North Tees and Hartlepool NHS
NHS Foundation Trust

Board of Directors Meeting

Thursday, 28 July 2022
at 10.00am

Boardroom
University Hospital of North Tees
and via MS Teams

North Tees and Hartlepool
NHS Foundation Trust

University Hospital of North Tees
Hardwick
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21July 2022

Dear Colleague

A meeting of the **Board of Directors** will be held in public, on **Thursday, 28 July 2022 at 10.00am** in the **Boardroom, University Hospital of North Tees.**

Yours sincerely

Professor Derek Bell, OBE
Joint Chair

Agenda

			Led by
1.	(10.00 am)	Apologies for Absence	Chair
2.	(10.00 am)	Declaration of Interest	Chair
3.	(10.00 am)	Patient Story	L Robertson
4.	(10.20 am)	Minutes of the meeting held on, 8 June 2022 **(enclosed)**	Chair
5.	(10.25 am)	Matters Arising and Action Log **(enclosed)**	Chair

Items for Information

6.	(10.30 am)	Report of the Joint Chair **(enclosed)**	Chair
7.	(10.40 am)	Joint Partnership Board Update **(verbal)**	S Hall
8.	(10.50 am)	Report of the Chief Executive **(enclosed)** [NENC Provider Collaborative Governance Documents - Matt Brown attending the meeting to present]	J Gillon

Performance Management

9.	(11.10 am)	Board Assurance Framework Quarter 1 Report: 2022/23 **(enclosed)**	L Hunter

Professor Derek Bell, OBE
Chair

Julie Gillon
Chief Executive

10. (11.20 am)	Integrated Compliance and Performance Report **(enclosed)**	L Hunter, L Robertson, N Atkinson & G Raffell

Strategic Management

11. (11.35 am)	Capital Programme Performance Quarter 1: 2022/23 **(enclosed)**	N Atkinson

Operational Issues

12. (11.45 am)	Care Quality Commission Update (verbal)	L Robertson
13. (11.55 am)	Learning from Deaths Report Quarter 1: 2022/23 **(enclosed)**	D Dwarakanath
14. (12.05 pm)	NHS Workforce Race Equality Standard (WRES) 2022 and NHS Workforce Disability Equality Standard (WDES) **(enclosed)**	G Raffell

Items to Receive

15. (12.15 pm)	Quality Accounts 2021/22 **(enclosed)**	L Robertson
16.	Carbon Reduction Programme Performance Targets 2021/22 **(enclosed)**	N Atkinson
17.	Health, Safety and Security Annual Report 2021/22 **(enclosed)**	I Simpson
18. (12.30 pm)	Any Other Business	Chair

Date of next meeting
(Thursday, 22 September 2022, Boardroom, University Hospital of North Tees)

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 Our 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, 8 June 2022 at 9:30
at the University Hospital of Hartlepool / Via Video Link

Present:

Professor Derek Bell, Joint Chair*	Joint Chair
Steve Hall, Vice-Chair/Non-Executive Director*	Vice Chair
Ann Baxter, Non-Executive Director*	AB
Julie Gillon, Chief Executive*	CE
Ian Simpson, Interim Non-Executive Director*	IS
Deepak Dwarakanath, Medical Director/Deputy Chief Executive*	MD/DCE
Neil Atkinson, Director of Finance*	DoF
Levi Buckley, Chief Operating Officer*	COO
Gillian Colquhoun, Interim Chief Information and Technology Officer	ICITO
Hilton Heslop, Associate Director of Corporate Affairs and Strategy	ADoCA&S
Linda Hunter, Interim Director of Performance and Planning	IDoP&P
Lindsey Robertson, Chief Nurse/Director of Patient Safety and Quality*	CN/DoPS&Q
Ruth Dalton, Associate Director of Communications & Marketing [via video link]	ADoC&M

In Attendance:
Sarah Hutt, Company Secretary [note taker]
David Jennings, Vice Chair, South Tees Hospitals NHS Foundation Trust
Tony Horrocks, Elected Governor, Stockton (Lead Governor) [via video link]
Lynda White, Elected Governor, Stockton

BoD/4793 Apologies for Absence / Welcome

Apologies for absence were noted from Chris Macklin, Interim Non-Executive Director and Fay Scullion, Interim Non-Executive Director.

The Joint Chair welcomed everyone to the Public Board of Directors meeting including David Jennings, Interim Vice Chair, South Tees Hospitals NHS Foundation Trust.

BoD/4794 Declaration of Interests

Declarations of interest were noted from SH in respect to his role with Optimus Health Ltd, and the DoF for his role as a member of the LLP Management Board.

BoD/4795 Patient Story

The CN/DoPS&Q introduced a patient's story about Paul who had collapsed at home and was taken to hospital by ambulance, his wife Janice described it as a very scary experience. Paul was taken to Ward 41 and he could not talk, walk, or swallow and was doubly incontinent. Janice explained it was difficult not being able to visit Paul due to the Covid-19 restrictions on visiting however being able to see each other on an IPad was comforting. The care from all of the teams involved was excellent and both Paul and Janice felt that the work of the teams on the Stroke Unit was life changing. Paul is now at home and is under the care of the community teams and again the care had been excellent. Paul has had Botox treatment which has had a positive effect in helping to strengthen his muscles on his right side and allow him to stand. Paul still has a long way to go, but both he and Janice were staying positive.

The CE highlighted that Paul and Janice's experience exemplified the compassionate nature of staff and correlated with outcomes from the staff survey in relation to the Stroke Unit which were very

* voting member

positive.

The Joint Chair sought clarification regarding mechanism to pass on the thanks of the Trust and suggested an alternative method be considered as well as a formal letter, which the CN/DoPS&Q would take forward. The MD highlighted the impact of a stroke on a patient and their family and the range of care and rehabilitation required. The Joint Chair highlighted that one of the Trust Stroke physiotherapists was becoming a Trust Public Health fellow for 12 months.

AB reported that patient stories were shared at the Patient Safety and Quality Standards Committee.

Resolved: (i) that, the patient story be noted; and
(ii) that, a mechanism to thank patients for their stories be considered.

BoD/4796 Minutes of the meeting held on, Thursday, 28 April 2022

Resolved: that, the minutes of the meeting held on, Thursday, 28 April 2022 be confirmed as an accurate record.

BoD/4797 Matters Arising and Action Log

There were no matters arising and an update was provided against the action log.

Resolved: that, the verbal update be noted.

BoD/4798 Report of the Joint Chair Update

A summary of the report of the Joint Chair was provided with key points highlighted.

- The Joint Board Away Day on 18 May was well attended and had been a positive event. A follow-up event was scheduled for 15 June 2022 and would also be facilitated.
- Monthly visits to the University Hospital of Hartlepool continued with Governors in attendance and feedback was positive. The Lead Governor reported he was impressed with Ward 9 and the Access Lounge at UHH, which was a good facility for elective work however perhaps there was scope to broaden its usage. The COO explained there would be as the transition to Ward 4 took place.
- The NHSE/I governance review remained ongoing, the Joint Chair and CE had met with Richard Barker and Sam Allen recently. It was anticipated the report would be available during June.
- The national Ockenden Team had visited the Trust on 19 May which had been very positive. The Joint Chair thanked the CN/DoPS&Q, AB and, the teams for their hard work and input.
- Board Walkabouts – as COVID-19 restrictions continued to be lifted Board walkabouts would resume in the Trust and joint walkabouts would be arranged with Board members from South Tees Hospitals NHS Foundation Trust.
- The Regional Chair's meeting had been attended by Sam Allen who had highlighted the key priorities, which included emergency care, workforce, integration with social care and community care.
- The NHS Confederation Chairs meeting had focused on lower paid workers and the disproportionate impact of inflation and energy costs which was being taken seriously. Concern had also been raised regarding the 4.5% CIP target for 2022/23.

It was noted that Richard Barker had been awarded a CBE.

Resolved: that, the content of the Joint Chairs report be noted.

BoD/4799 Joint Partnership Board Update

The Vice Chair reported that he and the new Vice Chair for South Tees Hospitals NHS Foundation Trust (South Tees), David Jennings had made contact and were looking forward to driving joint initiatives including the second Joint Board away day on 15 June.

The Vice Chair reported that a programme of visits to departments and services was being developed for Non-Executive colleagues in addition to arranging joint visits for board members with South Tees.

Resolved: that, the verbal update be noted.

BoD/4800 Report of the Chief Executive

The Chief Executive presented the Report of the Chief Executive and highlighted key points.

- As of 7 June the Trust was caring for 23 Covid-19 positive patients. The alert level for the management of Covid-19 had been reduced to regional alert level 3. The 3 key priorities included delivering timely urgent and emergency care, increasing elective care and improving patient experience.
- There were ongoing operational pressures across the North East and North Cumbria (NENC) system in relation to emergency care. An internal Integrated Coordination Centre had been developed to enable being able to predict, plan and optimise patient flow.
- The Trust's approach to integrated hospital discharge was recognised locally and nationally. During May the Trust hosted a series of events including collaboration with North East Commissioning Support and Palantir on the development of the Optica Discharge Optimisation Tool to provide a multi-agency interactive tool to support the discharge process.
- The National Director for Urgent and Emergency Care was visiting the Trust soon with members of the national NHS team to understand the discharge model and share practice nationally.
- The CE met with Dr Jeanelle de Gruchy, the Deputy Chief Medical Officer on 9 May in her capacity as Senior Responsible Officer across the NENC for Health Inequalities.
- The focus on health and wellbeing for staff continued with the launch of a revised Health and Wellbeing Strategy which would be rolled out across the organisation.
- Midwife Sharon Gowans was appointed as one of the Trust's Principal Investigators for research and was the first non-medic to be placed in the research network's top five highest recruiters. Of note there were two high recruiting studies in Obstetrics and Gynaecology in 2022/23.
- The formal establishment of the Integrated Care Board was the 1 July 2022 having operated in shadow form since 1 April 2022. The Chief Nurse had been appointed and there were two further Non-Executive Directors to be appointed.
- The NENC Provider Collaborative continued to focus on governance arrangements and the work plan in readiness for the new ICS formal structure. Two members of the NENC Provider Collaborative would join the Integrated Care Board.
- The Tees Provider Collaborative continued to move forward and would build on the success of the Joint Board Away on 15 June regarding common purpose and building a work programme.
- A programme board had been established to take forward the strategic plan to develop diagnostic capacity in Tees, including the proposed new build Community Diagnostic Centre (CDC) by the end of 2025. Dr Phil Woolfall from the Trust and Dr Simon Milburn from South Tees Hospitals NHS Foundation Trust were jointly appointed to the CDC Clinical Lead role.
- The new Endoscopy Training Academy at the University Hospital of Hartlepool was due to be completed by 18 June 2022. Dr Chris Wells from the Trust was appointed as Clinical Director for the Endoscopy Training Academy programme across the North East and North Cumbria.
- The Ockenden national team had visited the Trust on 19 May and commended the organisation for its positive culture and the great work being undertaken.
- Since the last meeting, Dr Miller was appointed as a Consultant in Acute Medicine.

The Vice Chair reported on an engagement event in respect of Equality, Diversity and Inclusion (EDI), as Board champion. The CE highlighted that the Trust continued to engage with partners regarding EDI and explained that the Consultant in Public Health was working with the local population to understand potential exclusion, and was widening the engagement with the ICS. The Trust had an established network of champions representing inclusive groups. The Trust had commissioned an independent piece of work with a mental health trust to better understand the needs of patients. The ICPO noted short term actions from the EDI engagement event were being developed into a plan and were reviewing the staff survey results to understand the cultural aspects.

In respect of the Endoscopy Training Academy, the Joint Chair sought clarity regarding diagnostic

provision and whether separate JAG accreditation would be required. The MD/DCE explained that although JAG accreditations were undertaken as a whole for the organisation regardless of centres, dedicated training facilities would require separate accreditation to be undertaken.

Resolved: that, the contents of the 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, be noted.

BoD/4801 Board Assurance Framework 2022/23: Quarter 1 Report

The ADoS&CA presented the Board Assurance Framework (BAF) Interim Report for Quarter 1 and highlighted the key points.

- There were 12 risk domains against the 4 strategic objectives;
- All strategic risks were managed via the Committee structure;
- There were currently four principle risks that included a high risk rating;
- The Risk Radar diagram demonstrated the breadth of risks currently being monitored.

A discussion ensued regarding the risk level of Strategic Risk 3E. It was agreed the current risk rating would remain however would continue to be monitored and removed when appropriate.

Resolved: that, the Board Assurance Framework Interim Quarter 1: 2022/23 Report be noted.

BoD/4802 Integrated Compliance and Performance Report

The IDoP&P presented the Integrated Compliance and Performance report which outlined the Trust's compliance against key access standards in April 2022 including quality, workforce and finance.

It was noted that the Integrated Compliance and Performance Report had been refreshed to align with Priorities and Operational Planning submission for 2022/23, as well as a refresh of the dashboards and introduction of nationally compliant Statistical Process Control (SPC) charts.

The Trust was moving towards business as usual against the ongoing impact of Covid-19. There were 24 Covid-19 positive patients currently in the organisation.

Highlights included:

Performance:

- Challenges remained for the cancer standards with the two-week rule and 62-days standards not met. This was a similar position, regionally and nationally; Breaches were due to complex pathways, diagnostic pathways, outpatients capacity and patient choice;
- Continued achievement against the 28 day faster diagnosis standard;
- No outcome currently regarding the national consultation to combine the 9 key cancer standards into 3, which included 28 day faster diagnosis, 62 day and 31 day decision to treat;
- The Trust had seen a slight increase in the overall waiting list compared to the previous month. 58 patients were over 52 week waits in April which was above target. One patient was waiting over 78 weeks with no over 104 week waits. A full review of the waiting list had been undertaken to be able to maximise capacity;
- Diagnostic waiting times were impacted by pressures in Ultrasound due to staffing however an improved position was expected for May. Other pressure areas included Endoscopy and MRI;
- Work was ongoing with NEAS to improve compliance with ambulance turnaround times within 30 minutes. Although below the reporting standard of 95%, the Trust was second in the region;
- The Trust continued to receive requests for mutual aid and deflections in emergency pathways increasing pressure on the organisation;
- As part of annual operating guidance a reduction in outpatient review appointments to 75% of those delivered in 2019/20 was required. The Trust was currently working to achieve 85%.

Quality and safety:

- HSMR and SHMI remained positive within the expected range, although a slight increase from the previous month was reported for HSMR at 85.31 compared to 84.87;
- Overall reduction in the number of complaints but there was a slight increase in the number of stage 3 complaints. There was an increase in the number of compliments;
- There was a slight increase in the number of falls with no harm, however this was a reduction following a rise in December 2021.

Workforce:

- Sickness absence had reduced at 5.92% compared to 6.44% the previous month. The top reason for sickness absence was anxiety/stress/depression;
- There were currently 18 members of staff with Covid-19 related absence;
- Staff turnover although above target was a slight reduction from the previous month;

Finance:

- A a year end deficit of £1.4m;
- At Month 1 the Trust was reporting a surplus of £888K; ;
- The cash position was £68.5m against a plan of £55.5m.

IS requested a break-down of sickness absence into short term/long term and a breakdown of turnover into external/internal. Further work was being undertaken to inform the workforce report.

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

(ii) that, the significant ongoing operational and workforce pressures and system risks to key performance indicators and the intense mitigation work being undertaken to address this be noted;

(iii) that, a further understanding of sickness data be presented in this report.

BoD/4803 Annual Report and Accounts 2021/22

The ADoCA&S presented the draft Annual Report and Accounts 2021/22 consistent with statutory guidance, the Foundation Trust Annual Reporting Manual (FT ARM) and Department of Health and Social Care Group Accounting Manual. Date for submission to NHS England was 22 June 2022. Comments received from internal and external were currently being reviewed and would culminate in a final audit opinion and sign-off via the Audit Committee.

The DoF reported that the draft annual accounts had been submitted on 21 April and received ISO260 which was positive. The Head of Internal Opinion provided overall good assurance. The outstanding governance report from NHS England was being considered by internal and external auditors in relation to signing off of the Annual Report and Accounts 2021/22.

External publication would take place once the information was laid before parliament and then published on the Trust website, NHSE/I website and formally presented at the Trust's AGM in September.

The Joint Chair commended those involved in the preparation of the Annual Report and Accounts.

Resolved: (i) that, the draft Annual Report and Accounts 2021/22 be noted, acknowledging that non-statutory content changes would be made; and

(ii) that, approval be granted for the Annual Report and Accounts 2021/22 to be submitted to NHS Improvement pending external and internal audit approval, and for the final report to be laid before parliament.

BoD/4804 Nursing and Midwifery Workforce Report

The CN/DoPS&Q presented a comprehensive Nursing and Midwifery Workforce Report for the February and March 2022. The report provided assurance that controls and daily arrangements ensured safe staffing was in the right place at the right time to be able to deliver the right care. Daily workforce reviews were undertaken with appropriate escalation in place for any concerns raised regarding staffing levels. Three areas were identified as requiring revised establishments and this was being addressed through business planning and robust interim arrangements.

The number of registered nursing (RN) vacancies was reduced from 84.9 wte (6.24%) in March to a forecasted position of 76.65 wte (5.56%) in April. The first cohort of internationally recruited nurses were due to arrive during June following recruitment in India and the Philippines. Unregistered nursing vacancies continued to reduce month on month and turnover rates were also beginning to reduce. The recruitment process for registered nurses was a core part of the Professional Workforce Strategy.

The key priorities and next steps were outlined and a detailed discussion ensued. AB confirmed that the Patient Safety and Quality Standards (PS & QS) Committee had oversight of any staffing issues and were comfortable with the escalation and triangulation provided. The CE explained the benefit of partnership working in being able to address attrition and vacancies and it was noted that following the appointment of the Chief Nurse for the Integrated Care Board a more system wide approach was anticipated. The Joint Chair highlighted the disparity between the turnover data in the report and that contained in the Integrated Performance Report which should be addressed as part of the deep dive. Formal feedback regarding the integration of the newly recruited international nurses to be presented at a future board.

Resolved:
(i) that, the significant work to ensure ongoing safe staffing adopted during February and March 2022 be noted; and
(ii) that, the ongoing work to reduce the registered nurse and midwife vacancies be noted; and
(iii) that, the disparity regarding turnover data be explored; and
(iv) that, feedback be provided at a future meeting regarding the integration of the newly appointed international nurses.

BoD/4805 Annual Self-Certifications

The ADoCA&S presented the Trust's Annual Self-Certifications, in line with NHS Improvement Annual Planning requirements and licence conditions to complete annual self-certifications of compliance against governance requirements. An overview of the Trust's position for each declaration was provided.

The Trust's Annual Priorities and Operating Plan for 2022/23 had been presented at the Board of Directors meeting on 28 April 2022. The IDoP&P reported that further narrative was required to support delivery against the standards not currently being met, including consistent delivery of the 62 day referral to treatment cancer standard, the impact of the Covid-19 pandemic on delivery of the elective and non-elective pathways.

The DoF reported that the system financial envelope had been set at an Integrated Care System (ICS) level for 2022/23, with an overall deficit of £122m. The Trust was currently forecasting a deficit of £1.4m driven by utility costs and inflation costs. £1.5bn inflationary monies was being made available, nationally and it was anticipated that c£60m would be available to off-set the system deficit. A further submission of financial plans was required by 20 June to reduce the forecast deficit position.

Due consideration had been given against each of the Self-Certifications based upon performance in 2021/22, the forecast pressures for 2022/23 and the mitigating actions in place to improve the 2022/23 position.

Compliance against the declarations was noted and delegated responsibility given to the Chairman and Chief Executive to sign the statements of self-certification on behalf of the Board.

Resolved: (i) that, due diligence had been paid by the Board of Directors in assessing on-going compliance with governance requirements, specifically those illustrated in regular seminars and committee discussion, in line with the NHS Provider Licence Conditions; and
(ii) that, the Board of Directors delegate responsibility to the Chairman and Chief Executive to sign the statements of self-certification contained within the enclosed attachments on behalf of the Board.

BoD/4806 External National Reports – Maternity Update

The CN/DoPS&Q presented an update on Maternity Services and the Ockenden Report. A lot of development work had been undertaken to strengthen the leadership and culture of Maternity Services in the Trust incorporating the principles of Better Births to provide safe and more personalised care for patients. Part 1 of the Ockenden Report published in December 2020 set-out seven immediate and essential actions for organisations to self-assess against. The Trust was initially compliant with five out of the seven actions and partially compliant for the remaining two actions. These were in relation to having the pathways of care available clearly set-out on the Trust website for patients to access and having a patient to chair the Maternity Voices Partnership to enable robust feedback. A patient chair had been appointed and the content of the website was being addressed.

The national Ockenden Team visited the Trust on 19 May 2022 to undertaken an assessment against the seven immediate and essential actions. Feedback from the visit was positive, with members of the Team commending the Trust's improvement culture and the potential to be great. The Trust was also commended for the positive relationships between staff from floor to board, that staff were able to visualise a brighter future and the exemplary work in relation to smoking cessation.

As part of providing assurance the CN/DoPS&Q and AB, Maternity Board Champion undertook regular walk-abouts to meet with staff; attended the Maternity Neonatal Safety Champions Group, were implementing a revised governance structure and were undertaking a leadership review.

Part 2 of the Ockenden Report contained a further 15 immediate and essential actions for organisations to be assessed against, which the Trust was working on. The deadline for evidence was September 2022, following which further visits would be undertaken by the national team. Further update to be provided at the October Board meeting,

The CN/DoPS& reported that an unannounced core service visit had taken place by the Care Quality Commission (CQC) the previous month to Maternity Services and and Children and Young Peoples Services which had been followed by a well-led review. The initial high level feedback had been positive overall. The outcome report was expected early July.

Resolved: (i) that, the progress on implementing the Ockenden seven immediate and essential actions to date be noted, and
(ii) that, the positive outcome of the visit by the Ockenden national team be noted; and
(iii) that, an update regarding part 2 of the Ockenden Report be presented at the Board of Directors meeting in October; and
(iv) that, the outcome report following the visit by the CQC was anticipated in early July.

BoD/4807 Freedom to Speak Up Update and Annual Report 2021/22

The Freedom to Speak Up Guardian (FTSUG), Fiona Gray presented the Freedom to Speak Up Annual Report 2021/22. The FTSUG role had been in place since 2016, and in line with guidance from the National Guardian Office was now full-time from August 2021. The Trust advocated an open and honest culture and encouraged staff to feel able to raise concerns through the various routes of escalation and the FTSUG was supported in the role by the executive team and Board members in addition to external bodies. Regular Keep In Touch meetings were held with the Executive Team to

ensure a proactive and positive approach to freedom to speak up.

Currently, there were ten Freedom to Speak Up Champions across the Trust to support staff and signpost to the most appropriate route to speak up. The provision of Freedom to Speak Up within the NHS was expanding including ambulance trusts, GP practices, dental practices, NHS Blood and Transplant and the Parliamentary and Health Service Ombudsman. The number of cases reported via FTSU had increased nationally, with the Trust reporting 50 cases during 2021/22, however, the results of the National Guardian Office Survey and the NHS Staff Survey indicated a reduction in the number of FTSU cases, reporting a positive culture of speaking up in organisations and the proportion of staff feeling able to speak up safely indicating further work was required. Staff involved in FTSU cases welcomed being kept updated particularly with more complex issues that took longer to resolve.

The FTSUG highlighted that there were a number of training resources available which was available to all staff and it was being considered to include modules as part of mandatory training. It was suggested that a development session for Governors regarding Freedom to Speak Up be arranged. SH reported that Fay Scullion had been appointed as the Board Champion for Freedom to Speak Up.

Resolved: (i) that, the content of the report and progress to date be noted; and
(ii) that, a Governor Development Session regarding Freedom to Speak Up be arranged.

BoD/4808 Guardian of Safe Working Hours Report

The MD/DCE presented the Guardian of Safe Working Hours Report for Quarter 4: 2021/22. The frequency of the doctor's forum had been increased to bi-monthly in order to increase the level of support being provided to doctors and address or escalate any concerns. Exception reporting was the method used to highlight any non-compliance with safe working hours, lack of support and missed educational opportunities. It was noted that during the reporting period trainees required to work additional hours due to staffing levels was a consistent theme and compounded by staff absence as a result of the Covid-19 pandemic. Some work had been carried out regarding the correct escalation processes regarding cannulation requirements.

Resolved: that, the content of the report be noted and accepted.

BoD/4809 Adult, Children and Young People Vulnerability Annual Report

The CN/DoPS&Q presented the Adult, Children and Young People Vulnerability Annual Report for 2021/22 and highlighted the key points. The Trust's Vulnerability Team although one resource comprised dedicated specialists for Adult Safeguarding and Children's Safeguarding. An Independent Domestic Violence Advocate was welcomed into the Team and had been able to support a number of individuals affected by domestic abuse. The Trust had contributed to the new evolving Multi Agency Child Exploitation, local authority arrangements to provide a more robust and timely response regarding child protection.

Resolved: that the contents of the Adult, Children and Young People Vulnerability Annual Report 2021/22 be noted.

BoD/4810 Director of Infection, Prevention & Control Annual Report 2021/22

The CN/DoPS&Q presented the Director of Infection, Prevention and Control Annual Report for 2021/22 and highlighted the key points. There had been a reduction in the number of healthcare associated infection particularly in MRSA, Clostridium Difficile, E coli and Klebsiella which was positive given the challenges of the Covid-19 pandemic. There was also a reduction in the number of diarrhoea and vomiting outbreaks. Increases in outbreaks of Covid-19 were in line with local community transmission rates

The CN/DoPS&Q and the Infection, Prevention and Control team were commended for their continued efforts.

Resolved: that, the contents of the Director of Infection, Prevention and Control Annual Report 2021/22 be noted.

BoD/4811 Any Other Business

a. Care Quality Commission Review

The Joint Chair reported that the Care Quality Commission (CQC) had recently visited the Trust to undertake an unannounced core service review of Maternity Services and Children and Young Peoples Services, followed by a well-led review at the end of May. The outcome report was expected in early July, however, the high level feedback following the visit had been positive.

Resolved: that, the verbal update be noted.

BoD/4812 Date and Time of Next Meeting

Resolved: that, the next meeting be held on, Thursday, 28 July 2022 in the Boardroom at the University Hospital of North Tees.

The meeting closed at 12.20pm.

Signed:  Date: 28 July 2022

BoD Public

Date	Ref.	Item Description	Owner	Deadline	Completed	Notes
27 May 2021	BoD/4537	***Maternity Services*** Market place event to be considered to showcase the great work being done within Maternity Services	L. Robertson			An event will be planned for September.
27 January 2022	BoD/4701	***Joint Partnership Board Update*** Revised Terms of Reference for the Joint Partnership Board to be presented back to a future meeting for approval by the Board of Directors	S. Hutt			An updated Terms of Reference with changes to the membership and quoracy were presented on 14 June 2022, prior to ratification at the Joint Partnership Board on 20 July 2022.
8 June 2022	BoD/4795	***Patient Story*** A mechanism to thank patients for their stories to be considered.	L. Robertson			
8 June 2022	BoD/4802	***Integrated Compliance and Performance Report*** A further understanding of sickness data to be presented in future Integrated Performance Reports	S. Cook			
8 June 2022	BoD/4804	***Nursing and Midwifery Workforce Report*** The disparity in turnover data compared to the data in the Integrated Performance Report to be reviewed as part of a workforce review.	L. Robertson			
8 June 2022	BoD/4804	***Nursing and Midwifery Workforce Report*** An update to be provided at a future meeting regarding the integration of the newly appointed international nurses from the Philippines and India into the Trust.	L. Robertson			
8 June 2022	BoD/4806	***Maternity Update*** An update regarding Ockenden Report: Part 2 to be presented a the Board of Directors meeting in October 2022.	L. Robertson			
8 June 2022	BoD/4807	***Freedom to Speak Up Annual Report*** A Governor Development Session on Freedom to Speak Up to be arranged.	S. Hutt			Agreed with Fiona Gray, Freedom to Speak Up will be the topic of the Governor Development Session on 8 September 2022.

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Joint Chair's Report										
Date:	28 July 2022										
Prepared by:	Sarah Hutt, Company Secretary										
Sponsor:	Professor Derek Bell, Joint Chair										
Purpose of the report	The purpose of the report is to update 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:

The report provides an overview of the health and wider contextual related news and issues that feature at a national, regional and local level.

Key issues for Information:

- Joint Partnership Board;
- NHS England / Improvement;
- Care Quality Commission;
- Messenger Report;
- COVID-19 Public Inquiry;
- Digital Plan;
- Department and site visits;
- Board Walkabouts;

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

There are no risk implications associated with this report.

Committees/groups where this item has been discussed	N/A
Recommendation	The Board of Directors are asked to note the content of this report.

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

28 July 2022

Report of the Joint Chair

1. Introduction

This report provides information to the Board of Directors on key local, regional and national issues.

2. Key Issues and Planned Actions

2.1 Joint Partnership Board

The second facilitated Joint Board Away Day with the Boards of South Tees Hospitals NHS Foundation Trust and the Trust took place on 15 June 2022, building on the progress from the May meeting. A number of actions were agreed and would be taken forward through the Joint Partnership Board.

2.2 NHS England / Improvement

The report detailing the outcomes and recommendations of an investigation carried out by NHS England / Improvement earlier in the year was still in progress

2.3 Care Quality Commission

The report from the Care Quality Commission (CQC) following their focused core service and well-led reviews was anticipated for mid-August.

2.4 Messenger Report

The findings of the review into leadership in health and social care led by General Sir Gordon Messenger and Dame Linda Pollard was published on 8 June. Encompassing seven recommendations, the report highlights the requirement to better support chief executives and delivering a consistent approach to leadership development.

In addition, the report describes the need to create a more diverse leadership in the NHS through better support mechanisms for staff from all ethnic minority backgrounds, and a greater commitment to improve diversity in senior leadership and board appointments. This is mirrored in the revised Code of Governance by setting out a new focus on equality, diversity and inclusion, among board members as well as training in EDI for those undertaking director-level recruitment and the development of plans for boards and senior management of the organisation to reflect the diversity of the local community or workforce.

An example of such a focus can be found in the report The Way Forward: the experience of Black, Asian and Other Ethnic (BAE) Non-Executive Directors in the NHS developed with the Seacole Group, a network for BAE NEDs and Hunter Healthcare.

2.5 COVID-19 Public Inquiry

The COVID-19 Public Inquiry was formally launched on 21 July 2022 by the Chair of the Inquiry, Baroness Hallett. The Inquiry would be broken down into three modules with teams across the UK investigating each module. There would also be an opportunity for those

impacted by the pandemic, including the bereaved to take part in a listening exercise to provide evidence in a less formal setting.

2.6 Digital Plan

A plan for digital health and social care was published on 29 June 2022, setting out the vision for a digital future and digital transformation in health and social care with four key aims: equipping the system digitally for better care; supporting independent healthy lives; accelerating the adoption of proven technology and aligning oversight with accelerating digital transformation.

2.7 Department and site visits

The programme of monthly visits to the University Hospital of Hartlepool continue. A small number of Governors and I had an interesting visit to the Integrated Single Point of Access (iSPA) and clinical triage, hearing about developments for virtual wards and urgent community response and to the Holdforth Hub. It was a great opportunity to speak with staff about this positive work.

2.8 Board Walkabouts

The first full Board Walkabout since the pandemic took place on the North Tees site on 14 June providing a good opportunity to visit a wide range of services and speak to staff about the valuable work they do.

3. Recommendation

The Board of Directors are asked to note the content of this report.

Professor Derek Bell
Joint Chair

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Chief Executive Report														
Date:	28 July 2022														
Prepared by:	Julie Gillon, Chief Executive Donna Fairhurst, Personal Assistant														
Executive Sponsor:	Julie Gillon, Chief Executive														
Purpose of the report	The 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	X	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:

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 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 current position, emergency care challenges and continued recovery
- Health and Wellbeing Strategy
- Research and Development
- Integrated Care System and Integrated Care Board
- North East and North Cumbria Provider Collaborative
- Tees Provider Collaborative
- Community Diagnostic Centre
- Endoscopy Training Academy
- Faculty for Leadership and Improvement
- North Tees and Hartlepool NHS Foundation Trust Estates Strategy
- Consultant Appointments
- NHS Birthday
- Bowel Screening Programme
- Breast Screening Service
- George Cross for the NHS
- Rowan Suite

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 are discussed at Executive Team and other relevant committees within the governance structure to ensure consideration for strategic intent and delivery.
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

28 July 2022

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. Strategic Objective: Putting our Population First

2.1 Current Position and Continued Recovery

2.1.1 COVID-19

As previously reported to the Board of Directors, May saw a gradual reduction in covid positive patients. However, there was a steady increase in Covid patients during June, which continues into July 2022. As at 21 July 2022, the Trust is caring for 80 Covid-19 positive patients, one of which requires critical care intervention.

As Chart 1 below demonstrates, the current number of Covid patients in hospital is similar to the position in early April. This is echoed in hospitals nationally and across the North East and North Cumbria Integrated Care System (NENC ICS). The total has been rising at an average of about 20% a week. Despite intelligent forecasting, it is unclear at this time whether the rates will continue to rise or potentially plateau and the Trust continues to adapt elective and non-elective pathways in response to the rising levels of Covid patients in hospital.

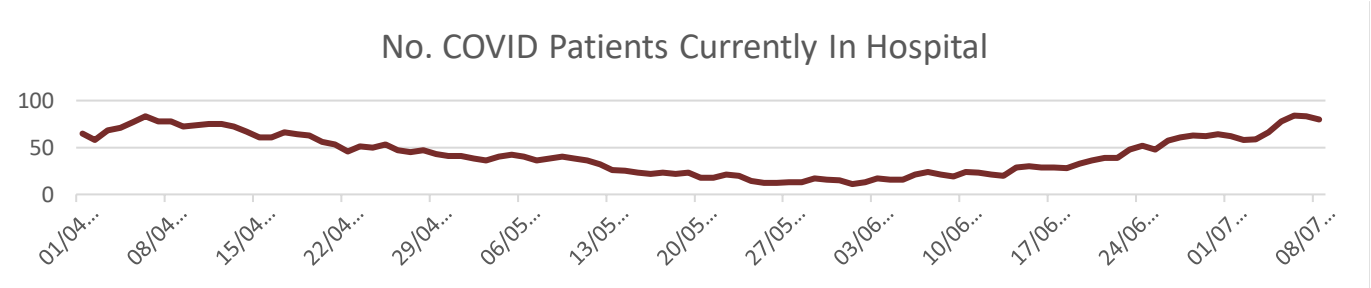

Chart 1: No. COVID Patients Currently In Hospital

The consequential impact on both increasing staff absence and reducing the risks of nosocomial infections have required the reintroduction of face masks in clinical areas for staff and patients. Visitors will be asked to wear masks in clinical and patient-facing areas within the hospital. There has been no change to the visiting policy at this time.

2.1.2 Operational Challenges

The NENC ICS has seen increased demand for services with an increased number of patient attendances to Emergency and Urgent Care Departments exacerbated further with the impact of ambulance diverts and deflections within the system. Reducing ambulance handover delays continues to be an area of focus for quality improvement, embedding changes, sustaining performance and further leadership development to minimise the impact for patients. Improvement during Quarter 1 2022/23 is evident, with the team presenting their success to date at the Celebrating Excellent event on 15 July 2022.

Although challenges continue to be challenges the Trust saw an ambulance handover delay (>60 min) rate of 0.7% (n=10) against the ICS rate of 4.4% (n=764) with a further improvement in May to 0.4% (n=7). However, sustained improvement work including medical, surgical and community pathways remain core to delivering timely care for patients.

A continued focus on timely discharge and the use of the OPTICA discharge tool to support the management of patients who do not meet the criteria to reside has been a key enabler in managing the current operational challenges. The Trust continues to work closely with system partners to address improvements collectively and to help reduce pressure across the system. The Trust has continued to provide additional capacity to address the Covid backlog and the recovery of elective waiting lists with a (comparatively successful) performance position, both locally and nationally.

2.1.3 COVID-19 Public Inquiry

The Final Terms of Reference for the Public Inquiry on the government's handling of the Covid-19 pandemic has been published and officially commenced on the 28th June 2022. The focus of the Inquiry is expounded to include:

- The impact on the mental health and wellbeing of the population, including but not limited to those who were harmed significantly by the pandemic;
- The impact on mental health and wellbeing of the bereaved, including post bereavement support;
- The impact on children and young people, including health, wellbeing and social care, and do education and early years provision;
- Safeguarding and support for victims of domestic violence;
- Antenatal and postnatal care.

The Trust is liaising with the NENC ICS Emergency Preparedness, Resilience and Response teams to support the local Covid Inquiry preparations; this is monitored through the Trust Resilience Forum with direct reporting and escalation to the Executive Team. Currently, the Trust is undertaking a review on the implementation of guidance received during the pandemic to evidence decision-making, escalation and reporting mechanisms. It is unclear the level of data that will be required from individual providers at this stage, with the focus of the inquiry reinforcing the central government decision making as the initial phase.

3. Strategic Objective: Health and Wellbeing

3.1 Health and Wellbeing Strategy

The revised Health and Well-being Strategy has three headline objectives; Putting our People First, Leadership and Culture and Engagement. The strategy devised by the Executive Team and shared with the People Committee supports the 'back to basics' approach from the Board. The strategy is aligned to and part of a more comprehensive approach to the staff survey and to the overarching People Plan and the People Promise with a clear foundation of knowledge and understanding of the overarching areas, which ensure staff feel safe, healthy, and ready for the future.

Following discussion at the People Committee on the 9th of June 2022, the associated action plan that was developed externally will be revised to ensure that it is aligned more specifically to the Trust's needs and to ensure that it dovetails with work on culture, equality, diversity and inclusion and reward and recognition with new measures assigned to each action. It is anticipated this work will be completed in August 2022.

3.2 Research and Development

The 12-month improvement plan for Research and Development (R&D) highlighted key areas of focus for this year.

Increased participation in research across a broader range of specialisms - Focusing on Orthopaedics, Surgery, Respiratory, Diabetes, Critical Care, and Paediatrics to support with post-COVID bounce back.

Ensure patients and their contribution to research is valued and supported and that the CQC requirements are met. The research team is to input into Quality Assurance & Safety Council going forward.

Increased engagement from and development of Nursing, Midwifery and Allied Health Professionals and Clinical Research Professionals –undertaken by attending community of practice and Trust Senior Nursing Team meeting. Also looking to extend South Tees NHS Foundation Trust "Be Curious" campaign to North Tees and Hartlepool NHS Foundation Trust.

Increased collaboration and mentorship internally and externally R&D Seminar series being planned across Tees Valley Research Alliance for Autumn and Matt Dewhirst, Consultant Cardiologist is planning his first Cardio Investigation study and grant application in collaboration with the new Academic Cardiovascular Unit at South Tees..

The Trust is the top recruiting site for the Senior Randomised Intervention Treatment of Angina (RITA) cardiology trial (patients presenting with type 1 Non-ST-elevation myocardial infarction (NSTEMI) aged ≥75 years randomised between invasive and conservative treatment strategies, to compare time from randomisation to cardiovascular death or non-fatal myocardial infarction).

It was also noted that the Trust is the fourth highest recruiting UK site for a randomised controlled trial of contrast-enhanced colonoscopy in the reduction of right sided bowel cancer (CONSCOP2) to reduce bowel cancer mortality.

The recent Tees Valley Research Alliance event was a huge success with over 130 attendees from both Trusts with a keynote speech from our Joint Chair.

A "Celebrating Excellence in research" event is being planned for the Autumn to allow the Board, Executive, Senior Nurses and Clinical Directors to see the range of studies the Trust is participating in and the opportunities for staff and patients.

4. Strategic Objective: Transforming our Services

4.1 Integrated Care System (ICS)

4.1.1 Integrated Care Board (ICB)

On 1 July 2022, the North East and North Cumbria Integrated Care Board (NENC ICB) became a statutory NHS organisation. The ICB held its first public Board meeting during the week of 1 July with the meeting dedicated to approving and ratifying governance arrangements and providing an update on the performance and financial position across the Region. Going forward the ICB will focus on three key strategies; Communities and People Involvement and Engagement Strategy, Plans to reduce Health Inequalities within the Region and the three-year plan to deliver their goal to become England's greenest region.

4.2 North East and North Cumbria Provider Collaborative (PvCv)

Following the publication of the Government's white paper 'Integration and Innovation: working together to improve health and social care for all' in February 2021 and subsequent passing of the Health and Social Care Bill this year, all NHS Acute Trusts and Mental Health Trusts are required to work as part of at least one formal provider collaborative from 1 July 2022.

The 11 Foundation Trusts in the NENC have been working in broad collaboration since September 2020, exploring appropriate working relationships that add value. Under the chairship of Ken Bremner and the Managing Director (Matt Brown) the Provider Collaborative set out to develop 4 key elements:

- Formal governance arrangements
- Operating Model
- Responsibility agreement
- Detailed work plan and priorities

Three of the four elements have been developed and form the basis of this update (attached as Appendix 1). The detailed work plan is intended to evolve over time and is currently in development. All 11 Foundation Trusts within the NENC region will operate as a Provider Leadership Board (PLB) chaired by one of the 11 Chief Executives on a rotational basis supported by a Deputy Chair who will then take over as Chair.

The five key priorities for the NENC Provider Collaborative are to:

1 Develop a strategic approach to clinical services encompassing acute, mental health, learning disabilities and community whilst focusing on vulnerable services with a strategic response to clinical networks and associated cross-system working;

2 Deliver on elective recovery including inpatient, diagnostics, cancer care, mental health and learning disabilities in order to meet and exceed national benchmarks, standards and targets;

3 Deliver urgent care standards (including ambulance standards) and requirements across NENC providers and local systems to reduce variation and improve consistency of response;

4 Build capacity and capability in clinical support services (in particular Diagnostics) to ensure appropriate infrastructure is in place to deliver clinical priorities;

5 Support the wider ICS sustainable transformation, establishing and delivering appropriate corporate strategies to enhance integration and tackle variation e.g. collective planning, aligned estate strategies, workforce strategies and commitment to ICS green plan.

The NENC Provider Collaborative will facilitate horizontal collaboration between Trusts and will be focused at a system level whilst complimenting and supporting the work of individual Trusts at sub-system and place level. For this Trust this will mean a number of variations on 'place' – individual Local Authority basis; Hartlepool and Stockton as a locality; and Tees Valley, as illustrated through the work of the Tees Valley Health Inequalities Summit.

4.3 Tees Provider Collaborative

4.3.1 Service and Estate Developments

4.3.1.1 Community Diagnostic Centre – Proposed Plans Tees

A strategic plan for the health system in Tees Valley to develop diagnostic capacity, including a proposed new build Community Diagnostic Centre (CDC) by the end of 2025 has been agreed by the system. A programme board has been established to take forward the development of the CDC which reports into the Clinical Services Strategy Board.

A report considered by the Tees Valley CCG Governing Body in May 2022, sought approval for the recommended site for the permanent hub. This site was identified as the result of an independently commissioned site appraisal across Tees Valley, which considered the best location using a number of criteria including local geography and proximity with diagnostic spoke sites to ensure maximum coverage across the patch, one public estate principles, and accessibility for patients, health outcomes, inequalities, deprivation, cost effectiveness and deliverability. The Tees Valley CCG approved the Castlegate Campus site in Stockton and will be part of the Stockton on Tees Borough Council Waterfront Masterplan development. A partnership board has been established with Stockton on Tees Borough Council to ensure effective working relationships are developed, that there is development of clear communications, governance and decision making between the respective

schemes and that timelines are aligned to meet the requirements of the NHS England CDC capital funding timescales.

Work with clinical teams on development of the outline business case (OBC) is nearing completion. The final version OBC has been submitted to the Trust Boards) in July with approval to progress to the next stage of the process and submit the OBC to NHS England (NHSE). Once feedback is received from NHSE and subject to agreement, a final business case will be developed for approval by Trust Boards and the Integrated Care Board of the ICS before submission to NHSE for final agreement and sign off with a number of risks to be mitigated and supported to enable delivery and implementation.

4.3.1.2 Endoscopy Training Academy

Building work on the new Endoscopy Training Academy at the University Hospital of Hartlepool was completed on the 18th June. Recruitment of clinical, managerial and administrative staff to support operational delivery of the academy is underway utilising funding provided by Health Education England, Northern Cancer Alliance and the Trust. The Academy will be delivered collaboratively with South Tees NHS Foundation Trust and it is anticipated the academy will open in September 2022 with the first cohort of trainees.

5. Strategic Objective: Valuing our People

5.1 Faculty for Leadership and Improvement

At a recent virtual event for 100 Leaders, the Pack Leaders provided an overview of the projects being undertaken and the progress made to date. Engagement from the cohort has been excellent and these events bring people back together providing further opportunities for shared learning and connecting. The midpoint showcase is scheduled to take place on 1st August, over recent weeks; the Faculty have provided a focus on sustainability to ensure this is considered as part of each project.

The introduction of the Chief People Officer to Faculty meetings will bring a cohesion to the strategic direction of the Trust and the strategies around leadership development and quality improvement will be further developed. The Faculty is working with stakeholders to ensure appropriate candidates are recruited for Quality, service improvement and redesign (QSIR) cohorts two and three, ensuring the organisation maximises the opportunity to build capability in support services.

5.2 North Tees and Hartlepool NHS Trust Estate Strategy

The Trust is working on refining the estates strategy and on building the case for investment for future service and estate provision with the ambition of a new hospital. This includes case for change, vision for the future and the value proposition and benefits realisation.

In recent weeks, the Trust has worked on the development of an options appraisal with stakeholders in order to inform the preferred way forward. This has been supported by a robust demand and capacity model in addition to a draft economic and financial model. The first draft of the Strategic Outline Case (SOC) is expected to be complete by the end of July.

5.3 Consultant Appointments

Since the Board of Directors meeting on 8 June 2022, the following appointments have been made:

Dr James Dundas appointed to Consultant Cardiologist post
Mr Siddek Isreb appointed to Consultant Upper GI Surgeon
Mrs Angela Bolch appointed to the role of Chief Pharmacist

These appointments will see the further manifestation of strategy delivery in pathways and on ambitious role for Pharmacy medicine optimisation and alternative workforce models.

5.4 National Health Service (NHS) – 5 July 2022

The NHS celebrated its 74th birthday on 5 July 2022 and the Trust took part in celebrations by reflecting and celebrating how the NHS has innovated and adapted to meeting the changing needs of each generation.

5.5 Bowel Screening – Quality Assurance Visit

The Trust was involved in a Bowel Screening Quality Assurance Review on 7 July 2022 and received excellent feedback regarding quality, research and patient experience. The unit was recognised as being at the forefront of the national bowel-screening programme. The formal report will be available in 10 weeks.

5.6 Breast Screening Unit – University Hospital of North Tees

The Breast Screening Unit at the University Hospital of North Tees has been cited as one of the top two in the country in terms of screening recovery and round length. The Board of Directors will join me in congratulating the teams' hard work, skill and resilience over the last two years to achieve this fantastic accolade.

5.7 George Cross for the NHS

The NHS has received the George Cross from Her Majesty the Queen. Everyone at North Tees and Hartlepool NHS Foundation Trust is committed to improving the health of the local population. Receiving the George Cross is a wonderful recognition of that commitment and we are honoured to be given this historic accolade.

5.8 Rowan Suite

There was disappointment for the Rowan Team at the 2022 Parliamentary Awards – who were shortlisted but unfortunately missed an award at a special ceremony in Westminster this month. The midwife-led service at the University Hospital of Hartlepool has been a fantastic success – we having received positive feedback from every parent who has used the service. It is an initiative completely led by the maternity team – and an example of a key service development at Hartlepool Hospital site.

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.

North East and North Cumbria
Provider Collaborative

North East and North Cumbria Provider Collaborative Governance

Update for NHS Foundation Trust Boards

July 2022

1. Purpose

This report summarises the proposed formal work structure and governance for the North East and North Cumbria (NENC) Provider Collaborative, setting out how the 11 NHS Foundation Trusts (the Trusts) will operate, with the creation of a Provider Leadership Board (PLB), set out in the Ambition, Operating Model and Collaboration Agreement. There are separate arrangements for other collaboratives, such as those specifically for specialised mental health, learning disability and autism services.

Trust Boards are asked to note progress and confirm agreement to the proposed governance arrangements.

2. Context

National policy required that by the 1st July 2022 all NHS acute and mental health trusts are working as a provider collaborative with a requirement that they:

- Are formally convened with a focus on collaborative working to deliver local and national requirements
- Are established as a formal entity
- Have in place appropriate engagement and collective decision-making structures.

The intention of the legislation is that this supports closer system working and that it provides a basis for formal agreement between the Provider Collaborative and the Integrated Care Board (ICB) on jointly determined objectives and ways of working to deliver against those objectives.

