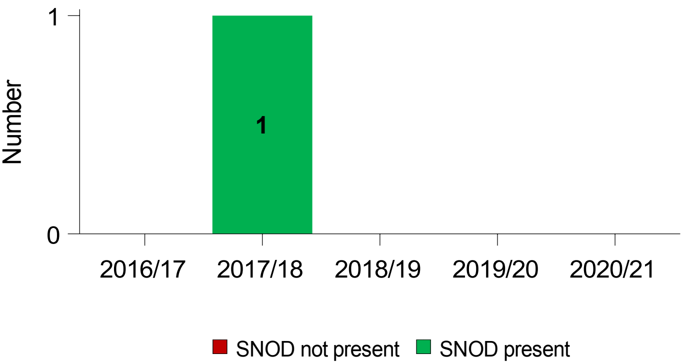
Figure 5.1 Number of patients meeting referral criteria that died in the ED, 1 April 2016 - 31 March 2021



5.2 Organ donation discussions

Goal: No family is approached in ED regarding organ donation without a SNOD present.
Aim: There should be no red on the following chart.

Figure 5.2 Number of families approached in ED by SNOD presence, 1 April 2016 - 31 March 2021



[4] NHS Blood and Transplant, 2016.
Organ Donation and the Emergency Department
[accessed 10 May 2021]

6. Additional data and figures

Regional donor, transplant, and transplant list numbers

Data in this section is obtained from the UK Transplant Registry

6.1 Supplementary Regional data

Table 6.1 Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	North East*	UK
1 April 2020 - 31 March 2021		
Deceased donors	67	1,180
Transplants from deceased donors	148	2,943
Deaths on the transplant list	27	497
As at 31 March 2021		
Active transplant list	209	4,256
Number of NHS ODR opt-in registrations (% registered)**	1,047,167 (40%)	26,746,406 (41%)

*Regions have been defined as per former Strategic Health Authorities
** % registered based on population of 2.62 million, based on ONS 2011 census data

Key numbers and rates on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

6.2 Trust/Board Level Benchmarking

North Tees and Hartlepool NHS Foundation Trust has been categorised as a level 3 Trust. Levels were reallocated in July 2018 using the average number of donors in 2016/17 and 2017/18, Table 6.2 shows the criteria used and how many Trusts/Boards belong to each level.

Table 6.2 Trust/Board level categories

		Number of Trusts Boards in each level
Level 1	12 or more (≥ 12) proceeding donors per year	35
Level 2	6 or more but less than 12 (≥ 6 to <12) proceeding donors per year	45
Level 3	More than 3 but less than 6 (>3 to <6) proceeding donors per year	47
Level 4	3 or less (≤ 3) proceeding donors per year	41

Tables 6.3 and 6.4 show the national DBD and DCD key numbers and rates for the UK by Trust/Board level, to aid in comparison with equivalent Trusts/Boards. Note that percentages have been excluded where numbers are less than 10.

Table 6.3 National DBD key numbers and rate by Trust/Board level, 1 April 2020 - 31 March 2021

	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Your Trust	6	6	-	6	-	6	5	5	5	-	3	-	3
Level 1	979	818	84	968	99	813	751	677	651	96	479	71	424
Level 2	420	339	81	407	97	330	299	268	260	97	205	76	168
Level 3	283	228	81	276	98	227	206	181	178	98	140	77	125
Level 4	128	105	82	126	98	104	97	84	79	94	67	80	60

Table 6.4 National DCD key numbers and rate by Trust/Board level, 1 April 2020 - 31 March 2021

	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DCD donors
Your Trust	20	18	90	20	7	0	0	-	0	-	0
Level 1	2552	2143	84	2350	1366	606	537	89	399	66	252
Level 2	2001	1487	74	1843	852	238	214	90	143	60	84
Level 3	990	785	79	923	407	128	112	88	76	59	45
Level 4	484	355	73	444	235	70	62	89	47	67	23