Within NENC the 11 Foundation Trusts agreed to work together as a provider collaborative in September 2020. Since then, the Trusts have been developing working relationships, governance arrangements and determining areas for focus in the first instance. Though this work, the Provider Collaborative determined that this joint work would underpinned by four key documents:

1. A formal memorandum of agreement to be made between the Trusts, setting out how the Provider Collaborative will work, the **"Collaboration Agreement"**

2. A document setting out the aspiration and ambition that Trusts have together, as a form of prospectus, particularly designed for partners and stakeholders, in **"Our Ambition"**
3. A work programme which will need to evolve over time, setting out priorities and the mechanisms for operational delivery such as capacity, workstreams and meeting structures, the **"Operating Model"**
4. A documented agreement between the Provider Collaborative and the ICB, setting out a shared view on priorities, work areas for the Provider Collaborative to take forward on behalf of the ICB, accountabilities and resourcing, the **"Responsibility Agreement"**.

Since Summer 2021, the 11 Trusts have worked together to develop their governance model and wider approach through a series of facilitated workshops and along with specialist support from the legal firm Hill Dickinson to draft a governance structure.

3. Collaboration Agreement

The Collaborative Agreement includes as signatories all 11 Trust members of the Provider Collaborative, setting out the following key provisions:

- the overarching purpose and aims of the Collaborative and the status of the collaborative agreement;
- the proposed term of the agreement and arrangements for its regular review and updating;
- the principles of collaboration agreed between the Trusts, acknowledging each Trust's statutory duties and contractual obligations and the requirement for / ability of the Trusts to participate in other collaborative arrangements;
- the work programmes that have been agreed at the outset to be taken forward by the Collaborative and the resources the Trusts have agreed to commit (including to fund the Collaborative infrastructure (e.g. PMO)) etc;
- the governance arrangements to take forward the work programmes including the Provider Leadership Board and any sub-groups, together with terms of reference;
- a development plan setting out the key areas and priorities the Collaborative has agreed to focus on in further developing its governance and overall approach over the next 12-24 months;
- the process for resolving disagreements between the Trusts;
- the parameters of information sharing between the Trusts and dealing with conflicts of interest; and
- the process for members to terminate the arrangements, or for withdrawal of an individual Trust member and the process for admitting new members to the Collaborative.

The Collaboration Agreement sets out the governance approach, with a key vehicle for Provider Collaborative decision-making being the establishment of a 'Provider Leadership Board' (PLB). The Provider Leadership Board representation will be the Chief Executives of each of the 11 Trusts and is established as the overarching body, overseeing and directing the jointly agreed programme of work. Under this approach individual Trust boards would retain final decision-making authority with

each board giving their respective chief executive (or nominated organisational representative) delegated authority to make decisions as appropriate. Decisions would be made on a consensus basis.

A number of alternative approaches were considered that would see more formal delegation to the Provider Collaborative, but were not felt to be appropriate at this point. For reference, the key alternatives considered were Committees in Common (CiC) and Joint Committee (which are now permissible under the Health Act). In these approaches, formal decision making is delegated to organisational representatives with decisions taken in the CiC or Joint Committee binding on constituent organisations. In the provider leadership approach, final decisions rest with the individual organisations and this works on the basis that the partners trust agree formally to work together but individual trust boards retain full decision making powers.

The provider leadership model was felt to be appropriate as:

- It built from the existing model and work to date
- Allowed for a formalised decision making without becoming overly bureaucratic
- Was a flexible solution that could adjust to wider system working requirements as they evolve and emerge
- Was not restrictive, in that it would allow for growth and development into approaches which allowed for greater delegated authority, should the Trusts wish to evolve in that way over time.

The Collaboration Agreement sets out that the chair of the Provider Leadership Board would be one of the chief executives with a 24 month term of office, with a potential extension of a further 24 month term of office. The PLB Chair would be one of the two Integrated Care Board FT members and the tenure is aligned accordingly. A vice-chair would also be appointed, with the intention that the vice-chair is the successor to the chair, and a new vice-chair appointed by the Provider Leadership Board members. In January 2022, Ken Bremner was appointed as the chair and Lyn Simpson as the vice-chair.

4. Our Ambition

Our Ambition is intended to be a document that is externally facing, summarising how the Provider Collaborative seeks to deliver system priorities and how it will link, interface and work with other partners and stakeholders.

This document describes who the Provider Collaborative is, its role and what it seeks to achieve and how it will facilitate horizontal collaboration between Trusts. It highlights that the focus is at system level and therefore will complement and support work at place-level and with nested collaboratives, such as on a sub-regional basis. It recognises that there will be different partnership and collaborations at different levels in this system.

The Provider Collaborative will be one of a number of partnerships that the ICB will work with and through to deliver its overall aims and objectives. The role of the Provider Collaborative will be evolve over time in line with ICB requirements.

5. Operating Model

The Operating Model is intended to be a document that will evolve over time, setting out the key priorities for the Provider Collaborative and the way in which these will be taken forward operationally, including people, meeting and governance structures. The work programmes are structured around three broad areas of clinical, clinical support and corporate programmes, which is consistent with other, well-established provider collaboratives from around the country. The document sets out that the Provider Collaborative will have its own programmes and priorities as well as those agreed with the ICB.

The Provider Collaborative has set out to have a programme management approach with a particular focus over the next we months on:

- Clinical programmes, including
    - Elective and system recovery, reducing long waits for patients and taking forward the programme of transformation
    - Urgent and emergency care, supporting colleagues in local systems with collaborative solutions to pressures
    - Strategic approach to clinical services, tackling vulnerable services collectively such as issues with non-surgical oncology, supporting and leading clinical networks, and developing a strong model of clinical leadership
- Clinical support programmes, not least the development of the NENC Provider Collaborative Aseptics Manufacturing Hub and continuing to focus on collaborative opportunities for pathology and diagnostics
- Corporate programmes, where there are opportunities to make improvement by working together, particularly in seeking to take a more consistent, convergent approach to decisions affecting workforce and estates, while recognising the different circumstances for each organisation.

Programme reporting will be directly to the Provider Leadership Board, through Chief Executives taking on a Senior Responsible Officer role, supported by a programme management structure overseen by the Managing Director. Initial pump-priming resource to support the development of the collaborative and programme management capacity has come from NECS.

6. Integrated Care Board Working Arrangements (Responsibility Agreement)

The Collaborative Agreement, Operating Model and Our Ambition documents have been shared with the Integrated Care Board (ICB) and formally supported by the ICB Executive Team, prior to seeking final approval by FT Boards. The Provider Collaborative and the ICB are aligned on the intended priorities, governance approach and ways of working set out in these documents. However, it has not yet been possible to formally reflect this into a Responsibility Agreement, given the ICB has only been established in July 2022.

It was determined that the Collaboration Agreement, Operating Model and Our Ambition documents should be shared with Trust Boards for support and approval, whilst the Responsibility Agreement is developed. The Responsibility Agreement will be shared with Trust Boards once concluded and will document clearly shared priorities, governance, escalation, accountability and resourcing.

7. Recommendation

The FT Boards of the eleven NENC Provider Collaborative members are asked to:

- Note the progress made on the development of the NENC Provider Collaborative
- Note and formally approve the documents setting out the Collaboration Agreement, Operating Model and Our Ambition

Matt Brown

Managing Director

North East and North Cumbria Provider Collaborative

8th July 2022

Enclosures

- **Enc. A: Collaborative Agreement (MoU)**
- **Enc. B: Operating Model**
- **Enc. C: Ambitions Document**

Enclosure A

8TH JULY 2022

1. **COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST**
2. **CUMBRIA, NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST**
3. **GATESHEAD HEALTH NHS FOUNDATION TRUST**
4. **THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST**
5. **NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TUST**
6. **NORTH EAST AMBULANCE SERVICE NHS FOUNDATION TRUST**
7. **NORTH TEES AND HARTLEPOOL HOSPITALS NHS FOUNDATION TRUST**
8. **NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST**
9. **SOUTH TEES HOSPITALS NHS FOUNDATION TRUST**
10. **SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST**
11. **TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST**

COLLABORATION AGREEMENT

FOR THE NORTH EAST AND NORTH CUMBRIA PROVIDER COLLABORATIVE

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No	Date	Version Number	Author
1	140322	1	Hill Dickinson (EV)
2	240322	2	Hill Dickinson (EV)
3	290422	3	PvCv (NS)
4	270622	4	PvCv (NS)
5	300622	5	PvCv (NS)
6	060722	6	PvCv (MB)

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Overarching Note

This Collaboration Agreement is based on a memorandum of understanding approach to provide an overarching, non-legally binding, framework for collaboration between the Trust parties.

The Agreement sets out the current purpose, objectives, and initial priorities of the Collaborative. It also sets out its initial governance structure for the Trusts to come together to make aligned decisions in specific areas. The format of the Agreement is designed to work alongside existing services contracts held by the Trusts such as the NHS Standard Contract (the Services Contract), and does not affect or override any of the current Services Contracts in any way.

Some areas of the Agreement will need significant development around the nature and function of the Collaborative over time, as outlined in the Operating Model in Schedule 4. In particular, the Integrated Care Board (ICB) and Provider Collaborative have set out the need for a Responsibility Agreement, to define agreed areas of work, accountability, escalation and resourcing. This Responsibility Agreement will set out the part that the Provider Collaborative plays in the context of the wider system and will be developed throughout the Summer of 2022, following the formal establishment of the ICB.

The Integrated Care Board Executive team has supported the content of this Collaboration Agreement.

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Date: **8th July 2022**

This **Collaboration Agreement** ("**Agreement"**) is made between:

1. **County Durham and Darlington NHS Foundation Trust** of Darlington Memorial Hospital Hollyhurst Road, Darlington, County Durham, DL3 6HX;

2. **Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust** of St. Nicholas Hospital, Jubilee Road, Gosforth, Newcastle upon Tyne NE3 3XT;

3. **Gateshead Health NHS Foundation Trust** of Queen Elizabeth Hospital, Sheriff Hill, Gateshead NE9 6SX;

4. **The Newcastle Upon Tyne Hospitals NHS Foundation Trust** of Freeman Hospital, Freeman Road, High Heaton, Newcastle upon Tyne, NE7 7DN;

5. **North Cumbria Integrated Care NHS Foundation Trust** of NCIC Trust HQ, Pillars Building, Cumberland Infirmary, Infirmary Street, Carlisle, CA2 7HY;

6. **North East Ambulance Service NHS Foundation Trust** of Bernicia House, Goldcrest Way Newburn Riverside, Newcastle upon Tyne, NE15 8NY;

7. **North Tees and Hartlepool Hospitals NHS Foundation Trust** of Hardwick Road, Hardwick, Stockton-on-Tees TS19 8PE;

8. **Northumbria Healthcare NHS Foundation Trust** of 7, Northumbria House, Cobalt Business Park, 8 Silver Fox Way, Newcastle upon Tyne NE27 0QJ;

9. **South Tees Hospitals NHS Foundation Trust** of The James Cook University Hospital, Marton Road, Middlesbrough, Cleveland, TS4 3BW;

10. **South Tyneside and Sunderland NHS Foundation Trust** of Sunderland Royal Hospital, Kayll Road, Sunderland, SR4 7TP;

11. **Tees, Esk and Wear Valleys NHS Foundation Trust** of Trust Headquarters, West Park Hospital, Edward Pease Way, Darlington, Durham, DL2 2TS,

together referred to in this Agreement as the "**Trusts**" and "**Trust**" shall be construed accordingly.

BACKGROUND

1. The white paper published by the Department of Health and Social Care in February 2021[1] (the "**White Paper**") builds on the NHS Long Term Plan vision of integrated care

[1] *Integration and Innovation: working together to improve health and social care for all* (Integration and Innovation:

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and sets out the key components of a statutory integrated care system ("**ICS**"). One of these components is a provider collaborative, a partnership arrangement involving two or more trusts working across multiple places to realise the benefits of mutual aid and working at scale. The Health and Care Bill 2021 implements proposals from the White Paper with effect from 1 July 2022, including new mechanisms to enable provider NHS trusts to make joint decisions.

2. Guidance[2] states that provider collaboratives should have a shared purpose and effective decision-making arrangements to:

   (a) reduce unwarranted variation and inequality in health outcomes, access to services and experience;

   (b) improve resilience by, for example, providing mutual aid; and

   (c) ensure that specialisation and consolidation occur where this will provide better outcomes and value.

3. The Trusts have been working together informally as a provider collaborative since 2020 (the "**Collaborative"**). With the NHS North East & North Cumbria Integrated Care Board ("**ICB**") established on 1 July 2022 pursuant to the Health & Care Bill, there is a need for the Collaborative to formalise its governance arrangements and ways of working to ensure it can be proactive in setting its relationship with the ICB, and other stakeholders, moving forward.

4. Aligned to the Collaborative's agreed purpose, the Trusts have agreed to undertake several initial programmes of work that they will pursue through the Collaborative governance (see Schedule 3). The Trusts have also agreed a plan for the further development of the Collaborative from the Commencement Date, as detailed in the Operating Model in Schedule 4.

5. This Agreement provides an overarching governance framework for the Trusts to work and make decisions together on matters within the remit of the Collaborative. The framework set out is intended to enable, and not prevent, smaller groups of Trusts to come together on specific programmes of work where it makes sense for them to do so.

6. While, through this Agreement, the Trusts are documenting their agreed governance arrangements for the Collaborative as at the Commencement Date, the governance

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working together to improve health and social care for all (publishing.service.gov.uk)

[2] *Working together at scale: guidance on provider collaboratives* (NHS England, August 2021)

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model is likely to evolve over time as the Trusts develop their working relationships further and as the ICB's operating model develops. A Responsibility Agreement will be developed to define the relationship between the ICB and the Collaborative. New governance mechanisms will become available when the Health & Care Bill becomes law, including the ability for the Trusts to form joint committees with each other, and with the ICB. The Collaborative will also need to evolve to be capable of receiving, delivering and providing assurance to the ICB on the exercise of any ICB functions delegated to or commissioned from the Collaborative, alongside any existing programmes agreed by the Trusts. It is therefore anticipated that this Agreement will be reviewed and updated regularly by agreement of the Trusts.

OPERATIVE PROVISIONS

1. DEFINITIONS AND INTERPRETATION

1.1 In this Agreement, capitalised words and expressions shall have the meanings given to them in Schedule 1.

1.2 In this Agreement, unless the context requires otherwise, the following rules of construction shall apply:

1.2.1 a person includes a natural person, corporate or unincorporated body (whether or not having separate legal personality);

1.2.2 a reference to a "**Trust**" includes its personal representatives, successors or permitted assigns;

1.2.3 a reference to a statute or statutory provision is a reference to such statute or provision as amended or re-enacted. A reference to a statute or statutory provision includes any subordinate legislation made under that statute or statutory provision, as amended or re-enacted;

1.2.4 any phrase introduced by the terms "**including**", "**include**", "**in particular**" or any similar expression shall be construed as illustrative and shall not limit the sense of the words preceding those terms; and

1.2.5 a reference to writing or written includes faxes and e-mails.

2. PURPOSE AND EFFECT OF THE AGREEMENT

2.1 The Trusts have agreed to work together to form a single voice and act in concert to bring further improvements to care in their combined areas of operation. The Trusts

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wish to record the basis on which they will collaborate with each other in this Agreement and intend to act in accordance with its terms.

2.2 This Agreement sets out:

2.2.1 the agreed purpose, strategic objectives and principles of the Collaborative;

2.2.2 the initial Key Delivery Priorities for the Collaborative;

2.2.3 the governance structures the Trusts will put in place;

2.2.4 the programme management arrangements for the Collaborative;

2.2.5 the respective roles and responsibilities of the Trusts; and

2.2.6 a plan for the further development of the Collaborative for 2022/23, which the Trusts will work together to implement through this Agreement.

2.3 The Trusts agree that, notwithstanding the good faith consideration that each Trust has afforded the terms set out in this Agreement, this Agreement shall not be legally binding. The Trusts enter into this Agreement intending to honour all their obligations to each other.

3. ACTIONS TAKEN PRIOR TO AND POST THE COMMENCEMENT DATE

3.1 Each of the Trusts acknowledges and confirms that as at the date of this Agreement it has obtained all necessary authorisations to enter into this Agreement.

4. DURATION

4.1 This Agreement shall commence on the Commencement Date and will continue for the Initial Term, unless and until terminated in accordance with its terms.

4.2 On the expiry of the Initial Term this Agreement will expire automatically without notice unless, no later than 6 months before the end of the Initial Term, the Trusts agree in writing that the term of the Agreement will be extended for a further term to be agreed between the Trusts ("**Extended Term**").

4.3 The Trusts will review progress made by the Collaborative against the Key Delivery Priorities and the terms of this Agreement no later than 12 months following the Commencement Date and at such intervals thereafter as the Trusts may agree, but at least annually. The Trusts may agree to vary the Agreement to reflect developments as appropriate in accordance with Clause 16 (*Variations*).

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5. THE COLLABORATIVE PURPOSE, OBJECTIVES AND PRIORITIES

5.1 The Trusts have agreed that the common purpose for the Collaborative is to bring together the Trusts in order to:

5.1.1 improve the health and wellbeing of the North East and North Cumbria population, with particular focus on improving health inequalities that exist within the region;

5.1.2 optimise the delivery, quality and efficiency of local health and care services provided by the Trusts; and

5.1.3 support the Trusts by taking the necessary collaborative, or where possible, collective, action, including mutual aid and support,

the "**Collaborative Purpose**".

5.2 The Trusts have agreed to work together to perform their obligations under this Agreement in order to achieve the Collaborative Purpose, and more specifically, have agreed the following objectives for the Collaborative:

5.2.1 development of a strategic approach to clinical services focusing on vulnerable services and a strategic response to clinical networks and associated cross system working arrangements;

5.2.2 delivery of elective recovery (covering inpatient, diagnostics and cancer) to meet or exceed national benchmarks, standards and targets;

5.2.3 delivery of urgent care standards and requirements across providers and local systems to reduce variation and improve consistency of response;

5.2.4 building capacity and capability in clinical support services to achieve appropriate infrastructure in place to deliver strategy clinical aims; and

5.2.5 establishing and delivering appropriate corporate strategies to enhance integration and tackle variation including approaches to collective planning, rationalised and aligned estates / capital processes and development of underpinning approaches to workforce,

(the "**Objectives**").

5.3 The Trusts have agreed a number of Key Delivery Priorities for 2022/23 in pursuit of the Objectives, as set out in Schedule 3. The Trusts will agree any changes to the Key Delivery Priorities during the NHS financial year 2022/23 if required, and will review and refresh the Key Delivery Priorities in any event in advance of each new NHS financial year.

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5.4 Each programme of work within a Key Delivery Priority will be sponsored by a Trust Chief Executive as Senior Responsible Owner ("**SRO**"). SRO roles will be distributed across the Trust Chief Executives. Each SRO will be responsible to the Provider Leadership Board for the planning and delivery of their work programme and will be supported by the Programme Management Office.

5.5 The Trusts acknowledge and confirm that the success of the Collaborative will depend on the Trusts' ability to effectively co-ordinate and combine their expertise, workforce, and resources as providers in order to deliver the Key Delivery Priorities and achieve the Objectives.

5.6 Each Trust acknowledges that in order to achieve the Collaborative Purpose, it will need to collaborate with the other Trusts to provide mutual aid and solve challenges in line with the Collaborative Principles. Where practicable, the Trusts will work together to agree a joint plan for tackling such challenges which will also set out the agreed roles and responsibilities of each Trust.

5.7 The work of the Collaborative will be in the context of the Integrated Care System, in close partnership with the ICB, and will conducted in line with statutory and legislative requirements, such as the guidance on service change in the NHS[3].

6. THE COLLABORATIVE PRINCIPLES

6.1 The aim of this Clause 6 is to identify the high level collaborative principles which underpin how the Trusts will work together for the delivery of the Objectives and Key Delivery Priorities under this Agreement and to set out key factors for the success of the Collaborative.

6.2 The principles referred to in Clause 5.1 are that the Trusts will work together in good faith and, unless the provisions in their individual Services Contract(s) or this Agreement state otherwise, through the Collaborative the Trusts will:

6.2.1 look to provide mutual aid and support to each other in pursuit of the Collaborative Purpose and Objectives;

6.2.2 make collective decisions that speed up service changes and transformation, whilst ensuring that these are discussed with system partners, as relevant; and compliant with statutory and legislative requirements

[3] *Planning, assuring and delivering service change for patients* (NHS England, amended May 2022)

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6.2.3 challenge and hold each other to account through agreed systems, processes and ways of working;

6.2.4 act collaboratively and in good faith with each other in accordance with Guidance, the Law and Good Practice to achieve national priorities and the Objectives having at all times regard to the welfare of the population of the North East and North Cumbria;

6.2.5 actively promote a culture that facilitates integrated working and empowers staff to work collaboratively with other Trust staff to deliver better outcomes for the population of the North East and North Cumbria;

6.2.6 ensure strong clinical leadership is built into the Collaborative governance and work programmes;

6.2.7 engage with and involve the population and wider stakeholders in the ICB area in relation to the work of the Collaborative, primarily through each Trust's membership of place-based partnerships within the ICB area;

6.2.8 support each other (informally and publicly) in taking decisions in the best interests of the North East and North Cumbria population;

6.2.9 take responsibility for and manage the risks in delivering the Key Delivery Priorities together as a Collaborative;

6.2.10 promote and develop a co-operative and high performing culture, and way of working across the Collaborative:

(i) that promotes and drives co-operation, innovation and continuous improvement;

(ii) where information is shared;

(iii) where communication is honest and respectful; and

(iv) which is founded upon ethical and responsible behaviour and decision making,

without losing sight of each Trust's corporate and statutory accountability;

together these are the "**Collaborative Principles**".

7. PROBLEM RESOLUTION AND ESCALATION

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7.1 The Trusts agree to adopt a systematic approach to problem resolution between them on matters which relate to the Collaborative which recognises the Collaborative Principles, the Objectives and Key Delivery Priorities (set out in Clauses 5 and 6).

7.2 If a problem, issue, concern or complaint comes to the attention of a Trust in relation to the Key Delivery Priorities or any matter within the scope of this Agreement, such Trust shall notify the other Trusts and the Trusts each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion between the relevant affected Trusts.

7.3 Save as otherwise specifically provided for in this Agreement, any dispute arising between the Trusts out of or in connection with this Agreement will be resolved in accordance with Schedule 5 (*Dispute Resolution*).

7.4 If any Trust receives any formal inquiry, complaint, claim or threat of action from a third party (including, but not limited to, claims made by a supplier) in relation to the Key Delivery Priorities or other work of the Collaborative, the Trust will liaise with the Provider Leadership Board as to the contents of any response before a response is issued.

8. OBLIGATIONS AND ROLES OF THE TRUSTS

8.1 Each Trust acknowledges and confirms that:

8.1.1 it remains responsible for performing its obligations and functions for delivery of services to the Commissioners in accordance with its Services Contract(s);

8.1.2 it will be separately and solely liable to the Commissioners for the provision of services under its own Services Contract; and

8.1.3 the intention of the Trusts is to work together with each other, and with the Commissioners, to achieve better use of resources and better outcomes for the population of the North East and North Cumbria initially in respect of the Key Delivery Priorities and to create a collaborative culture in, and between, their organisations.

8.2 Each Trust undertakes to co-operate in good faith with the others to facilitate the proper performance of this Agreement and in particular will:

8.2.1 use all reasonable endeavours to avoid unnecessary disputes and claims against any other Trust;

8.2.2 not interfere with the rights of any other Trust and its servants, agents, representatives, contractors or sub-contractors (of any tier) on its behalf in

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performing its obligations under this Agreement nor in any other way hinder or prevent such other Trust or its servants, agents, representatives, or sub-contractors (of any tier) on its behalf from performing those obligations; and

8.2.3 (subject to Clause 8.3) assist the other Trusts (and their servants, agents, representatives, or sub-contractors (of any tier)) in performing those obligations so far as is reasonably practicable.

8.3 Nothing in Clause 8.2 shall:

8.3.1 interfere with the right of each of the Trusts to arrange its affairs in whatever manner it considers fit in order to perform its obligations under this Agreement in the manner in which it considers to be the most effective and efficient; or

8.3.2 oblige any Trust to incur any additional cost or expense or suffer any loss in excess of that required by its proper performance of its obligations under this Agreement.

8.4 Each of the Trusts severally undertakes that it shall:

8.4.1 subject to the provisions of this Agreement, comply with all Laws applicable to it which relate to the Key Delivery Priorities; and

8.4.2 inform the Provider Leadership Board as soon as reasonably practicable if at any time it becomes unable to meet any of its obligations and in such case inform, and keep the Provider Leadership Board informed, of any course of action to remedy the situation recommended or required by NHS England, the Secretary of State for Health and Social Care or other competent authority,

provided that, to avoid doubt, nothing in this Clause shall in any way fetter the discretion of the Trusts in fulfilling their statutory functions.

8.5 The Trusts have not agreed to share risk or reward between them under this Agreement and any future introduction of such provisions will require additional legally binding provisions to be agreed between the relevant Trusts.

9. COLLABORATIVE PROGRAMME MANAGEMENT RESOURCE

9.1 The Trusts have agreed that the Collaborative will be supported by a programme management office ("**PMO**"). The PMO will support each SRO in respect of the work programmes and Key Delivery Priorities. The initial PMO structure is set out in Schedule 4 (*Operating Model*).

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9.2 For the financial year 2022/23, PMO costs will be met through a financial contribution to the Collaborative from the NHS North East Commissioning Support Unit. The Trusts acknowledge that the funding of the PMO and any other proposed supporting infrastructure for the Collaborative for NHS financial year 2023/24 and beyond will need to be discussed and agreed by the Trusts and may comprise or include financial or other resource contributions from the Trust members of the Collaborative.

10. REPORTING REQUIREMENTS

10.1 Each of the Trusts will during the Term:

10.1.1 promptly provide to the PMO or to any other Trust involved in the delivery of the Key Delivery Priorities, such information about their work in respect of such Key Delivery Priorities and such co-operation and access as the PMO or other Trust may reasonably require from time to time in line with the Collaborative Principles, provided that if the provision of such information, co-operation or access amounts to a change to this Agreement then it will need to be proposed as such to the Provider Leadership Board and the variation procedure set out in Clause 16 will apply; and

10.1.2 identify and obtain all consents necessary for the fulfilment of its obligations in respect of the Key Delivery Priorities,

limited in each case to the extent that such action does not cause a Trust to be in breach of any Law, its obligations under Clause 12 (*Information Sharing and Conflicts of Interest*) Clause 17 (*Confidentiality*) or any legally binding confidentiality obligations owed to a third party.

11. GOVERNANCE

11.1 The Trusts all agree to establish the Provider Leadership Board ("**PLB**"). For the avoidance of doubt the PLB shall not be a committee of any Trust or any combination of Trusts.

11.2 The PLB is the group responsible for leading and overseeing the Trusts' collaborative approach to the Key Delivery Priorities and working in accordance with the Collaborative Principles. The PLB may establish supporting and/or task and finish groups to take forward programmes in respect of the Key Delivery Priorities as appropriate, ensuring a strong clinical voice and involving input from a range of functions across the Trusts. The PLB will have other responsibilities as defined in its terms of reference set out in Schedule 2 (Provider Leadership Board – Terms of Reference).

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11.3 The PLB will invite the Chairs of each Trust's board to a meeting of the PLB at 6 monthly intervals in order to brief the Chairs on the Collaborative's work and progress against the Objectives and Key Delivery Priorities.

11.4 The Trusts will communicate with each other clearly, directly and in a timely manner to ensure that the members of the PLB are able to make effective and timely decisions.

11.5 The Trusts will ensure appropriate attendance from their respective organisations at all meetings of the PLB and that their representatives act in accordance with the Collaborative Principles.

11.6 The Trusts acknowledge that they each participate in other collaborative arrangements outside of the Collaborative, including with other providers on a sector basis, and at place level. The Trusts will work together to ensure that the governance arrangements under this Agreement are streamlined and do not unnecessarily duplicate decision-making arrangements in other collaboratives.

12. INFORMATION SHARING AND CONFLICTS OF INTEREST

12.1 The Trusts will provide to each other all information that is reasonably required in order to deliver the Key Delivery Priorities and achieve the Objectives.

12.2 The Trusts have obligations to comply with competition law. The Trusts will therefore make sure that they share information, and in particular Competition Sensitive Information, in such a way that is compliant with competition law and, accordingly, the PLB will ensure that the exchange of Competition Sensitive Information will be restricted to circumstances where:

12.2.1 it is essential;

12.2.2 it is not exchanged more widely than necessary;

12.2.3 it is subject to suitable non-disclosure or confidentiality agreements which include a requirement for the recipient to destroy or return it on request or on termination or expiry of the Agreement; and

12.2.4 it may not be used other than to achieve the Collaborative Purpose and Objectives under this Agreement in accordance with the Collaborative Principles.

12.3 The Trusts acknowledge that it is for each Trust to decide whether information is Competition Sensitive Information but recognise that it is normally considered to include any internal commercial information which, if it is shared between Trusts who are

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providers, would allow them to forecast or co-ordinate commercial strategy or behaviour in any market.

12.4 The Trusts will make sure the PLB establishes appropriate non-disclosure or confidentiality agreements between and within the Trusts so as to ensure that Competition Sensitive Information and Confidential Information are only available to those Trusts who need to see it for the purposes of the better delivery of the Key Delivery Priorities and Objectives and for no other purpose whatsoever so that they do not breach competition law.

12.5 It is accepted that the involvement of the Trusts in this Agreement may give rise to situations where information will be generated and made available to the Trusts, which could give them an unfair advantage in competitions or which may be capable of distorting such competitions (for example, disclosure of pricing information or approach to risk may provide one Trust with a commercial advantage over a separate Trust). The Trusts therefore recognise the need to manage the information referred to in this Clause 12.5 in a way which maximises their opportunity to take part in competitions operated by the Commissioners by putting in place appropriate procedures, such as appropriate non-disclosure or confidentiality agreements in advance of the disclosure of information.

12.6 Where there are any Patient Safety Incidents or Information Governance Breaches relating to the Key Delivery Priorities, for example, the Trusts shall ensure that they each comply with their individual Services Contract and work collectively and share all relevant information for the purposes of any investigations and/or remedial plans to be put in place, as well as for the purposes of learning lessons in order to avoid such Patient Safety Incident or Information Governance Breach in the future.

12.7 The Trusts will:

12.7.1 disclose to each other the full particulars of any real or apparent conflict of interest which arises or may arise in connection with this Agreement or the delivery of the Key Delivery Priorities, immediately upon becoming aware of the conflict of interest whether that conflict concerns the Trust or any person employed or retained by them for or in connection with the delivery of the Key Delivery Priorities or Objectives;

12.7.2 not allow themselves to be placed in a position of conflict of interest or duty in regard to any of their rights or obligations under this Agreement (without the prior consent of the other Trusts) before they participate in any decision in respect of that matter; and

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12.7.3 use best endeavours to ensure that their representatives on the PLB and other Collaborative governance groups also comply with the requirements of this Clause 12 when acting in connection with this Agreement.

12.8 The Trusts shall comply with their obligations under the Data Protection Legislation.

13. TERMINATION, EXCLUSION AND WITHDRAWAL

13.1 The PLB may resolve to terminate this Agreement in whole where:

13.1.1 a Dispute cannot be resolved pursuant to the Dispute Resolution Procedure;

13.1.2 automatically and immediately where there exists just one Trust that remains party to this Agreement; or

13.1.3 where the Trusts agree for this Agreement to be replaced by a formal legally binding agreement between them.

Exclusion

13.2 A Trust may be excluded from this Agreement on written notice from all of the remaining Trusts in the event of a material or a persistent breach of the terms of this Agreement by the relevant Trust which has not been rectified within 30 calendar days of notification issued by the remaining Trusts or which is not reasonably capable of remedy. In such circumstances this Agreement shall be partially terminated in respect of the excluded Trust.

Voluntary withdrawal of a Trust

13.3 Any Trust may withdraw from this Agreement by giving at least 60 calendar days' notice in writing to the other Trusts.

Consequences of termination / exclusion / withdrawal

13.4 Where a Trust is excluded from this Agreement, or withdraws from it, the excluded Trust shall procure that all data and other material belonging to any other Trust shall be delivered back to the relevant Trust, deleted or destroyed as soon as reasonably practicable and confirm to the remaining Trusts when this has been completed.

14. INTRODUCING NEW PROVIDERS

14.1 Additional providers may become parties to this Agreement on such terms as the Trusts will jointly agree, acting at all times in accordance with the Collaborative

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Principles. Any new provider will be required to agree to the terms of this Agreement before admission.

15. CHARGES AND LIABILITIES

15.1 Except as otherwise provided, the Trusts shall each bear their own costs and expenses incurred in complying with their obligations under this Agreement, including in respect of any losses or liabilities incurred due to their own or their employees' actions.

15.2 Except as otherwise provided, no Trust intends that any other Trust shall be liable for any loss it suffers as a result of this Agreement.

16. VARIATIONS

16.1 The provisions of this Agreement may be varied at any time by a Notice of Variation signed by the Trusts in accordance with this Clause 16.

16.2 If a Trust wishes to propose a variation to this Agreement ("**Variation**"), that Trust must submit a draft notice setting out their proposals in accordance with Clause 16.3 (a "**Notice of Variation**") to the other Trusts and the Chair of the PLB to be considered at the next meeting (or when otherwise determined by the Trusts) of the PLB.

16.3 A draft Notice of Variation must set out:

16.3.1 the Variation proposed and details of the consequential amendments to be made to the provisions of this Agreement;

16.3.2 the date on which the Variation is proposed to take effect;

16.3.3 the impact of the Variation on the achievement of the Key Delivery Priorities and Objectives; and

16.3.4 any impact of the Variation on any Services Contracts.

16.4 The PLB will consider the draft Notice of Variation and either:

16.4.1 accept the draft Notice of Variation (all Trusts consenting), in which case all Trusts will sign the Notice of Variation;

16.4.2 amend the draft Notice of Variation, such that it is agreeable to all Trusts, in which case all Trusts will sign the amended Notice of Variation; or

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16.4.3 not accept the draft Notice of Variation, in which case the minutes of the relevant PLB shall set out the grounds for non-acceptance.

16.5 Any Notice of Variation of this Agreement will not be binding unless set out in writing and signed by or on behalf of each of the Trusts.

17. CONFIDENTIAL INFORMATION

17.1 Each Trust shall keep in strict confidence all Confidential Information it receives from another Trust except to the extent that such Confidential Information is required by Law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorised disclosure by a Trust. Each Trust shall use any Confidential Information received from another Trust solely for the purpose of delivering the Key Delivery Priorities and complying with its obligations under this Agreement in accordance with the Collaborative Principles and for no other purpose. No Trust shall use any Confidential Information received under this Agreement for any other purpose including use for their own commercial gain in services outside of the Key Delivery Priorities or to inform any competitive bid for any elements of the Key Delivery Priorities without the express written permission of the disclosing Trust.

17.2 To the extent that any Confidential Information is covered or protected by legal privilege, then disclosing such Confidential Information to any Trust or otherwise permitting disclosure of such Confidential Information does not constitute a waiver of privilege or of any other rights which a Trust may have in respect of such Confidential Information.

17.3 The Parties agree to procure, as far as is reasonably practicable, that the terms of this Clause 17 (*Confidential Information*) are observed by any of their respective successors, assigns or transferees of respective businesses or interests or any part thereof as if they had been party to this Agreement.

17.4 Nothing in this Clause 17 (*Confidential Information*) will affect any of the Trusts' regulatory or statutory obligations, including but not limited to competition law.

18. INTELLECTUAL PROPERTY

18.1 In order to meet the Collaborative Purpose and Objectives each Trust grants to each of the other Trusts a fully paid up non-exclusive licence to use its existing Intellectual Property provided under this Agreement insofar as is reasonably required for the sole purpose of the fulfilment of that Trusts' respective obligations under this Agreement.

New Intellectual Property

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18.2 If any Trust creates any new Intellectual Property through the operation of the Collaborative, the Trust which creates the new Intellectual Property will grant to the other Trusts a fully paid up non-exclusive licence to use the new Intellectual Property for the sole purpose of the fulfilment of that Trusts' obligations under this Agreement.

19. FREEDOM OF INFORMATION

19.1 If any Trust receives a request for information relating to this Agreement or the Integrated Services under the Freedom of Information Act 2000 or the Environmental Information Regulations 2004, it shall consult with the other Trusts before responding to such request and, in particular, shall have due regard to any claim by any other Trust to this Agreement that the exemptions relating to commercial confidence and/or confidentiality apply to the information sought.

20. NOTICES

20.1 Any notice or other communication given to a Trust under or in connection with this Agreement shall be in writing addressed to that Trust at its principal place of business or such other address as that Trust may have specified to the other Trust in writing in accordance with this Clause, and shall be delivered personally, or sent by pre-paid first class post, recorded delivery or commercial courier.

20.2 A notice or other communication shall be deemed to have been received: if delivered personally, when left at the address referred to in Clause 20.1; if sent by pre-paid first class post or recorded delivery, at 9.00 am on the second Operational Day after posting; or, if delivered by commercial courier, on the date and at the time that the courier's delivery receipt is signed.

21. NO PARTNERSHIP

21.1 Nothing in this Agreement is intended to, or shall be deemed to, establish any partnership between any of the Trusts, constitute any Trust the agent of another Trust, nor authorise any Trust to make or enter into any commitments for or on behalf of any other Trust except as expressly provided in this Agreement.

22. COUNTERPARTS

22.1 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Agreement, but all the counterparts shall together constitute the same agreement. The expression "counterpart" shall include any executed copy of this Agreement scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment. No counterpart shall be effective until each Trust has executed at least one counterpart.

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23. GOVERNING LAW AND JURISDICTION

23.1 This Agreement, and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims), shall be governed by, and construed in accordance with, English law, and, subject to Clause 6, the Trusts irrevocably submit to the exclusive jurisdiction of the courts of England.

Signed by .....

for and on behalf of **COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST** [ ]

Signed by .....

for and on behalf of **CUMBRIA, NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST** [ ]

Signed by .....

for and on behalf of **GATESHEAD HEALTH NHS FOUNDATION TRUST** [ ]

Signed by .....

for and on behalf of **THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST** [ ]

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Signed by .....

for and on behalf of **NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST** [ ]

Signed by .....

for and on behalf of **NORTH EAST AMBULANCE SERVICE NHS FOUNDATION TRUST** [ ]

Signed by .....

for and on behalf of **NORTH TEES AND HARTLEPOOL HOSPITALS NHS FOUNDATION TRUST** [ ]

Signed by .....

for and on behalf of **NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST** [ ]

Signed by .....

for and on behalf of **SOUTH TEES HOSPITALS NHS FOUNDATION TRUST** [ ]

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Signed by for and on behalf of **SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST**	..... [ ]
Signed by for and on behalf **TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST**	..... [ ]

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SCHEDULE 1

Definitions and Interpretation

1 The following words and phrases have the following meanings in this Agreement:

Agreement	this collaboration agreement incorporating the Schedules
Collaborative	the provider collaborative formed by the Trusts and as detailed pursuant to this Agreement
Collaborative Principles	the collaborative principles for the Collaborative as set out in Clause 6.2
Collaborative Purpose	the common purpose for the Collaborative as set out in Clause 5.1
Commencement Date	1 April 2022
Commissioners	Pre 1 July 2022: Clinical commissioning groups in the North East and North Cumbria ICS area Post 1 July 2022: the ICB
Competition Sensitive Information	Confidential Information which is owned, produced and marked as Competition Sensitive Information by one of the Trusts and which that Trust properly considers is of such a nature that it cannot be exchanged with the other Trusts without a breach or potential breach of competition law. Competition Sensitive Information may include, by way of illustration, trade secrets, confidential financial information and confidential commercial information, including without limitation, information relating to the terms of actual or proposed contracts or sub-contract arrangements (including bids received under competitive tendering), future pricing, business strategy and costs data, as may be utilised, produced or recorded by any Trust, the publication of which an organisation in the same business would reasonably be able to expect to protect by virtue of business confidentiality provisions

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Confidential Information	all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Agreement, including Commercially Sensitive Information and Competition Sensitive Information;
Data Protection Legislation	all applicable Laws relating to data protection and privacy including without limitation the UK GDPR; the Data Protection Act 2018; the Privacy and Electronic Communications Regulations 2003 (SI 2003/2426); the common law duty of confidentiality and the guidance and codes of practice issued by the Information Commissioner, relevant Government department or regulatory in relation to such applicable Laws
Dispute	any dispute arising between two or more of the Trusts in connection with this Agreement or their respective rights and obligations under it
Dispute Resolution Procedure	the procedure set out in Schedule 5 (*Dispute Resolution Procedure*) to this Agreement
Extended Term	has the meaning set out in Clause 4.2
Good Practice	has the meaning set out in the Services Contracts
Guidance	any applicable health or social care guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the Trusts have a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Trust by a Commissioner and/or any relevant regulatory body
ICB	NHS North East and North Cumbria Integrated Care Board, expected to be established on 1 July 2022
IG Guidance for Serious Incidents	NHS Digital's Checklist Guidance for Information Governance Serious Incidents Requiring Investigation June 2013,

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	available at Data Security and Protection Toolkit - NHS Digital
Information Governance Breach	an information governance serious incident requiring investigation, as defined in the IG Guidance for Serious Incidents
Initial Term	3 years from the Commencement Date
Intellectual Property	patents, rights to inventions, copyright and related rights, trade marks, business names and domain names, goodwill, rights in designs, rights in computer software, database rights, rights to use, and protect the confidentiality of, Confidential Information and all other intellectual property rights, in each case whether registered or unregistered and including all applications and rights to apply for and be granted, renewals or extensions of, and rights to claim priority from, such rights and all similar or equivalent rights or forms of protection which subsist or will subsist now or in the future in any part of the world
Key Delivery Priorities	the priorities of the Collaborative, the initial priorities being those set out in Schedule 3, as may be amended from time to time by a Notice of Variation
Law	(a) any applicable statute or proclamation or any delegated or subordinate legislation or regulation; (b) any enforceable EU right within the meaning of section 2(1) European Communities Act 1972; (c) any applicable judgment of a relevant court of law which is a binding precedent in England; (d) Guidance; and (e) any applicable code in each case in force in England and Wales, and "Laws" shall be construed accordingly

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NHS Standard Contract	the NHS Standard Contract as published by NHS England from time to time
Notice of Variation	has the meaning set out in Clause 16.2
Objectives	the objectives for the Collaborative as set out in Clause 5.2, as may be amended from time to time
Operational Days	a day other than a Saturday, Sunday or bank holiday in England
Patient Safety Incident	any unintended or unexpected incident that occurs in respect of a Service User, during and as a result of the provision of the Services, that could have led, or did lead to, harm to that Service User
Programme Management Office or PMO	the programme management office for the Collaborative, as further described in Clause 9.1 and Schedule 4 (*Operating Model*)
Operating Model	Document that describes how the Collaborative will work summarised in in Schedule 4 (*Operating Model*)
Provider Leadership Board or PLB	the group established by the Trusts pursuant to Clause 11.1, the terms of reference for which are set out in Schedule 2 (*Governance*)
Senior Responsible Owner or SRO	a Trust Chief Executive responsible for the planning and delivery of a work programme pursuant to a Key Delivery Priority
Services	the services provided, or to be provided, by a Trust to a Commissioner pursuant to its respective Services Contract which may include services which are the subject of one or more Key Delivery Priorities for the Collaborative
Services Contract	a contract entered into by one of the Commissioners and a Trust for the provision of Services, and references to a Services Contract include all or any one of those contracts as the context requires
Service User	a patient or service user for whom a Commissioner has

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	statutory responsibility and who receives Services under any Services Contract
Term	the Initial Term of this Agreement plus any Extended Term(s) agreed in accordance with the terms of this Agreement
UK GDPR	has the meaning given to it in section 3(1) (as supplemented by section 205(4) of the Data Protection Act 2018
Variation	a proposed variation to this Agreement, effected in accordance with Clause 16
White Paper	has the meaning set out in Background paragraph 1.

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SCHEDULE 2

Governance

Terms of Reference for the Provider Leadership Board

NORTH EAST AND NORTH CUMBRIA PROVIDER COLLABORATIVE PROVIDER LEADERSHIP BOARD Terms of Reference	
Version	**1.0**
Implementation Date	**1 April 2022**
Review Date	**1 April 2023**
Approved By	**Trust boards**
Approval Date	**8 July 2022**

REVISIONS			
Date	**Section**	**Reason for Change**	**Approved By**

1.	Purpose	The purpose of the Provider Leadership Board ("PLB") is to provide strategic leadership of the North East and North Cumbria Provider Collaborative (the "Collaborative") in setting its strategic direction and

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		priorities. The PLB will oversee the delivery of the Collaborative Purpose, Objectives and Key Delivery Priorities (as set out in the Agreement and Operating Model).
2.	Status and authority	The PLB is established by the Trusts, each of which remains a sovereign organisation, to provide a governance framework for the further development of collaborative working between the Trusts in line with the Collaborative Principles. The PLB is not a separate legal entity, and as such is unable to take decisions separately from the Trusts, or bind any one of them; nor can one Trust 'overrule' any other on any matter. As a result, the PLB will operate as a place for discussion of issues with the aim of reaching consensus between the Trusts to make recommendations and proposals to statutory Trust boards as necessary. The PLB will function through engagement and discussion between its members so that each of the Trusts makes a decision in respect of, and expresses its views about, each matter considered by the PLB. The decisions of the PLB will, therefore, be the decisions of the individual Trusts, the mechanism for which shall be authority delegated by the individual Trusts to their members on the PLB. Each Trust will ensure that their designated member: - is appointed to attend and represent their Trust on the PLB with such authority as is agreed to be necessary for the PLB to function effectively in discharging its responsibilities as set out in these terms of reference which is to the extent necessary, recognised in the relevant Trust's respective scheme of delegation - has equivalent delegated authority to the designated representatives of all other Trusts comprising the PLB (as confirmed in writing and agreed between the Trusts); and - understands the status of the PLB and the limits of their responsibilities and authority.
3.	Accountability	The PLB is accountable to each of the boards of the Trusts.
4.	Responsibilities	The PLB is responsible for leading the Trusts' collaborative approach to the Collaborative Objectives and Key Delivery Priorities working in

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		accordance with the Collaborative Principles, in line with the terms of the Agreement. The PLB members will make decisions together at PLB meetings in respect of the Key Delivery Priorities, including in relation to recommendations from supporting/working groups as may be established by the PLB from time to time. The PLB will also be responsible for developing the Trusts' collaborative approach across the North East and North Cumbria and beyond the initial Key Delivery Priorities. When making decisions together at PLB meetings, the PLB members will act in line with the Collaborative Principles and their respective obligations under the Agreement. The PLB may establish working groups and/or task and finish groups to support its agreed functions.
5.	Membership and attendance	The PLB will include the following members: - The Chief Executive or nominated deputy from each Trust signatory to the Agreement as notified to the PLB from time to time. It is important that members or their deputies commit to attending PLB meetings. Where a member cannot attend a meeting, the member may nominate a named deputy to attend, provided that the member gives reasonable notice of the deputy attending to the chair. Deputies must be able to contribute and make decisions on behalf of the Trust they are representing. The PLB may invite others to attend, observe and/or participate in PLB meetings, as agreed by the members from time to time. Such attendees shall not participate in decision-making or count towards the quorum.
6.	Quorum	The PLB will be quorate if eight (8) of the Trust members of the PLB, one of whom is the chair, are present.
7.	Chairing arrangements	Meetings of the PLB will be chaired by a member, initially selected by a vote of attending members at the first meeting of the PLB and thereafter on an agreed schedule where the chair is rotated to each member in turn with each carrying out the role for a twenty four (24) month period, with a potential extension for a further twenty four

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		months (to align with ICB representative requirements). The successor chair in line with the agreed schedule will be the vice-chair for the preceding twenty four (24)month period to their appointment as chair.
8.	Decision making	The PLB will aim to achieve consensus wherever possible. Each member of the PLB will be representing their appointing Trust and will only make decisions at the PLB in respect of their own Trust in accordance with any delegated authority. Not all decisions within the remit of the PLB will affect all of the Trusts. Where this is the case, and the members of the PLB agree which of the Trusts are affected by a decision, then the relevant decision will be taken by the members of the affected Trusts, with the aim of achieving consensus.
9.	Conduct of business	Meetings of the PLB will be held monthly or such other frequency as may be agreed between the Trusts. Meetings may be held by telephone or video conference. Members of the PLB may participate (and count towards quorum) in a face-to-face meeting via telephone or video-conference. Any member may call extraordinary meetings of the PLB at their discretion subject to providing at least five working days' notice to PLB members. Circulation of the meeting agenda and papers via email will take place at least five working days prior to the meeting from the Chair. In the event members wish to add an item to the agenda they must notify the Chair. Requests made less than 7 working days before a meeting may be included on the agenda at the discretion of the Chair. The PLB will have administrative support from the Programme Management Office of the Collaborative to: - take minutes of the meetings and keep a record of matters arising and issues to be carried forward; and - maintain a register of interests of PLB members. Draft minutes of PLB meetings will be sent to the Trust's representative members within 14 days of each meeting. Approval of the minutes of the previous meeting of the PLB will be a standing

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		item on each meeting agenda. It will be the members' responsibility to disseminate minutes and notes from the PLB inside their respective Trusts.
10.	Conflicts of interest	The members of the PLB must refrain from actions that are likely to create any actual or perceived conflicts of interests. PLB members must disclose all actual, potential or perceived conflicts of interest to the Chair in advance of each meeting to enable appropriate management arrangements to be put in place and ensure that such conflicts are managed in adherence with their organisation's conflict of interest policies and statutory duties. All members are required to uphold the Nolan Principles and all other relevant NHS requirements applicable to them. If there is any conflict between these terms of reference and the Agreement, the latter will prevail.
11.	Review	These terms of reference will be reviewed on an annual basis.

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SCHEDULE 3

Key Delivery Priorities for 2022/23

The Trusts have identified the initial Key Delivery Priorities for the Collaborative (as may be agreed and amended from time to time) below.

The inclusion of any additional Key Delivery Priorities under this Schedule may only be made with the mutual written consent of all the Trusts.

NENC PvCv will:

- Optimise the resource available for healthcare (by collectively organising, managing and deploying workforce where appropriate, utilising the full NHS estate to best effect, sharing risk and gains financially to deliver an overall balanced position etc)
- Standardise pathways and interventions to reduce unwarranted clinical variation, thereby achieving improved outcomes for patients and more efficient use of the capacity available
- Leverage the assets within the PC that Trusts offer to attract inward investment (e.g. AHSC, Centre for Ageing, BRC, TREE, innovation appetite and opportunity) but this needs to be part of a coherent approach playing to the academic strengths of the member Trusts
- Facilitate data sharing to enable the NHS and care resource to be targeted more closely to need; to reduce inequalities and improve the equity of patient outcomes across the ICS and to enable prediction and prevention of health and care demand.
- Support member Trusts individually in their role as anchor institutions with the PvCV acting as a bridge aid economic recovery and the prevention agenda (through providing employment opportunities, local procurement and commitment to overall NE achievement of carbon net zero)

Given this overarching approach the PvCv will operate across four strategic objectives (underpinning work for 2022-25):

<u>Clinical Programmes</u>

1. Development of strategic approach to clinical services focusing on vulnerable services and a strategic response to clinical networks and associated cross system working arrangements

2. Delivery of elective recovery (covering inpatient, diagnostics and cancer) to meet or exceed national benchmarks, standards and targets

3. Delivery urgent care standards and requirements across providers and local systems to reduce variation and improve consistency of response

<u>Clinical Support Programmes</u>

4. Building capacity and capability in clinical support services to achieve appropriate infrastructure in place to delivery strategic clinical aims

<u>Corporate Programmes</u>

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5. Establish and deliver appropriate corporate strategies to enhance integration and tackle variation including approaches to collective planning, rationalised and aligned estates/capital process and development of underpinning approaches in workforce.

Provider Collaborative Development

6. To continue to build capacity and capability within and across the PvCv to meet ongoing requirements.

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NENC Key Delivery Priorities for 2022/23

Key delivery priority	How will we deliver it?	Q in which it will be achieved?	How will we know it has been achieved?	Current Delivery Mechanism
Clinical Programmes				
Strategic Objective 1				
1. Strategic Approach to Clinical Services *Development of strategic approach to clinical services focusing on vulnerable services and a strategic response to clinical networks and associated cross system working arrangements*	Working with ICB to develop overarching clinical strategy/approach in line with system priorities. Focus action on agreed risk/vulnerable areas (e.g. Clinical Oncology)	Tbc	Overarching clinical aligned clinical strategy in place. Agreed action delivered for identified areas: non-surgical medical oncology revised arrangements in place with evaluation complete by q4 22/23 with view to sustainable system approach for 23/24	Range of groups support clinical strategy with ICS/B focus through Optimising Health group. Specific mechanisms targeted for work include Cancer Alliance. Clinical Networks range of responsibility/accountability arrangements linked to commissioning.
Strategic Objective 2				
2. Elective recovery *Delivery of elective recovery (covering inpatient, diagnostics and cancer) to meet or exceed national benchmarks, standards and targets*	Working through established COOs and associated mechanism formally brought under PvCv (with ICB agreement). Elective Board established	In line with national milestones	Performance in line (or exceeding) national milestones Development of elective centres, management of waiting list and associated innovations	SRO leadership from PvCv. Elective Board reporting to ICB established with operational delivery through PvCv COOs group. Requirement to establish mechanism for longer term transformation. (Note linkages to wider system groups e.g. 'Waiting Well'.
Strategic Objective 3				
3. Urgent Care *Delivery urgent care standards and requirements across providers and local systems*	Working through established locality and system groups PvCv will take overview through SRO putting in place action at system levels as necessary	In line with national milestones	Performance in line (or exceeding) national milestones	SRO lead from PvCv Established locality structure feeding through to ICP and system level group

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Key delivery priority	How will we deliver it?	Q in which it will be achieved?	How will we know it has been achieved?	Current Delivery Mechanism
to reduce variation and improve consistency of response				
Clinical Support Programmes				
Strategic Objective 4: *Building capacity and capability in clinical support services to achieve appropriate infrastructure in place to delivery strategic clinical aims*				
1.Clinical Support Services – Diagnostics & Pathology	Establish working groups under auspices of agreed SRO	Tbc	Delivery in line with plans	Program developed under Optimising Health with CEO SRO leadership for specific elements
2.Clinical Support Services – Aseptics Pharmacy	Time limited project group established to lead work	Q2 – delivery of outline business case Q4 – Full service model & plan	Agreement of approach to aseptic services across provider collaborative Plan and delivery of revised (agreed) model	Project established under auspices of PvCv with SRO leadership in place
Corporate Support Programmes				
Strategic Objective 5: *Establish and deliver appropriate corporate strategies to enhance integration and tackle variation including approaches to collective planning, rationalised and aligned estates/capital process and development of underpinning approaches in workforce.*				
1.Corporate Strategy – assessment of requirements	Review of existing mechanism to establish opportunities, requirements and potential approaches with development of agreed programme	Q2 – Delivery of proposal	Establishment of work programme with clear reporting and associated requirements	Tbc
2.Corporate strategy – Estates/finance/planning	Establishment of agreed approach to capital prioritisation, finance and planning to deliver collective	As per agreed milestones	As per agreed outcomes	SRO for Capital/Estates work established, agreed planning approach for 22/23.

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Key delivery priority	How will we deliver it?	Q in which it will be achieved?	How will we know it has been achieved?	Current Delivery Mechanism
	response			
Provider Collaborative Development				
1. Establish the collaborative as a vehicle for our joint work with appropriate governance, methods of working (with CEOs leading work streams) and a resource plan	Formalisation of PvCv as a Provider Leadership Forum with associated governance arrangements	Q1 22/23	Sign off by PvCv with updates agreed via constituent Trust boards	
2. Development of appropriate programme management structures and support to deliver programmes (including reporting and associated oversight)	Identification of resource needs and requirements on a rolling basis (noting some elements will link to existing programmes, require support as part of ICS changes as well as utilisation of internal resource)	Rolling implementation based on agreed programmes and support Established reporting and associated structures	Clear, accountable SRO arrangements for programmes agreed for the PvCv delivery with agreed support implemented	

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SCHEDULE 4

Operating Model

The Operating Model is the overarching document that describes what the Collaborative is, its purpose and how it works. Along with the Collaborative's Ambitions document the Operating Model has two core functions/purposes to provide:

1. A summary of what the Collaborative is, how it works and its membership in order to support discussion and agreement of the role the Collaborative will play in the NENC integrated care system as well as facilitating the agreement of the specific system objectives the Collaborative will be leading on and supporting. This is detailed in the Operating Plan but also set out in the Ambitions document.
2. Detail on the mechanism and approaches the Collaborative will use describing the programmes and detailing the specific requirements for delivery.

The Operating Model recognises that the Collaborative's role within the NENC ICS has three dimensions:

- Where the PvCv is leading on agreed objectives, with delegated authority and responsibility from the ICB
- Where the PvCv is working jointly, in partnership with ICB; working through existing mechanisms and/or groups (either leading or supporting) or as a joint committee of the ICB

It is recognised that depending on the issue, objective and requirement there may be different approaches needed for delivery

- In addition to the work to delivery ICS objectives there will be elements of the PvCv work that reflects the member's needs, requirements and priorities.

The following graphic summarises the PvCv operational model (as at April 2022), with full details found in the Operating Model and Ambitions document

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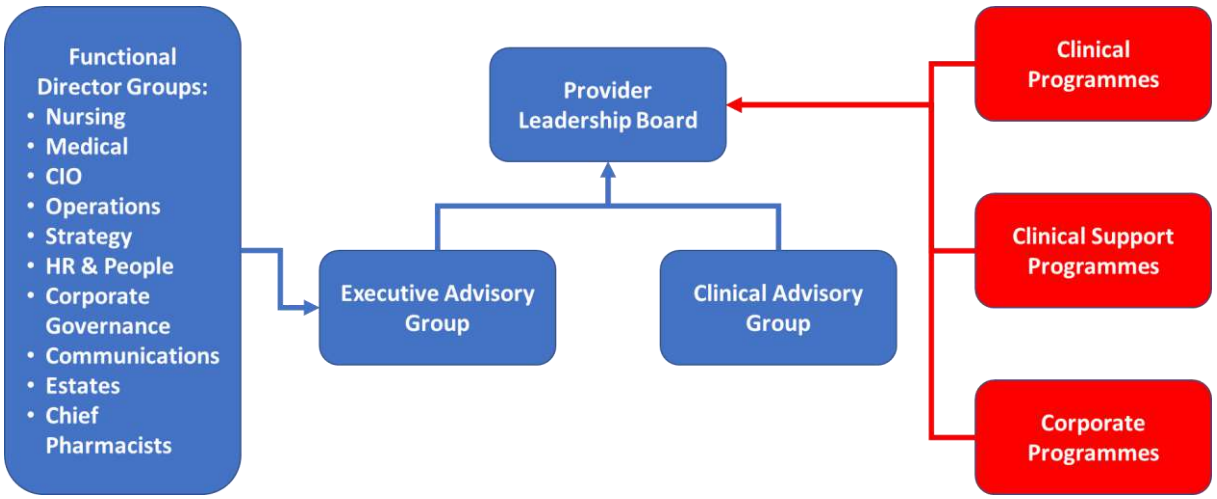
Figure 1: Summary of NENC Provider Collaborative Operating Model



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SCHEDULE 5

Dispute Resolution Procedure

1 Avoiding and Solving Disputes

1.1. The Trusts commit to working co-operatively to identify and resolve issues to mutual satisfaction so as to avoid so far as possible dispute or conflict in performing their obligations under this Agreement. Accordingly, the Trusts shall collaborate and resolve differences between them in accordance with Clause 7 (*Problem Resolution and Escalation*) of Agreement prior to commencing this procedure.

1.2. The Trusts believe that:

1.2.1. by focusing on the Collaborative Principles;

1.2.2. being collectively responsible for all risks; and

1.2.3. fairly sharing risk and rewards,

they will reinforce their commitment to avoiding disputes and conflicts arising out of or in connection with the Key Delivery Priorities.

1.3. The Trusts shall promptly notify each other of any dispute or claim or any potential dispute or claim in relation to this Agreement (each a "**Dispute**") when it arises.

1.4. The Provider Leadership Board shall seek to resolve any Dispute to the mutual satisfaction of each of the Trusts involved in the Dispute.

1.5. The Provider Leadership Board shall deal proactively with any Dispute in accordance with the Collaborative Principles and this Agreement so as to seek to reach a unanimous decision. If the Provider Leadership Board reaches a decision that resolves, or otherwise concludes a Dispute, it will advise the Trusts involved in the Dispute of its decision by written notice.

1.6. The Trusts agree that the Provider Leadership Board may determine whatever action it believes is necessary including the following:

1.6.1. if the Provider Leadership Board cannot resolve a Dispute, it may select an independent facilitator to assist with resolving the Dispute; and

1.6.2. the independent facilitator shall:

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1.6.2.1. subject to the provisions of this Agreement, be provided with any information they request about the Dispute;

1.6.2.2. assist the Provider Leadership Board to work towards a consensus decision in respect of the Dispute;

1.6.2.3. regulate their own procedure and, subject to the terms of this Agreement, the procedure of the Provider Leadership Board at such discussions;

1.6.2.4. determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Operational Days of the independent facilitator being appointed; and

1.6.2.5. have their costs and disbursements met by the Trusts involved in the Dispute equally or in such other proportions as the independent facilitator shall direct.

1.6.3. If the independent facilitator cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this Schedule 5 and only after such further consideration again fails to resolve the Dispute, the Provider Leadership Board may decide to:

1.6.3.1. terminate the Agreement; or

1.6.3.2. agree that the Dispute need not be resolved.

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ENCLOSURE B

NHS Provider Collaborative
North East and North Cumbria ICS

North East and North Cumbria
Provider Collaborative

Operating Model

May 2022

Operating Model

The eleven FTs in North East and North Cumbria (NENC) have set out how they will work together as the NENC Provider Collaborative, along with their purpose, principles and objectives in a memorandum of understanding ("Collaboration Agreement").

This document is intended to supplement the Collaboration Agreement with some more specific operational practicalities.

Provider Leadership Board

As set out in the Memorandum of Understanding, the eleven Foundation Trusts across North East and North Cumbria have agreed to establish a Provider Leadership Board (PLB), which is the group responsible for leading and overseeing the Trusts' collaborative approach to the Key Delivery Priorities and working in accordance with the Collaborative Principles.

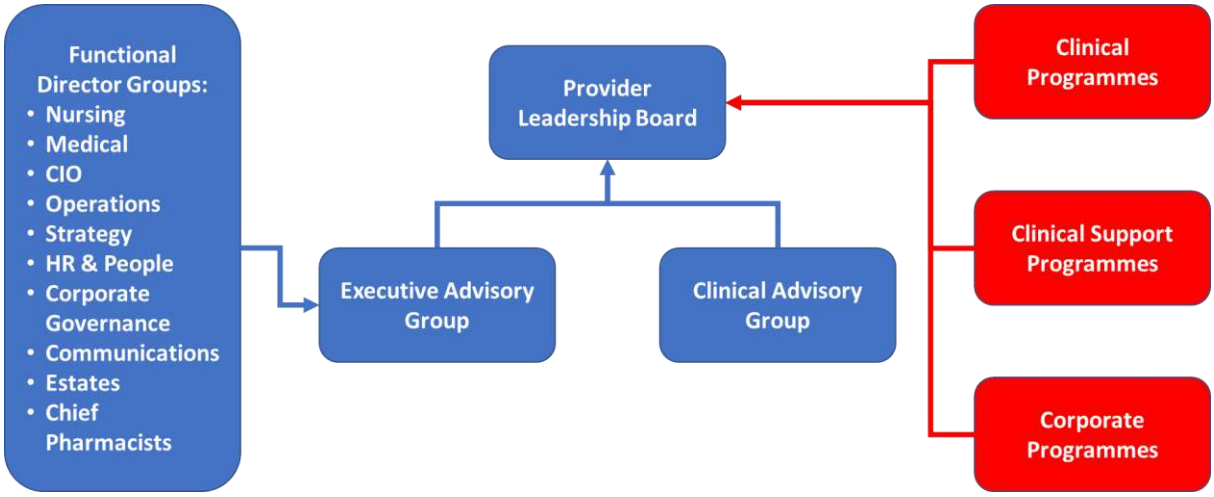
The PLB features all 11 CEOs and it is anticipated that CEOs will keep FT Boards regularly updated, supported by periodic written papers from the Provider Collaborative. The MoU sets out that Chairs of the FT Boards should be invited to meetings of the PLB at 6 monthly intervals, to discuss the work programme and progress with delivery.

The PLB may establish supporting and/or task and finish groups to take forward programmes in respect of the Key Delivery Priorities as appropriate, ensuring a strong clinical voice and involving input from a range of functions across the Trusts.

The Provider Collaborative determined that subgroups would be necessary to deliver key functions and the work programme. There is, however, a clear risk of overlap with the ICS and particularly the previous clinical advisory machinery established to support commissioning. As a consequence, this will need to be considered iteratively in the context of broader conversations with the ICB team. It was also noted that the subgroup structure should be mindful of bureaucratic burden.

For now, it is proposed that the programmes of work report directly to the Provider Leadership Board and that it is supported by an Executive Advisory Group and a Clinical Advisory Group. The Provider Leadership Board has been established, with the Executive and Clinical Advisor Groups to be put in place during Summer 2022.

In addition, the PLB will be strongly supported by nested collaboratives, such as those for mental health and at sub-regional geographies, to ensure decision making, direction and delivery take place at the right levels.



Clinical Advisory Group

The purpose of the Clinical Advisory Group is to ensure that the Provider Collaborative has strong clinical leadership and a constant focus on the key areas of collective clinical concern. The Clinical Advisory Group would draw on and provide a point of escalation for clinical networks.

Membership would need to feature clinical leads from all FTs with good medical, nursing and AHP leadership. Initial conversations with the ICB have suggested that this could be a joint body with the ICB, co-chaired by clinical leadership from within the Provider Collaborative and the ICB Medical Director, to align clinical input across the ICS. In this case, having wider clinical views, such as from general practice and community pharmacy, could support broader transformational work and enable the group to support both the Provider Collaborative and the ICB. PCN clinical leaders would be key in this.

As the ICB develops, consideration can be given as to whether it is feasible for this group to drive the strategic approach to clinical services, and the opportunity to align clinical groups generally, including the ICS Optimising Health Services Group. It should also be noted that the role and responsibility of the Provider Collaborative in the development of the ICS clinical strategy still needs to be worked through and agreed with the ICB and partners.

Executive Advisory Group

The purpose of the Executive Advisory Group is to provide a mechanism for strategic clarity across and through the Provider Collaborative FTs, making sure that a full range of functional perspectives are considered throughout the work programmes. The Executive Advisory Group will provide a sounding board and point of professional escalation for Managing Director and PMO on programmes and projects, facilitating quick access to appropriate functional expertise, in addition to being tasked with the delivery of specific projects.

This creates a mechanism to check and challenge proposals going to Provider Leadership Board, in addition to a coordinated approach to identifying risks or opportunities for collaborative work.

It is anticipated that membership of this group would be the chairs of the directors' networks, including a Director of Nursing, Medical Director, CIO, COO, Director of Finance, Director of Planning & Performance, Director of Workforce, Director of Corporate Governance, Director of Communications, Director of Estates and Chief Pharmacist.

Work Programme

Each programme of work within a Key Delivery Priority will be sponsored by a Trust Chief Executive as Senior Responsible Owner ("SRO"). SRO roles will be distributed across the Trust Chief Executives. Each SRO will be responsible to the Provider Leadership Board for the planning and delivery of their work programme and will be supported by the Programme Management Office. It is anticipated that Provider Collaborative SROs will lead some of the ICS workstreams, where appropriate.

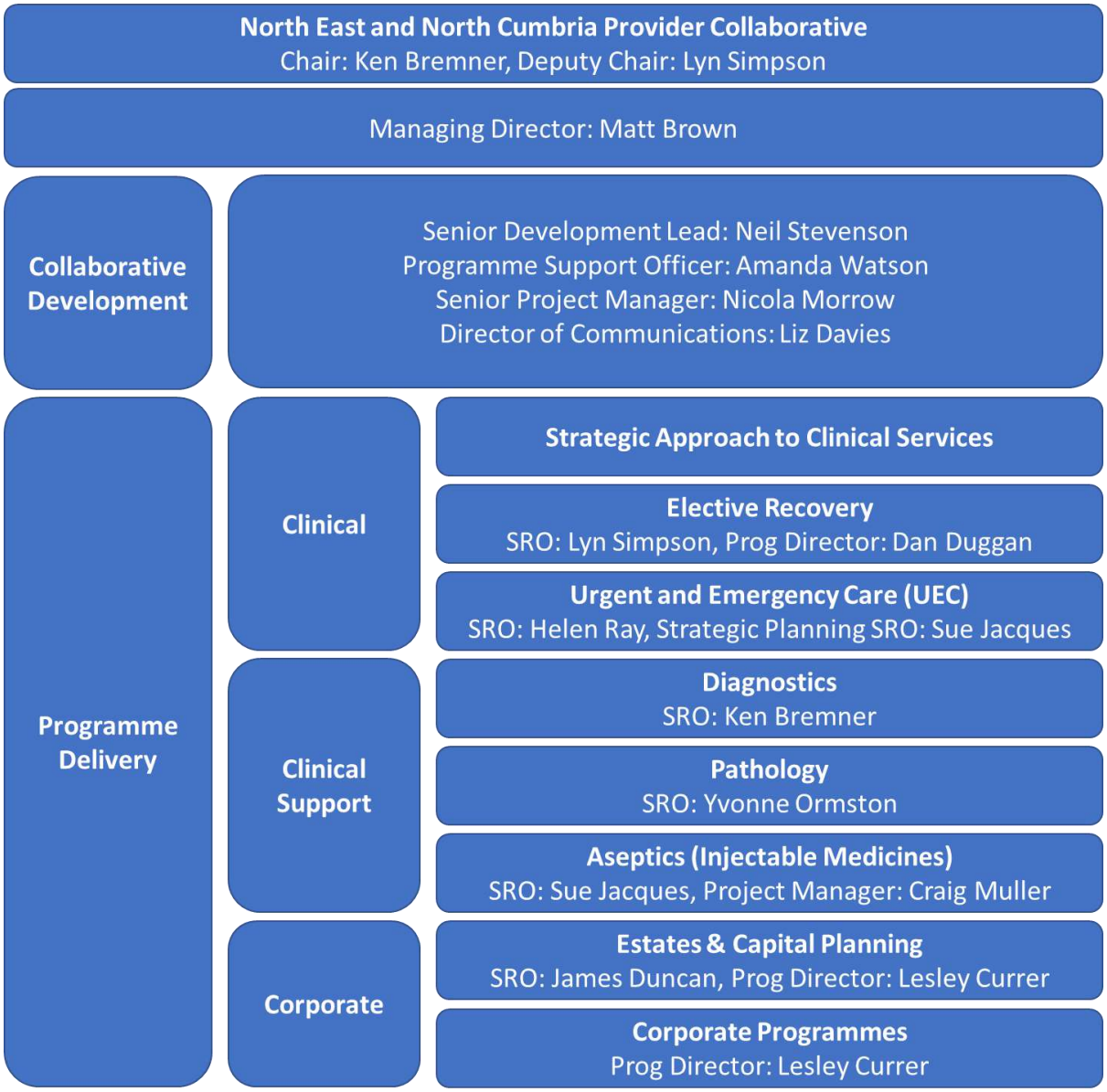
The SRO will effectively work as a Chair for the supporting programme infrastructure, with a dedicated programme management support and it is intended that there should be a designated Programme Director for each Key Delivery Priority. The Programme Director should work extremely closely with the SRO to ensure progress, direction, reporting and communication. The governance structure will be different for each Key Delivery Priority.

These teams will be supported by a general pool of project management capacity and a small core collaborative team.

Each of the five Key Delivery Priorities will report to the Provider Leadership Board on a monthly basis, using a programme highlight report, to be distributed one week before the meeting. This will focus on progress, key risks and issues for escalation. The Provider Leadership Board will ensure clear objectives and scope under each Key Delivery Priority.

The Managing Director will work closely with the SROs and Programme Directors to ensure oversight and coordination across the Key Delivery Priorities.

The following chart reflects the capacity specifically deployed by Provider Collaborative, but there are other people from the system involved in the work programmes already, such as in supporting the UEC, diagnostics and pathology ICS programmes.



Clinical Programmes – Strategic Approach to Clinical Services

It is proposed that this programme is focussed on developing a strategic approach to clinical services across North East and North Cumbria, supporting nested collaborative working. This should focus initially on tackling vulnerable services, unwarranted clinical variation and providing coordination & escalation for clinical networks. The output of this programme should be heavily informed by population health management and help guide strategic decision making on collaborative opportunities and challenges around estates, technology and workforce.

Programme infrastructure needs to be developed for this Key Delivery Priority. It is proposed that the governance for this has two forums, one clinically-led focussed on the clinical challenges and solutions through the Clinical Advisory Group, one managerially-led focussed on the corporate governance support required.

Clinical Programmes – Elective

The elective programme has a duality of focus, on the performance management aspects of elective recovery in the here and now, particularly on long waits, alongside the transformation requirements for the years ahead. In doing so, the programme seeks to tackle health inequalities, particularly of access and outcomes.

A Strategic Elective Care Board has been in established to take this work forward, with oversight of performance management, clinically-led transformation programmes, independent sector strategy, strategic productivity and collaborative opportunities (eg capitalising on GIRFT and Model Hospital) and ensuring connection to the broader programmes such as waiting well and health literacy.

Clinical Programmes – Urgent and Emergency Care

In 2022/23, the UEC Network has prioritised the long-term plan, operating guidance and national 10-point recovery plan. Specific priorities focus on UEC operating models, including community care, digital and hospital discharge.

Governance arrangements are being revised with the establishment of a UEC Board, which will provide NENC oversight, leadership on winter planning, assurance to ICB and direct connection with LADBs for place-based delivery.

Clinical Support Programmes

There are a number of key strands of work under Clinical Support programmes, particularly around diagnostics and pathology. In addition, a steering group with dedicated project management is overseeing the development of a business case for aseptics (injectable medicines) production facility for the Provider Collaborative.

The NENC Diagnostic Programme Board reports directly into the Optimising Health Services Group, then into the ICS Management Group, with a dotted line to the Provider Collaborative. The Pathology Network Board reports into the Diagnostic Programme Board.

Corporate Programmes

There are a range of active, and potential, work programmes across the Corporate Key Delivery Priority, including work on strategic planning for capital and estates. There is great potential here to make efficiencies but also to harness and maximise the many assets that exist across North East and North Cumbria. The intention is to adopt a series of evidence based programmes designed to get added value for every pound spent. These might include in the short term - redesigning and standardising care pathways, optimising sites, optimising workforce, supporting staff with cost of living pressures, adoption of innovation at pace and scale, sharing and adoption of best practice, but could also include in the longer term policies on workforce, digital innovation, back office support cost reduction, taking a rigorous approach to anchor institution development and so forth.

It is proposed that specific programme infrastructure is established for the Key Delivery Priority, with oversight, identification of opportunities and challenges through the Executive Advisory Group.

Provider Collaborative Leadership and Management Resource

The Managing Director will be accountable to the Chief Executives through the Chair of the Provider Leadership Board and will oversee the collaborative team and Programme Management Office. This team will include a secretariat function to provide administration and support across all Provider Collaborative programmes, specific programme management capacity, transformation resource, analytical capacity and communications and engagement resource. The Provider Collaborative is keen to ensure that access to, and shared leadership of, quality improvement capability.

Access to data has been determined to be a key element of being able to deliver the evidence based programmes required, in particular the use of cross system, multi sectoral data to allow benchmarking and analysis of warranted and unwarranted variation. It is anticipated that much of this will come through FTs, with analytical support from NECS and NEQOS, supported by other sources such as GIRFT and Model Hospital.

The PMO will be accountable to the Managing Director, who will have oversight across all Key Delivery Priorities.

The collaborative team will have a combination of specific staff and seconded staff, both clinical and managerial, to meet programme requirements. For the majority of collaborative programmes, the team will work with FTs to support them in delivery.

The Provider Collaborative team will need to develop over time, in line with resourcing, and alongside the Integrated Care Board (ICB).

It is expected that there will be a phased development of resources in line with increase in development and responsibilities. In the first instance, a sum of £400k has been allocated from NECS for the Provider Collaborative to draw down in 21/22, with a further £500k in 22/23.

In future years, there will need to be consideration of future funding arrangements, depending on the extent of allocated funding from either NECS or the ICB, likely to be as part of negotiation of the Responsibility Agreement. The Provider Collaborative has expressed a desire for FTs to engage collective capacity and an appetite for subscription or other contribution models.

The Development of the Provider Collaborative, including both OD and governance, will be led by the Chair and Vice-Chair. This will explicitly seek to take a strategic approach to talent management and development of a culture of collaboration.

NENC Provider Leadership Board Chair and Deputy

The Chair and Deputy Chair will act as convenors for the Collaborative, bringing together Chief Executives from the constituent FTs through the Provider Leadership Board, in line with the working arrangements set out in the Collaborative Agreement.

The Chair and Deputy will work with colleagues identifying issues for consideration and action by the Collaborative, facilitating discussion across the Collaborative to reach collective agreement on agreed action and ensuring appropriate assurance mechanisms are in place to ensure timely delivery. This will be achieved through distributed leadership, ensuring that all Chief Executives are appropriately involved in and leading Collaborative programmes. The Chair and Deputy will Provide direction, oversight and support to the Managing Director.

The position of Chair/Deputy will be elected from the constituent members and it is expected that the Chair will serve a tenure of 12-15 months. The Deputy will then step into the role of Chair, with a new Deputy nominated.

Senior Responsible Officer (SRO)

To deliver the Collaborative's work programme, a distributed leadership model will be enacted, with a Chief Executive fulfilling the Senior Responsible Officer (SRO) role in leading and facilitating delivery of agreed programmes.

The SRO will effectively act as Chair for the programme, with a designated programme director, and be responsible for ensuring that a programme or project meets its objectives and delivers the projected benefits. The SRO will act as the visible owner of the programme and the key leader in driving forward.

Managing Director

The Managing Director is responsible for leading the foundation and development of the Provider Collaborative through the establishment of governance arrangements and working infrastructure, including staffing/resourcing. The Managing Director will lead the development and delivery of the agreed work programme in line with the priorities established by the Provider Leadership Board.

The MD will ensure the leadership, development and success of the Collaborative's work programme and its contribution to the NENC ICS, coordinating the Collaborative as a membership organisation, working closely and fairly with all its constituent Trusts and ensuring it is established as a credible, robust and respected membership organisation across the North East and North Cumbria.

Programme Director

The Programme Director will work to the Programme SRO to oversee and ensure every aspect of programme delivery, from conception to implementation. Responsibilities include developing and

deploying the project team, securing appropriate resources to support delivery, developing the programme business case and milestones and ensuring that the programme meets the objectives and requirements to agreed timescales and resources. The Managing Director will have oversight of the Programme Directors.

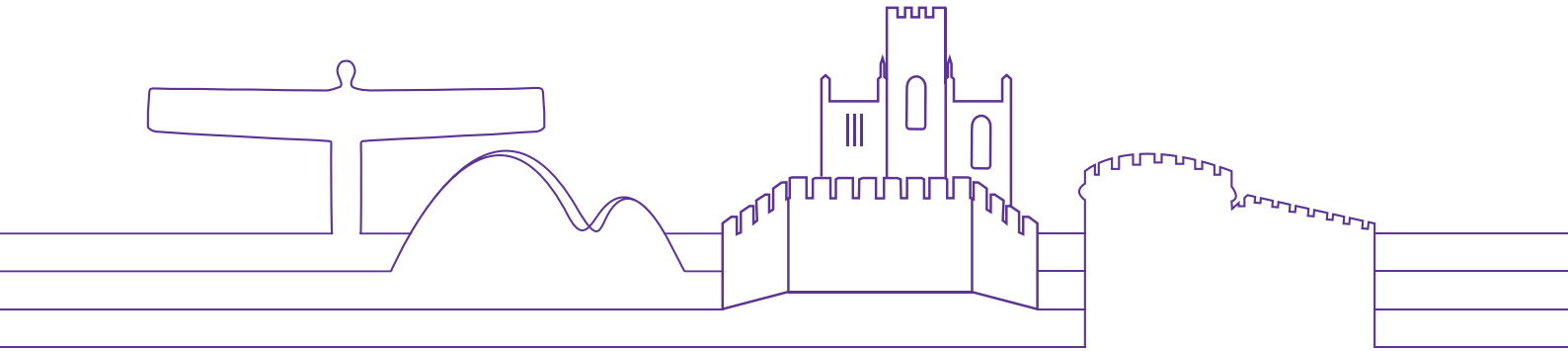
Enclosure C

North East and North Cumbria
Provider Collaborative

WORKING TOGETHER TO IMPROVE HEALTH, WEALTH AND WELLBEING

Setting out our ambitions for the future

May 2022



WHO ARE WE?

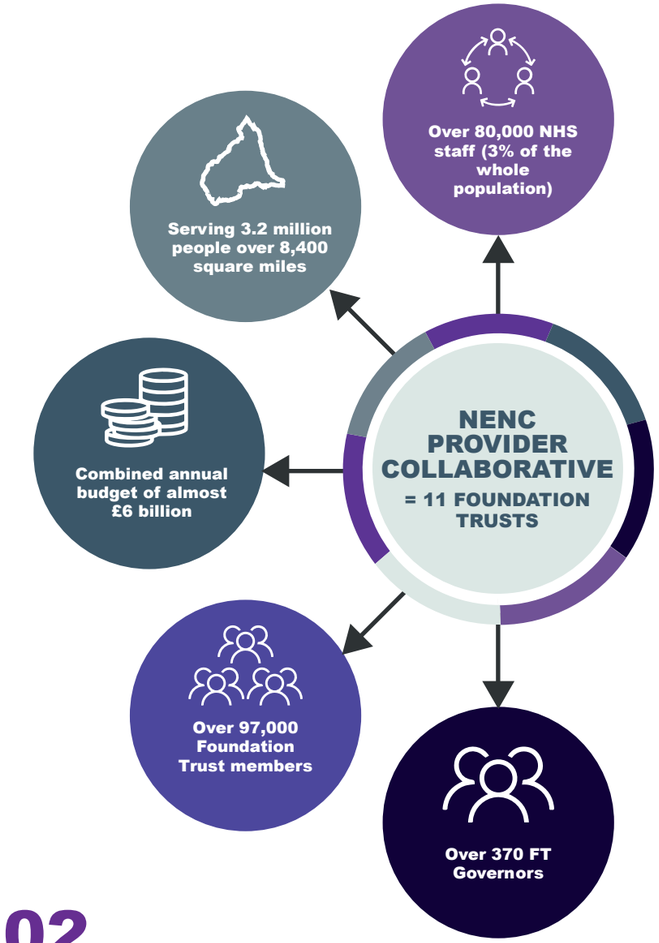
The North East and North Cumbria (NENC) Provider Collaborative is a formal partnership of all 11 NHS Foundation Trusts (FTs)* in the region. Together we cover the entire geographical footprint of the Integrated Care System and, between us, we provide the vast majority of all secondary NHS care services with millions of patient interactions every single day. This includes:

- **Community care and mental health services**
- **Acute hospital services and highly specialist care**
- **Ambulance, patient transport and emergency response services**

Our workforce is the largest in the region and we are major employers within our communities providing significant opportunities for local people. We are very proud of our strong track record, over many years, for providing some of the very best care, patient outcomes and organisational performance across the whole NHS. But we know there is more to do and especially as we recover from the impact of the pandemic.

Through the NENC Provider Collaborative our collective focus now is to ensure we consistently provide the highest quality of care right across our region and the best possible experience for our staff. Given the sheer size and scale of our organisations, we also have a significant role to play in improving the overall health, wealth and wellbeing of the local population.

OUR IMPACT



NENC Provider Collaborative Members:

- Northumbria Healthcare NHS Foundation Trust
- Newcastle upon Tyne Hospitals NHS Foundation Trust
- Gateshead Health NHS Foundation Trust

- South Tyneside and Sunderland NHS Foundation Trust
- County Durham and Darlington NHS Foundation Trust

- North Tees and Hartlepool NHS Foundation Trust
- South Tees Hospitals NHS Foundation Trust

- North Cumbria Integrated Care NHS Foundation Trust

- North East Ambulance Service NHS Foundation Trust
- Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust

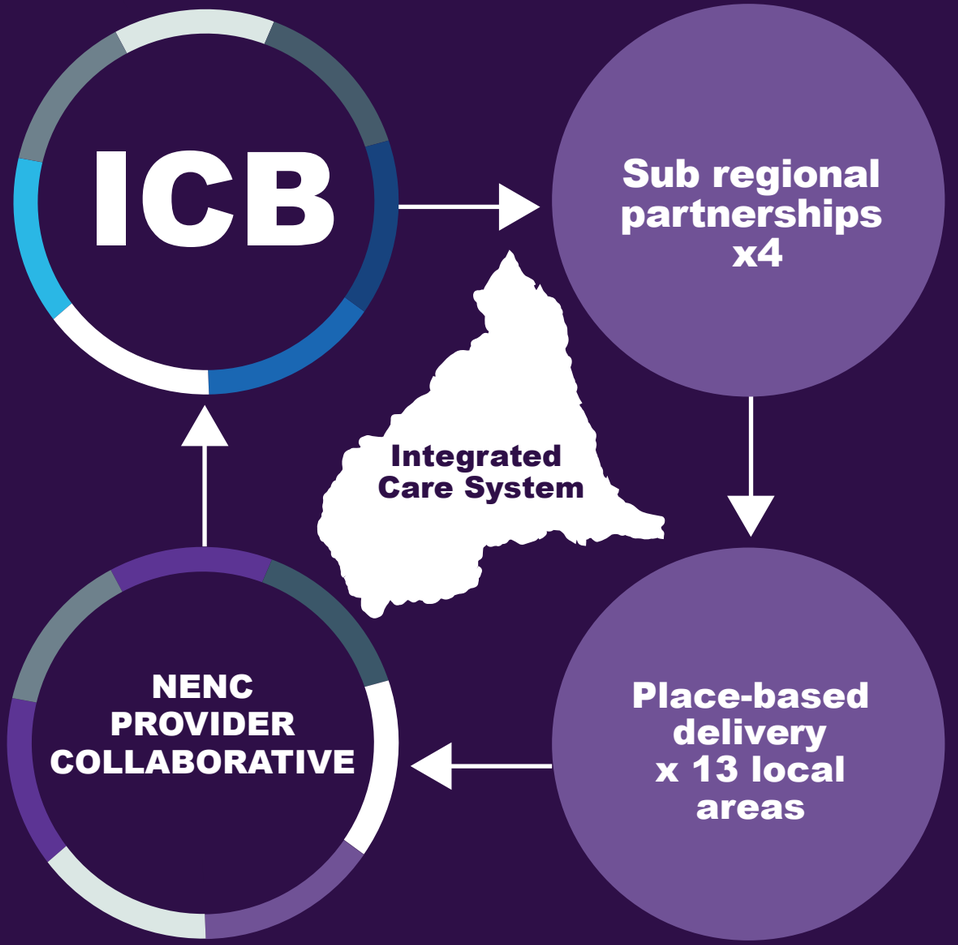
WHAT IS THE ROLE OF PROVIDER COLLABORATIVES?

Provider Collaboratives are an important part of our new system architecture. By July 2022, all NHS Foundation Trusts and NHS Trusts are expected to be part of one or more formal Provider Collaboratives, working together to agree plans for the future and deliver benefits at scale.

Our region was one of the first in England to form a Provider Collaborative ahead of national requirements. Since September 2019 all 11 of our NHS Foundation Trusts have been working together formally to discuss and address many challenges facing us all and, most importantly, to start to plan together as one for the future.

As a collective, we believe we have to continue to think differently about the way we deliver services if we want to be one step ahead and able to face the challenges, as well as the opportunities, the future presents to us.

The NENC Provider Collaborative now provides us with the formal mechanism for us to make collective decisions, to coordinate action on important issues and take forward programmes to improve health and care through collaboration. We will act on behalf of, and take decisions that represent the views of our 11 FTs collectively, rather than being a separate formal entity in our own right. We are a key component of how our new Integrated Care System will work.



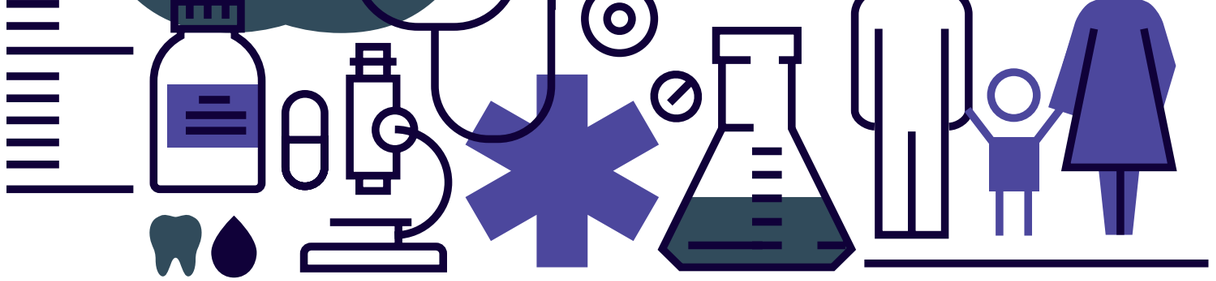
WHAT DO WE WANT TO ACHIEVE?

Our ambition as the NENC Provider Collaborative is simple:

“We want to further improve the quality of care across our Integrated Care System and use our influence to support the wider determinants of health, wealth and wellbeing across the region. We seek nothing less than for patients and the wider population within the North East and North Cumbria to have the highest possible standards of physical and mental health outcomes and positive life experiences.”

As major anchor organisations within our local communities, we recognise that we have a wider responsibility and impact across our Integrated Care System. Not only in the way we offer and deliver health and care services, but also in how we employ staff, how we procure goods and how we do business locally and achieve value for money.

As a NENC Provider Collaborative, we commit to doing all that we can to take collective action to improve health and health care services and support wider economic recovery, providing employment opportunities and local procurement.



We will work in partnership with the Integrated Care Board and share the same strategic objectives to:

Improve outcomes in population health and healthcare by focusing on improving health inequalities that exist within the region.

Tackle inequalities in outcomes, experience and access by optimising the delivery, quality and efficiency of local health and care services provided through our 11 FTs.

Enhance productivity and value for money by taking necessary collaborative. action, including mutual aid and support.

Help the NHS support broader social and economic development by providing opportunities and harnessing our collective strength to influence change.

OUR PRINCIPLES AND WAYS OF WORKING

We have ten principles which outline how we will work together. These will guide everything we do. They will help us to develop an even stronger culture of collaboration between our 11 NHS Foundation Trusts.

1.	**We will support each other and provide mutual aid in times of pressure.**
2.	**We will make shared decisions to speed up transformation and change.**
3.	**We will challenge each other and hold each other to account.**
4.	**We will always act in good faith and in the best interests of the people we serve.**
5.	**We will empower staff to work with other Trust staff to improve care.**
6.	**We will make sure there is strong clinical leadership and governance in all of our work.**
7.	**We will actively involve staff, patients, the public and wider stakeholders.**
8.	**We will show solidarity when making decisions for the local population.**
9.	**We will take responsibility for delivering on agreed priorities and manage risks together.**
10.	**We will promote a high performing culture of teamwork, innovation and continuous improvement. To do this we will share information, communicate honestly and respectfully and act ethically with responsible behaviour and decision making.**

KEY PRIORITIES

We have identified five key delivery priorities which will form the focus of our work in 2022/23 and beyond. This will be via three programmes of work:

Clinical Programmes

1. To develop a strategic approach to clinical services encompassing acute, mental health, learning disabilities and community. This will focus on vulnerable services and thinking about a strategic response to clinical networks and associated cross system working arrangements.

2. To deliver on elective recovery including all service aspects of inpatient, diagnostics and cancer care, as well as mental health and learning disabilities. Our aim is to meet or exceed national benchmarks, standards and targets.

3. To deliver urgent care standards (including ambulance standards) and requirements across all NENC providers and local systems to reduce variation and improve consistency of response.

Clinical Support Programmes

4. To build capacity and capability in clinical support services (in particular diagnostic capacity) to ensure appropriate infrastructure is in place to deliver the above clinical priorities.

Corporate Programmes

5. To support the wider ICS in sustainable transformation, establishing and delivering appropriate corporate strategies to enhance integration and tackle variation. This will include approaches to collective planning, rationalised and aligned estates/capital processes, the development of underpinning approaches in workforce and a commitment to the ICS green strategy.

WORKING AS PART OF THE WIDER ICS

In our role as the NENC Provider Collaborative we will take collective responsibility for the delivery of agreed service improvements and standards across FTS in the North East and North Cumbria. These will be agreed with the ICB.

We will facilitate horizontal collaboration between FTs, but that work will in no way reduce the primacy of place or hamper provider organisations playing full roles within their relevant place based partnerships. We recognise the crucial importance of place-based working, where our FTs work closely with local communities and partner organisations.

There will also be different collaborative arrangements (see page 12) where individual FTs will continue to work with each other on a geographical or sectoral basis All of this good work will not stop. Our role is not to cut across any of this, but to act as an enabler.

Our strength as the NENC Provider Collaborative will be through operating as a whole system collaborative when a response is best done once, together and at scale. This might be because the issue is complex, there is a need for critical mass, or requires standardisation to reduce unwarranted variation across multiple FTs.

To work effectively with the ICB we need to agree responsibilities as to how we can best contribute to the overall success of the ICS and meet the strategic objectives we all share.

We believe the NENC Provider Collaborative is best placed to lead on the priority areas identified on page 9. This includes:

- **Action to deliver recovery, specifically in tackling long waits in elective care and other services** with the development of longer term transformation solutions.
- **Addressing system level action to bring the urgent care system back to pre-pandemic levels of performance and above.**
- **Taking forward a strategic approach to clinical service development,** particularly where there are service vulnerabilities, or opportunities, that require at-scale consideration. This would include discussion and agreement around Clinical Networks and formal hosting and/or leadership arrangements.
- **Opportunities for at-scale solutions and strategic improvements to unwarranted variation or inefficiencies** within and across the 11 FTs (see page 7).

WORKING WITH HEALTH AND CARE PARTNERS

As the NENC Provider Collaborative, we are just one of a number of partnership arrangements that will work with the ICB to deliver the overall aims and objectives of the Integrated Care System. These are shown opposite.

We may interact with these other collaboratives acting as the NENC Provider Collaborative, or as individual FTs, depending on the nature of discussions taking place. However we collaborate, we want to interact and support the work of others as we collectively strive to plan, deliver and transform health and health care services for the future in our region.

DRIVING INNOVATION & IMPROVEMENT

As NENEC providers we have a high appetite for innovation and will seek a coherent approach which plays to the academic, commercial and industrial strengths of our FTs.

As part of this we will support and drive the development of research and continue our close working with vital partners. This includes working with Health Education England, education partners and professional bodies to provide high quality education and training, recruiting and retaining the workforce of today and attracting the workforce of tomorrow.

We aim to go much further than our role in directly improving health and delivering healthcare. We aim to capitalise on the substantial opportunities we have across our organisations and with our partners.

Academic Health Sciences Network	**North East Quality Observatory System**	**Biomedical Research Centre**
Academic Health Sciences Centre	**Universities of Northumbria, Newcastle, Durham, Sunderland and Teesside**	**NIHR Applied Research Collaborative**

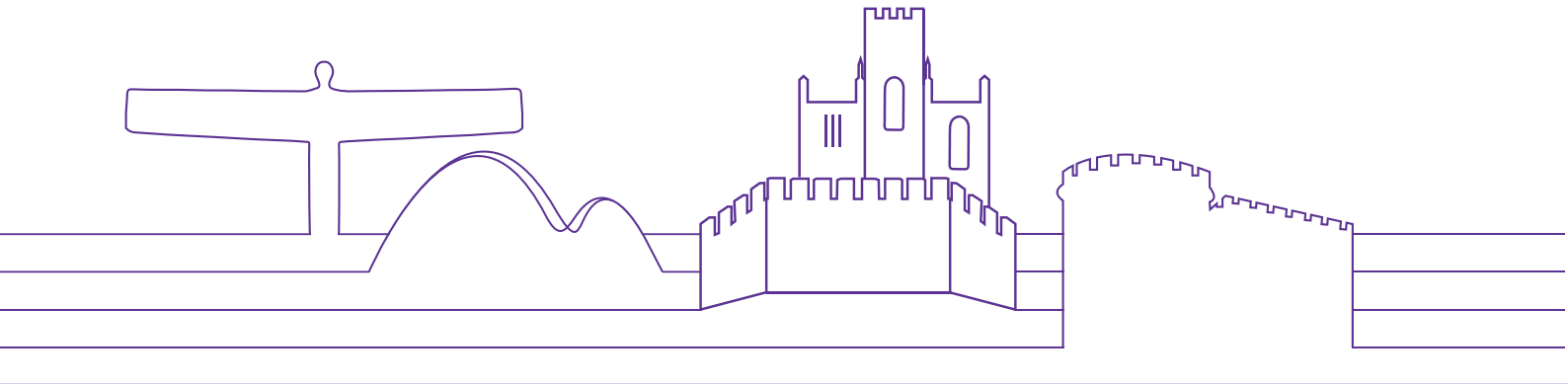
WHAT NEXT?