Appendices

Appendix A.1 Definitions

Potential Donor Audit Definitions

Potential Donor Audit inclusion criteria	1 October 2009 – 31 March 2010 All deaths in critical care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2010 – 31 March 2013 All deaths in critical and emergency care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2013 onwards All deaths in critical and emergency care in patients aged 80 and under

Donors after brain death (DBD) definitions

Suspected Neurological Death	A patient who meets all of the following criteria: Apnoea, coma from known aetiology and unresponsive, ventilated, fixed pupils. Excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates – less than 2 months post term'.
Potential DBD donor	A patient who meets all four criteria for neurological death testing excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates – less than 2 months post term' (ie suspected neurological death, as defined above).
DBD referral criteria	A patient with suspected neurological death
Discussed with Specialist Nurse – Organ Donation	A patient with suspected neurological death discussed with the Specialist Nurse – Organ Donation (SNOD)
Neurological death tested	Neurological death tests were performed
Eligible DBD donor	A patient confirmed dead by neurological death tests, with no absolute medical contraindications to solid organ donation
Absolute contraindications	Absolute medical contraindications to organ donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/6455/contraindications_to_organ_donation.pdf
Family approached for formal organ donation discussion	Family of eligible DBD asked to support patient's expressed or deemed consent/authorisation, informed of a nominated/appointed representative, asked to make a decision on donation on behalf of their relative, or informed of a patient's opt-out decision via the ODR.
Consent/authorisation ascertained	Family supported expressed or deemed consent/authorisation , nominated/appointed representative gave consent, or where applicable family gave consent/authorisation
Actual donors: DBD	Neurological death confirmed patients who became actual DBD as reported through the PDA
Actual donors: DCD	Neurological death confirmed patients who became actual DCD as reported through the PDA
Neurological death testing rate	Percentage of patients for whom neurological death was suspected who were tested
Referral rate	Percentage of patients for whom neurological death was suspected who were discussed with the SNOD
Consent/authorisation rate	Percentage of families or nominated/appointed representatives approached for formal organ donation discussion where consent/authorisation was ascertained
SNOD presence rate	Percentage of formal organ donation discussions with families or nominated/appointed representatives where a SNOD was present
Consent/authorisation rate where SNOD was present	Percentage of formal organ donation discussions with families or nominated/appointed representatives where a SNOD was present where consent/authorisation was ascertained

Donors after circulatory death (DCD) definitions

Imminent death anticipated	A patient, not confirmed dead using neurological criteria, receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within a time frame to allow donation to occur, as determined at time of assessment
DCD referral criteria	A patient in whom imminent death is anticipated (as defined above)
Discussed with Specialist Nurse – Organ Donation	Patients for whom imminent death was anticipated who were discussed with the SNOD
Potential DCD donor	A patient who had treatment withdrawn and death was anticipated within four hours
Eligible DCD donor	A patient who had treatment withdrawn and death was anticipated within four hours, with no absolute medical contraindications to solid organ donation
Absolute contraindications	Absolute medical contraindications to organ donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/6455/contraindications_to_organ_donation.pdf
Family approached for formal organ donation discussion	Family of eligible DCD asked to: support the patient's expressed or deemed consent/authorisation decision, informed of a nominated/appointed representative, make a decision themselves on donation, or informed of a patient's opt-out decision via the Organ Donor Register
Consent/authorisation rate	Percentage of families or nominated/appointed representatives approached for formal organ donation discussion where consent/authorisation was ascertained
SNOD presence rate	Percentage of formal organ donation discussions with families or nominated/appointed representatives where a SNOD was present
Consent/authorisation rate where SNOD was present	Percentage of formal organ donation discussions with families or nominated/appointed representatives where a SNOD was present where consent/authorisation was ascertained

UK Transplant Registry (UKTR) definitions

Donor type	Type of donor: Donation after brain death (DBD) or donation after circulatory death (DCD)
Number of actual donors	Total number of donors reported to the UKTR
Number of patients transplanted	Total number of patients transplanted from these donors
Organs per donor	Number of organs donated divided by the number of donors.
Number of organs transplanted	Total number of organs transplanted by organ type

Appendix A.2 Data Description

This report provides a summary of data relating to potential and actual organ donors as recorded by NHS Blood and Transplant via the Potential Donor Audit (PDA), the accompanying Referral Record, and the UK Transplant Registry (UKTR) for the specified Trust, Board, Organ Donation Services Team, or nation.