This document sets out our aspirations for the future and the ways of working we have developed so far as the NENC Provider Collaborative.

As work gathers pace towards our new structures and system architecture coming into place formally from July 2022, we will speak to partners about the role of the NENC Provider Collaborative and where you think we can add value to drive forward innovation and improvement.

In the coming months, we will work with the ICB to jointly agree how we can best support the delivery of ICS objectives and best use our skills and capabilities as we strive to maximise the flexibilities and freedoms of the new Health Bill when enacted. We recognise this can be achieved in several ways and we want to agree the appropriate mechanism, recognising that the basis of this working relationship will flex issue by issue.

We look forward to involving and engaging with you all along the way and building on the strengths of our relationships here in the North East and North Cumbria.



www.northeastnorthcumbria.nhs.uk/who-we-are/provider-collaborative

North Tees and Hartlepool
NHS Foundation Trust

Meeting of the Board of Directors

Title:	Board Assurance Framework Quarter 1: 2022/23										
Date:	28 July 2022										
Prepared by:	Hilton Heslop, Associate Director of Corporate Affairs & Strategy										
Executive Sponsor:	Julie Gillon, Chief Executive										
Purpose of the report	The aim of this paper is to provide assurance to the Board of Directors on the progress made to mitigate and manage the strategic risks within the Board Assurance Framework (BAF) for Quarter 1; 2022/23 and the actions for addressing the identified gaps in controls and assurance.										
Action required:	Approve		Assurance	X	Discuss	X	Information	X			
Strategic Objectives supported by this paper:	Putting Patients 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:

The BAF has **12 risk domains** associated with delivery of the four strategic objectives – Putting our population first, Valuing People, Transforming our services and Health and Wellbeing. The principal risks consist of **35 threats.**

There are currently 4 principal risks that include a **high** risk rating within one or more of the threats:

Strategic Risk 1A has a high risk (6434) aligned that relates to the ability to learn from national safety alerts linked to procurement and the inability to easily identify and quickly identify real time stock position in response to patient safety alerts / product recalls. This is being managed by the LLP in conjunction with the Trust and is monitored through the Patient Safety and Quality Standards Committee and the Master Services Agreement. An additional high risk (5818) linked to potential on-compliance with IG mandatory training is currently managed through Care group internal monitoring and management of compliance.

Strategic Risk 1A & 2A (6379) – has one associated risk relating to Pathology Consultant Staffing with challenges experienced due to vacancies, inability to recruit and increasing demand. Workforce challenges within pathology is recognised and forms part of the collaborative work and discussions of the Tees Valley and Friarage Pathology Group in looking at innovative solutions for the future.

Strategic Risk 3C has one associated high risk identified through the work of the Finance Committee in December 2021. Delivery of Savings (6188) and the challenges to deliver the CIP programme for 2021/22, the current rate of progress to identify CIP for 2022/23, and the potential impact of increased CIP that may be required to support future delivery of a breakeven position across the ICP/ICS, in light of indicative underlying financial positions. Previous HIGH rated risks i.e. Cost Containment (6203) and Wider Health Economy Issues

(6205) were both downgraded to MODERATE following monitoring by the Finance Committee.

Strategic Risk 3E reflects two threats to the principal risk as being 'High' with reference to the completion of the ICP Clinical Services Strategy and the progression of the Tees Valley and North Yorkshire Provider Collaborative due to the uncertainty faced across the ICS and this will continue to be monitored and reflected in the BAF. There are no other current or emerging 'High' risks relating to performance and compliance during the current period.

The risks and threats outlined above are reflected in minutes of relevant committees in addition to Executive Director summary papers. All sub-committees to the Board of Directors will provide routine reporting through the Executive Team Risk Management meeting to ensure there is oversight with appropriate actions being taken to mitigate the risks. A BAF Risk Radar is attached at Appendix 1 to demonstrate the breadth of risks currently monitored and managed by the trust. The radar will be updated on a quarterly basis to illustrate movement of risk ratings.

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

In Quarter 1 no individual strategic risks on the Board Assurance Framework was reporting as >15 (high) despite some 'High' rated threats linked to operational risks.

The Corporate Risk Register has seven risks reporting a current risk rating of >15 (high) as follows:

ID	Title	BAF Section	Risk Level	Current Risk level	Target Risk Level
6379	Insufficient Microbiology and Histology Consultant staff with substantive availability to support / advise clinical services.	**1A/2A**	**20**	**16**	**4**
6434	Procurement – Inability to easily identify real time stock position	**1A**	**15**	**15**	**5**
6188	Delivery of Savings	**3C**	**16**	**16**	**9**
6512	Structure and process for the management of written clinical communication leaving the trust does not meet the agreed standard	**1A**	**25**	**20**	**2**

Committees/groups where this item has been discussed	Patient Safety and Quality Standards Committee Planning, Performance and Compliance Committee Finance Committee People Committee Transformation Committee Digital Strategy Committee Executive Management Team Audit Committee
Recommendation	The Board of Directors is asked to note the risks contained in the BAF and specifically those based on a current risk rating of >15 (High).

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

28 July 2022

Board Assurance Framework, Quarter 1 Report April - June 2022

1 Purpose

1.1 The purpose of the report is to provide assurance to the Board of Directors on the principal risks to achieving the Trust's strategic objectives.

2 Background

2.1 The role of the Board Assurance Framework (BAF) is to provide evidence and structure to support effective management of strategic risk within the organisation. The BAF also provides evidence to support the Annual Governance Statement.

2.2 The BAF provides assurance to the Board of the key risks and identifies which of the objectives are at risk of not being delivered, whilst also providing assurance where risks are being managed effectively and objectives are being delivered. This allows the Board to determine where to make most efficient use of their resources or otherwise take mitigating action and address the issues identified in order to deliver the Trust's strategic objectives.

2.3 The process for gaining assurance is fundamentally about taking all of the relevant evidence together and arriving at informed conclusions. In order to do this the Board tasks its Board Sub Committees with undertaking scrutiny and assurance of the following:

- Controls in place
- Assurances in place and whether they give positive or negative assurance
- Gaps in controls or assurance
- Actions to close gaps and mitigate risk

2.4 Ensuring effective systems are in place to identify, monitor and mitigate risks and providing assurance to Board.

2.5 The Board of Directors is required to review the risk appetite and the appropriateness of its strategic risks on a regular basis. This will require the Board to consider the Trusts appetite for exploring and managing risks in patient stagey and quality; compliance, regulation and finance; innovation and transformation; workforce; technology; and reputation. This will require a discussion based around the themes of avoid, minimal, cautious, open, seek and mature, and will be considered in light of the many changes that have taken place during the last months.

2.6 This may span the advent and rise of COVID through to the changes in governance with the formation of the ICS and the role of ICBs alongside other critical policy developments within healthcare that may impact on the Trust. The Board will review the risk appetite for the Trust as we move into Quarter 2 (July-September) and this will take into account a review of all risk domains currently within the BAF.

3 Details

3.1 The BAF has **12 risk domains** associated with delivery of the four strategic objectives Putting our Population first, Valuing People, Transforming our Services and Health and Wellbeing. The principal risks consist of **35 threats.**

3.2 There are currently two (2) principal risks that are assessed with a **high** risk rating within one or more of the threats. There has been no change to the strategic risk ratings since the last report. A summary of the individual high rated risks is noted below. However, the principal risk of 'Patient Safety' includes three (3) aligned threats linked to operational issues e.g. procurement, staffing and clinical letters. Whilst these threats do not impact on the overall risk rating of the principal risk it is general practice to include in BAF.

3.3 The Board of Directors annual cycle of business ensures that all risks are reviewed within the sub-Committee structure to ensure there is consistency, alignment and relevance to the principal risks for the appropriate Committees.

3.4 All committees have reviewed and approved their respective BAF reports/templates as part of the assurance process..

3.5 High Rated Risks/threats – Quarter 4: 2021/22

Strategic Risk Patient Safety 1A

3.6 Risk 6434 is an aligned threat that relates to the ability to learn from national safety alerts. This is specifically linked to procurement and the inability to easily identify and quickly identify real time stock position in response to patient safety alerts / product recalls. This is being managed by the LLP in conjunction with the Trust and is monitored through the Patient Safety and Quality Standards Committee and governance arrangements with the Master Services Agreement.

3.7 Risk 6379 relates to Pathology Consultant Staffing with challenges being experienced due to vacancies, inability to recruit and increasing demand. Workforce challenges within pathology is recognised and forms part of the collaborative work and discussions of the Tees Valley and Friarage Pathology Group in looking at innovative solutions for the future.

3.8 Risk 6512 relates to the structures and processes for the management of written clinical communication leaving the trust that does not meet the agreed standard. This is currently managed and mitigated by weekly reports by Trust Administration Manager with a breakdown of letters waiting to be transcribed and awaiting verification to Chief Operating Officer (COO) and Care group leads providing current position.

Strategic risk Finance 3C

3.9 Risk 6188 relates to the delivery of savings within the Trust's Cost Improvement Programme (CIP) and specifically the challenges to deliver the CIP programme for 2021/22, the current rate of progress to identify CIP for 2022/23, and the potential impact of increased CIP that may be required to support future delivery of a breakeven position across the ICP/ICS, in light of indicative underlying financial positions.

3.10 A CIP plan for 2022/23 has been developed and is regularly reported to the Finance Committee. The PMIO team provides support to facilitate delivery of identified schemes and reasonable assurance on CIP report from AuditOne in 2021/22 with a planned follow-up audit in 2022/23.

Strategic Risk 3E – Innovation and Integration

3.11 There are two high rated threats to the overall strategic risk to innovation and integration at an external level:

3.12 **ICP Clinical Strategy** - Delivery of quality, equitable clinically sustainable services for patients of the Tees Valley and the failure to fully utilise and make best use of resources across the system;

Tees Valley & North Yorkshire Provider Collaborative - Changes to organisational form/structure may impact on the Trust quality, financial, clinical, workforce and operational delivery resulting in potential impact upon regulatory status including NHS Single Oversight Framework, financial control total delivery and CQC quality rating.

3.13 Work to deliver the clinical strategy at ICP and ICS level continues and is in alignment with the progress and work programme of the Provider Collaborative. The Board will be aware of the process of transition that surrounds the Provider Collaborative in line with the governance structures that have been implemented and are currently being exercised through the Joint Partnership Board. However, whilst the broad threat to the principal objective includes four specific areas (ICP/ICS, Clinical Services Strategy, Provider Collaborative and NHS Long Term Plan) it is clear that the Tees Provider Collaborative needs time to embed the structure, governance and cultural changes to ensure a committed and collaborative vehicle for improving health and care across the wider geography of North Yorkshire and Tees Valley.

3.14 The Board has discussed previously that the work to mitigate the two risks relies heavily on the progress of collaboration with partners, as well as the input from the Integrated Care Board (ICB) with the focus 'place' based planning and delivery. Whilst the two risks are rated as HIGH, there is a likelihood that both risks can be reduced as governance and collaboration expectations within 'place' become clearer.

3.15 The risks and threats outlined above are reflected in the minutes of the relevant Committees alongside Executive Director summary reports. A BAF Risk Radar is attached at Appendix 1 to demonstrate the breadth of risks currently monitored and managed by the trust. The radar will be updated on a quarterly basis to illustrate the movement of risk ratings.

4 Significant Risks

4.1 In Quarter 1 no overall strategic risks on the Board Assurance Framework was reporting as >15 (high) despite some 'High' rated specific threats as noted above and included in the table below. In respect to linked risks from the Corporate Risk Register, the following have been identified as a significant risk based on a current risk rating of >15 (High):

ID	Title	BAF Section	Risk Level	Current Risk level	Target Risk Level
6188	Delivery of Savings	**3C**	**16**	**16**	**9**
6379	Insufficient Microbiology and Histology Consultant staff with substantive availability to support / advise clinical services.	**1A**	**20**	**16**	**4**
6434	Procurement – Inability to easily identify real time stock position	**1A**	**15**	**15**	**5**

6512	Structure and process for the management of written clinical communication leaving the trust does not meet the agreed standard	**1A**	**25**	**20**	**2**

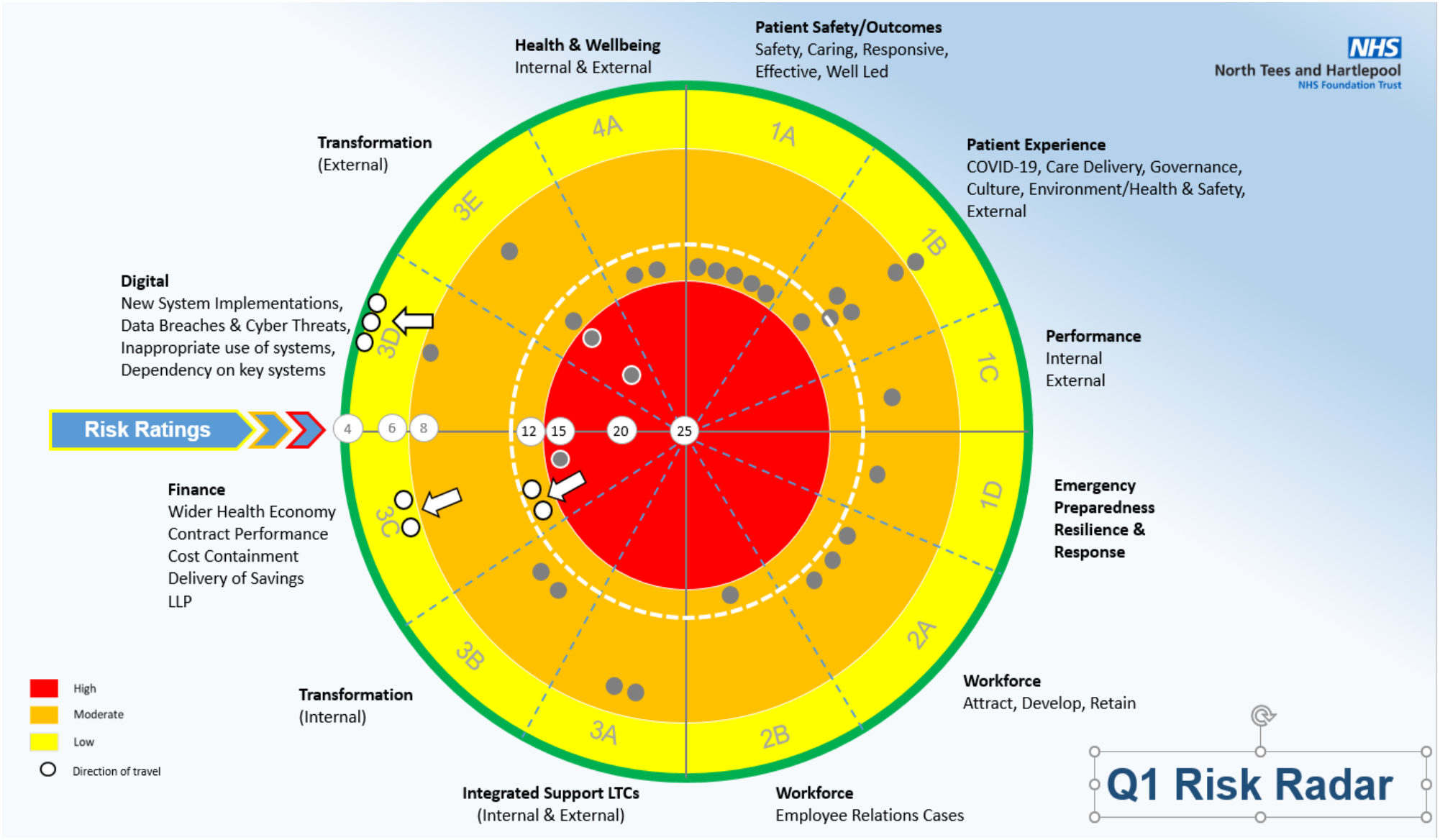
5. Recommendations

5.1 Actions are in place and being taken forward to mitigate the risks in the above sections, and the issues form part of regular discussions at the key Committees as well as being a focus of Executive Team discussions as part of the monthly Risk Management reporting.

5.2 The Board of Directors are asked to note the risks contained in the BAF and specifically those that are based on a current risk rating of >15 (High).

Prepared by: **Hilton Heslop, Associate Director of Corporate Affairs & Strategy**

Appendix 1


Health & Wellbeing
Internal & External
Patient Safety/Outcomes
Safety, Caring, Responsive, Effective, Well Led
NHS
North Tees and Hartlepool
NHS Foundation Trust
Transformation
(External)
Patient Experience
COVID-19, Care Delivery, Governance, Culture, Environment/Health & Safety, External
Digital
New System Implementations, Data Breaches & Cyber Threats, Inappropriate use of systems, Dependency on key systems
Performance
Internal
External
Risk Ratings
4
6
8
12
15
20
25
Finance
Wider Health Economy
Contract Performance
Cost Containment
Delivery of Savings
LLP
Emergency Preparedness Resilience & Response
4A
1A
3E
1B
3D
1C
3C
1D
3B
2A
3A
2B
High
Moderate
Low
Direction of travel
Transformation
(Internal)
Workforce
Attract, Develop, Retain
Integrated Support LTCs
(Internal & External)
Workforce
Employee Relations Cases
Q1 Risk Radar

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title:	Integrated Compliance and Performance Report										
Date:	28 July 2022										
Prepared by:	Mark MacDonald - Interim Head of Strategy, Planning & Performance Lindsey Wallace – Interim Deputy Director of Planning & Performance Keith Wheldon – Business Intelligence Manager										
Executive Sponsor:	Linda Hunter, Interim Director of Planning and Performance Lindsey Robertson, Chief Nurse/ Director of Patient Safety and Quality Susy Cook, Interim Chief of People Officer Neil Atkinson, Director of Finance										
Purpose	To provide an overview of performance and associated pressures for compliance, quality, finance and workforce.										
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:

The report outlines the Trust's compliance against key access standards in June 2022 including quality, workforce and finance.

Summary

- Operational and workforce pressures continued in June, affecting performance against key standards.
- The Trust continues to respond to surges in demand and pressures within services including IPC guidelines. Additional beds opened within available resource.
- Performance and Quality standards continue to be monitored closely through the established and robust internal governance structures, which supports further development of improved clinical pathways, quality and patient safety across the Trust.
- The Trust continues to perform well against the quality and patient safety indicators, including HSMR/SHMI and infection control measures.

- The number of patients waiting longer than 52 weeks has remained the same in June compared to last month
- The Trust achieved four of the nine cancer standards in May 2022
- Staff sickness continues to demonstrate an improved position since January 2022, this will be continuously monitored.
- Workforce continues to review recruitment and retention rates across the Trust

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.

Associated risks are outlined within the Board Assurance Framework

Committees/groups where this item has been discussed	Executive Team Meeting Audit 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 on-going operational pressures and system risks to regulatory key performance indicators and the associated mitigation.

North Tees and Hartlepool
NHS Foundation Trust

Integrated Performance Report

July 2022

Responsible Directors

NHS
North Tees and Hartlepool
NHS Foundation Trust

Linda Hunter
Interim Director of Planning & Performance

- System Oversight Framework
- Efficiency & Productivity

Lindsey Robertson
Chief Nurse and Director of Patient Safety & Quality

- Safety & Quality

Susy Cook
Interim Chief People Officer

- Workforce

Neil Atkinson
Director of Finance

- Finance

Introduction

NHS
North Tees and Hartlepool
NHS Foundation Trust

Performance highlights against a range of indicators including the System Oversight Framework (SOF) and the Foundation Trust terms of licence remains. The report is for the month of June 2022 and outlines trend analysis against key Compliance indicators, Operational Efficiency and Productivity, Quality, Workforce and Finance.

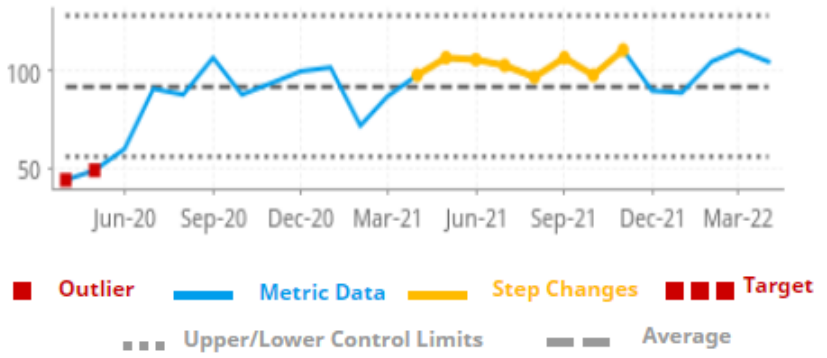
Statistical Process Control (SPC) Charts

A **Step Change** occurs when there are 7 or more consecutive points above or below the *average*.

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

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

Standard deviation tells you how spread out the data is. It is a measure of how far each observed value is from the average. In any distribution, about 95% of values will be within 2 standard deviations of the mean.



Executive Summary

NHS
North Tees and Hartlepool
NHS Foundation Trust

SOF and Efficiency & Productivity

As the Trust continues on its journey of recovery work to move to the delivery of the trajectories outlined in the planning submission for 2022/23, there continues to be a sustained increased demand for services. Continuing to respond to an increasing number of requests for mutual aid, diverts and deflections into the organisation from across the system with a high percentage of those patients being admitted. High bed occupancy rates has resulted in some patients waiting in the Emergency Department over 12 hours. An organisational focus on admission avoidance through our community services offer timely discharge with the Trust being a pilot site of the Optica system with Home First principle being at the forefront of delivery.

Despite the challenges the overall position for the majority of key standards, including RTT, cancer and diagnostics, remain comparable to national and regional position. Additional capacity continues to be delivered through continuation of insourcing supporting capacity within the elective programme whilst the internal workforce gaps are addressed and outsourcing of diagnostic reporting continues.

Work on delivering against Cancer standards continues with a number of initiatives in place including insourcing, pathway reviews supported by delivery groups and capacity and demand reviews across the services, given the increase in referrals into some specialities.

A full waiting list review is underway with Clinical teams continuing to review patients, currently waiting over 40 weeks, to ensure patient outcomes have been progressed and patients waiting for procedures or appointments are given dates.

Safety & Quality

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

The latest HSMR value is currently reporting at 84.18 (March 2021 to February 2022), with the latest SHMI value is 94.15 (February 2021 to January 2022) which remains within the control limits.

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

The number of Stage 1 increased during June 2022, with Stages 2 and 3 seeing a decrease. The number of complaints received this month continues to be consistent with pre-pandemic levels.

The number of high risks has reduced to the same as the mean over last few months and this remains within the expected variance, demonstrating a dynamic risk management process.

Executive Summary

NHS
North Tees and Hartlepool
NHS Foundation Trust

Workforce

Sickness absence levels have decreased in May 2022 which includes a fall in Covid-related absence; stress/anxiety/depression was the most prevalent reason for absence. Absence management clinics continue and work has started to look at Occupational Health KPIs and 231 managers have received Attendance Management Training.

Turnover has decreased slightly and there are actions in place to look at employee engagement, reward and recognition.

Overall mandatory training compliance stands at 90%, but there are hotspot topics where compliance is lower in Resus and safeguarding topics.

Work is ongoing to improve appraisal compliance (85% currently).

Finance

The Trust submitted an original financial plan for 2022/23 of a deficit of £1.4m. Following additional national funding to support excessive inflationary costs, the Trust has submitted a revised financial plan of £4.35m surplus.

The revised financial plan will be supported by additional income and an increase in the CIP target for 2022/23.

The revised financial plan has not impacted on control totals for care groups or corporate areas.

At month 3, the Trust is reporting an in-month surplus of £2.262m against a planned surplus of £1.153m, which is £1.109m ahead of plan.

The Trust is reporting a year to date surplus of £3.430m against a plan of £2.740m, which is £0.690m ahead of plan.

Phasing of the revised plan anticipated an ahead of plan position, but this will not continue and is expected to reduce during the year.

Total Trust income in M3 is £31.147m (including donated asset income).

M3 pay expenditure totalled £20.629m of which £0.162m is additional spend related to the Covid-19 response (including testing costs).

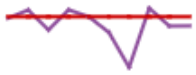
M3 non-pay expenditure totalled £8.235m of which £0.134m is additional spend related to Covid-19.

The month 3 year to date net contribution from Optimus is £0.067m against a plan of £0.041m (£0.026m ahead of plan) and the year to date net contribution from the LLP is £0.260m against a plan of £0.458m (£0.198m behind plan – which includes reinvestment expenditure of £82k).

Key risks at Month 3 relate to run rate control (workforce costs e.g. enhanced rates) and delivery of CIP.

System Oversight Framework 6

NHS
North Tees and Hartlepool
NHS Foundation Trust

Standard	Standard Achieved	Month	Performance	Standard	Trend
New Cancer Two Week Rule	✗	May-22	84.58%	93.00%	
Breast Symptomatic Two Week Rule	✗	May-22	92.83%	93.00%	
28-day Faster Diagnosis	✓	May-22	76.25%	75.00%	
New Cancer 31 Days	✓	May-22	96.10%	96.00%	
New Cancer 31 Days Subsequent Treatment (Drug Therapy)	✓	May-22	98.41%	98.00%	
New Cancer 31 Days Subsequent Treatment (Surgery)	✗	May-22	93.33%	94.00%	
New Cancer 62 Days	✗	May-22	54.49%	85.00%	
New Cancer 62 Days (Screening)	✗	May-22	86.11%	90.00%	
New Cancer 62 Days (Consultant Upgrade)	✓	May-22	92.31%	85.00%	

Narrative

Cancer

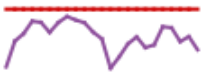
The reported May position, the latest validated position, sees the Trust achieving four out of the nine cancer standards which placed the Trust 2nd in the region. The Trust continues to achieve the 28 day faster diagnosis target, being only one of three organisations across the region to do so. The cancer 62 day target is still a pressure, with no Trust in the region achieving the standard. Issues in breast, gynaecology, colorectal and urology continue with peaks in referrals impacting on patient pathways. A continued focus through weekly Cancer PTL works to ensure all patients progress along the pathway as quickly as possible.

Cancer Delivery Groups continue to meet on a monthly basis to support and encourage change solutions and understand issues around complex pathways. All tumour groups are in the process of developing robust recovery action plans which will be monitored through the robust governance structure in place.

The Trust continues to await the outcome of the national consultation to review existing cancer standards.

System Oversight Framework 7

North Tees and Hartlepool NHS Foundation Trust

Standard	Standard Achieved			
	Month	*Performance*	*Standard*	*Trend*
Referral To Treatment Incomplete Pathways Wait (92%)	Jun-22	81.16%	92.00%	
Referral To Treatment Incomplete Pathways Wait (92nd Percentile)	Jun-22	29.00	28.00	
Incomplete Pathways Wait (Median)	Jun-22	8.14	7.20	
Incomplete Pathways Wait (>52 Week Wait)	Jun-22	62	15	
Diagnostic Waiting Times and Activity	Jun-22	84.24%	99.00%	

Narrative

RTT

The number of patients waiting longer than 52 weeks is 62, against a target in June of 15 with the aim to have zero patients waiting over 52 weeks by September 2022. The most recent regional data (May 2022) is reflective of the Trust having the second lowest number over 52 weeks in the region, the lowest being 35, and sitting third in the region for overall 18 week compliance At the end of June 2022 the Trust maintains the trajectory position with no patients waiting longer than 78 and 104 weeks.

Care Groups are working to increase capacity in identified specialties in line with recovery which is looking to improve patient flow, standardise processes, and develop an assurance framework.

The Trust continues to see an increase in referrals, 11.27% at end of June, compared to 2019/20 levels, with an increase to the overall waiting list in June reporting a 3.8% (n=716) in comparison to May 2022.

Diagnostics

Performance has seen a reduction in June compared to last month which regionally placed the Trust with the second highest compliance across the region. The pressures are primarily related to staffing capacity in a number of key areas.

Additional MRI capacity to reduce the backlog will be introduced in July with a mobile MRI scanner on the North Tees site and Endoscopy continue to provide additional weekend lists.

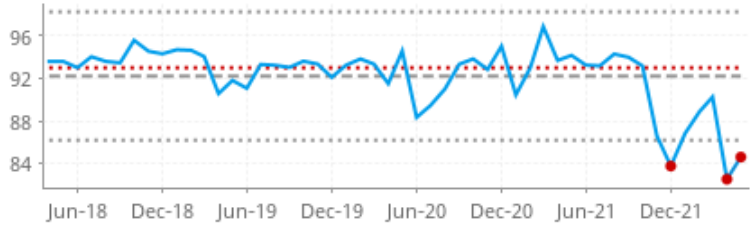
System Oversight Framework 8

North Tees and Hartlepool NHS Foundation Trust

Statistical Process Control (SPC) Charts

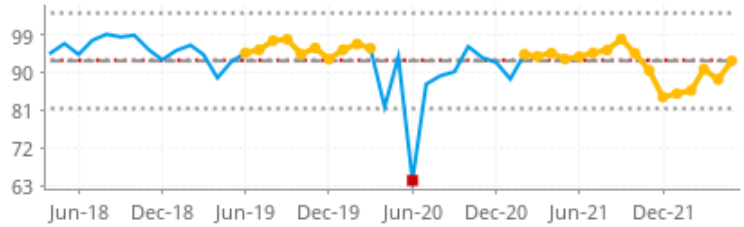
Cancer - 2 Week Rule

Month	Performance	Standard
May-22	84.58%	93.00%



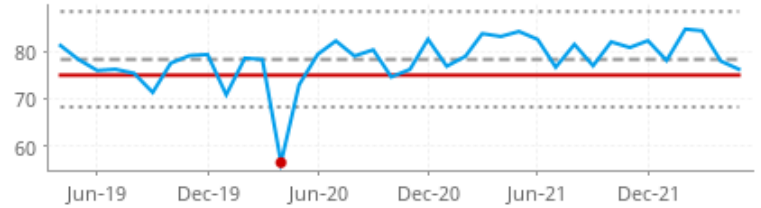
Cancer - Breast Symptomatic

Month	Performance	Standard
May-22	92.83%	93.00%



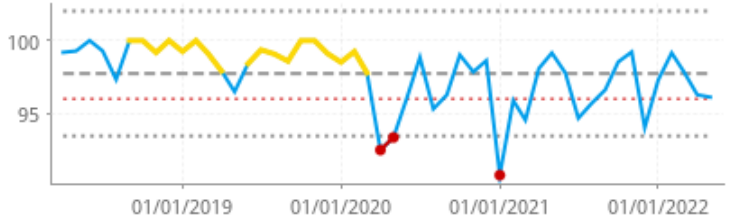
Cancer - 28 day Faster Diagnosis

Month	Performance	Standard
May-22	76.25%	75.00%



Cancer - 31 days

Month	Performance	Standard
May-22	96.10%	96.00%



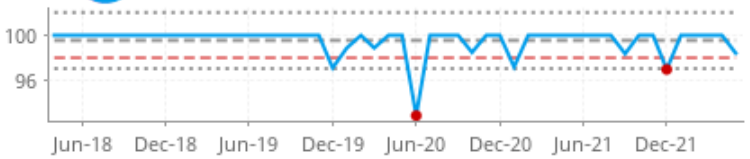
System Oversight Framework 9

North Tees and Hartlepool NHS Foundation Trust

Statistical Process Control (SPC) Charts

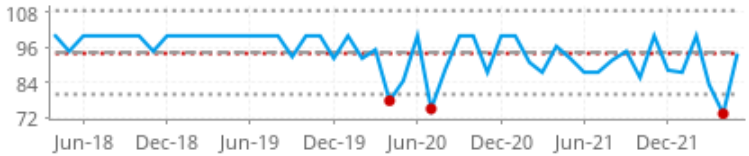
Cancer - 31 Day Drug Treatment

Month	Performance	Standard
May-22	98.41%	98.00%



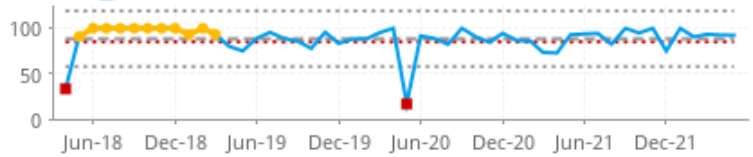
Cancer - 31 Day Surgical Treatment

Month	Performance	Standard
May-22	93.33%	94.00%



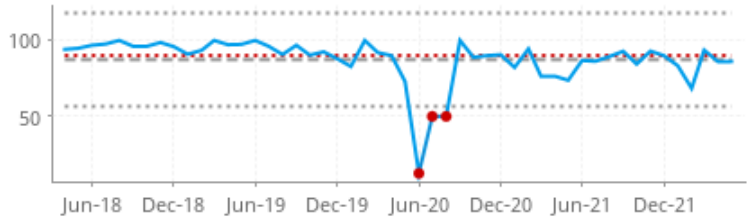
Cancer - 62 Consultant Upgrade

Month	Performance	Standard
May-22	92.31%	85.00%



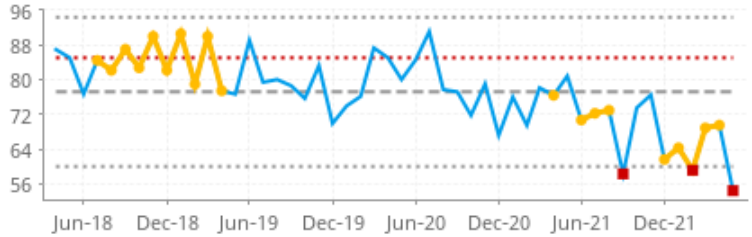
Cancer - 62 Days Screening

Month	Performance	Standard
May-22	86.11%	90.00%



Cancer - 62 Days

Month	Performance	Standard
May-22	54.49%	85.00%



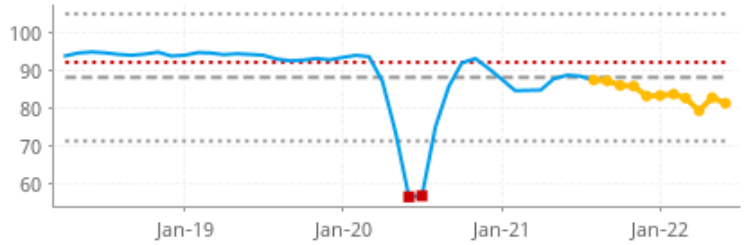
System Oversight Framework 10

North Tees and Hartlepool NHS Foundation Trust

Statistical Process Control (SPC) Charts

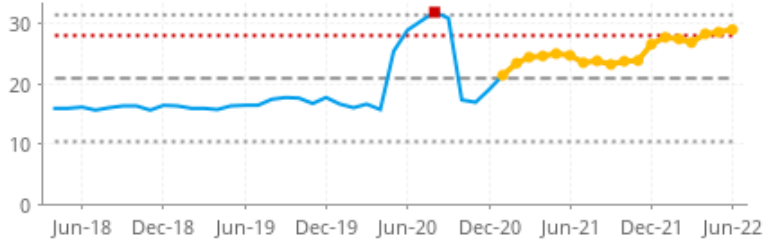
Referral To Treatment- Incomplete Pathways Wait (92%)

Month	Performance	Standard
Jun-22	81.16%	92.00%



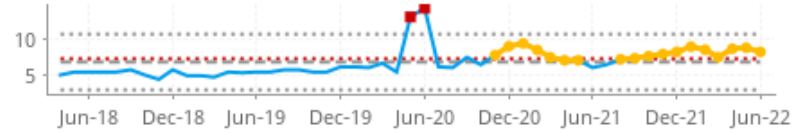
Referral To Treatment - Incomplete Pathways Wait (92nd percentile)

Month	Performance	Standard
Jun-22	29.00	28.00



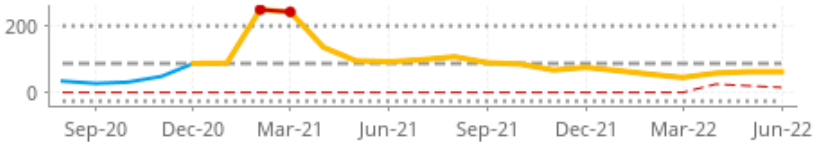
Referral To Treatment - Incomplete Pathways Wait (Median)

Month	Performance	Standard
Jun-22	8.14	7.20



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

Month	Performance	Standard
Jun-22	62	15



Diagnostic Waiting Times and Activity

Month	Performance	Standard
Jun-22	84.24%	99.00%

Efficiency & Productivity

NHS
North Tees and Hartlepool
NHS Foundation Trust

Standard	Month	Performance	Standard	Trend
Decision To Admit (DTA) (over 12 hours)	Jun-22	13	0	
Time to Initial Assessment (mean) Type 1 & 3	Jun-22	12.59	15.00	
Number of Ambulance Handovers waiting more than 60 Mins	Jun-22	15	0	
65% of Ambulance Handovers completed within 15 Mins	Jun-22	29.76%	65.00%	
95% of Ambulance Handovers completed within 30 Mins	Jun-22	58.62%	95.00%	
2 hour Urgent Community Response	May-22	64.01%	70.00%	

Narrative

Urgent and Emergency Care

The Trust continues to triage patients within the required national standard of 15 minutes however, pressures are noted within Ambulance handovers and overall time spent in the Emergency Department aligning to bed availability with occupancy regularly above the 90% standard throughout the month.

NEAS reported the Trust at 51.1% of ambulance turnaround times within 30 minutes (arrival to clear), this places the Trust 2nd regionally with an average turnaround time of 32 minutes. 30% of handovers were completed within 15 minutes and 59% within 30 minutes. Though below standard, there is an improving trend with a step change since October 2021.

The Trust continues to respond to a number of requests for mutual aid and ambulance diverts and deflections from neighbouring trusts with 45 patients received in June, which is significantly higher than the 15 reported in May, with 26 of those patients converting to an admission with an average length of stay of 5.3 days.

The Trust is committed to improving compliance with ambulance turnaround times and continues to work in partnership with NEAS colleagues.

Urgent Community Response

The Tees Valley Urgent Community Response Service brings together a range of Health and Social Care professionals to respond quickly to support patients to remain in their own home. The compliance has seen an increase in the latest position report for May, moving from 58.49% in April. The District Nurses Team in Stockton are the first individual team to achieve the 70% standard in May.

Staff have been developed as Key Trainers supporting in-month audits and workforce through individual action plans and the team are committed to achieving the standard by Q3 2022/23.

Efficiency & Productivity

12

North Tees and Hartlepool NHS Foundation Trust

Standard	Standard Achieved			
	Month	*Performance*	*Standard*	*Trend*
Outpatient Did Not Attend (Combined)	Jun-22	9.85%	9.20%	
Reducing Reviews	Jun-22	88.67%	85.00%	
Patient Initiated Follow Up (PIFU)	Jun-22	3.10%	5.00%	
Advice and Guidance	Jun-22	10.10%	16.00%	
Diabetic Retinopathy Screening	Jun-22	98.22%	95.00%	

Narrative

Outpatients

A slight improvement in performance against DNA rates is noted in June, when compared to May, with a continued upward trend evident. A sub group of the Outpatient Transformation Group will link in with Primary Care to understand, from a Health inequalities perspective, the reasons why a high percentage of patients from the lowest decile population are unable to attend their appointment.

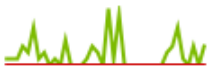
The continued focus on Patient Initiated follow ups (PIFU) has seen Orthopaedics implement a PIFU pathway in June for fracture and elective clinics, which should support an improved reporting position in the coming months. Please note a change to April's position following a rebased trajectory calculation to a cumulative monthly position rather than the full year effect.

As the organisation moves to more PIFU this will contribute to plan to reduce the number of patients seen in review clinics which has been set at 85% of what was delivered in 2019/20. The Trust is currently reporting 3.67% over that plan for June which is an improved position compared to May which reported 7.37% above plan.

Efficiency & Productivity

13

North Tees and Hartlepool NHS Foundation Trust

Standard	Standard Achieved				
		Month	*Performance*	*Standard*	*Trend*
Electronic Discharge Summaries	✗	Jun-22	87.95%	95.00%	
Super Stranded	✗	Jun-22	50	43	
Average Depth of Coding	✓	May-22	6.30	3.01	
Length of Stay - Elective	✓	Jun-22	1.39	3.14	
Length of Stay - Emergency	✓	Jun-22	2.85	3.35	
Day Case Rate	✓	Jun-22	81.26%	75.00%	
Pre-op Stays	✓	Jun-22	1.72%	4.50%	
Trust Occupancy	✗	Jun-22	93.90%	90.00%	
Re-admissions Rate 30 Days (Elective and Emergency)	✗	Apr-22	8.45%	7.70%	
Not reappointed within 28 days	✗	May-22	3	0	

Narrative

Electronic Discharge Summary (EDS)

All summaries are being completed however, some are outside of the required 24 hours. Care Groups receive a report which will drive focus in specific areas but unfortunately team sickness is negatively impacting the ability to complete within 24 hours.

Trust Occupancy

While admissions in June were 2.44% less than in May, the Trust continued to operate at a heightened occupancy rate (93.86% average) during June with surges in activity and an increase in Covid admissions from 11 patients at the end of May to 62 at the end of June.

A peak on 29 June 2022 saw occupancy rise to 98.68%, with 46 escalation beds opened. Escalation beds open throughout the month ranged from a minimum of 8, to a maximum of 46 (on 29 June).

Work is underway to review the core bed base in conjunction with the Trust's Operating Model to ensure that services are able to respond to surges in demand.

Readmissions

Readmissions continues an improving trend with a further reduction in April (latest available data) with deployments of patients to virtual wards and support from Hospital at Home enabling improvements in readmission rates across respiratory, although along with sepsis respiratory remains one of the main reasons for readmission.

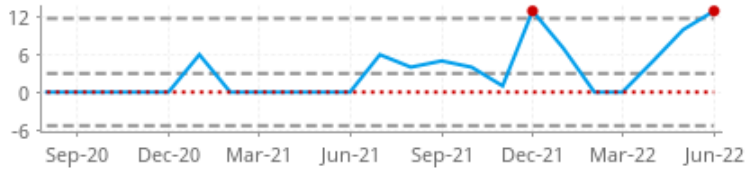
Efficiency & Productivity

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

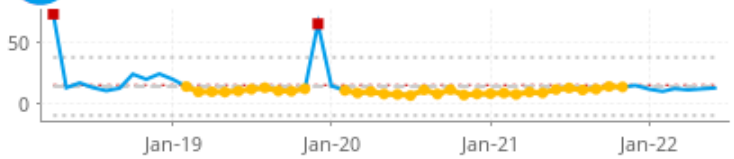
Decision to Admit (DTA) (Over 12 hours

Month	Performance	Standard
Jun-22	13	0



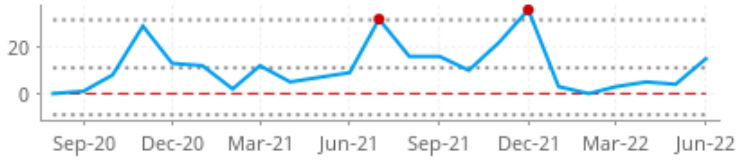
Time to Initial Assessment (mean) Type 1 & 3

Month	Performance	Standard
Jun-22	12.59	15.00



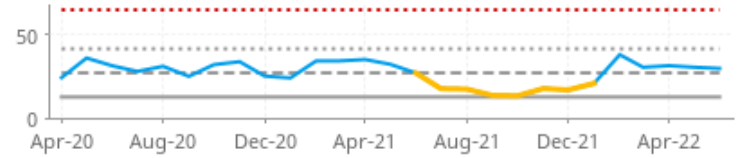
Number of Ambulance Handovers waiting more than 60 mins

Month	Performance	Standard
Jun-22	15	0



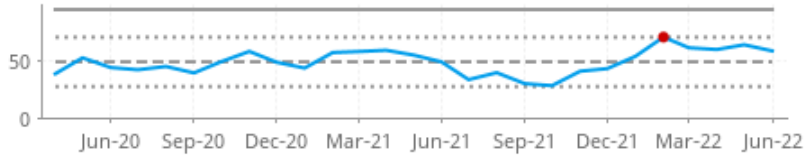
65% of Ambulance Handovers completed within 15 mins

Month	Performance	Standard
Jun-22	29.76%	65.00%



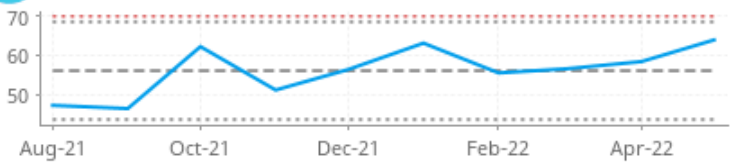
95% of Ambulance Handovers completed within 30 mins

Month	Performance	Standard
Jun-22	58.62%	95.00%



2 hour Urgent Community Response

Month	Performance	Standard
May-22	64.01%	70.00%



Efficiency & Productivity

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North Tees and Hartlepool NHS Foundation Trust

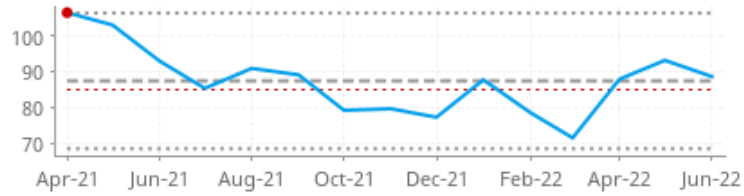
Statistical Process Control (SPC) Charts

Outpatient Did not Attend

Month	Performance	Standard
Jun-22	9.85%	9.20%

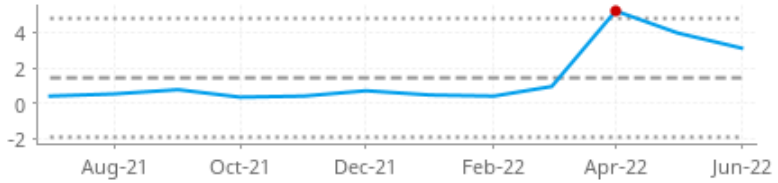
Reducing Reviews

Month	Performance	Standard
Jun-22	88.67%	85.00%



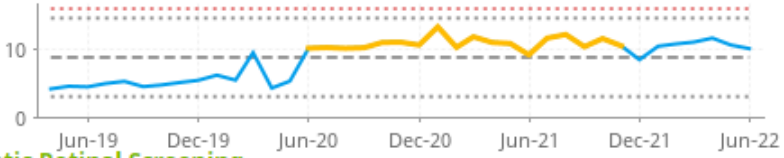
Patient Initiated Follow up

Month	Performance	Standard
Jun-22	3.10%	5.00%



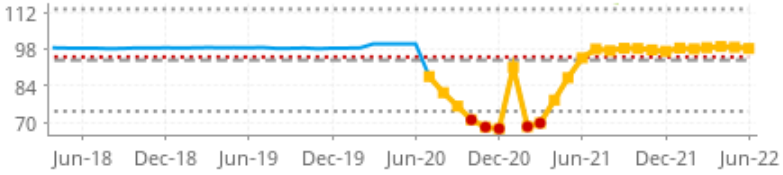
Advice and Guidance

Month	Performance	Standard
Jun-22	10.10%	16.00%



Diabetic Retinal Screening

Month	Performance	Standard
Jun-22	98.22%	95.00%



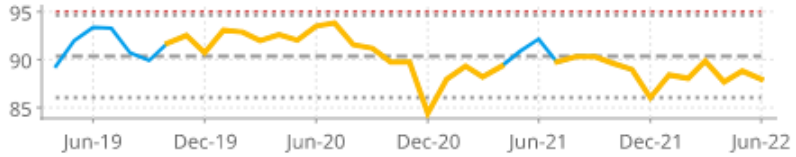
Efficiency & Productivity

North Tees and Hartlepool NHS Foundation Trust

Statistical Process Control (SPC) Charts

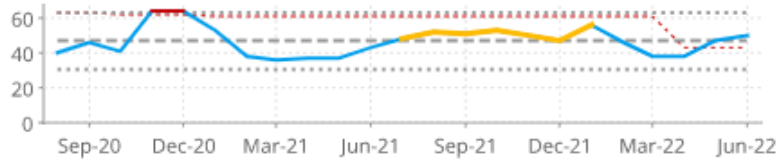
Electronic Discharge Summaries

Month	Performance	Standard
Jun-22	87.95%	95.00%



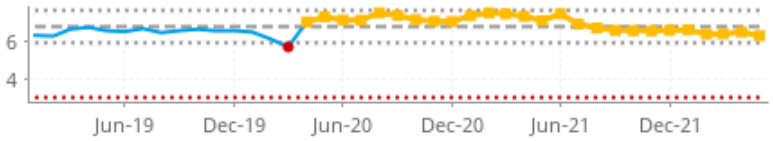
Super Stranded

Month	Performance	Standard
Jun-22	50	43



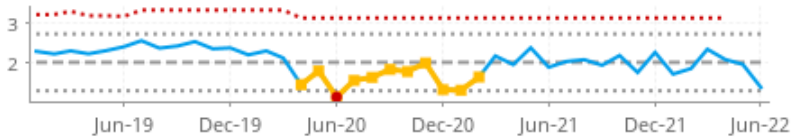
Average Depth of Coding

Month	Performance	Standard
May-22	6.30	3.01



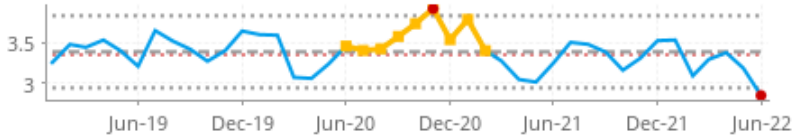
Length of Stay - Elective

Month	Performance	Standard
Jun-22	2.11	3.14



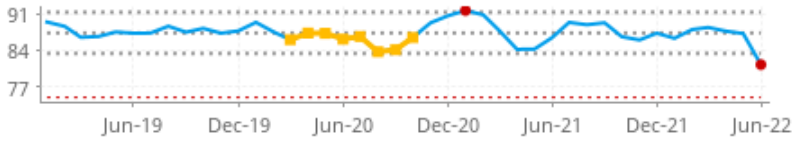
Length of Stay - Emergency

Month	Performance	Standard
Jun-22	2.85	3.35



Day Case Rate

Month	Performance	Standard
Jun-22	81.26%	75.00%



Efficiency & Productivity

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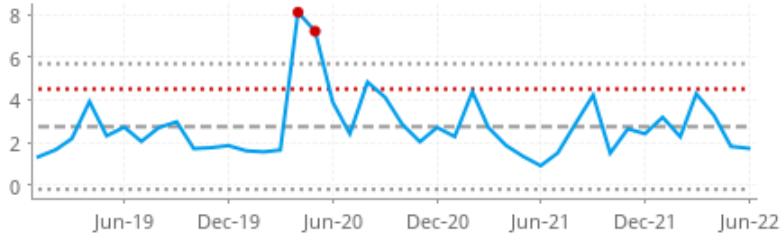
North Tees and Hartlepool NHS Foundation Trust

Statistical Process Control (SPC) Charts

Pre-op Stays

Month	Performance	Standard
Jun-22	1.72%	4.50%

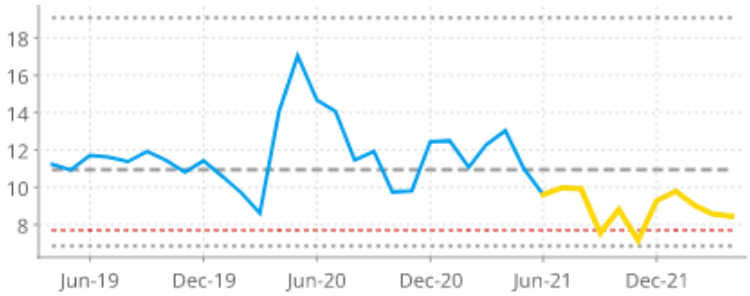


Trust Occupancy

Month	Performance	Standard
Jun-22	93.90%	90.00%

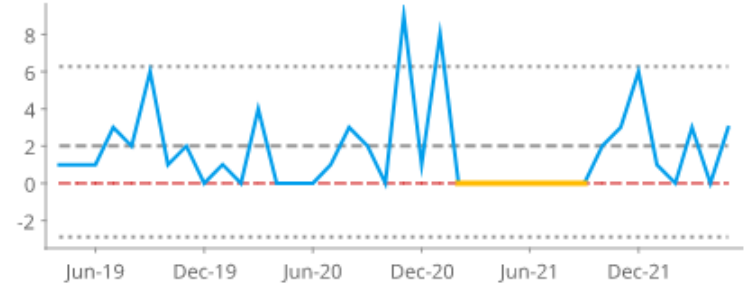
Re-admissions Rate 30 Days (Elective and Emergency Admission)

Month	Performance	Standard
Apr-22	8.45%	7.70%



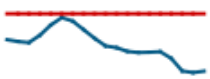
Not Reappointed within 28 days

Month	Performance	Standard
May-22	3	0



Safety & Quality

NHS
North Tees and Hartlepool
NHS Foundation Trust

Standard	Standard Achieved	Month	Performance	Standard	Trend
Hospital Standardised Mortality Ratio (HSMR)	✓	Mar 21 - Feb 22	84.18		
Summary Hospital-Level Mortality Indicator (SHMI)	✓	Feb 21 - Jan 22	94.15		
Stage 1 Complaint	✗	Jun-22	119	98	
Stage 2 Complaint	✓	Jun-22	4	4	
Stage 3 Complaint	✓	Jun-22	5	9	
Compliments	✓	Jun-22	309	255	

Narrative

Mortality

The latest HSMR value is currently reporting at 84.18 rebased (March 2021 to February 2022) which has increased from the previous rebased value of 83.78 (February 2021 to January 2021). The latest SHMI value is now 94.15 (February 2021 to January 2022) which has decreased from the previous rebased value of 94.74 (January 2021 to December 2021).

Complaints

The number of complaints has slightly decreased in June compared with the previous month, with an increase in Stage 1 complaints. There has been a slight decrease in stage 2 complaints and a large decrease of 13 in Stage 3 complaints. The numbers received and themes continue to be closely monitored. The Trust continues with the drive for local and face to face resolution of concerns, virtual meetings have been developed to support this process.

Limited visiting continues on an appointment basis. However, families continue to be supported through John's Campaign and provisions for those patients at End of Life. During June 2022, communication was the highest reported main issue in concerns raised to the Trust with 24 complaints. However, this is a decrease of 30 compared to the previous month. Increased analysis has been undertaken in relation to this theme and this is discussed during the weekly Safety Panel meetings. Trend analysis also continues to be addressed during weekly Senior Clinical Professional Huddles. This robust process continues to support timely identification of the themes.

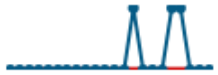
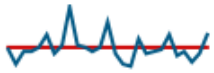
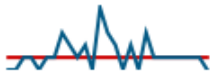
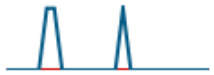
There has been a significant reduction in the number of relatives arranging virtual visits and the number of parcels and letters delivered to the Patient Experience Team as part of the patient's property drop off service. However, this service remains available. Ward staff continue to promote virtual visiting as an alternative option to face to face visiting.

Compliments

The Trust records the compliments received onto the Greatix platform. For June 2022 the number of compliments received is 309, which is higher than the mean of 255 compliments. Compliments consistently remain higher than the number of complaints the Trust receives.

Safety & Quality

NHS
North Tees and Hartlepool
NHS Foundation Trust

Standard	Standard Achieved	Month	Performance	Standard	Trend
High Risks	✓	Jun-22	4	4	
Never Events	✓	Jun-22	0	0	
VTE %	✗	Jun-22	94.47%	95.00%	
Fall No Harm	✗	Jun-22	84	81	
Fall Low Harm	✗	Jun-22	22	16	
Fall Moderate Harm	✓	Jun-22	0	1	
Fall Severe Harm	✓	Jun-22	0	0	

Narrative

Falls

During June all falls were recorded as leading to no harm, low harm or a near miss. Overall 75% of the falls resulted in no harm, 5% near misses without harm and 19.7% causing low harm such as grazes or bruising.

The National audit of inpatient falls data from 1st January – 31 December 2021 has been published. When compared to the previous year there has been a marked improvement in completion of lying and standing BP's, medication reviews, patients having a medical assessment within 30 minutes of a fall and completion of continence care plans. There is ongoing work to ensure these improvements are sustained and assurance provided to the Board.

The Falls Lead continues to work in collaboration with the Trust patient safety teams to ensure optimum learning from incidents, supporting service and quality improvement associated with risks, risk mitigation and patient care.

Safety & Quality

NHS
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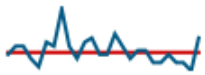
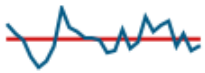
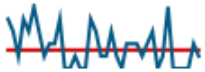
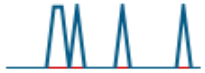
NHS Foundation Trust

Standard	Standard Achieved	Month	Performance	Standard	Trend
Pressure Category 1 (inpatient)	✗	May-22	8	5	
Pressure Category 2 (inpatient)	✓	May-22	18	22	
Pressure Category 3 (inpatient)	✓	May-22	1	2	
Pressure Category 4 (inpatient)	✓	May-22	0	0	

Narrative

Pressure Ulcers

In the May 2022 reporting period, there were 8 Category one pressure ulcers validated, which is above our expected standard, although we welcome early identification and action. An increase in Category two pressure ulcers, 18, which is below the accepted standard of 22 cases. There has been 1 Category three pressure ulcers identified in May 2022 and zero Category four pressure ulcers reported, both of which are in line with or below our expected standard.

Safety & Quality

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North Tees and Hartlepool
NHS Foundation Trust

Standard	Standard Achieved	Month	Performance	Standard	Trend
Hand Hygiene	✓	Jun-22	99%	95%	
Clostridium difficile	✓	Jun-22	2	4	
MRSA	✓	Jun-22	0	0	
MSSA	✗	Jun-22	3	2	
Ecoli	✓	Jun-22	6	6	
Klebsiella	✗	Jun-22	2	1	
Pseudomonas	✓	Jun-22	0	1	
CAUTI	✓	Jun-22	16	18	

Narrative

Infections

In June 2022, the Trust reported two cases of Clostridioides difficile infection, which is below our projected trajectory of 4 for June 2022. Our yearly objective for 2022-23 is 54 cases of Clostridioides Difficile, with our current case figure of 10.

The Trust has reported 6 E-coli bacteraemia in June 2022, which is significantly less than the previous month and in line with our projected case rate of six. Our yearly objective for E-coli bacteraemia for 2022-23 is 73 cases, which is a significant reduction on the previous year and we currently have had 28 cases since the start of the financial year.

There were no trust attributable cases reported for Pseudomonas infections. Our 2022-23 objective is 12 cases.

The trust reported two cases of Klebsiella in June 2022. This remains above our projected trajectory of one case for the month of June. Our yearly objective for Klebsiella species for 2022-23 is 21 cases, currently the trust stand at 10 cases.

There have been three healthcare-associated cases of MSSA in the month of June, which is one more than our monthly projected trajectory of two cases. There is no set national objective set for MSSA, but by applying the same criteria that the national team have to the other targets, our own internal trust target for MSSA for 2022-23 is 30 cases. The trust have had 9 cases in total for this financial year.

For the month of June, 16 CAUTI cases were reported for the trust, against our projected trajectory of 18.

The trust continues to report 0 MRSA bacteraemias, with a zero tolerance target for 2022-23.

Hand Hygiene compliance throughout the trust stands at 99%.

Safety & Quality

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NHS
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NHS Foundation Trust

Standard	Standard Achieved				
		Month	*Performance*	*Standard*	*Trend*
Friends and Family Test (FFT) - Emergency	✓	Jun-22	80.00%	75.00%	
Friends and Family Test (FFT) - Inpatients	✓	Jun-22	88.00%	75.00%	
Friends and Family Test (FFT) - Maternity	✓	Jun-22	100.00%	75.00%	
UNIFY - RN Day	✗	Jun-22	77.56%	>=80% and <=109.99%	
UNIFY - RN Night	✓	Jun-22	90.22%	>=80% and <=109.99%	
UNIFY - HCA Day	✓	Jun-22	86.81%	>=80% and <=109.99%	
UNIFY - HCA Night	✗	Jun-22	131.73%	>=110% and <=125.99%	

Narrative

Friends and Family

For June 2022 the Trust received 1,305 FFT returns, this has creased on the previous months returns of 1,488. The Very Good or Good responses returned for June 2022 is 90.42%.

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 remain challenging due a range of factors including continued vacancies and a higher sickness absence than planned. The daily challenges have been safely managed through appropriate routes of escalation up to the Deputy Chief and Chief Nurse. The nursing fill rates presented in June 2022 show that these pressures are still evident but continue with a positive forecast emerging from October/November 2022 following further recruitment plans and the deployment of planned international nurses.

Minimum of twice daily safe staffing meetings continue to review the acuity and dependency needs of patients to ensure the available staffing resource is deployed to the most suitable areas. Alternative models utilising nursing associate, therapy and un-registered nurse roles continues to support the process to meet the patient acuity and dependency, underpinned by professional judgement.

Monthly recruitment processes are on-going for both Registered Nurses and Health Care Assistants and cohort 3 of Team Support Workers (24wte) were recruitment in June 2022. Approx. 35wte Pre Reg Nurses were also interviewed and offered positions across all clinical areas in June 2022.

The international recruitment of up to 60wte registered nurses is currently underway which will further support increasing the shift fill rate and reducing the overarching nursing vacancy level.

Safety & Quality

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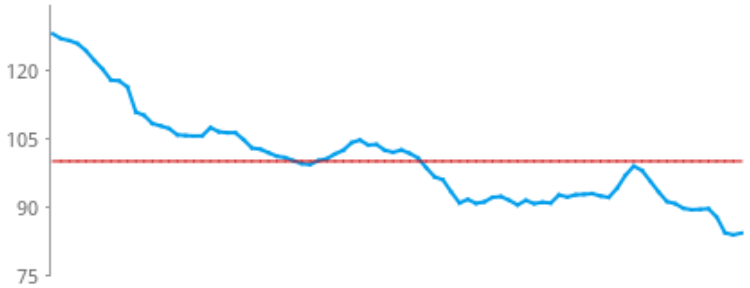
NHS Foundation Trust

Additional Detail Charts

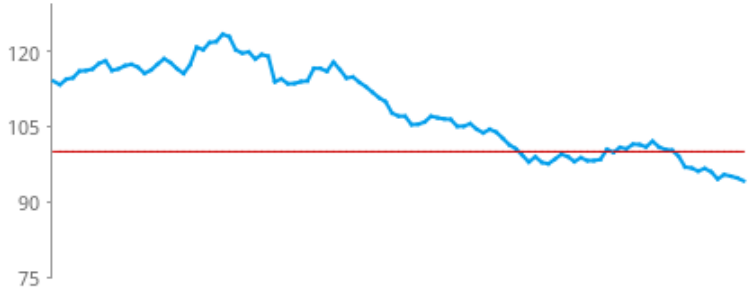
Hospital Standardised Mortality Ratio

Month	Performance
Mar 21 - Feb 22	84.18



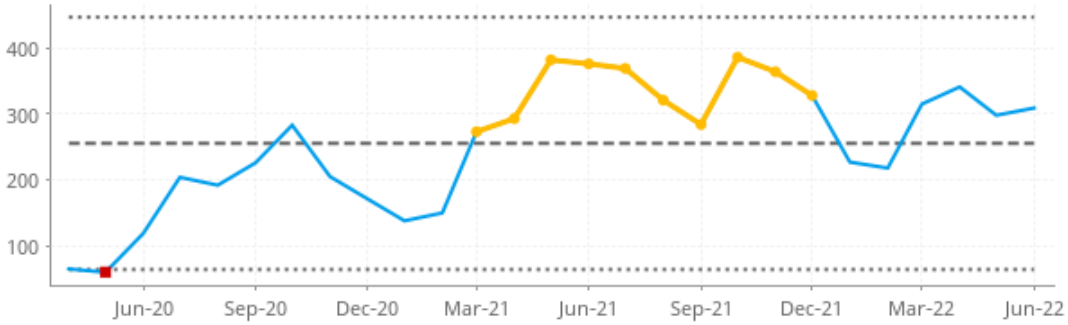
Summary Hospital-Level Mortality Indicator

Month	Performance
Feb 21 - Jan 22	94.15



Compliments

Month	Performance	Standard
Jun-22	309	255



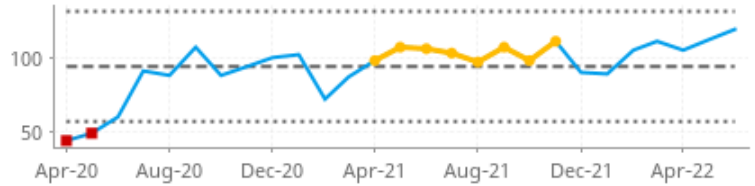
Safety & Quality

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

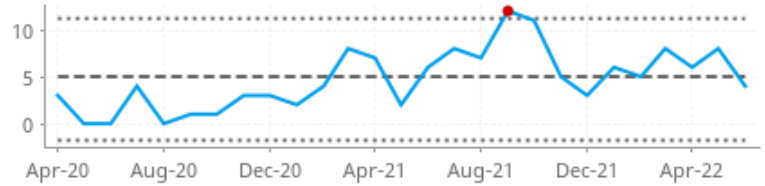
Stage 1 - Informal

	Month	Performance	Standard
✗	Jun-22	119	98



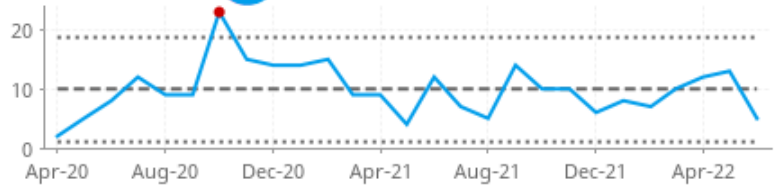
Stage 2 - Meeting

	Month	Performance	Standard
✓	Jun-22	4	4



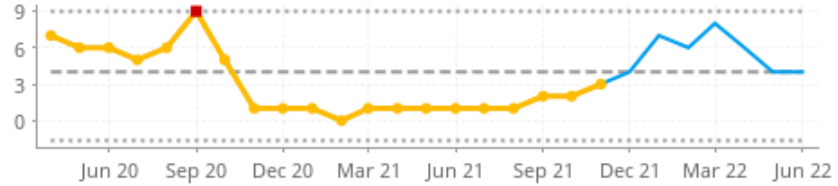
Stage 3 - Formal

	Month	Performance	Standard
✓	Jun-22	5	9



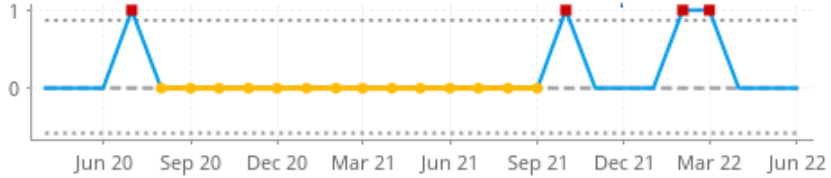
Red Risks

	Month	Performance	Standard
✓	Jun-22	4	4



Never Events

	Month	Performance	Standard
✓	Jun-22	0	0



VTE %

	Month	Performance	Standard
✗	Jun-22	94.47%	95.00%

Safety & Quality

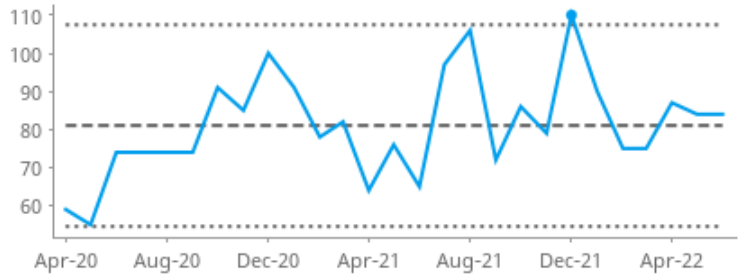
25

North Tees and Hartlepool NHS Foundation Trust

Statistical Process Control (SPC) Charts

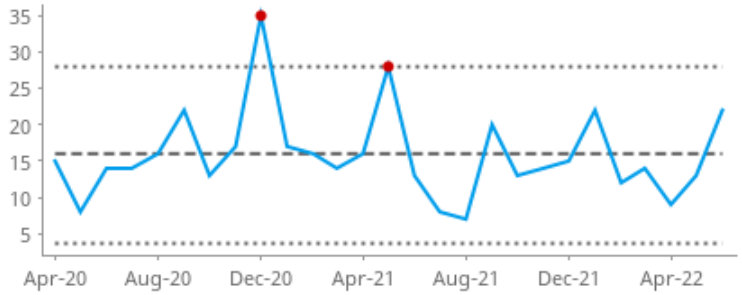
Fall No Harm

Month	Performance	Standard
Jun-22	84	81



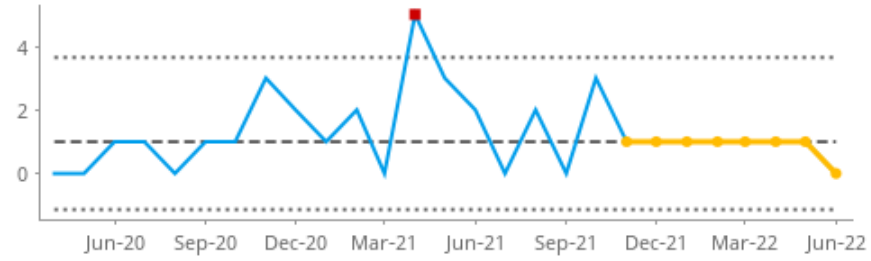
Fall Low Harm

Month	Performance	Standard
Jun-22	22	16



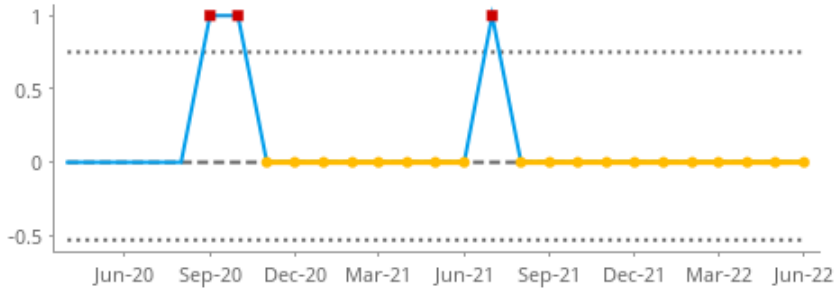
Fall Moderate Harm

Month	Performance	Standard
Jun-22	0	1



Fall Severe Harm

Month	Performance	Standard
Jun-22	0	0



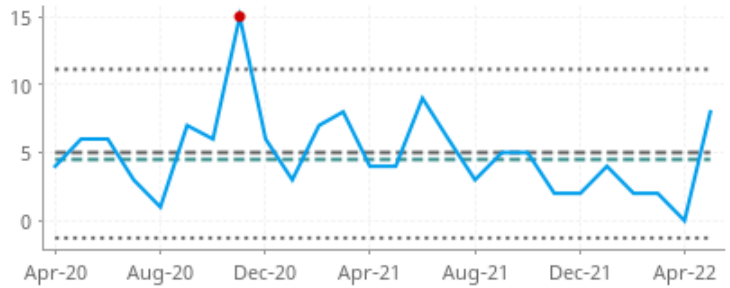
Safety & Quality

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

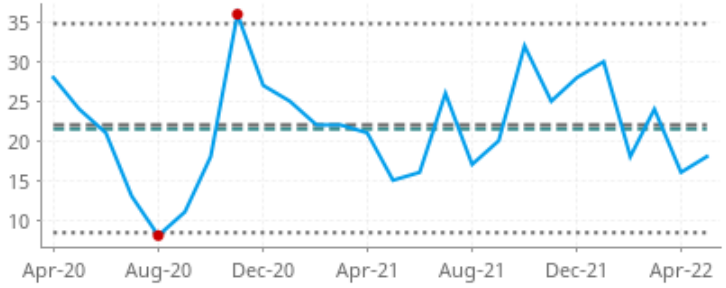
Pressure Ulcer Cat 1

Month	Performance	Standard
May-22	8	5



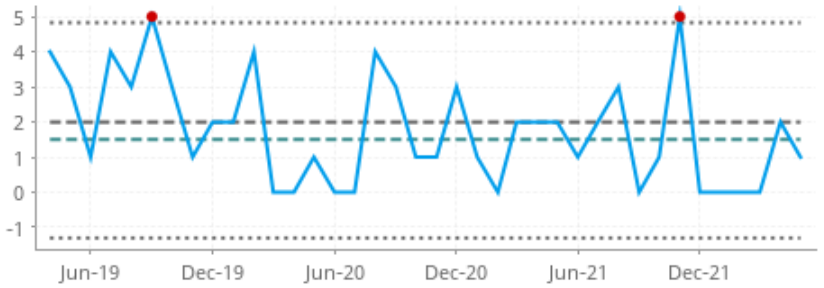
Pressure Ulcer Cat 2

Month	Performance	Standard
May-22	18	22



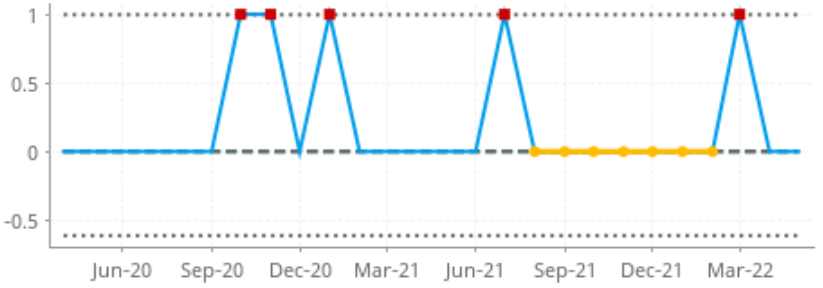
Pressure Ulcer Cat 3

Month	Performance	Standard
May-22	1	2



Pressure Ulcer Cat 4

Month	Performance	Standard
May-22	0	0



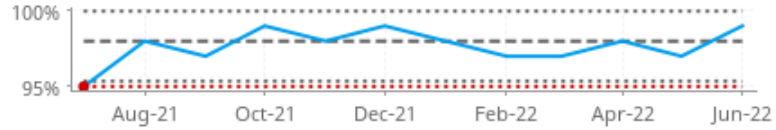
Safety & Quality

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

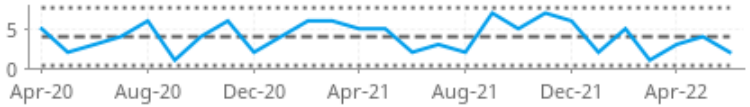
Hand Hygiene

Month	Performance	Standard
Jun-22	99%	95%



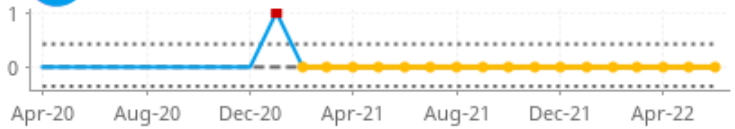
Cdiff

Month	Performance	Standard
Jun-22	2	4



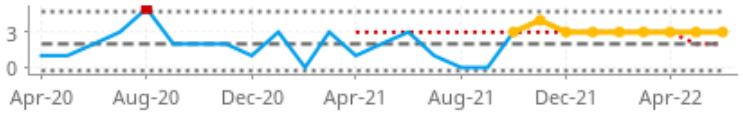
MRSA

Month	Performance	Standard
Jun-22	0	0



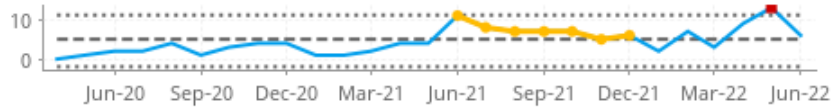
MSSA

Month	Performance	Standard
Jun-22	3	2



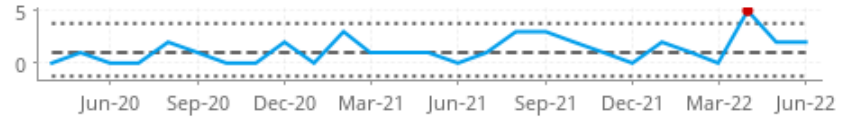
Ecoli

Month	Performance	Standard
Jun-22	6	6



Klebsiella

Month	Performance	Standard
Jun-22	2	1

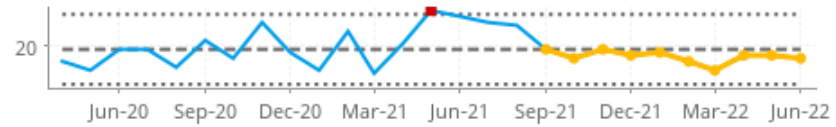


Pseudomonas

Month	Performance	Standard
Jun-22	0	1

CAUTI

Month	Performance	Standard
Jun-22	16	18



Safety & Quality

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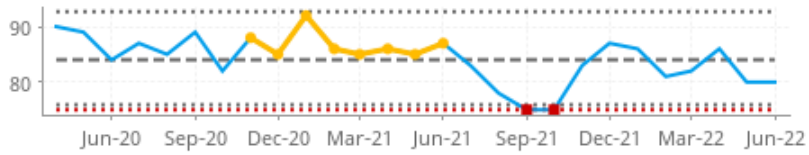
Statistical Process Control (SCP) Charts

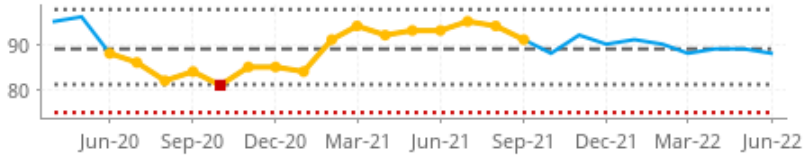
FFT Emergency Care

Month	Performance	Standard
Jun-22	80.00%	75.00%



FFT Inpatient

Month	Performance	Standard
Jun-22	88.00%	75.00%



FFT Maternity

Month	Performance	Standard
Jun-22	100.00%	75.00%

UNIFY RN Day

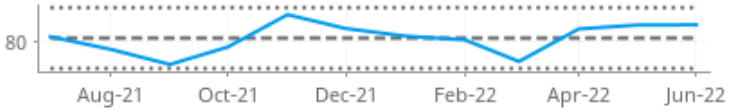
Month	Performance	Standard
Jun-22	77.56%	>=80% and <=109.99%

UNIFY RN Night

Month	Performance	Standard
Jun-22	90.22%	>=80% and <=109.99%

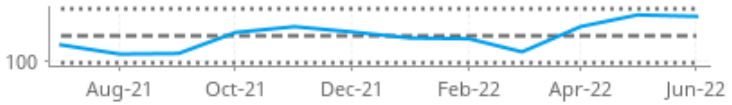
UNIFY HCA Day

Month	Performance	Standard
Jun-22	86.81%	>=80% and <=109.99%



UNIFY HCA Night

Month	Performance	Standard
Jun-22	131.73%	>=110% and <=125.99%



Workforce

NHS
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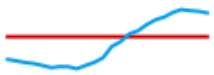
Standard	Standard Achieved			
	Month	*Performance*	*Standard*	*Trend*
Sickness				
✗	Jun-22	5.97%	4.00%	
Appraisals				
✗	Jun-22	85.07%	95.00%	
Turnover				
✗	Jun-22	11.83%	10.00%	
Mandatory Training				
✓	Jun-22	90.27%	80.00%	

Narrative

Sickness - The absence rate for May reported a 1.12%% decrease, of which 0.71% is attributable to Covid-19 related sickness and 4.80% attributable to other sickness. The 5.52% for sickness is compiled of 2.30% short-term and 3.21% long-term sick. This is reflective of a decrease in short term and slight increase in longer term absences. There has been a shift from 'Chest & respiratory problems' to stress/anxiety/depression being the main reason for absence in June. All appropriate support is in place to through the workforce advisors and team via absence management clinics and occupational health.

An engagement event is planned for July, with active involvement from managers from care groups, corporate areas, workforce, occupational health in order to gather feedback and understanding of where changes are needed with the objective of making improvements and ultimately reduce absence figures across the Trust.

Appraisals – Continued and focus work continues across care groups and corporate areas to improve compliance with a slight improvement seen in the June position. An offer of training is in place across planned session, bespoke and as part of the Engagement, Development and Wellbeing of Staff 2 day Managers Development Programme to ensure all managers have the appropriate training to ensure that the appraisal is appropriate and meaningful.

Staff Turnover - A further decrease of 0.13% is noted from the previous month with 'on boarding' processes being reviewed and developed further to ensure positive engagement from the outset of employment. The exit process has been enhanced with the aim of capturing information from those intending to leave, before they actually do so; ensuring any remedial action can be taken in a timely manner.

Mandatory Training - The compliance from June is reflective of a compliant positions, which has been consistently maintained for the last three months. There are a number of key areas of focus to improve compliance with appropriate capacity and support in place to ensure all staff receive their training in a timely manners.

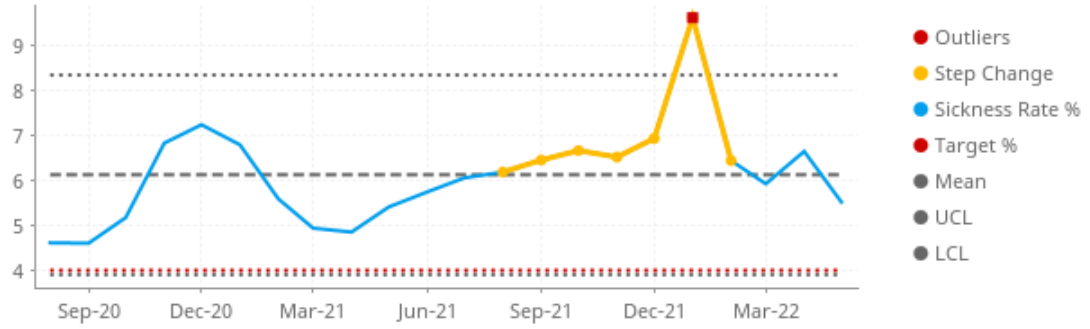
Workforce

NHS
North Tees and Hartlepool
NHS Foundation Trust

Statistical Process Control (SPC) Charts

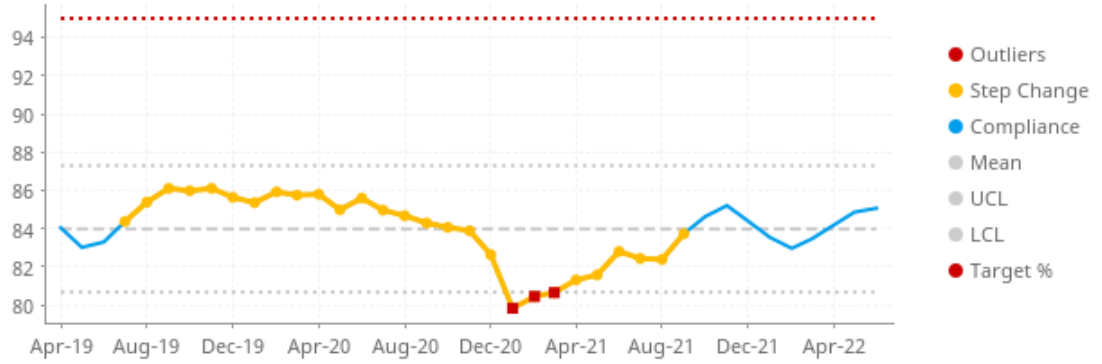
Sickness

Month	Performance	Standard
May-22	5.52%	4.00%



Appraisal

Month	Performance	Standard
Jun-22	85.07%	95.00%



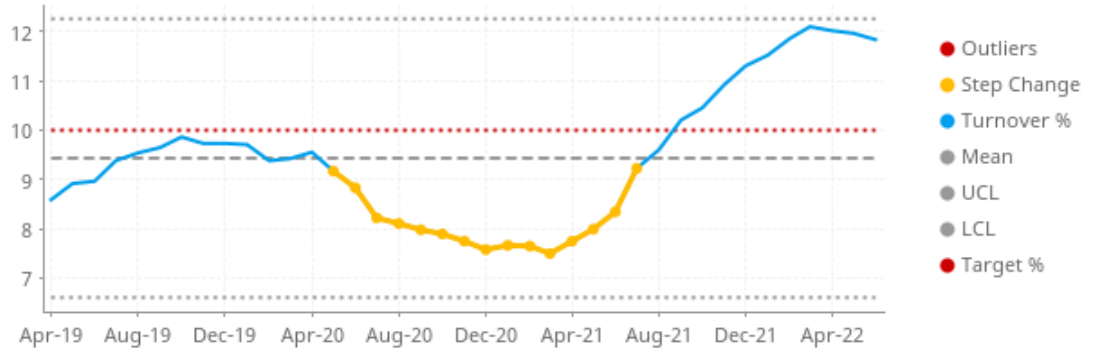
Workforce

North Tees and Hartlepool NHS Foundation Trust

Statistical Process Control (SPC) Charts

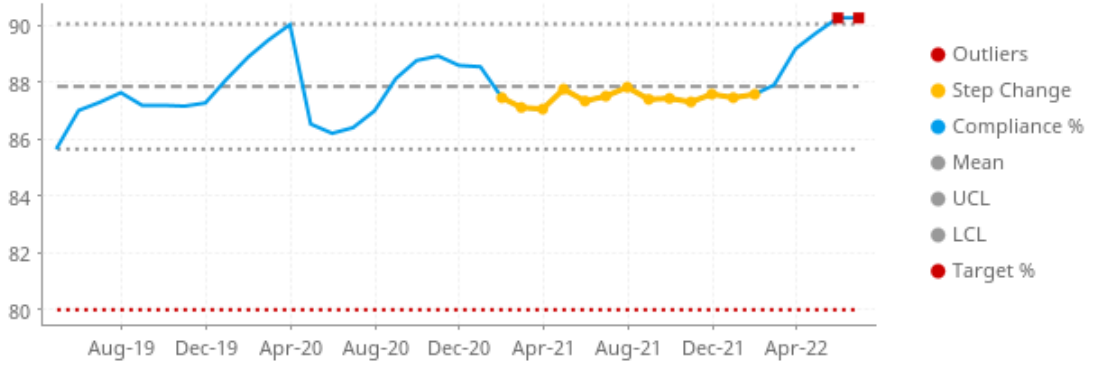
Turnover

Month	Performance	Standard
Jun-22	11.83%	10.00%



Mandatory Training

Month	Performance	Standard
Jun-22	90.27%	80.00%



Finance

North Tees and Hartlepool NHS Foundation Trust

Finance Overview - Month 3

Income/Expenditure

	Plan (£000)	Actual (£000)	
In Month	1,153	2,262	☺
Year to Date	2,740	3,430	☺

Balance Sheet

	£m
Cash Actual	72.0
Cash Plan*	68.4

*Explained by an improvement in the 2021/22 cash position

Capital (*)

	Plan (£m)	Actual (£m)	
In Month	0.033	0.5	☺
Year to Date	0.1	0.7	😐

* Capital plan rephased to commence from 01 July 2022

Use of Resources*

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

*UOR suspended in 2021-2022 - manual calculations

** Rating will only improve with increased cash reserves

NHS
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NHS Foundation Trust

Appendix 1

RTT and Cancer

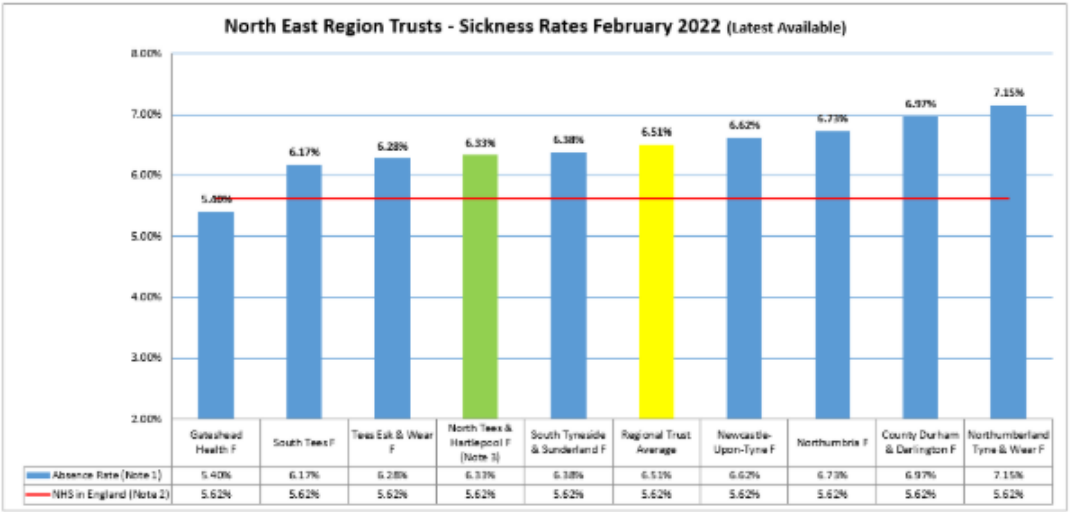
Measure	National	North East	North Tees & Hartlepool	S Tyneside & Sunderland	N Cumbria	Gateshead	Newcastle	Northumbria	S Tees	Durham & Darlington
RTT - May 22										
Incomplete Pathways waiting <18 weeks	63.5%		82.6%	84.3%	64.0%	75.9%	71.6%	86.1%	66.2%	72.1%
Half of incomplete patients wait less than	13		8	8	13	10	11	9	12	10
Half of admitted patients wait less than	12		8	16	27	13	11	13	8	7
19 out of 20 admitted patients wait less than	68		36	42	75	47	63	42	52	54
Half of Non admitted Pathways waited less than	8		5	8	10	5	6	7	6	6
19 out of 20 non admitted patients wait less than	48		28	28	50	33	38	34	33	26
Incomplete Pathways waiting >52 weeks	331623		62	84	878	71	3751	35	1364	1004

Cancer Waiting times Summary		S Tyneside and Sunderland	N Cumbria	Gateshead	Newcastle	Northumbria	S Tees	North Tees & Hartlepool	Durham & Darlington	NCA
2WW Referrals		92.8 (1302/1403)	83.82 (1088/1298	90.77 (1032/1137	79.52 (1739/2187)	96.48 (1699/1761)	59.35 (1127/1899)	84.58 (1004/1187)	87.23 (2111/2420	83.52 (11102/13292
Breast Symptomatic Referrals		0 (0/0)	82.26 (51/62)	97.78 (44/45)	68.94 (91/132)	92.65 (63/68)	90 (9/10)	92.83 (207/223)	88.32 (174/197)	86.7 (639/737)
31 Day First Treatments		98.98 (195/197)	88.33 (106/120)	98.4 (123/125)	83.84 (441/526)	96.79 (151/156)	94.69 (232/245)	96.1 (148/154)	95.26 (181/190)	92.06 (1577/1713)
31 Day Subsequent Treatments - Drugs		99.22 (128/129)	100 (1/1)	100 (61/61)	95.52 (192/201)	100 (28/28)	97.62 (82/84)	98.41 (62/63)	100 (5/5)	97.73 (559/572)
31 Day Subsequent Treatments - Radiotherapy		0 (0/0)	0 (0/0)	0 (0/0)	95.86 (394/411)	0 (0/0)	92.54 (186/201)	0 (0/0)	0 (0/0)	94.77 (580/612)
31 Day Subsequent Treatments - Surgery		86.36 (19/22)	80 (4/5)	100 (26/26)	60.19 (62/103)	100 (10/10)	100 (4/4)	93.33 (14/15)	72.22 (13/18)	74.88 (152/203)
62 Day Target - 2WW		70.48 (80/113.5)	46.67 (45.5/97.5)	37.93 (22/58)	58.76 (127.5/217)	66.67 (78/117)	66.76 (116.5/174.5	54.49 (45.5/83.5)	72.24 (101.5/140.5	71.56 (616.5/1001.5
62 Day Target -Screening		100 (2/2)	0 (0/0.5)	96.55 (28/29)	46.27 (15.5/33.5)	66.67 (1/1.5)	33.33 (1/3)	86.11 (31/36)	100 (6.5/6.5)	75.89 (85/112)
62 Day Target - Upgrade		92 (23/25)	100 (11/11)	100 (0.5/0.5)	50 (17/34)	56.25 (4.5/8)	81.54 (26.5/32.5)	92.31 (6/6.5)	63.64 (3.5/5.5)	74.8 (92/123)
28 Day Target - 2WW		70.48 (862/1223)	66.83 (800/1197	69.62 (779/1119	77.07 (1449/1880)	74.36 (1160/1560)	56.61 (801/1415)	72.54 (832/1147)	82.66 (1893/2043	74.03 (8576/11584
28 Day Target -Breast Symptomatic		0 (0/0)	86.67 (52/60)	100 (43/43)	80.49 (99/123)	62.2 (51/82)	90 (9/10)	96.71 (206/213)	93.1 (189/203)	88.42 (649/734)
28 Day Target - Screening		55.56 (5/9)	100 (1/1)	64.23 (79/123)	81.48 (132/162)	72.22 (39/54)	81.82 (9/11)	75.83 (182/240)	49.28 (34/69)	71.9 (481/669)
28 Day Target - Overall		70.37 (867/1232)	67.81 (853/1258	70.12 (901/1285	77.6 (1680/2165)	73.7 (1250/1696)	57.03 (819/1436)	76.25 (1220/1600)	91.4 (2116/2315)	74.74 (9706/12987

North Tees and Hartlepool NHS Foundation Trust

Appendix 2

Workforce



Notes

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Note 1 - Data extracted from NHS Digital published data and is based on extract from ESR, therefore may contain information in relation to NHS Trusts and NHS Subsidiary companies.

Note 2- Sickness Absence rate calculated across all NHS Workforce in England

Note 3 - The figure for North Tees and Hartlepool in this report may differ from the rates published internally (i) because there are some differences in the way the data is calculated; (ii) the national data includes NTH Solutions in the figures

North East Region Trusts - Sickness Rates February 2022 (*latest available)

The chart above shows the sickness absence figures for Acute and Mental Health Trust's in the North East region for February 2022.

North Tees and Hartlepool NHS Foundation Trust is represented by the green column (6.33%). The average rate for all North East Acute and Mental Health Care Trust's is shown by the yellow column (6.51%).

The red line is the average rate for the whole of the NHS in England (5.62%).

The sickness rate for North Tees and Hartlepool is 6.33%, slightly lower than the regional average of 6.51%.

Gateshead Health NHS Foundation Trust report the lowest sickness absence rate for February 2022 at 5.40%.

Northumberland, Tyne and Wear NHS Foundation Trust report the highest rate at 7.15%.