This report is provided for information and to facilitate case based discussion about organ donation by the Organ Donation Committee at your Trust/Board.

As part of the PDA, patients over 80 years of age and those who did not die on a critical care unit or emergency department are not audited nationally and are therefore excluded from the majority of this report. Data from neonatal intensive care units (ICU) have also been excluded from this report. In addition, some information may be outstanding due to late reporting and difficulties obtaining patient notes. Donations not captured by the PDA will still be included in the data supplied from the accompanying Referral Record or from the UKTR, as appropriate.

Percentages have not been calculated for level 3 or 4 Trust/Boards and where stated when numbers are less than 10.

Appendix A.3 Table and Figure Description

1 Donor outcomes	
Table 1.1	The number of actual donors, the resulting number of patients transplanted and the average number of organs donated per donor have been obtained from the UK Transplant Registry (UKTR) for your Trust/Board. Results have been displayed separately for donors after brain death (DBD) and donors after circulatory death (DCD).
Table 1.2	The number of organs transplanted by type from donors at your Trust/Board has been obtained from the UKTR. Further information can be obtained from your local Specialist Nurse – Organ Donation (SNOD), specifically regarding organs that were not transplanted. Results have been displayed separately for DBD and DCD.
Figure 1.1	The number of actual donors and the resulting number of patients transplanted obtained from the UKTR for your Trust/Board for the past 10 equivalent time periods are presented on a line chart.

2 Key numbers in potential for organ donation	
Table 2.1	A summary of DBD, DCD and deceased donor data and key numbers have been obtained from the PDA. A UK comparison is also provided. Appendix A.1 gives a fuller explanation of terms used.

3 Best quality of care in organ donation	
Figure 3.1	A stacked bar chart displays the number of patients with suspected neurological death who were tested and the number who were not tested in your Trust/Board for the past five equivalent time periods.
Table 3.1	The reasons given for neurological death tests not being performed in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.2	Stacked bar charts display the number of DBD and DCD patients meeting referral criteria who were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Table 3.2	The reasons given for not referring patients to the Organ Donation Service in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.3	The primary absolute medical contraindications to solid organ donation for DBD and DCD patients have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.3	Stacked bar charts display the number of families of DBD and DCD patients approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.
Figure 3.4	Stacked bar charts display the number of families of DBD and DCD patients approached where consent/authorisation for organ donation was ascertained and the number approached where consent/authorisation was not ascertained in your Trust/Board for the past five equivalent time periods.
Table 3.4	The reasons why consent/authorisation was not ascertained for solid organ donation in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.5	The reasons why solid organ donation did not occur in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.

4 PDA data by hospital and unit	
Table 4.1	DBD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.
Table 4.2	DCD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.

5 Emergency department data	
Figure 5.1	Stacked bar charts display the number of patients that died in the emergency department (ED) who met the referral criteria and were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Figure 5.2	Stacked bar charts display the number of families of patients in ED approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.

6 Additional data and figures	
Table 6.1	A summary of deceased donor, transplant, transplant list and ODR opt-in registration data for your region have been obtained from the UKTR. Your region has been defined as per former Strategic Health Authority. A UK comparison is also provided.
Table 6.2	Trust/board level categories and the relevant expected number of proceeding donors per year are provided for information.
Table 6.3	National DBD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.
Table 6.4	National DCD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.