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 (May 2022)	9.29% (Mar 2021 - Feb 2022)	9.41% (Feb 2021 - Jan 2022)	-0.12 ↓	7.69%	7.61%	
2-day emergency readmission rate (12 mth rolling) HES Inpatients (May 2022)	2.21% (Mar 2021 - Feb 2022)	2.27% (Feb 2021 - Jan 2022)	-0.06 ↓	2.33%	2.01%	
7-day emergency readmission rate (12 mth rolling) HES Inpatients (May 2022)	4.95% (Mar 2021 - Feb 2022)	5.05% (Feb 2021 - Jan 2022)	-0.10 ↓	5.02%	4.31%	
14-day emergency readmission rate (12 mth rolling) HES Inpatients (May 2022)	7.45% (Mar 2021 - Feb 2022)	7.55% (Feb 2021 - Jan 2022)	-0.10 ↓	7.20%	6.14%	
28-day emergency readmission rate (12 mth rolling) HES Inpatients (May 2022)	10.43% (Mar 2021 - Feb 2022)	10.56% (Feb 2021 - Jan 2022)	-0.13 ↓	9.86%	8.36%	
Outpatient DNA rate (12 mth rolling) HES Outpatients (May 2022)	7.73% (Apr 2021 - Mar 2022)	7.59% (Mar 2021 - Feb 2022)	0.14 ↑	8.13%	7.62%	
Outpatient New to Follow-up ratio (12 mth rolling) HES Outpatients (May 2022)	2.54 (Apr 2021 - Mar 2022)	2.56 (Mar 2021 - Feb 2022)	-0.02 ↓	2.33	2.18	
Outpatient cancellation rate (12 mth rolling) HES Outpatients (May 2022)	0.00% (Apr 2021 - Mar 2022)	0.00% (Mar 2021 - Feb 2022)	No Change	9.17%	9.52%	
Cancer waiting times - 2-week wait to be seen after GP referral (12 mth rolling) Cancer Waiting Times (May 2022)	91.08% (Apr 2021 - Mar 2022)	91.60% (Mar 2021 - Feb 2022)	-0.52 ↓	79.40%	81.14%	
Cancer waiting times - 31-day wait for first treatment after decision to treat (12 mth rolling) Cancer Waiting Times (May 2022)	97.34% (Apr 2021 - Mar 2022)	97.05% (Mar 2021 - Feb 2022)	0.29 ↑	92.82%	93.47%	
Cancer waiting times - 62-day wait for first treatment after GP referral (12 mth rolling) Cancer Waiting Times (May 2022)	69.95% (Apr 2021 - Mar 2022)	70.72% (Mar 2021 - Feb 2022)	-0.77 ↓	68.85%	68.80%	
RTT - Referral within 18 weeks (admitted pathway) (12 mth rolling) RTT (May 2022)	74.26% (Apr 2021 - Mar 2022)	74.06% (Mar 2021 - Feb 2022)	0.20 ↑	67.37%	62.06%	
RTT - Referral within 18 weeks (non-admitted pathway) (12 mth rolling) RTT (May 2022)	87.53% (Apr 2021 - Mar 2022)	87.47% (Mar 2021 - Feb 2022)	0.06 ↑	85.39%	76.91%	
RTT - waiting less than 18 weeks (incomplete pathway) (12 mth rolling) RTT (May 2022)	85.58% (Apr 2021 - Mar 2022)	85.78% (Mar 2021 - Feb 2022)	-0.20 ↓	73.16%	59.81%	
Day case realisation rate (12 mth rolling) HES Inpatients (May 2022)	96.78% (Apr 2021 - Mar 2022)	96.71% (Mar 2021 - Feb 2022)	0.07 ↑	96.56%	96.67%	
Day case rate (12 mth rolling) HES Inpatients (May 2022)	86.64% (Apr 2021 - Mar 2022)	86.56% (Mar 2021 - Feb 2022)	0.08 ↑	84.91%	72.98%	

Average excess length of stay (12 mth rolling) HES Inpatients (May 2022)	0.12 (Apr 2021 - Mar 2022)	0.09 (Mar 2021 - Feb 2022)	0.03 ↑	0.34	0.47	
Average length of stay (12 mth rolling) HES Inpatients (May 2022)	3.19 (Apr 2021 - Mar 2022)	3.18 (Mar 2021 - Feb 2022)	0.01 ↑	3.79	4.53	
Average elective length of stay (12 mth rolling) HES Inpatients (May 2022)	1.94 (Apr 2021 - Mar 2022)	1.94 (Mar 2021 - Feb 2022)	No Change	3.23	4.52	
Average non-elective length of stay (12 mth rolling) HES Inpatients (May 2022)	3.32 (Apr 2021 - Mar 2022)	3.30 (Mar 2021 - Feb 2022)	0.02 ↑	3.87	4.52	
Average pre-operative length of stay (12 mth rolling) HES Inpatients (May 2022)	0.20 (Apr 2021 - Mar 2022)	0.21 (Mar 2021 - Feb 2022)	-0.01 ↓	0.23	0.24	
Average elective pre-operative length of stay (12 mth rolling) HES Inpatients (May 2022)	0.01 (Apr 2021 - Mar 2022)	0.01 (Mar 2021 - Feb 2022)	No Change	0.03	0.03	
Average non-elective pre-operative length of stay (12 mth rolling) HES Inpatients (May 2022)	0.35 (Apr 2021 - Mar 2022)	0.36 (Mar 2021 - Feb 2022)	-0.01 ↓	0.42	0.47	
Average post-operative length of stay (12 mth rolling) HES Inpatients (May 2022)	0.79 (Apr 2021 - Mar 2022)	0.82 (Mar 2021 - Feb 2022)	-0.03 ↓	0.97	0.93	
Average elective post-operative length of stay (12 mth rolling) HES Inpatients (May 2022)	0.20 (Apr 2021 - Mar 2022)	0.20 (Mar 2021 - Feb 2022)	No Change	0.31	0.26	
Average non-elective post-operative length of stay (12 mth rolling) HES Inpatients (May 2022)	1.23 (Apr 2021 - Mar 2022)	1.26 (Mar 2021 - Feb 2022)	-0.03 ↓	1.60	1.69	
Non-elective zero-day spells (12 mth rolling) HES Inpatients (May 2022)	36.55% (Apr 2021 - Mar 2022)	36.56% (Mar 2021 - Feb 2022)	-0.01 ↓	39.99%	34.64%	
Elective stranded rate (12 mth rolling) HES Inpatients (May 2022)	5.11% (Apr 2021 - Mar 2022)	5.15% (Mar 2021 - Feb 2022)	-0.04 ↓	11.13%	12.35%	
Emergency stranded rate (12 mth rolling) HES Inpatients (May 2022)	16.44% (Apr 2021 - Mar 2022)	16.37% (Mar 2021 - Feb 2022)	0.07 ↑	17.55%	20.79%	
Elective super-stranded rate (12 mth rolling) HES Inpatients (May 2022)	0.57% (Apr 2021 - Mar 2022)	0.54% (Mar 2021 - Feb 2022)	0.03 ↑	2.07%	3.11%	
Elective zero-day pre-op length of stay (12 mth rolling) HES Inpatients (May 2022)	90.36% (Apr 2021 - Mar 2022)	91.91% (Mar 2021 - Feb 2022)	-1.55 ↓	74.06%	78.16%	
Elective pre-op length of stay >3 days (12 mth rolling) HES Inpatients (May 2022)	0.21% (Apr 2021 - Mar 2022)	0.21% (Mar 2021 - Feb 2022)	No Change	0.79%	0.92%	
Relative risk length of stay (12 mth rolling) HES Inpatients (May 2022)	79.87 (Apr 2021 - Mar 2022)	78.53 (Mar 2021 - Feb 2022)	1.34 ↑	98.32	99.70	

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Capital Programme Performance Q1 – 2022/23										
Date:	28th July 2022										
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 2022 (Quarter 1) on the progress of delivering the 2022/23 capital programme, along with the current forecast position, highlighting any risks in delivery.										
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	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:

Capital Programme Delivery 2022/23

The Trust's overall capital programme plan at month 3 is £21.983m and is broken down as follows:

- CDEL is £21.584m (this includes internally funded schemes, IFRS16 new leases and PDC expected in year), and;
- Donated/grant funded assets are £0.399m

A full breakdown of capital schemes is provided in the table below;

Capital Schemes	Annual Plan £'000's
Estates Backlog	5,458
New Hospital Support	6,000
Robot Enabling Works	2,400
Pathology Callaboration	1,400
Medical Equipment Replacement	3,000
IT	1,300
Service Developments/Contingency	1,500
Tech capital funding - PDC funded	350
IFRS16 leases	176
TOTAL CDEL	**21,584**
Donated	399
EXTERNALLY FUNDED SCHEMES TOTAL	**399**
GRAND TOTAL	**21,983**

The capital plan demonstrates a continued commitment and investment to reducing the estates backlog, medical equipment, IT developments and supporting the Pathology collaboration. There is also a prudent contingency of £1.5m for emerging capital issues and business cases.

The annual capital plan for 2022/23 (detailed by scheme) will be presented at Capital and Revenue Management Group on 29th July 2022.

Capital Spend Phasing

The phasing of the capital plan is 14% July to September, 28% October to December and 58% January to March, to allow for approval of the plan in July 2022.

Month 3 Position

As at month 3, the Trust has spent £0.7m against a year-to-date plan of £0.1m. This spend relates to pre-committed schemes.

Forecast

It is early in the financial year, however the Trust has a strong track record of delivery of its capital programme and is forecasting to deliver the capital plan by year end. This will be underpinned by the reintroduction of the capital performance framework with effect from Month 4, which is reported to the Capital & Revenue Management Group.

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.

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

28 July 2022

Capital Programme Performance Q1 2022/23

Report of the Director of Finance

Strategic Aim
(The full set of Trust Aims can be found at the beginning of the Board Reports)

Transforming our Services

1. Introduction / Background

1.1 The purpose of this paper is to provide an update as of 30 June 2022 (Quarter 1) on the progress of delivering the 2022/23 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's overall capital programme plan at month 3 is £21.983m and is broken down as follows:

- CDEL is £21.584m (this includes internally funded schemes, IFRS16 new leases and PDC expected in year), and;
- Donated/grant funded assets are £0.399m

The table below illustrates the indicative capital programme:

Capital Schemes	Annual Plan £'000's
Estates Backlog	5,458
New Hospital Support	6,000
Robot Enabling Works	2,400
Pathology Callaboration	1,400
Medical Equipment Replacement	3,000
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Tech capital funding - PDC funded	350
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TOTAL CDEL	**21,584**
Donated	399
EXTERNALLY FUNDED SCHEMES TOTAL	**399**
GRAND TOTAL	**21,983**

The plan demonstrates a continued commitment and investment to reducing the estates backlog, medical equipment, IT developments and supporting the Pathology collaboration. There is also a prudent contingency of £1.5m for emerging capital issues and business cases.

The annual capital plan for 2022/23 (detailed by scheme) will be presented at the Capital and Revenue Management Group on 29th July 2022.

As at month 3, the Trust has spent £0.7m against a year-to-date plan of £0.1m. This spend relates to pre-committed schemes.

The phasing of the capital plan is 14% July to September, 28% October to December and 58% January to March, to allow for approval of the plan in July 2022.

2.2 **Estates**

Total expenditure on Estates schemes is £0.6m at the end of June 2022 against a year to date budget of £0.0m, so ahead of plan.

2.3 **Medical Equipment**

Total expenditure on Medical Equipment schemes is £0.0m at the end of June 2022, against a year to date budget of £0.0m.

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

Total expenditure on IT&S schemes is £0.1m at the end of June 2022, against a year to date budget of £0.0m, so ahead of plan.

2.5 **Forecast 2022/23**

The capital forecast for the year at June 2022 agrees to the annual plan.

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

2.7 The overall financial summary for the period to 30 June 2022 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 2022.

Neil Atkinson
Director of Finance

Gillian Colquhoun
Interim Chief Information and Technology Officer

Appendix 1 - Work Stream Reports

1. Estates Backlog Maintenance Programme

The 2022/23 backlog maintenance capital allocation was broken down into categories and specific projects to target high and significant risk backlog issues. CIR is currently £19.6m out of overall Trust backlog of £49.2m. 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 allows for monthly reporting against time and cost for the overall programme (as required by NHSI). £5.5m has been allocated to Backlog Maintenance which includes £1,657,658 of pre commitments carried forward from FY2021/22.

Theatre 1 Refurbishment and Future Proofing 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), installation of IPS / UPS to improve patient safety and future proofing enabling works to facilitate the theatre becoming an integrated theatre in the future. The design and procurement of the plant has now been completed with the majority of work on site due to be completed in Q4.

A successful TIF bid has allowed integration to be added to the theatre refurbishment project to improve patient outcomes. The overall project commenced on site in January 2022 and was completed in June 2022.

Lift Replacement UHH: Replacement of the 3 ageing lifts in the acute block at UHH. The first lift includes a bed evacuation capability. Work is planned to be completed by end of Q2.

Lift Replacement PCH: Replacement of the single lift at PCH. The works are due to start mid July and expected to take 5 to 6 weeks to complete.

Roofing Repairs UHH: A multi-year programme continues to progress, awarded to Group Tegula Ltd following a mini-competition in FY2020/21. The contract value is capped at £2m, and includes flexibility to address the high risk roofs and other roofs in dilapidated conditions. During Q4 work was ongoing to the acute block to maintain buildings in a safe and operational manner.

The project relates to the roof replacement of Hartlepool Main Ward Block. The project was split into two phases to ensure continuity of resources and prevent costly demobilising at the end of March and remobilisation in FY2022/23;

Phase 1 - £170,000 – Completed in FY2021/22.

Phase 2 - £497,588 and extra £10k contingency for market fluctuations. Overall cost £507,588 and started 1st April 2022 with completion planned for Q2 FY2022/23.

A £30k contingency is also proposed to cover any unknowns. There will also be the removal and refitting of roof antennas to factor in which will be around £15k.

Therefore total proposed spend is £553k spread over FY2021/22 and FY2022/23. Roofing repairs will remain a feature of the backlog capital 5 year programme over the remaining years programme.

Intrusive Structural Surveys – North Wing/South Wing/Tower Block UHNT: In response to concerns raised by Faithful and Gould/WS Atkins in the 6 Facet Survey further more detailed intrusive surveys are being carried out to assess the extent of any additional remedial works to ensure the

building remains safe and operational for the remainder of its 10 year life. The survey report will be updated to reflect the ongoing investigations to South Wing and a final version issued.

The initial findings have identified work that is required to be carried out in the short term (FY2022/23) as follows:

North & South Wings

There are signs of carbonation behind a large number of concrete panels. This is due to the failure of the mastic sealants thus allowing water to ingress. There is a strong possibility that this will affect the vertical & horizontal fixings of the panels. The required works are the removal and replacement of all the existing mastic to prevent any further corrosion and carry out local repairs as needed. Some panels have significant cracks and need to be replaced. Mullions on the South Wing have previously been covered with sheeting without any remedial work being carried out and this will need to be rectified now.

In an area of the North Wing Basement, there are signs of cracking in the concrete structure which requires further investigation before a final report is issued. Testing is currently being carried with a further update to follow.

North Wing
Budget Cost: £500,000 (excluding VAT)
Priority: 12 to 24 months

South Wing
Budget Cost: £930,000 (excluding VAT)
Priority: 6 to 12 months

A programme of works is currently being costed and agreed to carry out remedial works to part of South Wing to understand the full extent of the damage and the works required.

Tower Block

Above ground level there is evidence of cavity wall ties installed both during construction and also retrospectively. However, the wall ties are irregularly fitted and certainly not fitted in accordance with current BS regulations. Further investigations are being carried out to establish what additional supports are needed to give support to the inner leaf (7.0 x 3.0 high) which is only visibly tied in at the left hand edge – nothing visible at top or bottom edges. The specification to carry out the works is currently being prepared together with costings.

The outer and inner leaves are not cross bonded and there is no significant cavity between the two leaves. The retrospective ties are M10 Stainless Steel rod drilled and resin anchored into the ring beam and outer leaf (inner leaf is built from the top of the ring beam).

Budget Cost: £840,000 (excluding VAT)
Priority: 6 to 12 months

Hospital Streets

There is evidence of the primary support steelwork starting to fail due to water ingress. There is also signs of corrosion to the primary pipework in the locations of the supports. Temporary solutions need to be installed before remedials can be addressed in the concrete, however, there is asbestos and lead based paint present on both the pipework and walls. This will need removing first to allow the installation of temporary supports.

Once temporary supports are fitted and water ingress is stopped, a further option study would be required to decide on the best way to undertake the replacement of the primary pipework services and the method of connecting to the existing.

We expect to have the full survey report and recommended rectifications in Q2 of FY2022/23 and any remedial work will be incorporated in the FY2022/23 backlog maintenance plan, as a priority.

Budget Cost: £700,000 (excluding VAT)
Priority: 6 to 12 months

Fire Door Replacement UHNT / UHH: The fire door replacement programme has begun with fire doors being repaired / replaced / upgraded due to operational damage and change of use over the life of the buildings. Fire doors have been replaced for high risk areas including main staircase and the main circulation corridors around the lower ground floor and ground floor.

The replacement works will continue on both main sites into FY2022/23. West Wing remains a high priority for FY2022/23.

West Wing Fire Precautions: Initial remedial works were carried out and the alignment of the fire compartmentation is starting mid July 2022 on the first floor and within the roof space. One of the lifts is planned to be upgraded to a patient evacuation lift by Kone and work is planned to be completed by Q2. Possible decant options are being looked at to try and reduce the timescale for completion down from 4 months.

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 FY2020/21 and the remaining spend in FY2021/22. The installation is now 90% complete, with the majority of areas complete. The works has now extended into operational areas. 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 planned to be completed by Q2/Q3 FY2022/23 including staff training and change over.

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 now been completed with Veolia being the successful bidder, the order has been placed and design and construction offsite has commenced.

The cost of the replacement CHP is £640k and is planned to payback in energy cost savings to the Trust in 4-5 years. The plant has a 10 year lifespan and is planned to be completed by Q2 of FY2022/23.

Replacement Flooring UHNT: The works to replace the main entrance flooring, decoration and fire doors were completed in Q1 FY2022/23.

2. Other Estates Capital Developments

Community Diagnostic Hubs: Collaborative planning continues to deliver the Tees Valley element of the national plan to develop hub and spoke arrangements for diagnostic facilities outside of acute

settings and within the community. Plans have been developed for the spokes at UHH, Stockton (Lawson Street) and Redcar (South Tees). The spoke delivering additional MRI scanning capability became operational on the UHH site at the end of September with Respiratory and CT scanning services operational in Q1 FY2022/23.

Works associated with Cardiology services at Lawson Street were completed by the end of March 2022.

An independent option appraisal was carried out by P+HS Architects to determine the location of the main hub (Stockton or Middlesbrough). The Waterfront development in Stockton is the recommended location and this will feed into the business case seeking capital funding approval. The CDC Estates Project Group, which includes representatives from North Tees, CCG, NHS PS and South Tees supported the recommendation.

PA Consulting have been appointed to support development of the 2022/23 business case for design and development of the main hub.

Pathology Collaboration: The project team has been established and external design team appointed. Work to develop the 1:100 drawing for the new cellular pathology has been agreed and signed off by pathology stakeholders from North Tees and South Tees. The overall estate plan is for microbiology to be vacated and works to commence in November with completion by end of Q4.

Endoscopy Academy: This project is funded from a successful TIF bid that applied for external funding in October 2021. The bid was approved by DoH in December 2021. The money will fund a training endoscopy facility within the Endoscopy Department UHH used to train endoscopy staff from our Trust and potentially other Trust's in the Northern ICS.

The scope of works includes internal alterations within the Rutherford Morrison Endoscopy Unit which will create an endoscopy room and training room with appropriate audio visual equipment to allow observation of operations for training purposes. Work commenced in Q4 and was completed in Q1 FY 2022/23.

Theatre Robots: Forming part of the wider clinical strategy, split over two key phases, for the development of perioperative services over the coming years. The purpose of this perioperative services strategy is to support the delivery of the Trusts business and dovetail the south ICP clinical services strategy.

Phase 1 - Additional (larger) theatre to facilitate robotic surgery in location of current storage and changing facilities. Relocation of displaced storage and changing facilities. Refurbishment and structural upgrade to theatre 1 and transformation into an integrated theatre.

Phase 2 of the theatre estate development plan concentrates on theatres 9 & 10, and the potential for development steered by the needs of the ICS.

The design work to achieve 1:100 drawing sign off for Phase 1 will be completed in Q2. 2 options were taken forward and will be costed to test against allocation and adjusted against inflation. The project will then progress in FY2022/23 with completion planned for FY2023/24.

3. Medical Equipment Replacement Programme

The Capital Medical Equipment Replacement Programme is being prioritised against an initial allocation of £3m, of which £11,425 has been spent to date.

This spend is for a Medifa Gynaecology couch, urgently required to replace a damaged obsolete couch in OPD at UHH. It is a high priority item on the un-approved MER list and is included in this years spend.

In preparation for the MER list being approved, a quote has been requested to date for the following pieces of High priority equipment:

- Diabetic eye screening Fundus Camera for Lawson Street;
- 2 x full Colposcopy video stack systems to replace obsolete units at North Tees and at Hartlepool;
- A Linde Double Stacker Pallet Truck for Pharmacy;
- 3 x Mindray Patient monitors with CO2 monitoring for Endoscopy treatment rooms;
- 4 x Mindray BP/SPO2 monitors for Endoscopy admission rooms;

In addition, further information is being sought from QC Labs, Radiology and Endoscopy for other high risk items on the list.

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 but 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. Cisco finance lease comes to an end July 2022

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

TrakCare Hardware refresh: Now complete, this was to replace the Infrastructure on which TrakCare system runs to ensure continual reliability of the system and support. Payment agreement ends June 2023

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

Laptop replacement: This is an on-going scheme to replace laptops within the Trust on a rolling 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. Work scheduled to complete 24th July 2022.
- 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). Current work is being carried out to complete the old residences blocks. Expected to be ready for switch over by the end of September 2022.
- 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 services including:
    - Horizon VDI expansion – Virtual desktop technology to be increased from 100 to 200 desktops enabling a more seamless remote access solution for system access outside of the Trust. Hardware nodes now installed with system level setup to commence during August / September.
    - OPSWat –NAC (Network Access Control) for Internet access to Horizon. Cloud based posture assessment that evaluates the security states of the connecting system. Now in implementation phase with anticipated completion by the end of October 2022 – still on target but awaiting DPIA approval before deployment.

- 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 – Now installed, currently waiting

for final commissioning with supplier, expected September following upgrade to our storage data domain.
- Data Protection suite and Residency days for Dell / EMC Cyber Sense – sign off complete.

Telecomms

- **VC expansion** – Additional video conference facilities to support both Microsoft Teams and CMS (Cisco Meeting Service) collaboration.

Office Facilities

- **Switchboard Infrastructure** – Revamp of switchboard facilities to create additional space. Removal of disabled toilet and improved breakout area. Minor works raised in June circa £20k.
- ***ICT Office*** – Infrastructure – reconfiguration of ICT office to support a better working environment – currently out to tender due to additional costs.

5. Digital Strategy – Progress on developments

FY2022/23 capital funding allocation is £0.805m, this will enable the Trust to digitise all nursing admission documentation (NAD) into TrakCare EPR and also enable the full potential of an integrated patient record to be fully realised within Critical Care.

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

Nurse Admission Documentation (NAD)– the full business case was approved May 2022 for delivery this financial year. Design is on-going with Nursing Services around how to digitise the admission process. Equipment requirements for all wards have now been completed and will be ordered in the coming weeks.

ITU - Following the onsite discovery/information gathering session on 31st May, InterSystems have been working on their solution proposal; initial planning session was held on 5th July and responses to outstanding queries provided, as well as copies of all final documentation in use on the Unit. Functional specification for Interface between Mindray (BeneLink) and TrakCare has been drafted and shared for internal review. Current State 'As Is' process maps finalised awaiting final sign off from the Unit. Insight order raised, currently with procurement who are awaiting response from Insight regarding requirement for change control notice. Mindray conducted final review of the unit, order to be raised in due course. ITU and ICT contacted to draw down funds and commence recruitment process for required project resource.

GNCR - Shared Care Record Platform (Also known as The Health Information Exchange). The regional Health Information Exchange (HIE), a core module of the GNCR continues to expand wider. The HIE was made live on 9th March 2020 with data being shared from GPs and Community units in the North East and North Cumbria. A number of Trusts (North Tees included) are now contributing data to the HIE for sharing purposes.

The remaining Trusts to share data include South Tees and Northumbria who have slipped further with their proposed integration, new timelines are currently being agreed with both Trusts. Quarterly maintenance windows has been agreed with Cerner to deploy necessary changes to the system. This will reduce the amount of scheduled downtime and help plan and coordinate new connections being deployed.

The next phase of GNCR is looking at on boarding Hospices – requirements have been captured, NE SIGN have agreed the proposal, DPIA has been amended and work is underway with both St

Oswald's and Marie Curie. Indicative dates have been planned, subject to IG and commitment from each Hospice. Additional requirements are also being gathered to on-board Care Homes, Community Pharmacy, Community and Trust Dentistry, Prison Services and Child Health Information Services.

My 'GNCR' aka PEP (Patient Engagement Platform) – To provide a secure portal to allow patients to take control of aspects of their care, by providing electronic access to elements of their own health records. Key highlights include refined management portal requirements with input from regional operational leads.

Uptake of NHS App usage:

NHS App Registration Statistics (all time by area)											
	England & Wales	North East and North Yorkshire Region	Cumbria and North East STP	County Durham CCG	Newcastle Gateshead CCG	North Cumbria CCG	North Tyneside CCG	Northumberland CCG	South Tyneside CCG	Sunderland CCG	Tees Valley CCG
NHS App Registrations	21,889,719	3,114,816	1.063.602	187,325	182,698	100,952	86,426	115,596	51,596	101,384	237,625
% GP of patients (age 13+)	42.07%	39.75%	38.76%	38.22%	39.58%	34.21%	45.11%	36.16%	37.81%	41.21%	39.39%

Prostate Cancer Stratified Follow Up – The DPIA for the stratified follow up workflow has been received back from IG with only a small number of queries. The latest version has now been sent on to HealthCall for their input. The stratified follow up workflow within TrakCare has been developed for Gynae, staff are awaiting training before process goes live. Breast services is currently in development and will follow shortly after.

COVID Virtual Ward (Oximitry@Home), DPIA meeting scheduled with IG 4th July. Initial trial with a few test patients only, this will be used to support training of staff. Hazard Workshop has been scheduled to discuss potential risks/areas of improvement.

Imprivata phase 2 – Due to difficulties in recruitment within ICT roles, this project has not moved forward.

EPMA Phase 2 (includes Infusions and will remove all remaining cardex) - All remaining items from Build Group B are now LIVE. Endoscopy Order Sets went LIVE for use during inpatient episodes for April, followed by Bronchoscopy Procedure Order Sets for ease of prescribing and Antibiotic Indication mandatory questionnaire for completion when prescribing Ertapenem, Meropenem and Piperacillin/Tazobactam.
Development commenced around Prescribing/Administering of Warfarin, Insulin Paediatric Chart and Insulin Chart) will use same solution as Warfarin, once warfarin is signed off insulin will be configured.

EDM2 – Activity in June has primarily been focussed on achieving technical go live of deceased scanning and migration (Gateway 1) and preparing for training. The Live PAS was successfully loaded after several rounds of validation, with three remaining issues from HL7 testing identified and resolved. Decision was taken not to commence migration on 6th June as planned to allow further monitoring of HL7 feed.
Go Live Gateway 1 has been half met – scanning ceased in Documentum 10th June as the EDM team cutover to scanning deceased records in MediViewer. IMMJ were onsite 15-17th June to deliver training for Batch Manager and QA module – the team will now continue to scan deceased records to test the live system and processes until a backup and recovery solution is in place.

Alongside the technical work, the training team have been organising the super user training and developing eLearning content to support the migration to NHTop and mandatory training content for admin users. Content will be available w/c 11th July with targeted and Trust wide communications to encourage take-up.

CareScan+ Software Development Testing on the latest software release is still ongoing and it is anticipated that this testing phase will be completed early July with a Go-Live release in mid-July.
J2 Interactive have commenced the design and build of the MDIS (Medical Devices Information System) module and it is expected to take approx. 4-6 weeks for the development to be completed.

The Team continue to work closely with NHS Transformation Directorate (formally NHSD and NHSX combined) to develop the software to meet the NHS Mandated MDIS requirements and the ePOCT (Electronic Point of Care Tractability) programme. The production of on-line training guides have commenced and ready for use upon go-live.

Appendix 2 – Capital Programme Financial Position as at 30th June 2022

Capital Plan, Actual and Commitments

Reporting period: 1st April 2022 to 30th June 2022

	Annual Plan £'000's	YTD Plan £'000's	YTD Expenditure £'000	YTD Variance £'000	Commitments 2022/23 £'000
CAPITAL PROGRAMME					
Estates Backlog					
Building Sub Structure	0	0	155	(155)	349
Compliance	0	0	249	(249)	748
Energy Conservation	0	0	(0)	0	375
Patient Environment	0	0	188	(188)	308
Service Developments	5,458	0	31	(31)	103
Estates Backlog Total	**5,458**	**0**	**622**	**(622)**	**1,883**
New Hospital support					
New Hospital Support	6,000	0	0	0	
New Hospital Support Total	**6,000**	**0**	**0**	**0**	**0**
Robot Enabling Works					
Robot Enabling Works	2,400	0	0	0	
Robot Enabling Works Total	**2,400**	**0**	**0**	**0**	**0**
Pathology Callaboration					
Pathology Callaboration	1,400	0	0	0	
Pathology Callaboration Total	**1,400**	**0**	**0**	**0**	**0**
Medical Equipment					
Medical Equipment	3,000	0		0	21
Medical Equipment Total	**3,000**	**0**	**0**	**0**	**21**
IT					
ICT	1,300	0	89	(89)	401
IT Total	**1,300**	**0**	**89**	**(89)**	**401**
GDEFF					
GDEFF	0	0	(2)	2	9
GDEFF Total	**0**	**0**	**(2)**	**2**	**9**
Service Developments					
Contingency	1,500	0	2	(2)	46
Service Developments Total	**1,500**	**0**	**2**	**(2)**	**46**
Tech Capital Funding					
Tech Capital Funding	350	0	0	0	
Tech Capital Funding Total	**350**	**0**	**0**	**0**	**0**
IFRS16					
IFRS16	176	4	0	4	
IFRS16 Total	**176**	**4**	**0**	**4**	**0**
Community Diagnostic Hub					
Community Diagnostic Hub - North Tees	0	0	1	(1)	31
Community Diagnostic Hub - South Tees	0	0	(0)	0	0
Community Diagnostic Hub Total	**0**	**0**	**1**	**(1)**	**31**
Targeted Investment Fund					
TIF	0	0	61	(61)	115
Targeted Investment Fund Total	**0**	**0**	**61**	**(61)**	**115**
TOTAL CDEL	**21,584**	**4**	**774**	**(770)**	**2,506**
TOTAL CDEL	**21,584**	**4**	**774**	**(770)**	**2,506**
DONATED ASSETS					
Donated					
Donated	399	99	0	99	0
Donated Total	**399**	**99**	**0**	**99**	**0**
Digital Pathology					
Digital Pathology	0	0	(51)	51	0
Digital Pathology Total	**0**	**0**	**(51)**	**51**	**0**
DONATED ASSETS TOTAL	**399**	**99**	**(51)**	**150**	**0**
GRAND TOTAL	**21,983**	**103**	**723**	**(620)**	**2,506**

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Learning from Deaths Report, Quarter 1: 2022/23										
Date:	28 July 2022										
Prepared by:	Janet Alderton, Head of Patient Safety										
Executive sponsor:	Medical Director										
Purpose of the report	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.										
Action required:	Approve	X	Assurance	X	Discuss	X	Information	X			
Strategic Objectives supported by this paper:	Putting our Population First	X	Valuing our People		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:

1. The Trust HSMR value is 84.18 (March 2021 to February 2022), this is a slight increase from previous reported value of 83.78 (February 2021 to January 2022). The latest SHMI value h decreased slightly to 94.15 (February 2021 to January 2022) from the previously reported value 94.74 (January to December 2021). Both statistics remain "within expected" ranges.
2. The successful implementation of the Medical Examiners role has prompted a review of the Tru policies; the Trust Mortality Lead and the Lead ME are reviewing the overall strategy and policy relation to learning from deaths. The planned changes are expected to support clinical staff completing reviews and identifying learning to generate quality improvement measures.
3. There is summary information in the report relating to actions initiated as a result of learning fr deaths in patients in relation to the Deteriorating Patient Group, Surgery and Paediatric services.
4. During 2021-22, to the end of quarter 4, there has been one mortality case reviewed and assess to have been "Possibly preventable greater than 50-50"; this case had been reported and investiga as a serious incident. To date in 2022-23, there are two cases being investigated as Seric Incidents, the outcome of these investigations will be reported in future reports.

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

Any new risks identified through mortality review processes are assessed and added to the risk register as needed

Committees/groups where this item has been discussed	• Trust Outcome Performance Delivery and Operational Group • Patient Safety & Quality Standard Committee • Clinical Quality Review Group (following Board presentation)
Recommendation	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, but also how the speciality teams are linking this with learning from the reviews undertaken for patient who recover. 2. The Board are asked to note the on-going work programme to maintain the mortality rates within the expected range for the organisation. 3. The Trust Board are asked to support the current business case to support the collection of data to support analysis and learning to support the identification of quality improvement developments.

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

28 July 2022

Learning from Deaths Report, Q1: 2022/23

Report of the Medical Director

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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 may be related to the provision of safe and effective quality care. It is considered that as safety and quality improvements are initiated effectively and embedded, then the mortality statistics will naturally be maintained within "as expected" range.

1.3 The information presented in this report provides an overview of learning from deaths that has been obtained from mortality scrutiny and case reviews undertaken by the Trust. Information from a variety of speciality areas is being provided within the reports on a cyclical basis.

1.4 The number of mortality reviews undertaken by the Trust has been significantly reduced during the Covid-19 pandemic; the capacity of clinical staff to undertake required mortality reviews has been significantly restricted. The introduction of the Medical Examiners scrutiny has assisted in ensuring all in-patient deaths are reviewed.

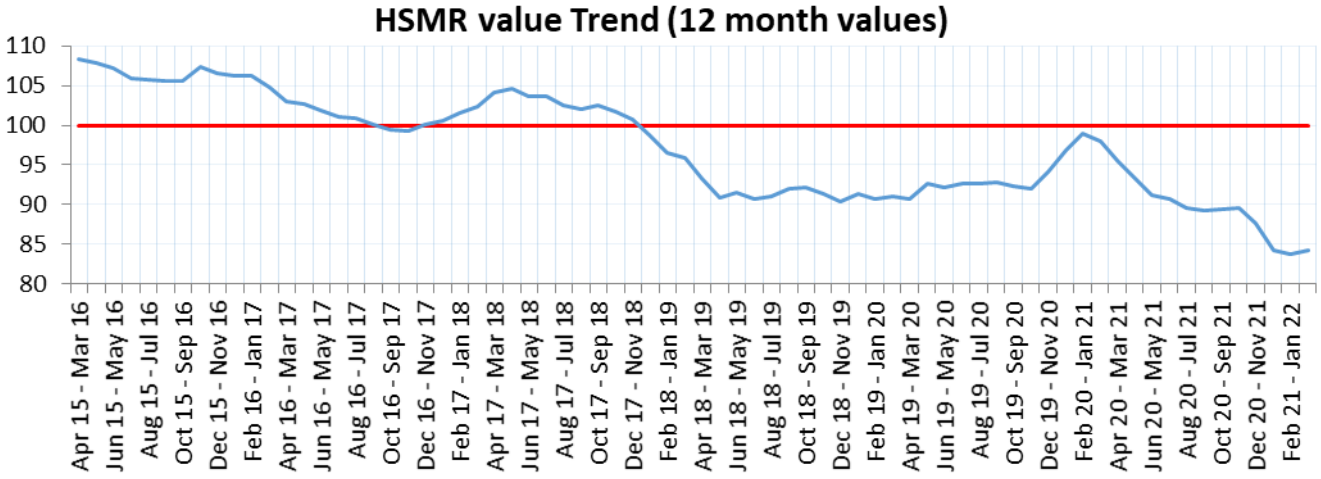
2. Mortality Data

2.1 Information related to mortality is gathered from data provided routinely by the Trust to the 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 **84.18** (March 2021 to February 2022), this is a slight increase from the previous reported value of **83.78** (February 2021 to January 2022).

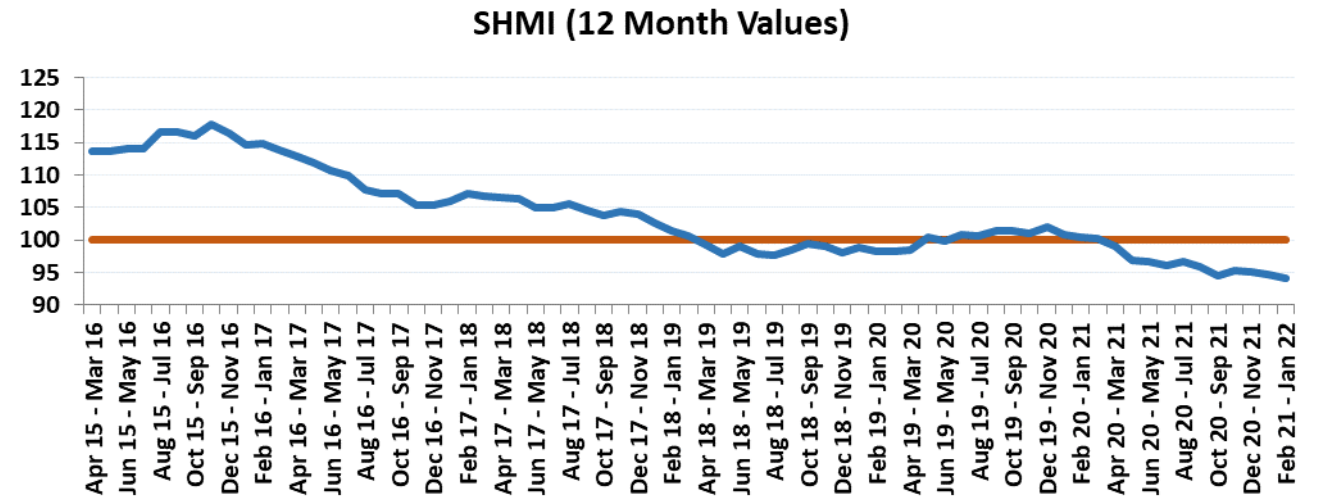
2.3 The value of 84.18 continues to remain inside the 'as expected' range. The following chart displays the 12 month rolling HSMR trends from April 2015 to February 2022:



2.4 The Trust currently has the 15th lowest HSMR value from the 124 Trusts nationally, and lowest value of the eight 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 **94.15** (February 2021 to January 2022) from the previously reported value of **94.74** (January to December 2021). The value of 94.15 continues to remain inside the 'as expected' range. The graph below shows the 12 month rolling SHMI from April 2014 to January 2022:



2.7 The Trust currently has the 34th lowest SHMI value from the 122 Trusts nationally, and the lowest value of the eight North East Trusts.

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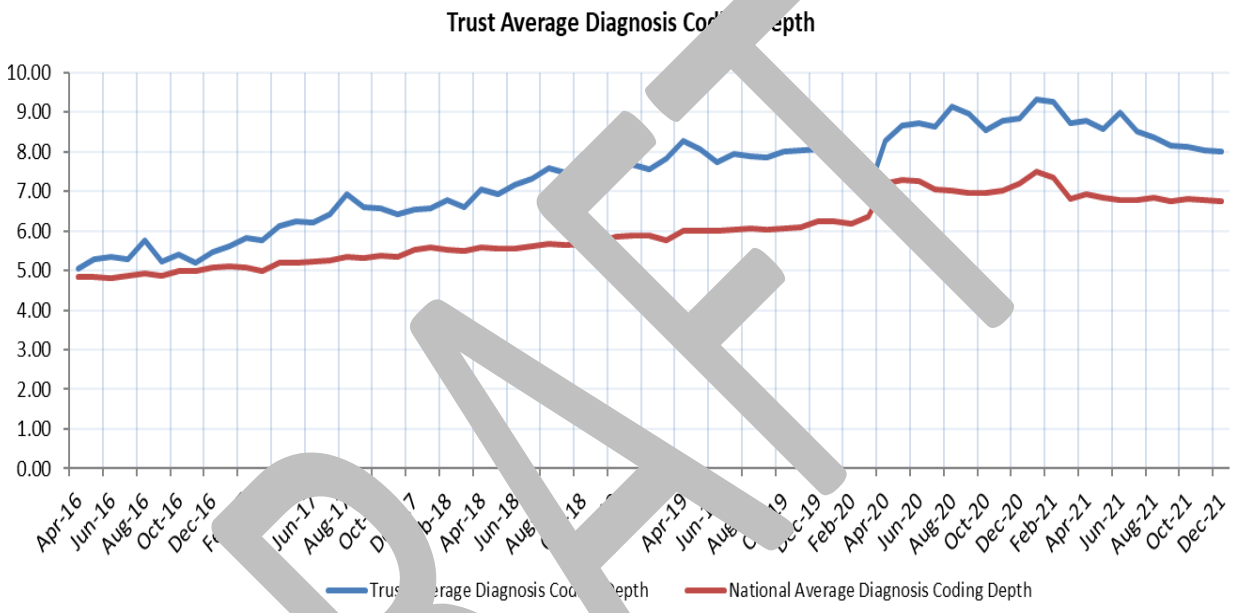
2.8 There continues to be an ongoing focus on ensuring there is accurate documentation of the diagnosis and co-morbidities; this information is required to ensure there is clear clinical communication between healthcare professionals who are caring for the patients.

The Trust is currently maintaining a high level of clinical coding, with a current average of eight co-morbidities recorded for patients; this level of coding is now thought to more accurately reflect overall health problems and deprivation within the local population. Maintaining this level of information reflects the quality in not only the clinical documentation, but also the quality of the clinical coding activity within the organisation. This has been challenging during the Covid pandemic, there had been changes in clinical coding national requirements; previous reports had highlighted that this had led to some uncertainty in relation to longitudinal prediction of the mortality statistics.



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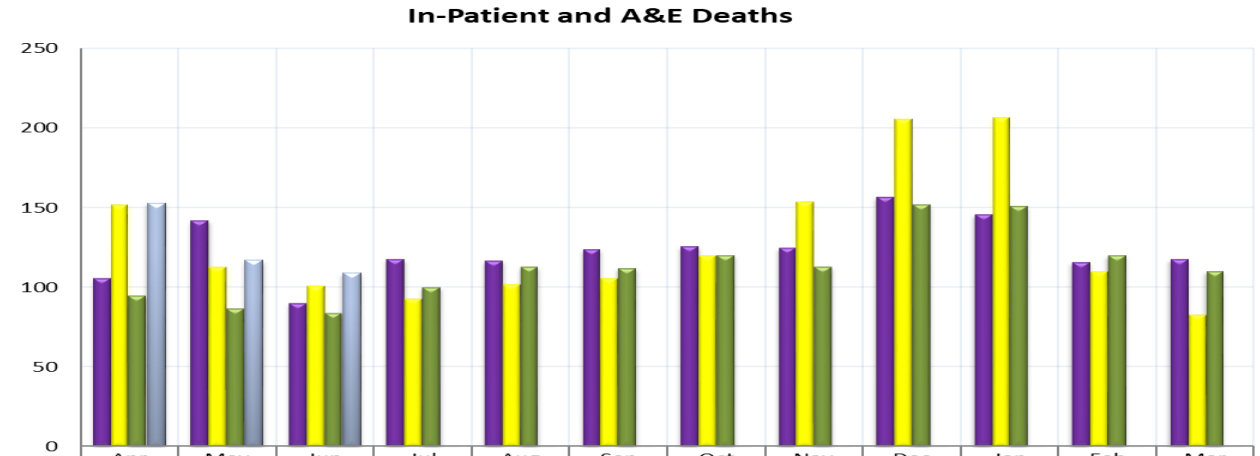
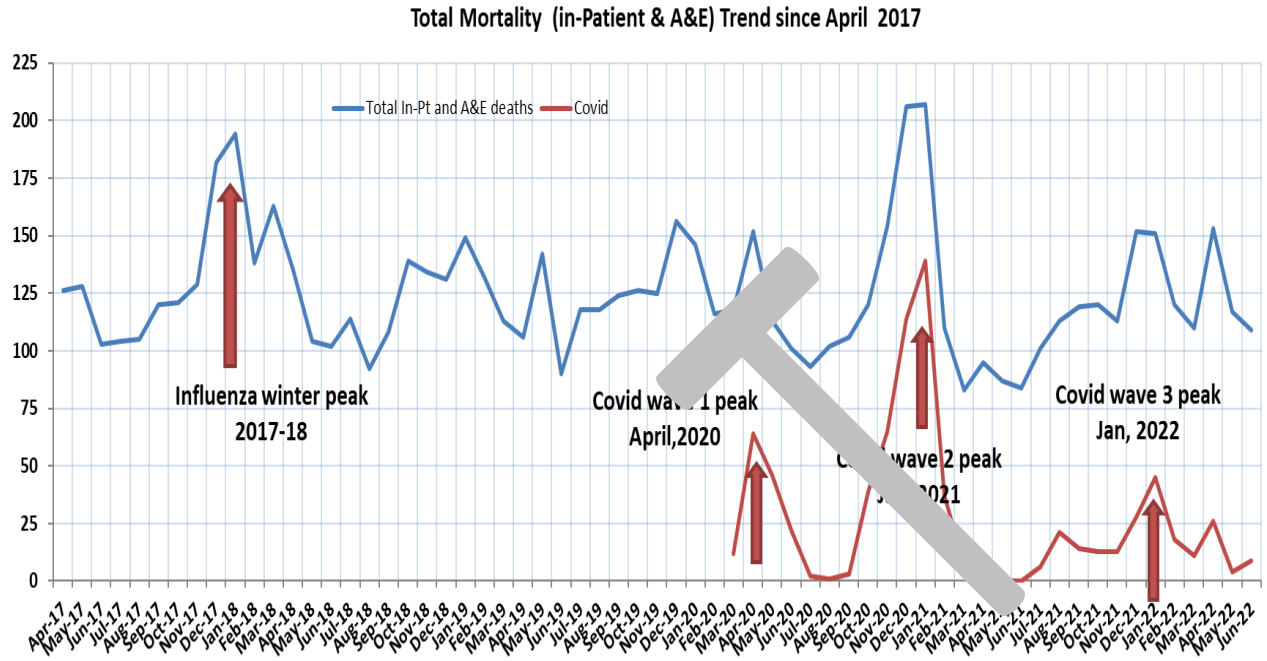
3. Mortality reviews

3.1 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 total numbers of deaths since April 2019 to the end of June 2022.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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	100	113	112	120	113	152	151	120	110
2022/23	153	117	109	0	0	0	0	0	0	0	0	0

3.2 The following chart shows the monthly trend and fluctuations in mortalities since April 2017 to June 2022. The red markers represent key areas of peak deaths linked with influenza over the winter of 2017-18 and Covid-19 from March 2020. The red line represents the numbers of Covid deaths logged by the Trust over the last 2 years.



3.3 All patient deaths are scrutinised by the Medical Examiners (ME) team, part of this involves contacting the patient's family or carers to discuss their death. This provides the opportunity for family's / carers to raise any concerns they might have but also for them to discuss with the ME, the medical cause of death or if there has been a referral to the Coroner, and why.

3.4 Mortality case reviews can be requested following the ME discussions, but 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), as this may also link into Perinatal Mortality or LeDeR reviews.
- All stillbirths – in conjunction with nationally agreed Perinatal Mortality Review tool; (these figures are not included within overall mortality data provided in the tables above).

3.5 The Trust is currently reviewing its processes for mortality case reviews; there will continue to be the required reviews as outlined above, however, these will be linked closely with learning from other complex cases where a patient may not have died or also any relevant thematic reviews that are identified. Cases will then be considered at a variety of speciality mortality and morbidity (M&M) meetings; the learning from these review sessions will then be shared at a Trust wide group to allow identification of overarching issues that may require local or more significant quality improvement work. These changes are based around the national "Better Tomorrow Programme: learning from deaths, learning for lives"; which is a national programme

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providing support and tools for Trusts to use. As the Trust work develops, more detail will be provided in future reports.

3.6 The following table provides a summary of the data, by financial quarters, for 2021-22. The numbers of mortality cases given scrutiny by the Medical Examiners team has been included in the chart below to demonstrate the integration of the two approaches to reviewing the care of our patients. The ME team can refer any cases into the overall mortality review system for further interrogation of clinical care or if necessary into the established governance structures.

2021-22	Q1	Q2	Q3	Q4	Total
Total deaths in scope	269	331	388	390	**1378**
Deaths in compulsory criteria	40	51	42	28	**161**
Compulsory case reviews completed (no.)	20	32	32	15	**99**
Compulsory case reviews completed (%)	50%	63%	76%	50%	**61%**
Compulsory reviews pending	20	19	10	13	**62**
Reviews & ME scrutiny completed	133	273	345	384	**1135**
Total completed (no.)	152	303	366	384	**1205**
Total completed (%)	56%	91%	94%	99%	**88%**
Reviewed Deaths considered avoidable (no.)	0	0	0	1	**1**
Reviewed Deaths considered avoidable (%)	0%	0%	0%	0%	**0%**
Reviewed Deaths considered not preventable (no.)	152	303	366	383	**1204**
Reviewed Deaths considered not preventable (%)	100%	100%	100%	99%	**99.9%**

3.7 The following table provides a summary of the data, by financial quarters, to date for 2022-23:

2022-23	Q1	Q2	Q3	Q4	Total
Total deaths in scope	380				**380**
Deaths in compulsory criteria	34				**34**
Compulsory case reviews completed (no.)	18				**18**
Compulsory case reviews completed (%)	53%				**53%**
Compulsory reviews pending	16				**16**
Reviews & ME scrutiny completed	379				**379**
Total completed (no.)	379				**379**
Review/ Scrutiny completed of all deaths (%)	99.9%				**99.9%**
Reviewed Deaths considered avoidable (no.)	0				**0**
Reviewed Deaths considered avoidable (%)	0%				**0%**
Reviewed Deaths considered not preventable (no.)	379				**379**
Reviewed Deaths considered not preventable (%)	100%				**100%**

3.8 Where a patient's death immediately raises concern, this is reported, and then 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.

3.9 During 2021-22, there has been one mortality case reviewed and assessed to have been "Possibly preventable greater than 50-50"; this case had been reported and investigated as a serious incident.

3.10 To date in 2022-23, there are two cases being investigated as Serious Incidents, the outcome of these investigations will be reported in future reports.

3.11 Over quarter 1, 99.9% of mortalities have been given either scrutiny by the ME team, or where the patient passed away on ITU, reviewed by the clinical team involved. There has been a low number of other SJRs completed for those cases identified as requiring further review. As the ME team are now identifying cases where they consider additional learning can be obtained, they are requesting SJRs are completed, the relevant clinical teams are being asked to complete these. The Trust Mortality Lead will be progressing this requirement in order to collate the learning from these reviews; the output from these will then be utilised to enhance the content of future reports.

3.12 The Trusts Safety Panel receives summary reports giving details of thematic learning from the following groups:

- Cardiac arrest reviews
- Intensive Care deaths
- Medical Examiner scrutiny
- Emergency Department deaths

These areas provide a monthly summary providing details of the number of cases reviewed; these provide information to help identify trends in "real time" so that actions can initiated promptly; the information obtained is included later in the report in the appropriate sections.

3.13 From March 2020 to the end of June 2022, the Trust has notified 735 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 continues 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.

4. Learning from Deaths

4.1 Deteriorating patient

Recognition and management of the deteriorating patient has been identified as one of the most important areas of learning from all types of case reviews, not only for patients who have died but also those who have survived. Information obtained in the thematic work identified in

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section 3.12 is examined by the Deteriorating Patient Group; this ensures that any emerging issues are promptly acted on and included in the assurance framework.

The Deteriorating Patient Group has been established to provide oversight in relation to this area of learning. The group is led by senior clinical staff and is multidisciplinary, with all speciality groups are represented, acute and community, this is to ensure good communication and sharing of information. This Trust group is also working in collaboration with the Regional Deteriorating Patient Group, with information being shared at both groups for wider learning.

The Trusts Sepsis pathway is monitored to assess compliance against key performance indicators (KPIs); the Sepsis audit results have been integrated into the Trusts Deteriorating Patient dashboard so that all teams can view their own results readily. The results had shown that sepsis screening was not being well documented for in-patients; to improve this, the Trusts sepsis screening tool/bundle has recently been updated to support completion and to also reflect the updated UK Sepsis Trust guidance. Future audits should demonstrate improvement as a result of having these on the same system and linked with, the other patient records.

The Trust is also in the process of employing a member of staff specifically to promote the improvement work ongoing for sepsis and the deteriorating patient. The impact of this role should be clearly identified through the information in future reports.

Following recognition of sepsis, or a deterioration in a patients National Early Warning Score (NEWS), the key focus is escalation to ensure that senior staff are involved in the management and decision making for these patients. Within the Trust, healthcare assistants provide necessary support in relation to ensuring clinical observations, such as NEWS, are completed, recorded and escalated as required. In order to provide these colleagues with the necessary support to do this the Trust has recently implementing additional training sessions to enhance the understanding of this group of staff around what to escalate to qualified staff and how. This additional training has just been implemented and the impact will be evaluated in future reports.

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

The Deteriorating Patient Group “dashboard” displays data to reflect compliance with the key areas of work linked to the group. The dashboard displays all KPIs in relation to the deteriorating patient, including compliance with mandatory training such as NEWS, Basic Life Support (BLS), Immediate life Support (ILS), Acute Illness Management (AIMs), sepsis, acute kidney injury (AKI) prevention and other specialist training modules linked to its work.

The mandatory training requirements linked to identification and management of the deteriorating patient are being reviewed; this will lead to changes in the training requirements for a variety of staff. This work remains underway with oversight from the Deteriorating Patient Working Group.

The Deteriorating Patient Dashboard also supports the analysis of incidents reported related to the identification, management and escalation linked to the deteriorating patient. This allows the group to examine and consider any trends identified through incident reporting and then to generate any necessary actions to reduce the impact and the chances of these recurring.

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4.2 Surgical update

The Surgical department has continued to undertake reviews of all in-hospital mortalities at their monthly Mortality and Morbidity (M&M) meetings. These reviews focus on cases where complications have occurred, and where patients may have died under their care, which are thankfully uncommon.

The monthly M&M meetings encourage Multidisciplinary Team (MDT) involvement in the case reviews to promote shared analysis and learning. The reviews also give the wider range of professionals an opportunity to have frank discussions and identify any actions that may need to be taken for future learning. The surgical team have agreed regular shared clinical governance sessions with other specialities to ensure there is a broader review of cases to improve patient experience and enhance patient safety. The surgical team have also established a regular review of any patients who require follow up surgery (returns to theatre) to assist in identifying and confirming any complications; this then supports the appropriate management and the maintenance of high standards of care.

In the previous report the team advised that the Trust had a lower proportion of high-risk patients going to the Intensive Care Unit (ITU) postoperatively and this was below the standards identified by the National Emergency Laparotomy Audit (NELA). As a result, it had been confirmed with the ITU team that a higher number of high-risk post-operative emergency laparotomy patients would be cared for in ITU. The team are pleased to report that for the latest quarterly analysis, 100% of high risk cases were taken to ITU post operatively.

The surgical team are planning to discuss any NELA patients, who may die in ITU, with the intensivists on a weekly basis. This will be in addition to their M&M work but will enhance the learning for both departments to share at surgery and anaesthetic meetings, but to also identify cases for discussion in joint governance meetings in coming months.

4.3 Paediatric Reviews

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

The Paediatric team have used the reviews as opportunities to ensure clinical guidance, policies and procedures are up to date. The team have focused on ensuring there is a structured and standardised approach to the recognition and response of acute illness in children and young people within all paediatric areas. There is currently no nationally agreed Paediatric Early Warning Score (PEWS); there is a tool to be published but this remains unavailable. Until this national tool is available the Trust has implemented the regional PEWS to support management of acutely ill children; this is supported by local guidance for staff and monitoring of this is now part of the Trusts electronic observation system.

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The Paediatric and Emergency Department teams have recently reviewed the whole pathway for children attending the Trust. This has led to the recent development and implementation of the Paediatric Integrated Assessment Unit (PIAU). This joint team approach will ensure that the child/young person and their families are at the centre of all decision-making and that they are seen at the right time, by the right person in the right setting. The development of joint clinical pathways and standards of care has improved the journey of the child by reducing the numbers of handovers, transfers between areas and clinicians involved in a child's care.

The PIAU has senior medical and nursing staff, including paediatric nurse practitioners based within the unit at all times. All children or young people attending the unit are initially assessed and have a plan of care initiated including a full paediatric early warning score (PEWS). Having senior staff available to manage the children, from arrival, supports timely recognition of sepsis and its initial management. This is widely recognised as being particularly challenging in children with complex care needs.

In order to support record keeping and continuation of care through clinical handovers, the Paediatric service has progressed to using electronic records; this means that PEWS information and clinical records are available to support robust handovers between teams. Having records available also readily supports effective escalation when concerns are identified relating to ongoing monitoring of trends in PEWS parameters. The PEWS and relevant escalation processes are audited by senior staff; this allows the team to identify any generic issues with the completion of the PEWS but also supports individual feedback to staff where necessary. Learning from the audits is used to enhance the paediatric resuscitation training sessions; this allows the programme to be flexible to immediate requirements while still ensuring the core training is completed. The Paediatric team have rolling programme of joint multidisciplinary training and teaching sessions, these include updates covering PEWS, recognition and management of the deteriorating child, professional challenge, leadership, sepsis, pain management and Child Safeguarding.

Following reviews of some cases where children required transfer out of the Trust to a specialist unit; the Paediatric team have arranged bi-annual meetings with the regional children's transport team (NECTAR) along with representation from Trusts emergency and anaesthetic departments. These meeting support a wider multidisciplinary critical review of the management of the children involved, and the transfer arrangements. These reviews have supported the development of a standardised approach to care across the region; which includes improvements in timely escalation of the level of care for critically unwell children. The team have recently undertaken a review all transfers over 2 years, this included some children who unfortunately later died; this review has resulted in identification of areas of good practice as well as areas for learning. The service are currently analysing this information and will provide details of improvements made and any evaluation of this in a future report. Recent monitoring of the paediatric transfers has identified that there has been good practice in relation to timely review and communication with the tertiary centre and the transfer team. This has supported rapid transfer arrangements to ensure the children involved get the necessary specialist input into their care.

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5. Conclusion/Summary

5.1 The Trust HSMR value is 84.18 (March 2021 to February 2022), this is a slight increase from the previous reported value of 83.78 (February 2021 to January 2022). The latest SHMI value has decreased slightly to 94.15 (February 2021 to January 2022) from the previously reported value of 94.74 (January to December 2021). Both statistics remain "within expected" ranges.

5.2 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. The planned changes are expected to support clinical staff in completing reviews and identifying learning to generate quality improvement measures.

5.3 There is summary information in the report relating to actions initiated as a result of learning from deaths in patients in relation to the Deterioration Patient Group, Surgery and Paediatric services.

5.4 During 2021-22, to the end of quarter 4, there has been one mortality case reviewed and assessed to have been "Possibly preventable greater than 50-50"; this case had been reported and investigated as a serious incident. To date in 2022-23, there are two cases being investigated as Serious Incidents, the outcome of these investigations will be reported in future reports.

6. Recommendations

6.1 The Board of Directors is asked to note the contents of this report and the information provided in relation to the identification of trends to assist with learning lessons from the mortality reviews, but also how the speciality teams are linking this with learning from the reviews undertaken for patient who recover.

6.2 The Board is asked to note the ongoing work programme to maintain the mortality rates within the expected range for the organisation.

6.3 The Trust Board are asked to support the current business case to support the collection of data to support analysis and learning to support the identification of quality improvement developments.

Dr D Dwarakanath

Medical Director / Deputy Chief Executive

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North Tees and Hartlepool NHS Foundation Trust

Trust Board of Directors

Title:	Workforce Race Equality Scheme (WRES) 2022												
Date:	28 July 2022												
Prepared by:	Elizabeth Morrell, Employee Relations Manager												
Executive Sponsor:	Susy Cook, Interim Chief People Officer												
Purpose of the report	The Trust is commitment to improve staff experience in relation to Equality, Diversity and Inclusion (EDI) align with the Trust's wider organisational strategic goals, specifically 'Valuing our People'; aligning with the NHS People Plan and the People Promise: 'We are compassionate and inclusive'. As a Trust we aim is to make a positive difference for our colleagues and also the patients we care for and we believe that everybody in the Trust has a role to play in fostering a culture of inclusion and belonging and tackling inequality. Understanding the lived experiences of colleagues is important so good practice can be celebrated, improvements made and to ensure a supportive and inclusive workplace for everyone. The annual completion and analysis of the Workforce Race Equality Scheme (WRES) forms part of this wider EDI agenda; enabling us to understand the current position and experiences of our people and consider if we are on the correct journey for making and delivering improvements.												
required:	Approve		Assurance		Discuss	X	Information	X					
Strategic Objectives supported by this paper:	Putting our Population First		Valuing our People	X	Transforming our Services		Health and Wellbeing	X					
Which CQC Standards apply to this report	Safe		Caring		Effective		Responsive		Well Led	X			
Executive Summary and the key issues for consideration/ decision:													
The Board are asked to note the following key points from the data: • There has been a slight increase in the number of BAME staff employed by the Trust - an increase of 0.4% to 11.4%. There is higher representation within the medical staffing group and also at Bands 5 and 8d. There has been a reduction in the numbers at Band 9 for and there continues to be no representation at VSM level.													

- BAME at Board level is under represented at 7.1%. This has increased since 2021, however this is due to a reduction in the number of total Board Members, rather than an increase in the number of BAME individuals at Board level.

- Shortlisted BAME applicants are less likely to be appointed following shortlisting than white applicants, however this metric has significantly improved when compared to the 2021 report.

- BAME colleagues are less likely to enter the formal disciplinary process, however all cases recorded for BAME staff resulted in no formal action which calls into question the appropriateness of initiating an investigatory process and whether this could have been addressed at an earlier stage.

- BAME staff continue to be more likely to experience harassment, bullying/abuse from patients than white staff (34.9% compared to 26.2%).

- BAME staff continue to be more likely to experience harassment, bullying/abuse from staff than white staff (30.1% compared to 18.7%).

- White staff continue to report a higher belief in equal opportunities than BAME staff (64.8% compared to 48.2%).

- BAME staff continue to be more likely to report discrimination (16.8% compared to 5.2%).

There have been some improvements to the metrics since 2021 and this includes: wider representation across the organisation including senior grades; likelihood of being appointed; likelihood of formal disciplinary action, and; likelihood of accessing non-mandatory training.

However, for all of the staff survey metrics (indicators 5-8) there has been a reduction in staff experience. The NHS Survey Co-ordination Centre has developed a new interactive tool for 2022 which will allow us for the first time, to examine this data at a more detailed level, i.e. by staff group and comparison with other protected characteristics.

We continue to promote the activities and good practice that we already undertake, including: promotion of the BAME Staff Network; embedding the Cultural Ambassadors programme; undertaking fair and transparent recruitment processes, including values based recruitment; delivery of unconscious bias training and promotion of various leadership and development opportunities which exist across the Trust.

We are undertaking analysis of the impact of the current work to establish if it is driving the change and improvement that we are looking for and if not, why not. This is aligned with the wider EDI review and recommendations to ensure that this is not just an annual report but part of our desire to create an inclusive culture.

We are sharing the data with our staff and looking at how we incorporate conversations around this agenda into our engagement strategy which is being reviewed currently. We need to listen to our staff to understand their experiences before we can develop solutions to address these and reduce the disparity that currently exists.

Please note that we are required to publish our WRES data no later than 31 August 2022.

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

This report impacts on the current risk – availability of staff. It is intended that this report will have a positive impact on the risk by improving the Trust's ability to recruit and retain staff.	
Committees/groups where this item has been discussed	ETM
Recommendation	The Board are requested to acknowledge the results for the Trust's Workforce Race Equality Standard (2022), as reported within section 3 of this paper and approve publication of the paper and data.
Next steps for presentation e.g. Board Committee/Board meeting	The WRES Report (2022) will be shared with the People Committee and the BAME Staff Network.

North Tees & Hartlepool NHS Foundation Trust

Trust Board of Directors

28 July 2022

NHS Workforce Race Equality Standard 2022

1. Introduction

The Workforce Race Equality Standard (WRES) programme was established in 2015. It requires organisations to report against nine indicators of race equality and supports continuous improvement through robust action planning to tackle the root causes of discrimination.

Inequalities in any form are at odds with the values of the NHS. Research shows that the fair treatment of our staff is directly linked to better clinical outcomes and better experience of care for patients.

This report represents the eighth publication since the WRES was established. There are some positive findings in this report and there are also areas where further analysis of the information is required to fully understand the results, particularly in relation to staff survey feedback.

The Trust is committed to tackling racial discrimination to bridge the gaps in experience, opportunity and differential attainment in our diverse workforce. A key tool to understanding and correcting these inequities is the presentation of detailed data to key work streams, which will allow us to identify the targets for action.

2. Trust Requirements

In order to meet the requirements for 2022, the Trust is required to publish our WRES data no later than 31 August 2022 to NHS England via the NHS Digital Strategic Data Collection Service (SDCS).

The Trust must also publish the WRES data on the Trust's corporate website no later than 31 October 2022.

3. WRES Indicators 2022

A summary of the results for North Tees and Hartlepool NHS Foundation Trust is shown in the table below. This includes comparison of the Trust's results covering a five-year period (2018 to 2022).

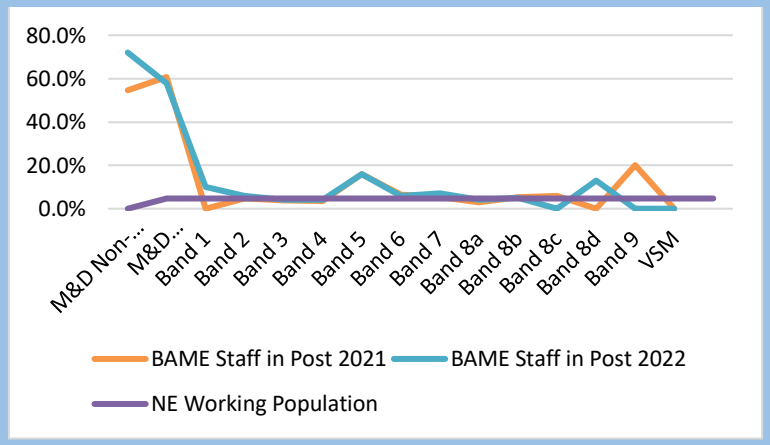
The baseline data has been extracted from ESR, Workforce databases and the Trac recruitment system to calculate a response to each of the nine WRES indicators.

WRES Indicators 2022			2017	2018	2019	2020	2021	2022
1	Percentage of BME staff	Overall	9.0%	10.0%	11.0%	11.0%	11.0%	11.4%
		VSM	0.0%	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	1.43
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	0.88
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	0.96
			2016	2017	2018	2019	2020	2021
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%	34.9%
		White	26.6%	29.2%	26.9%	28.0%	24.8%	26.2%
6	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	BME	20.0%	38.0%	31.3%	33.8%	29.2%	30.1%
		White	19.8%	22.5%	18.3%	18.4%	20.4%	18.7%
7	Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion	BME		56.0%	62.5%	57.4%	55.7%	48.2%
		White		65.6%	65.1%	63.6%	61.7%	64.8%
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%	16.8%
		White	5.1%	5.0%	4.4%	4.3%	5.1%	5.2%
			2017	2018	2019	2020	2021	2022
9	BME Board membership	BME	7.1%	6.7%	6.7%	5.3%	5.6%	7.1%

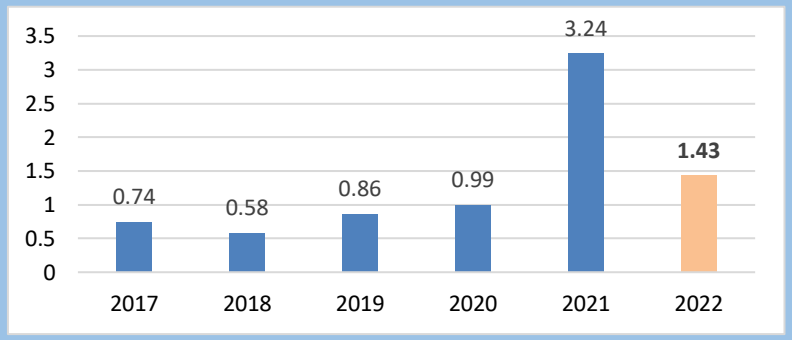
4. Key Findings for 2022

The key findings in respect of the nine WRES indicators for 2022 are summarised below.

We are currently only able to undertake benchmarking for those areas which relate to the staff survey (indicators 5-8). Full benchmarking information is published by the national WRES team and this is expected for March 2023.

Indicators 1 and 9 Representation across the organisation	
	**Representative Workforce across all protected characteristics at all levels.** There has been a slight increase in the number of BAME staff employed by the Trust - an increase of 0.4% to 11.4%. Overall BAME representation remains broadly representative of the BAME communities in the North East, but not across all grades. There is significantly higher representation within the medical staffing group and also at Band 5 and Band 8d. There has been a reduction in the numbers at Band 9 for 2022 and there continues to be no representation at VSM level. **Representation of BAME at Board and senior management levels.** BAME at Board level is under represented at 7.1%, as compared to the overall BAME workforce of 11.4%. This has increased since the 2021 report, however this is due to a reduction in the number of total Board Members, rather than an increase in the number of BAME individuals at Board level.

Indicator 2 Likelihood of staff being appointed from shortlisting



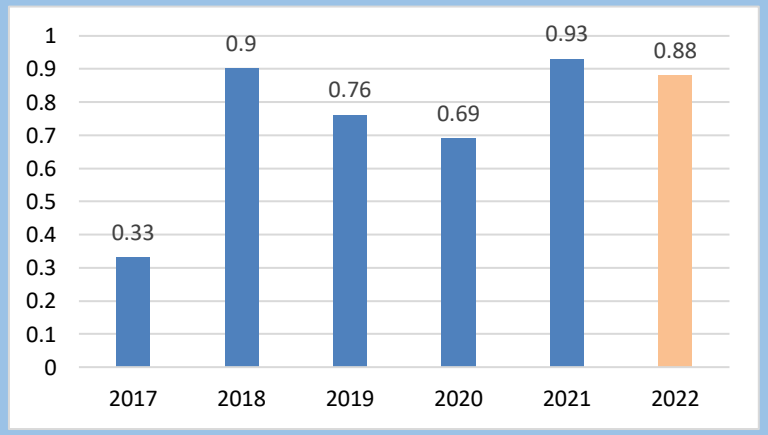
Equity of Experience.

This information is obtained from the Trac Recruitment System.

Shortlisted BAME applicants are less likely to be appointed following shortlisting than White applicants, however there has been a significant reduction from the figure reported in 2021 and we are committed to reducing this further.

This will continue to be a priority area for improvement, with work ongoing to identify trends in relation to grades and occupational groupings. We are also working with NHSEI to understand disparity ratios in relation to nursing and midwifery posts, with plans to consider extending this to other staff groups.

Indicator 3 Likelihood of staff entering formal disciplinary process



Equality of Experience.

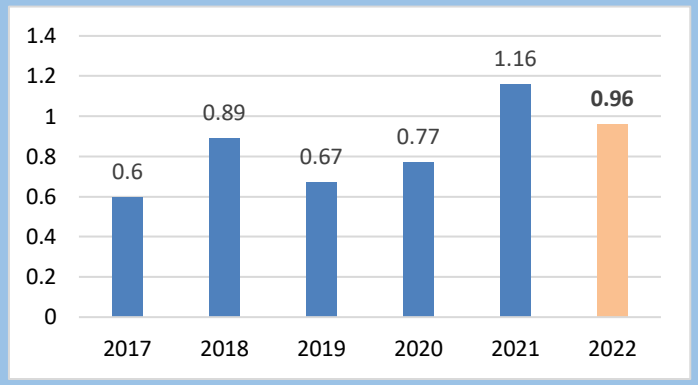
This information is obtained from Workforce Databases.

BAME colleagues were less likely to enter the formal disciplinary process, with a ratio of 0.88 (a figure higher than 1 would indicate that BAME staff are more likely to enter a formal process).

This information has been calculated over a two-year period, with a total of 7 cases recorded, as compared to 61 cases involving staff with a White ethnicity. Of the 7 cases recorded, all resulted in no formal action.

The Trust has trained an additional four Cultural Ambassadors in April 2022, who will be assigned to all employment relations cases for 2022/23. A key area of focus will be to review why the recent cases involving BAME employees resulted in no formal action, to identify if decisions could have been reached at an earlier stage in the process, thereby averting the need for formal investigation.

Indicator 4 Likelihood of staff accessing non mandatory training and continuous personal development



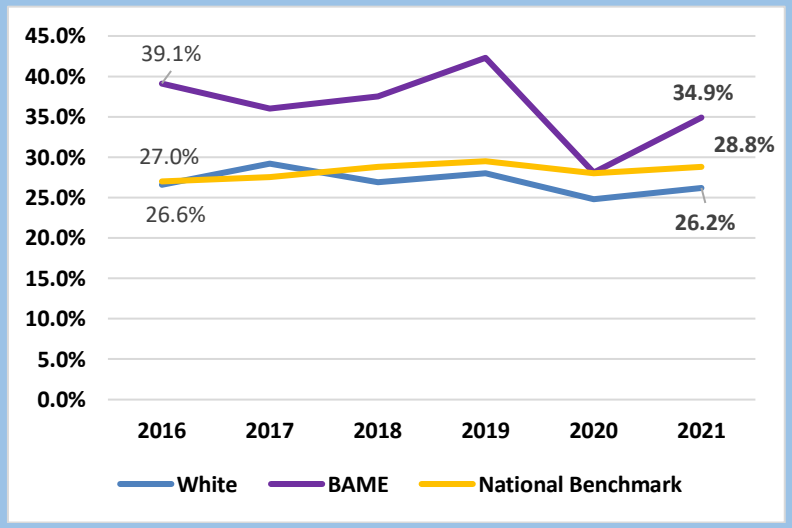
Belief in Equal Opportunities.

BAME staff are more likely to access non-mandatory training and continuous personal development as compared to White staff.

This is a change to 2021 where the ratio had crept above 1.0 for the first time, however it is now reported as less than 1 which is consistent with previous years.

The % of BAME staff accessing training has increased from 29.85% in 2021, to 36.64% for 2022, whilst the number of White staff has remained static at 35%.

Indicator 5 Percentage of staff experiencing harassment, bullying/abuse from patients, relatives/public



Staff Survey Key Findings - B&H (Public)

This information is obtained from the 2021 staff survey.

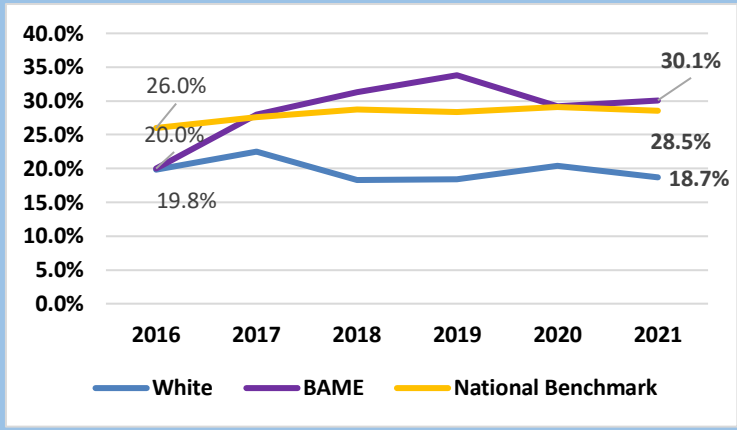
Staff survey results show an increase in the number of BAME staff experiencing harassment, bullying and abuse from patients, relatives/public (34.9% compared to 28.1% for 2020).

BAME staff continue to be more likely to experience harassment, bullying/abuse from patients than white staff and the gap for 2021 is reported as 8.7%.

The national benchmarking data for 2021 indicates that 28.8% of BAME staff have experienced harassment and abuse from patients, which is 6.1% lower than the Trust figure.

Staff are required to log all incidents of service user violence and harassment via Datix and the information is then reported through Yellowfin. The Trust's Keeping People Safe group reviews this information on a regular basis to identify trends and this includes analysis of related themes including race.

Indicator 6 Percentage of staff experiencing harassment, bullying/abuse from staff



Staff Survey Key Findings - B&H Staff

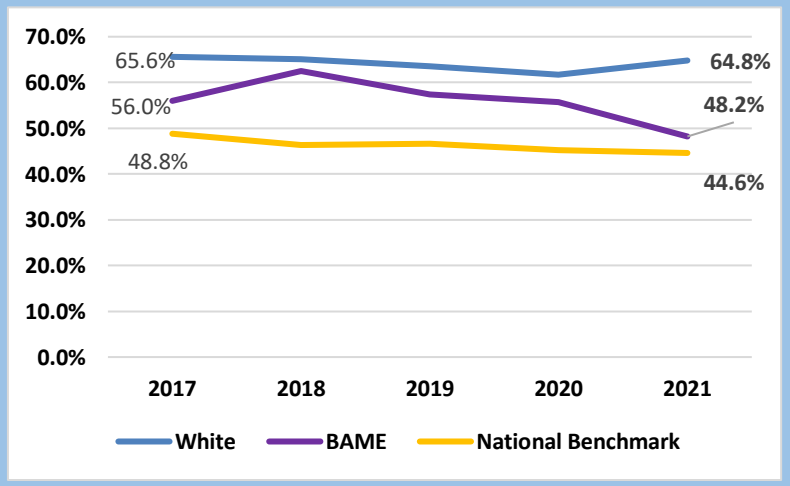
Staff survey results are static in terms of the number of BAME staff experiencing harassment, bullying and abuse from staff (30.1% compared to 29.2% in 2020).

BAME staff continue to be more likely to experience harassment, bullying/abuse from staff than White staff and the gap for 2021 is reported as 11.4%.

The national benchmarking data for 2021 indicates that 28.5% of BAME staff have experienced harassment and abuse from staff, which is 1.6% lower than the Trust figure.

It is important that staff are encouraged to report concerns regarding bullying and harassment and all cases are logged and monitored by the Workforce Team. Work is ongoing to understand why the number of formally reported cases is lower than the staff survey results would suggest.

Indicator 7 Percentage of staff believing the Trust provides equal opportunities for career progression or promotion



Staff Survey Key Findings - Equal Opportunities

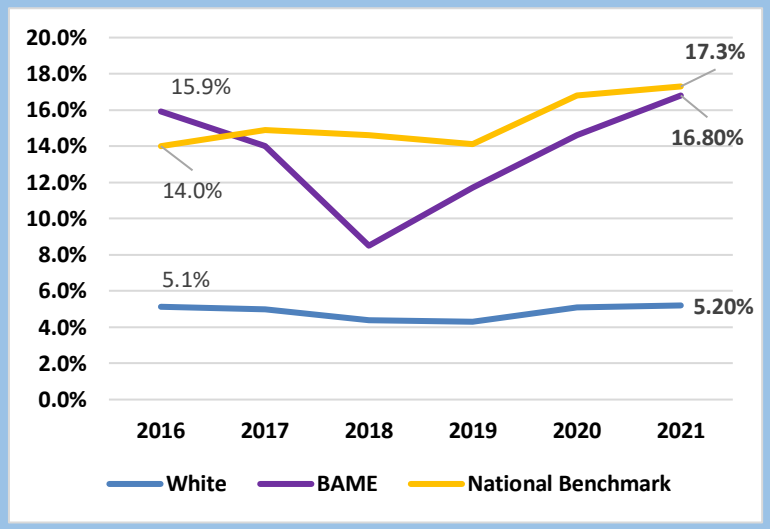
There has been a reduction in the % of BAME staff who believe that the Trust provides equal opportunities for career progression/promotion (a reduction from 55.7% to 48.2%). This is the lowest figure for the past 4 years. (The data for 2017 is not available as the survey co-ordination centre has changed the calculation for 2021 and they have only recalculated back to 2017).

As in previous years, white staff continue to report a higher belief in equal opportunities than BAME staff. The gap in experience has increased for 2021, and this is currently reported as 16.6%.

The national benchmarking data for 2021 indicates that 44.6% of BAME staff believe their organisation provides equal opportunities for career progression. This is 3.6% lower than the Trust figure.

The national team have developed an interactive tool for 2021 to allow for analysis of this metric at a more detailed level, including comparison with other protected characteristics, department and staff group. This is a priority area for further analysis.

Indicator 8 Percentage of staff experiencing discrimination at work from their manager, team leader or other colleagues



Staff Survey Key Findings - Discrimination.

There has been a further increase in the % of BAME staff who have reported experience of discrimination at work (from 14.6% to 16.8%). There is a continued widening of the gap in experience, with BAME staff reporting a poorer experience as compared to White staff (11.6% differential).

The national benchmarking data for 2021 indicates that 17.3% of BAME staff have experienced discrimination, which is 0.5% higher than the Trust figure.

Staff are encouraged to report concerns regarding discrimination and all cases are logged and monitored by the Workforce Team. Work is ongoing to understand why the number of formally reported cases is lower than the staff survey results would suggest.

The national team have developed an interactive tool for 2021 to allow for analysis of this metric at a more detailed level, including comparison with other protected characteristics, department and staff group. This is a priority area for further analysis.

5. Conclusion and Next Steps

The Trust is committed to meeting the requirements of the Workforce Race Equality Standard for NHS Trusts and this is our eighth publication against the standard.

Our actions to improve the Trust's WRES Indicators (2022) align with the Trust's wider organisational strategic goals, specifically 'Valuing our People'. They also support our commitments to the NHS People Plan and the People Promise: 'We are recognised and rewarded'.

By taking action to improve the experience of our ethnic minority colleagues, we aim to support the organisation to be an employer of choice; an outstanding place where people want to work and are proud to work, and somewhere which provides equality for everyone.

The Trust continues to implement a number of programmes/activities to promote and support racial equality in the workplace. Some of these actions/activities are detailed below:

- The Trust's BAME staff network continues to offer staff a place where they can come together, share experiences and facilitate learning and development. The network will also assist in the shaping and delivery of organisational strategy and policy, working with us to improve staff experience on specific race related issues and adding more depth to our WRES Action Plan.

- All of our staff networks (BAME, Disability, LGBTQ+, Women, Men, Age, Multi-faith) aim to:

    - Promote equal rights and opportunities;
    - Pro-actively tackle discrimination or disadvantage in all its forms;
    - Create an open and inclusive culture where equality, diversity and inclusion can be comfortably discussed;
    - Encourage our staff to have a voice in the organisation – to share their experiences so that we can listen and act on staff feedback.

- As a fair and equal employer, we appoint the best candidates during our recruitment campaigns regardless of ethnicity or any other protected characteristic.

- As part of our commitment to embedding Values Based Recruitment, we are implementing a structured interview template, which aims to ensure that every candidate has an equal chance for promotion/employment through the use of consistent measures.

- We have appointed a Champion of Flexible Working and a Health and Wellbeing Guardian in line with our responsibilities under the People Plan.

- We continue to embed and grow the Cultural Ambassador programme within the Trust and a cohort of four individuals have completed their training in April 2022. The skills of the Cultural Ambassador are expected to have a positive impact in terms of identifying and 'calling out' ethnicity related bias within the employee relations caseload.

- We actively analyse our staff survey data from an ethnicity perspective by comparing the experiences of our BAME and White staff. The themes of bullying, harassment and abuse from patients and staff, belief in equal opportunities for career progression and experience of discrimination form part of the WRES metrics (indicators 5 - 8). The NHS Survey Co-ordination Centre has developed a new interactive tool for 2022 which for the first time,

will allow us to examine this data at a more detailed level, i.e. by staff group and comparison with other protected characteristic groups.

We take racial equality seriously and whilst we have already implemented a number of practices which will have a positive impact in this area, we understand that change will require a significant cultural shift within the organisation. We know that our workforce ethnicity profile will not change overnight, however we are starting to see a gradual increase in the number of ethnic minority staff working in the Trust. It is also important that we continue to grow the membership of our BAME staff network to help us facilitate the voices of our ethnic minority staff and improve staff experience.

We continue to promote the activities and good practice that we already undertake, including undertaking fair and transparent recruitment processes, delivery of unconscious bias training and promotion of various leadership and development opportunities which exist across the Trust.

We are considering how this is incorporated into our engagement strategy and how we can improve our communication around both the data for the Trust and what we are doing in response to this. This will be considered as we enter Phase 2 of the Equality, Diversity and Inclusion review and this will inform how we continue to improve as a Trust.

8.0 Recommendation

The Board are requested to acknowledge the Trust's WRES Results (2022) as reported within section 3 of this paper and to confirm their approval for the results to be submitted to the NHS Digital Strategic Data Collections Service (SDCS) by the deadline of 31 August 2022.

The Board are asked to note that improvements to the WRES indicators (alongside other key reporting gaps for protected characteristics) is included in the EDI recommendation and plan for 2022/23. This is to include targets in order to demonstrate improvement and outcomes.

North Tees and Hartlepool NHS Foundation Trust

Trust Board of Directors

Title:	Workforce Disability Equality Scheme (WDES) 2022
Date:	28 July 2022
Prepared by:	Elizabeth Morrell, Employee Relations Manager
Executive Sponsor:	Susy Cook, Interim Chief People Officer
Purpose of the report	The Trust is commitment to improve staff experience in relation to Equality, Diversity and Inclusion (EDI) align with the Trust's wider organisational strategic goals, specifically 'Valuing our People'; aligning with the NHS People Plan and the People Promise: 'We are compassionate and inclusive'. As a Trust we aim is to make a positive difference for our colleagues and also the patients we care for and we believe that everybody in the Trust has a role to play in fostering a culture of inclusion and belonging and tackling inequality. Understanding the lived experiences of colleagues is important so good practice can be celebrated, improvements made and to ensure a supportive and inclusive workplace for everyone. The annual completion and analysis of the Workforce Disability Equality Scheme (WDES) forms part of this wider EDI agenda; enabling us to understand the current position and experiences of our people and consider if we are on the correct journey for making and delivering improvements.

required:	Approve		Assurance		Discuss	X	Information	X
Strategic Objectives supported by this paper:	Putting our Population First		Valuing our People	X	Transforming our Services		Health and Wellbeing	X

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

Executive Summary and the key issues for consideration/ decision:

The Board are asked to note the following key points from the data:

- There has been an increase in the number of staff who have declared they have a disability - an increase of 1% to 3%. There has been an increase in representation at Bands 5, 8a and 8c and also at VSM level.

- For the first time, we have reported that there is disability representation at Board level at 7.1%.

- Shortlisted disabled applicants are more likely to be appointed following shortlisting than non-disabled applicants, and this is close to achieving the required ratio of 1.0 (currently reported as 0.98).

- There have been no formal capability cases involving staff with a disability or long term condition, therefore it remains the case that staff without a disability are more likely to enter a formal capability process.

- Disabled staff continue to be more likely to experience harassment, bullying/abuse from patients than non-disabled staff (28.6% compared to 26.3%).

- Disabled staff continue to be more likely to experience harassment, bullying/abuse from managers than non-disabled staff (14.2% compared to 7.6%).

- Disabled staff continue to be more likely to experience harassment, bullying/abuse from colleagues than non-disabled staff (19.9% compared to 13.3%).

- In respect of the % of staff reporting that they have experienced harassment, bullying/abuse, the numbers are broadly the same for both disabled and non-disabled staff (46.2% compared to 47.3%).

- Non-disabled staff continue to report a higher belief in equal opportunities than disabled staff (65.5% compared to 57.6%).

- Disabled staff are more likely to feel pressure from their manager to attend work whilst unwell (27.8% compared to 21%), however there has been a positive reduction when compared to the results for 2020.

- Staff with a disability/LTC continue to be less likely to feel valued than staff who do not have a disability (37.4% compared to 47.6%).

- The staff survey results remain static in terms of the number of disabled staff who have reported that the Trust has made adequate reasonable adjustments to enable them to carry out their work (74.1% compared to 74.2% for 2020).

- Staff with a disability or long term condition continue to be more likely to report lower levels of staff engagement than staff who do not have a disability (7.1 compared to 6.6).

There have been some very positive improvements to the metrics since the WDES 2021 report. The experience of disabled staff has improved in relation to the number of staff experiencing harassment or abuse from patients, managers and colleagues. Belief in equal opportunities and feeling valued by the organisation has increased and the number of staff feeling pressure to attend work whilst unwell has reduced. The number of disabled staff reporting reasonable adjustments and staff engagement has remained static, however this is still a positive indicator when considered that staff experience in these areas for non-disabled staff has reduced.

It is extremely positive that the number of staff reporting that they have a disability has increased and we now have representation at senior grades, including Board level. Disabled staff are more likely to be appointed from shortlisting and no disabled staff have entered into a formal capability process.

These are all positive improvements, however we are not complacent and we will continue to promote the activities and good practice that we already undertake, including: promotion of the Disability Staff Network; embedding the Cultural Ambassadors programme; undertaking fair and transparent recruitment processes, including values based recruitment; delivery of unconscious bias training and promotion of various leadership and development opportunities which exist across the Trust.

We are undertaking analysis of the impact of the current work to establish if it is driving the change and improvement that we are looking for and if not, why not. This is aligned with the wider EDI review and recommendations to ensure that this is not just an annual report but part of our desire to create an inclusive culture.

We are sharing the data with our staff and looking at how we incorporate conversations around this agenda into our engagement strategy which is being reviewed currently. We need to listen to our staff to understand their experiences before we can develop solutions to address these and reduce the disparity that currently exists.

Please note that we are required to publish our WDES data no later than 31 August 2022.

How this report impacts on current risks or highlights new risks:
This report impacts on the current risk – availability of staff. It is intended that this report will have a positive impact on the risk by improving the Trust's ability to recruit and retain staff.

Committees/groups where this item has been discussed	ETM
Recommendation	The Board are requested to acknowledge the results for the Trust's Workforce Disability Equality Standard (2022), as reported within section 3 of this paper and approve publication of the paper and data.
Next steps for presentation e.g. Board Committee/Board meeting	The WDES Report (2022) will be shared with the People Committee and the Ability Staff Network.

North Tees & Hartlepool NHS Foundation Trust

Trust Board of Directors

28 July 2022

NHS Workforce Disability Equality Standard 2022

1. Introduction

The Workforce Disability Equality Standard (WDES) programme was established in 2019. It requires organisations to report against ten indicators of disability equality and supports continuous improvement through robust action planning to tackle the root causes of discrimination.

Inequalities in any form are at odds with the values of the NHS. Research shows that the fair treatment of our staff is directly linked to better clinical outcomes and better experience of care for patients.

This report represents the fourth publication since the WDES was established. There are some very positive findings in this report and there are also areas where further analysis of the information is required to fully understand the results.

The Trust is committed to tackling disability discrimination to bridge the gaps in experience, opportunity and differential attainment in our diverse workforce. A key tool to understanding and correcting these inequities is the presentation of detailed data to key work streams, which will allow us to identify the targets for action.

2. Trust Requirements

In order to meet the requirements for 2022, the Trust is required to publish our WDES data no later than 31 August 2022 to NHS England via the NHS Digital Strategic Data Collection Service (SDCS).

The Trust must also publish the WDES data on the Trust's corporate website no later than 31 October 2022.

3. WDES Indicators 2022

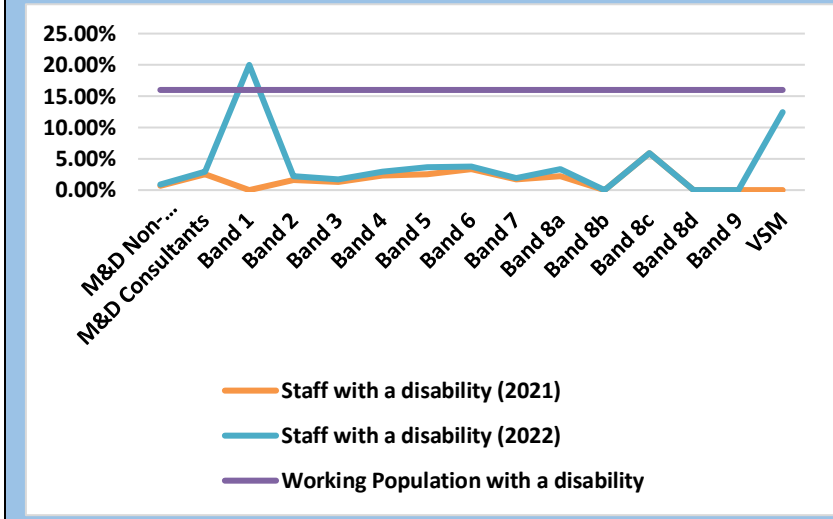
A summary of the results for North Tees and Hartlepool NHS Foundation Trust is shown in the table below. This includes comparison of the Trust's results covering a four-year period (2019 to 2022).

WDES Indicators 2022			2019	2020	2021	2022
1	Percentage of staff with a disability or long term health condition	Overall	2.0%	2.0%	2.0%	3.0%
		Non-Clinical	2.0%	2.0%	2.0%	3.0%
		Clinical	2.0%	2.0%	2.0%	3.0%
2	The relative likelihood of Disabled staff being appointed from shortlisting compared to Non-Disabled staff		1.64	1.34	0.94	0.98
3	The relative likelihood of Disabled staff entering the formal capability process compared to Non-Disabled staff		0	0	0	0
			2018	2019	2020	2021
4a	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	Staff with a disability or LTC	35.4%	35.5%	29.6%	28.6%
		Staff without	26.7%	27.8%	24.1%	26.3%
4b	Percentage of staff experiencing harassment, bullying or abuse from manager in the last 12 months	Staff with a disability or LTC	16.3%	14.2%	18.3%	14.2%
		Staff without	5.8%	7.3%	7.5%	7.6%
4c	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%	19.9%
		Staff without	12.4%	14.7%	13.8%	13.3%
4d	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%	46.2%
		Staff without	52.9%	46.3%	47.3%	47.3%
5	Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion	Staff with a disability or LTC	54.0%	59.3%	54.5%	57.6%
		Staff without	67.0%	63.8%	62.6%	65.5%
6	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%	27.8%
		Staff without	19.2%	24.0%	24.9%	21.0%
7	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%	37.4%
		Staff without	53.4%	54.1%	53.3%	47.6%
8	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%	74.1%
9	Staff Engagement Score (0-10)	Staff with a disability or LTC	6.50	6.7	6.7	6.6
		Staff without	7.2	7.3	7.3	7.1
		Overall	7.1	7.2	7.1	6.9
			2019	2020	2021	2022
10	Disabled/LTC Board Membership		0.0%	0.0%	0.0%	7.1%

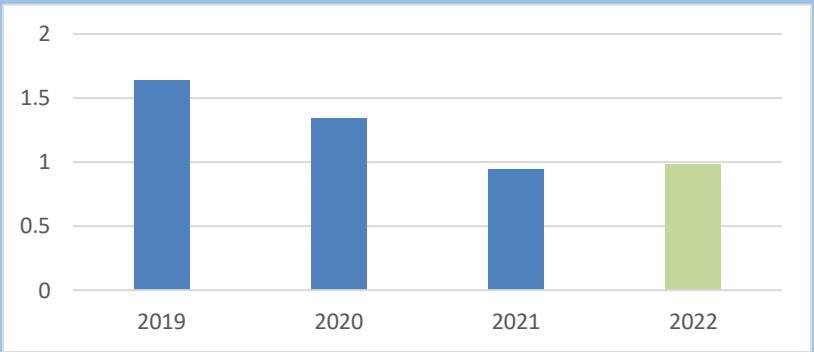
4. Key Findings for 2022

The key findings in respect of the ten WDES indicators for 2022 are summarised below.

We are currently only able to undertake benchmarking for those areas which relate to the staff survey (indicators 4-9). Full benchmarking information is published by the national WDES team and this is expected for March 2023.

Indicators 1 and 10 Percentage of staff with a disability or long term health condition	
	**Representative Workforce across all protected characteristics at all levels** There has been a positive increase in the number of staff who have reported their disability status on ESR - an increase from 2% to 3%. This is a result of a targeted staff campaign, which included development of a user guide illustrating how to complete an online self-declaration. Representation of staff with a disability or long-term condition is significantly lower than the disabled adult working population (3% as compared to the national figure of 16%) and it is expected that the true figure is much higher than that currently reported. **Representation of Disabled staff at Board and senior management levels** For the first time, we have reported disability representation at Board level. This is currently reported as 7.1% which is higher than the overall workforce figure of 3%. We have also seen a positive increase at Bands 8a, 8c and VSM. Over 50% of Board Members have not declared their disability status.

Indicator 2 The relative likelihood of Disabled staff being appointed from shortlisting compared to Non Disabled staff



Equity of Experience

Shortlisted disabled applicants continue to be more likely to be appointed following shortlisting than non-disabled applicants.

This is a continued improvement on previous years, and is close to achieving the required ratio of 1.0 (currently reported as 0.98).

A total of 167 applicants with a declared disability were shortlisted, of which 51 individuals were successfully recruited.

Indicator 3 The relative likelihood of Disabled staff entering the formal capability process compared to Non Disabled staff

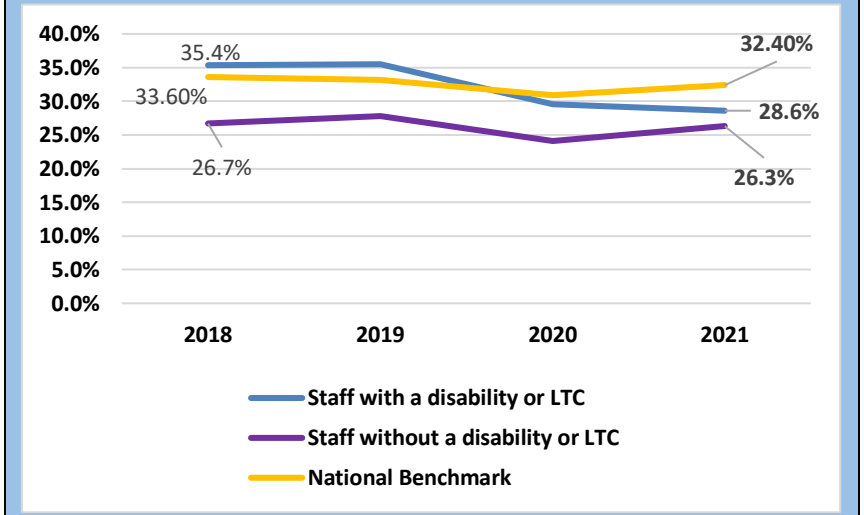
Equality of Experience.

There have been no formal capability cases involving staff with a declared disability or long-term condition, therefore it remains the case that staff *without* a disability are more likely to enter a formal capability process.

There was one individual who had not declared their disability status, which is potentially a missed opportunity where consideration of reasonable adjustments could have taken place and formed part of the supportive development plan.

Whilst we are not required to declare the number of informal cases, we have reviewed this information and again there are no individuals with a recorded disability or long-term condition, however there are 3 individuals with an undeclared status.

Indicator 4a 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

This information has been obtained from the 2021 Staff Survey results.

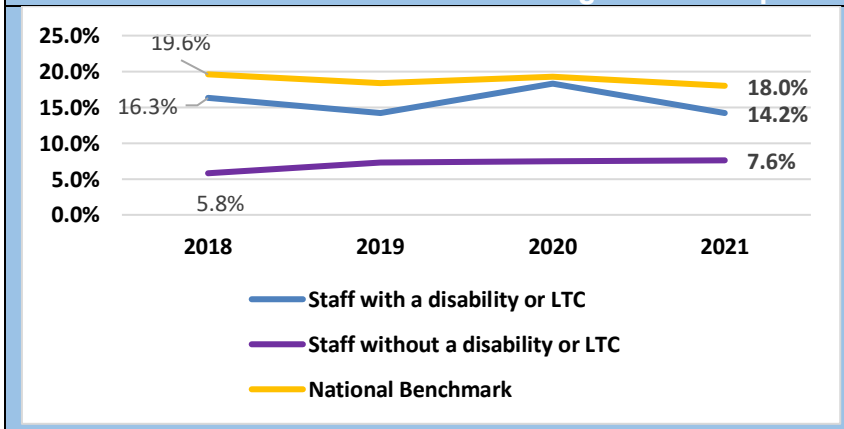
The results show a further reduction in the number of disabled staff who have experienced harassment, bullying and abuse from patients, relatives/public (28.6% compared to 29.6% in 2020).

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 continues to narrow and the gap for 2021 is reported as 2.3%.

The national benchmarking data for 2021 indicates that 32.4% of disabled staff have experienced harassment and abuse from patients, which is 3.8% higher than the Trust figure.

Staff are required to log all incidents of service user violence and harassment via Datix and the information is reported through Yellowfin. The Trust's Keeping People Safe group reviews this information on a regular basis to identify trends and this includes analysis of related themes.

Indicator 4b Percentage of staff experiencing harassment, bullying or abuse from manager in last 12 months



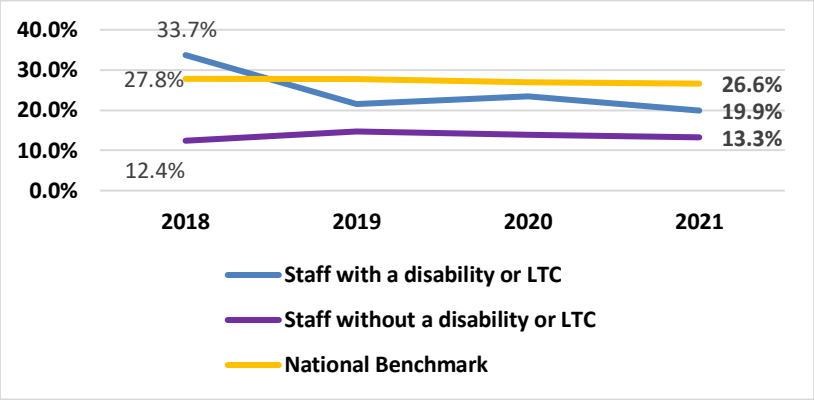
Staff Survey Key Findings - B&H Manager

Staff survey results show a reduction in the number of disabled staff experiencing harassment, bullying and abuse from a manager (14.2% compared to 18.3% in 2020).

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, although the gap has narrowed for 2021 and this is currently reported as 6.6%.

The national benchmarking data for 2021 indicates that 18% of disabled staff have experienced harassment and abuse from their manager, which is 3.8% higher than the Trust figure.

Indicator 4c Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months



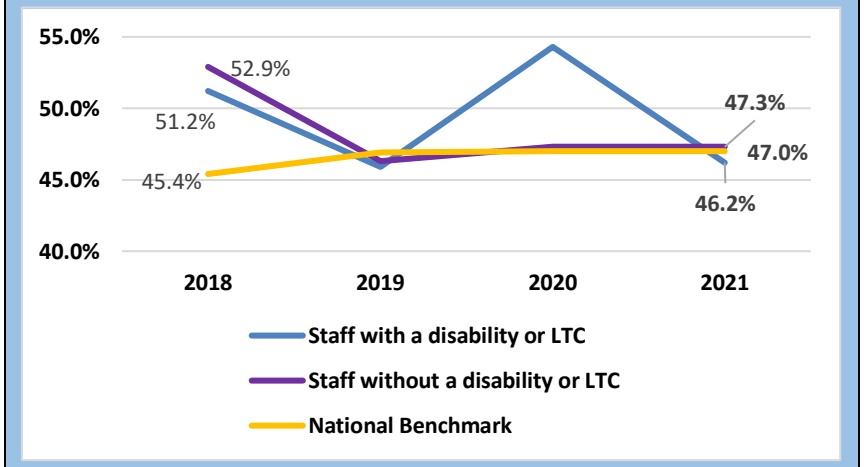
Staff Survey Key Findings - B&H Colleagues

Staff survey results show a decrease in the number of disabled staff experiencing harassment, bullying and abuse from a colleague (19.9% compared to 23.4% in 2020).

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, although the gap has narrowed for 2021 and this is currently reported as 6.3%.

The national benchmarking data for 2021 indicates that 26.6% of disabled staff have experienced harassment and abuse from colleagues, which is 6.7% higher than the Trust figure.

Indicator 4d 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

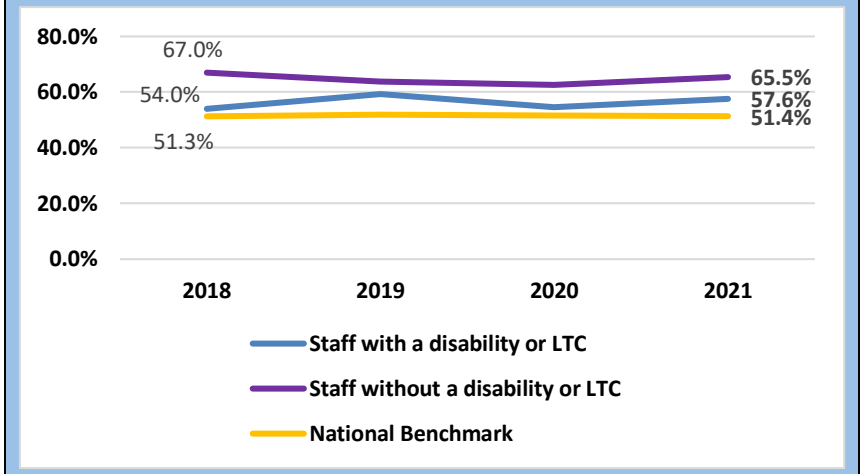
Staff survey results show a significant (negative) reduction in the number of disabled staff who have reported harassment, bullying and abuse (46.2% compared to 54.3% for 2020).

Staff with a disability/LTC are marginally less likely to report harassment, bullying/abuse than staff who do not have a disability, with a reported gap of 1.1%.

The national benchmarking data for 2021 indicates that 47% of disabled staff have reported harassment and abuse, which is 0.8% higher than the Trust figure.

It is important that staff are encouraged to report concerns regarding bullying and harassment and all cases are logged and monitored by the Workforce Team. Work is ongoing to understand why the number of formally reported cases is lower than the staff survey results would suggest.

Indicator 5 Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion



Staff Survey Key Findings - Equal Opportunities

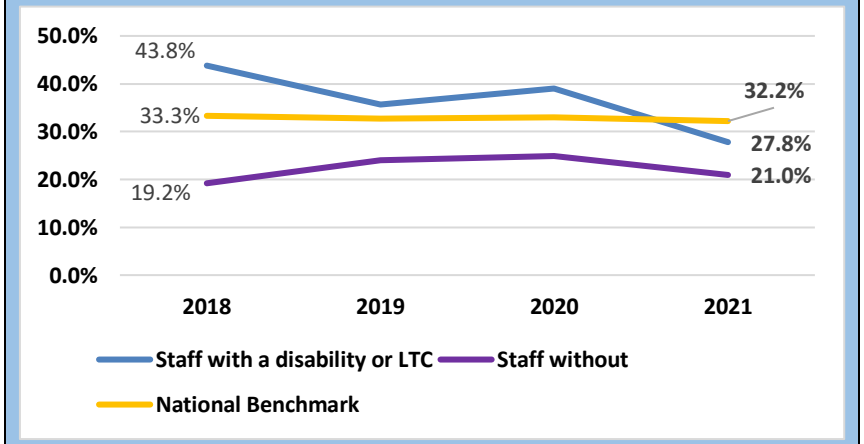
Staff survey results show a slight increase in the number of disabled staff who believe the organisation provides equal opportunities for career progression or promotion (57.6% compared to 54.5% for 2020).

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, with a reported gap of 7.9%.

The national benchmarking data for 2021 indicates that 51.4% of disabled staff believe their organisation provides equal opportunities for career progression, which is 6.2% lower than the Trust figure.

The national team have developed an interactive tool for 2021 to allow for analysis of this metric at a more detailed level, including comparison with other protected characteristics, department and staff group.

Indicator 6 Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties



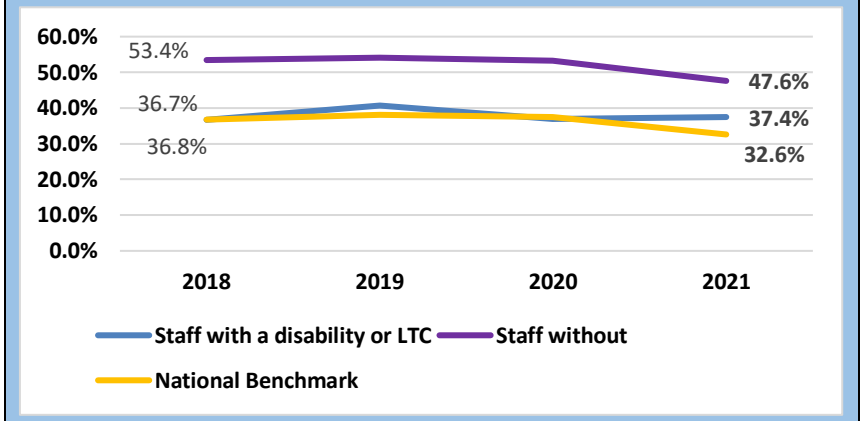
Staff Survey Key Findings - Attendance at work whilst unwell

Staff survey results show a significant reduction in the number of disabled staff who have felt pressure from their manager to come to work whilst unwell (27.8% compared to 39% for 2020).

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, although the gap has narrowed for 2021 and this is reported as 6.8%.

The national benchmarking data for 2021 indicates that 32.2% of disabled staff have felt pressure to attend work, which is 4.4% higher than the Trust figure.

Indicator 7 Percentage of staff satisfied with the extent to which their organisation values their work



Staff Survey Key Findings - Feeling Valued

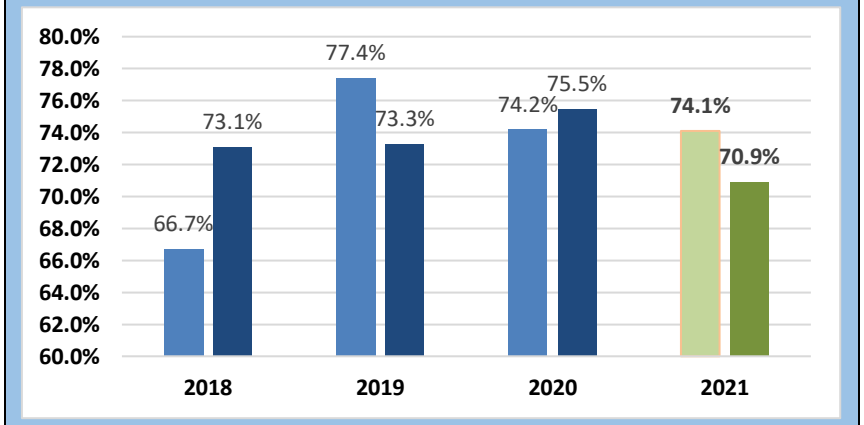
The number of disabled staff who feel satisfied that the organisation values their work has marginally increased for 2021 (37.4% compared to 36.9% for 2020).

Whilst this is only a small increase, it is a positive outcome as the trend for non-disabled staff has seen a reduction for this indicator and this is also the same at a national level for disabled staff.

Staff with a disability/LTC continue to be less likely to feel valued than staff who do not have a disability, although the gap has narrowed for 2021 and this is reported as 10.2%.

The national benchmarking data for 2021 indicates that 32.6% of disabled staff feel valued by their organisation, which is 4.8% lower than the Trust figure.

Indicator 8 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



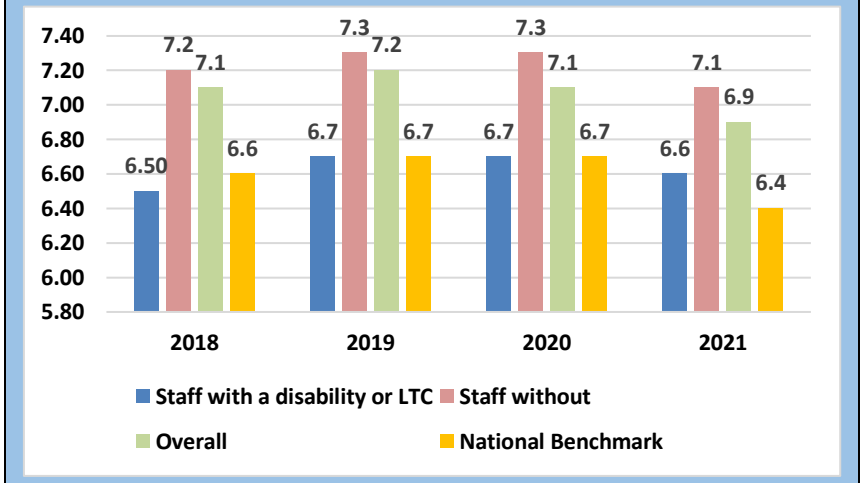
Staff Survey Key Findings - Reasonable Adjustments

Staff survey results remain static in terms of the number of disabled staff who have reported that the Trust has made adequate reasonable adjustments to enable them to carry out their work (74.1% compared to 74.2% for 2020).

The Attendance Management Policy has been reviewed and enhanced in 2022 to include additional guidance for managers in respect of equality and diversity and consideration of reasonable adjustments, and this includes templates for documented agreements, which encourage positive discussions to support staff.

The national benchmarking data for 2021 indicates that 70.9% of disabled staff have reported that their manager has made adequate adjustments, which is 3.2% lower than the Trust figure. The trend at a national level has remained static for the previous three years, with a reduction in 2021 therefore it is encouraging that the Trust has been able to maintain our score in this area.

Indicator 9 Staff engagement score (0 10)



Staff Survey Key Findings - Staff Engagement

Staff survey results show that the staff engagement score for disabled staff remains broadly the same as the previous year at 6.6.

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. However, it is positive that we have been able to retain this score for 2021, as it can be seen that the engagement score for non-disabled staff has reduced from 7.3 to 7.1 and for the overall workforce it has reduced from 7.1 to 6.9.

The national benchmarking data for 2021 indicates that the engagement score for disabled staff is 6.4, which is 0.2 lower than the Trust figure. The national figure has seen a reduction of 0.3 since 2020, whereas the Trust reduction was lower at 0.1.

5. Conclusion and Next Steps

The Trust is committed to meeting the requirements of the Workforce Disability Equality Standard for NHS Trusts and this is our fourth publication against the standard.

Our actions to improve the Trust's WDES Indicators (2022) align with the Trust's wider organisational strategic goals, specifically 'Valuing our People'. They also support our commitments to the NHS People Plan and the People Promise: 'We are recognised and rewarded'.

By taking action to improve the experience of our disabled colleagues, we aim to support the organisation to be an employer of choice; an outstanding place where people want to work and are proud to work, and somewhere which provides equality for everyone.

Our culture is shaped by the actions that we take and we continue to implement a number of programmes/activities to promote and support disability equality in the workplace. Some of these actions/activities are detailed below:

The Trust's Ability staff network continues to offer staff a place where they can come together, share experiences and facilitate learning and development. The network will also assist in the shaping and delivery of organisational strategy and policy, working with us to improve staff experience on specific disability related issues and adding more depth to our WDES Action Plan. The network has developed a monthly newsletter which is distributed to all staff and we have invited various organisations to speak at the network such as Access to Work and Project Choice.

- All of our staff networks (BAME, Disability, LGBTQ+, Women, Men, Age, Multi-faith) aim to:

    - Promote equal rights and opportunities;
    - Pro-actively tackle discrimination or disadvantage in all its forms;
    - Create an open and inclusive culture where equality, diversity and inclusion can be comfortably discussed;
    - Encourage our staff to have a voice in the organisation – to share their experiences so that we can listen and act on staff feedback.

- Our workforce Disability Awareness event took in November 2021, where members of the Ability staff network recorded a series of videos which were promoted across the Trust to highlight the experiences of our disabled staff. Members of the network also took the opportunity to visit a number of clinical areas to raise awareness of disabilities and promote the network as a place to receive support.

- A campaign took place to encourage staff to complete their disability declaration on ESR to ensure that we are able to accurately report on our workforce profile. This included development of a user guide which was issued to all employees via our communications bulletins. This has had a positive impact in the numbers of staff who have declared a disability, but it has also helped to reduce the numbers of staff with an undeclared status.

- We were accredited by the Disability Confident Scheme as a Level 2 Disability Confident Employer in 2021 in recognition of our commitment to disabled workers. Our application was endorsed by members of the Ability staff network and we are planning to apply for Level 3 Disability Confident Leader status in 2022/23.

- The Trust's Attendance Management Policy was reviewed and enhanced in 2022 to include additional guidance for managers in respect of equality and diversity considerations and guidance for making reasonable adjustments. This included the implementation of a structured template aimed at promoting positive discussions to support staff in relation to reasonable adjustments, with a documented agreement which sets out both the manager and employee commitments.

- As a fair and equal employer, we appoint the best candidates during our recruitment campaigns regardless of disability or any other protected characteristic.

- As part of our commitment to embedding Values Based Recruitment, we are implementing a structured interview template, which aims to ensure that every candidate has an equal chance for promotion/employment through the use of consistent measures.

- We have appointed a Champion of Flexible Working and a Health and Wellbeing Guardian in line with our responsibilities under the People Plan.

- We continue to embed and grow the Cultural Ambassador programme within the Trust and a cohort of four individuals have completed their training in April 2022. The skills of the Cultural Ambassador are transferable to all areas of equality and it is expected that this will also have a positive impact in terms of identifying and 'calling out' disability related bias.

- We actively analyse our staff survey data from a disability perspective by comparing the experiences of our disabled and non-disabled staff. The themes of bullying, harassment and abuse from patients, managers and colleagues, belief in equal opportunities for career progression, pressure to attend work whilst unwell, feeling valued, adequate reasonable adjustments and overall staff engagement form part of the WDES metrics (indicators 4-9). The NHS Survey Co-ordination Centre has developed a new interactive tool for 2022 which for the first time, will allow us to examine this data at a more detailed level, i.e. by staff group and comparison with other protected characteristic groups.

We take disability equality seriously and whilst we have already implemented a number of practices which will have a positive impact in this area, we understand that change will require a significant cultural shift within the organisation. We know that our workforce disability profile is under reported and this will not change overnight, however we are starting to see a gradual increase in the number of staff choosing to declare their disability status. It is also important that we continue to grow the membership of our Ability staff network to help us facilitate the voices of our disabled staff and improve staff experience.

We are continuing to promote the activities and good practice that we already undertake, including undertaking fair and transparent recruitment processes, delivery of unconscious bias training and promotion of various leadership and development opportunities which exist across the Trust.

We are considering how this is incorporated into our engagement strategy and how we can improve our communication around both the data for the Trust and what we are doing in response to this. This will be considered as we enter Phase 2 of the Equality, Diversity and Inclusion review and this will inform how we continue to improve as a Trust.

8.0 Recommendation

The Board are requested to acknowledge the Trust's WDES Results (2022) as reported within section 3 of this paper and to confirm their approval for the results to be submitted to the NHS Digital Strategic Data Collections Service (SDCS) by the deadline of 31 August 2022.

The Board are asked to note that improvements to the WDES indicators (alongside other key reporting gaps for protected characteristics) is included in the EDI recommendation and plan for 2022/23. This is to include targets in order to demonstrate improvement and outcomes.

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title:	Quality Accounts 2021/22										
Date:	28 July 2022										
Prepared by:	Keith Wheldon, Business Intelligence Manager										
Executive Sponsor:	Lindsey Robertson, Chief Nurse and 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 2021/22, 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 2021/22 and identifying the objectives for 2022/23.

NHS Trusts were informed that the national timescale for annual Quality Accounts remains 30 June 2022. The changes to the requirements for this year's Account include:

- no requirement to have the document audited
- no quality report is required within the annual report for 2021/22
- the Quality Account now only needs to be added to the Trusts website
- 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 2020-21. 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 2021/22 there continues to be 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 was submission to the Trust website

North Tees and Hartlepool
NHS Foundation Trust

Quality Accounts 2021-22

Contents

Part 1: Statement on quality from the Chief Executive

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

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

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

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

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

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

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

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

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

The Trust continues to perform well. During 2021-22 in relation to the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) mortality values, we reported within the 'as expected' range and below the national average. We recognise that death is the natural part of life, however we recognise of the impact of death on loved ones. We continue to improve the management and experience of patients and families at this very difficult time, this is underpinned by the role of the Medical Examiner who supports bereaved relatives

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

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

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

This is why our Quality Accounts are developed with our patients, carers, staff, governors, commissioners and other key contributors including health scrutiny committees, local involvement networks (Healthwatch) and Healthcare User Group (HUG).

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

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

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

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

Julie Gillon
Chief Executive
Date: 31 May 2022

What is a Quality Report/Accounts?

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

Our Quality Pledge - Our Board of Directors receive and discuss quality, performance and finance at every Board meeting. We use our **Patient Safety and Quality Standards** (PS & QS) Committee and our **Audit Committee** to assess and review our systems of internal control and to provide assurance in relation to patient safety, effectiveness of service, quality of patient experience and to ensure compliance with legal duties and requirements. The PS & QS and Audit Committees are each chaired by Non-Executive directors with recent and relevant experience, these in turn report directly to the Board of Directors.

The Board of Directors seek assurance on the Trust's performance at all times and recognise that there is no better way to do this than by talking to patients and staff at every opportunity.

Quality Standards and Goals - The Trust greatly values the contributions made by all members of our organisation to ensure we can achieve the challenging standards and goals which we set ourselves in respect of delivering high quality patient care. The Trust also works closely with commissioners of the services we provide to set challenging quality targets. Achievement of these standards, goals and targets form part of the Trust's four strategic quality aims.

Unconditional CQC Registration - During 2021-22 the Trust met all standards required for successful and unconditional registration with the Care Quality Commission (CQC) for services across all of our community and hospital services.

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

Over the last year we have spoken with over **20,000** patients in a variety of settings including their own homes, community clinics, and our inpatient and outpatient hospital wards as well as departments. We always ask patients how we are doing and what we could do better.

CQC Rating - The most recent CQC visit took place 2017 utilising revised inspection format, with the well-led element taking place during the week commencing 18 December 2017. The Trust has been rated as **'Good'**, for all domains additional detail regarding the recent visit is located in the CQC section on page 95.

Part 2a: 2020-21 Quality Improvement 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 2020-21. We are very pleased to report some significant achievements during the course of the year.

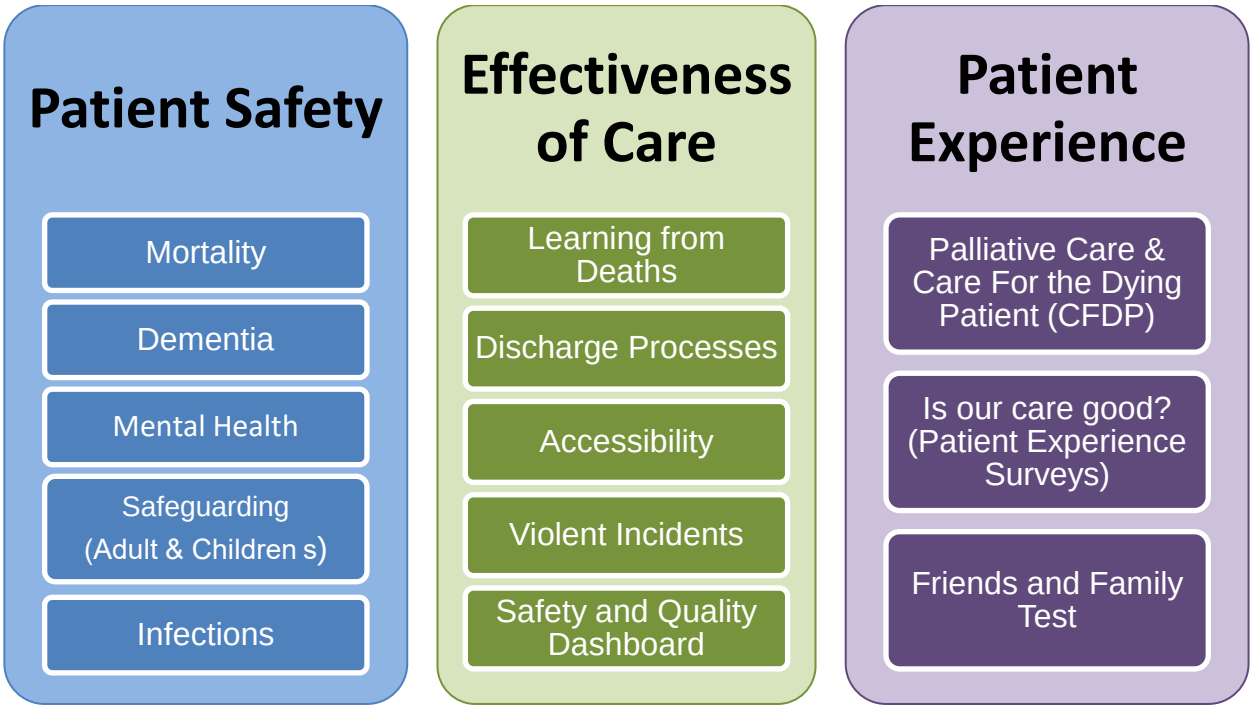
Consideration has also been given to feedback received from patients, staff, governors and the public.

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

Progress is described in this section for each of the 2021-22 priorities.

Stakeholder priorities 2021-22

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



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

Priority 1: Patient Safety

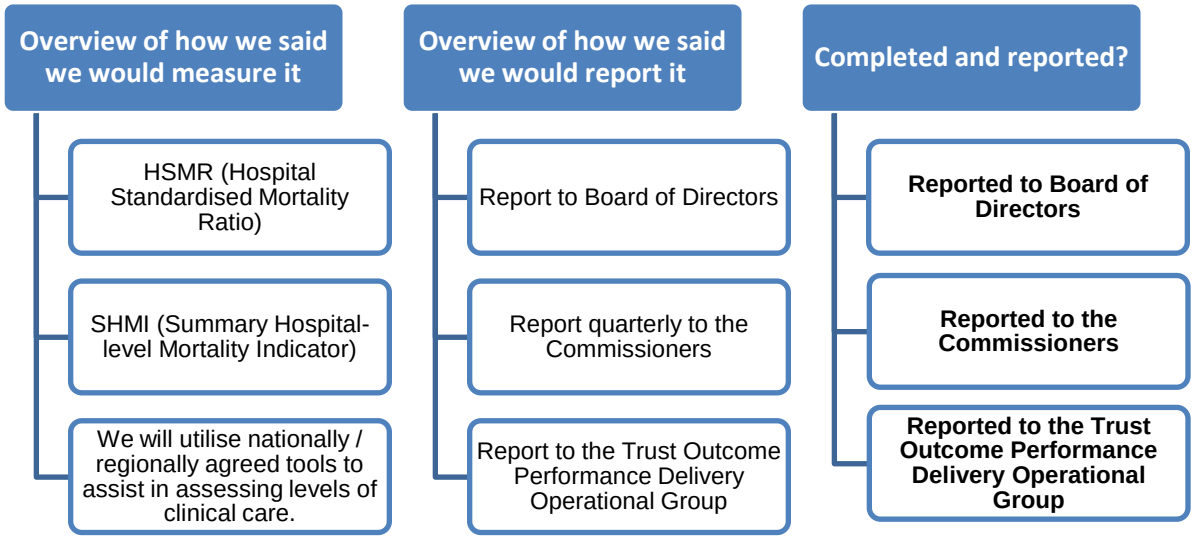
Mortality

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

Overview of how we said we would do it

The Trust used the Healthcare Evaluation Data (HED) benchmarking tool to monitor and interrogate the data to determine areas that require improvement. We will also review/improve existing processes involving palliative care, documentation and coding process.

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



The Trust Board of Directors continues to understand the values of both Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI). The Trust has achieved reductions for both metrics, to such an extent they are now consistently in the **'as expected'** range.

The Trust, while using national mortality measures as a warning sign, is investigating more broadly and deeply the quality of care and treatment provided. The Trust established a clinical link between consultants and the Trusts Coding Department, this work throughout 2021-22 continues to reap great rewards in respect of depth of coding. This increase in the number of co-morbidities being captured and documented per patient to over seven, from the lows of just over three, has had a profound effect on the HSMR and SHMI values, as well as giving a more accurate reflection of the patient's true level of sickness.

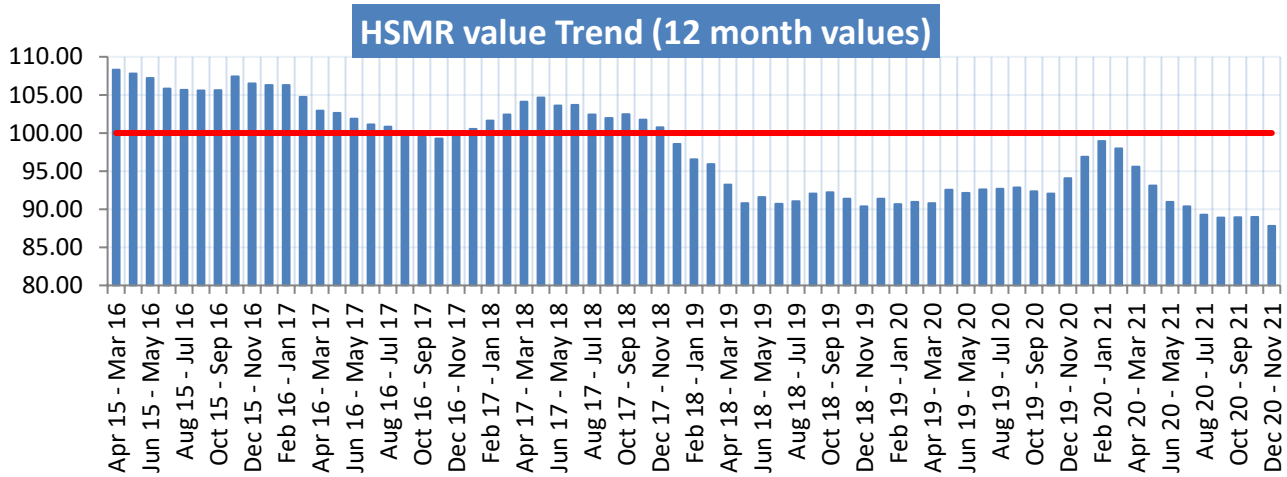
The following data is from the two nationally recognised mortality indicators of Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI).

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

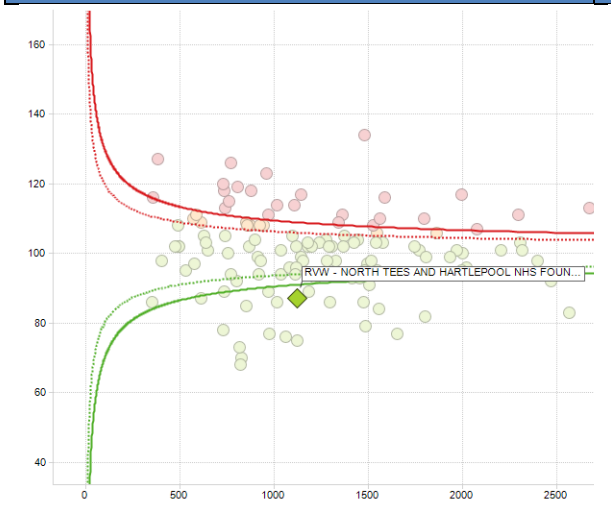
The Trust **HSMR** value is **87.81** for the reporting period from **December 2020 to November 2021**; this value continues to place the Trust in the **'as expected'** range. The National Mean is 100, which denotes the same number of people dying as expected by the calculations, any value higher means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

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

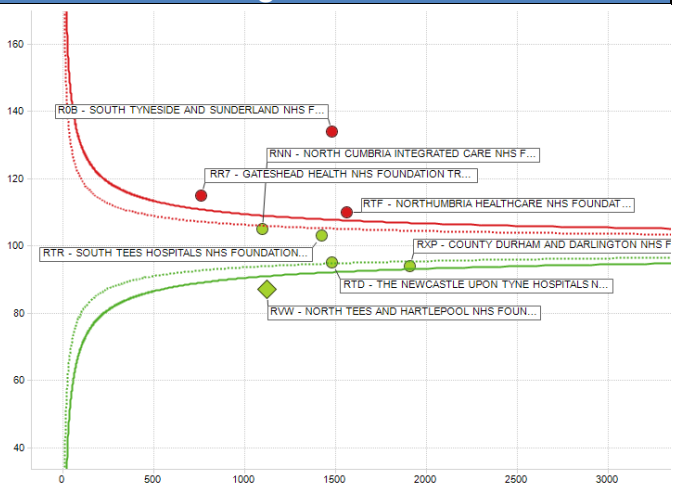
*Crude Mortality Rate (CMR)



National View



Regional View



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

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

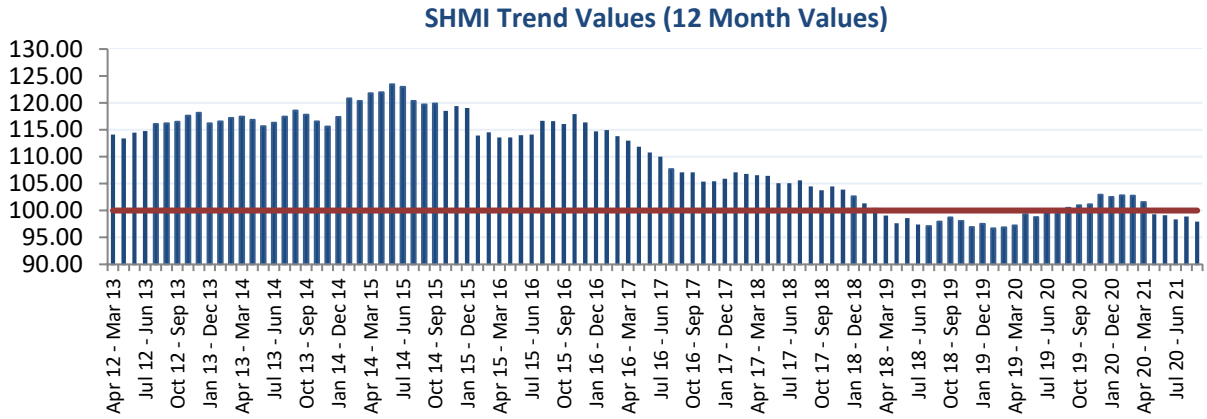
The **SHMI** indicator provides an indication on whether the mortality ratio of a provider is as expected, higher than expected or lower than expected when compared to the national baseline in England.

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

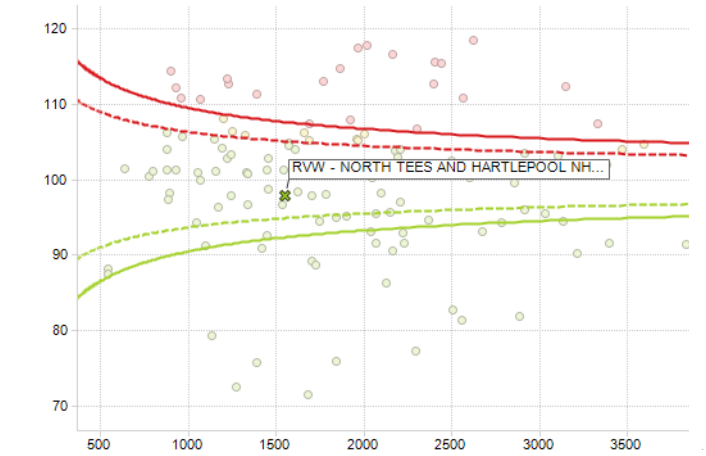
The latest SHMI value of **97.95 (September 2020 to August 2021)** continues to reside in the **'as expected'** range.

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

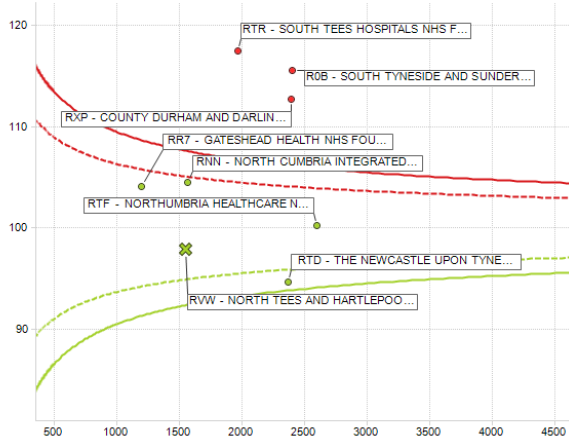
*Crude Mortality Rate (CMR)



National View



Regional View

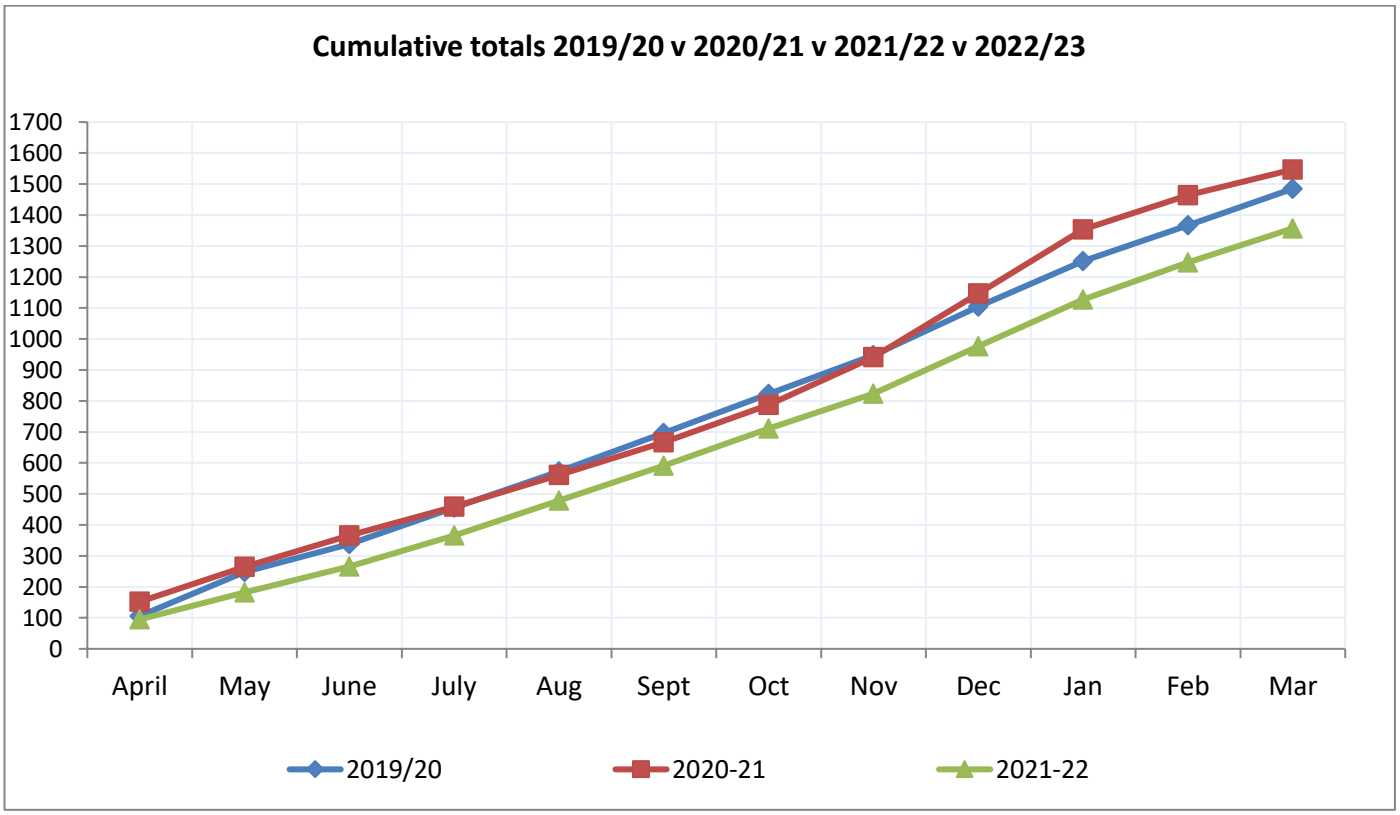


*Data obtained from the Healthcare Evaluation Data (HED)

Trust Raw Mortality

The following table and chart demonstrates the raw number of mortalites the Trust has experienced since 2016-17. For the latest financial year of 2021-22, the Trust experienced **1,357** mortalities (April to March), this is **190** fewer mortalities than experienced in 2020-21.

	Cumulative Totals											
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
2016-17	142	273	396	515	622	719	851	970	1114	1269	1405	1541
2017-18	126	254	357	461	566	686	807	936	1118	1312	1450	1613
2018-19	135	239	341	455	547	655	794	928	1060	1209	1341	1454
2019-20	106	248	338	456	573	697	823	948	1105	1251	1367	1485
2020-21	152	265	366	459	561	667	787	941	1147	1354	1464	1547
2021 22	**95**	**182**	**266**	**366**	**479**	**591**	**711**	**824**	**975**	**1127**	**1247**	**1357**



Priority 1: Patient safety

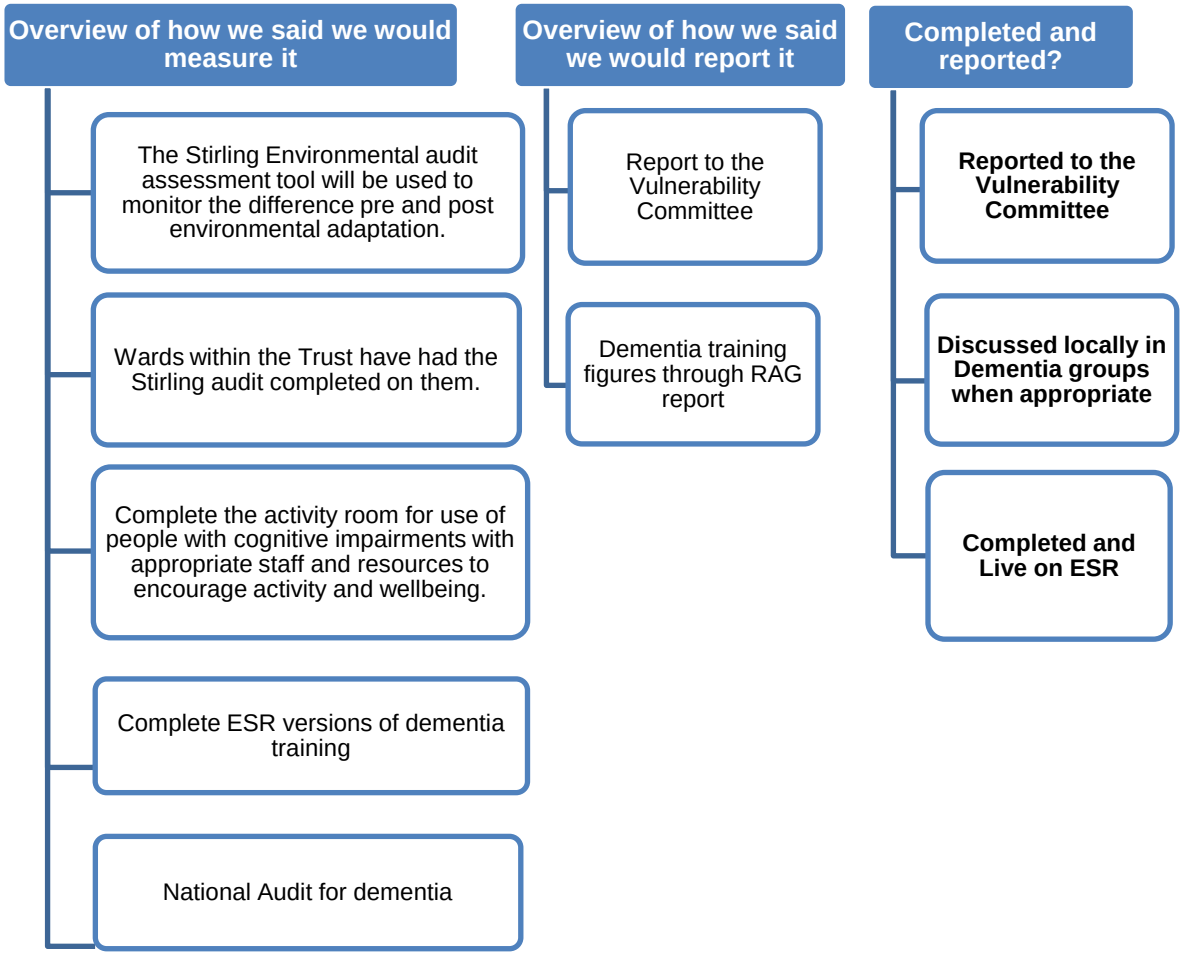
Dementia

Rationale: NHS Hartlepool/Stockton on Tees has the highest projected increase of dementia across the North East by 2025. All stakeholders identified dementia as a key priority. The region has an 85.8% diagnostic rate. This is significantly higher than the 66.7% national benchmark; which shows the progress the region has made in relation to accurate and timely diagnosis.

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

Overview of how we said we would do it

- Introduce the 4at delirium assessment tool into the new falls pathway in nursing notes, to identify and delirium sooner after admission
- We will use the Stirling Environmental Tool to adapt our hospital environment
- We will make it mandatory that all patients over 65 receive an Abbreviated Mental Test (AMT) and are, where appropriate, referred for further assessment.
- Patients with Dementia will be appropriately assessed and referred on to specialist services if needed.
- Development of a new North Tees and Hartlepool Dementia Strategy to share and promote our vision for supporting people living with dementia that we serve.
- Creation of a separate room in Accident and Emergency where people with acute confusion or dementia can wait to be seen in a more private and less stimulating environment than the main waiting room.
- Creation of a dementia friendly activity room for use to assess and provide therapeutic interventions for people with dementia in a safe, calm and appropriately equipped environment.
- Cross referencing people regarding a dementia diagnosis on North Tees and Hartlepool Trust Trakcare and Datix systems with (Tees, Esk and Wear Valleys NHS Foundation Trust) TEWV Paris system (electronic care record system) to confirm if a clinical diagnosis has been given by mental health services. If the diagnosis of dementia is confirmed, then an alert will be added to Trakcare system. This alert will aid and assist a dementia champion that is available on every ward.



Carers Support

- Informs carers what services they have access to
- Increases information on how they can access individual carer's assessment
- Both Local authorities gave detailed directory of services to support the low level interventions required for people in their own homes.
- If carers feel more supported, there is less risk of admission of the people they care for
- Supports financial and social benefit
- Community Dementia Liaison service run carers support sessions through The Bridge at Hartlepool, to support and educate carers of people living with a dementia.
- Continue to promote the John's Campaign (www.Johnscampaign.org.uk) with the trust lead. This supports carers to outline which elements of care/support they would prefer to do for the patient whilst in hospital, and which elements they would prefer staff to complete. It also outlines allowances for carers and family i.e. if family/carers are spending significant amounts of time visiting, allowing flexible visiting, ability to order from the hospital menu for themselves and the Trust now has an agreement with Parking Eye regarding parking allowances for eligible families and carers.
- We now have John's campaign as an alert on Trakcare for staff awareness. We have also negotiated a discount at Costa and staff discount in the canteen. We have produced a card that the carers can produce to get this discount.
- PET team are doing follow ups questions for families and carers that have used John's campaign, so we can evaluate data and improve the service further.
- University Hospital of North Tees has become part of Dementia Friendly Stockton and University Hospital of Hartlepool has also been given this accolade. The aim is to continue to develop close and consistent links with relevant local agencies.

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

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

Financial Year	Patients admitted to the Trust with a diagnosis of Dementia/Delirium	Increase or Decrease from Previous Year
2016-17	3,298	+587
2017-18	3,614	+316
2018-19	4,218	+604
2019-20	3,784	-434
2020-21	3,253	-531
*2021 22	3,624	+371

*Data from Information Management Department April 2021 to March 2022

Dementia Training Levels

Level 1 - Dementia Awareness Raising

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

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

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

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

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

The team also provide a 1.5 hour face to face training session. This is constantly evaluated and updated. It is also delivered to all new recruits to the Trust- overseas nurses, newly qualified staff, students, return to practice nurses, trust induction and can be delivered on request for team days.

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

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

This is the level of 'Trust Dementia Champions'.

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

To support this level of training we have the Trust Dementia Champion programme which, following feedback, has been reviewed and now runs over two consecutive days on alternate months. The purpose of the Dementia Champions is to create an individual with a high level of knowledge of dementia. The 6 stages of 'Barbara's Story' is used and discussed. This training involves support from other multi-disciplinary teams as well as guest speakers. It is open to all staff, of any profession or grade, either inpatient or community. This new programme enables it to be carried out 5 times a year, excluding winter months when staffing pressure on the trust is expected to be higher.

We are also placing more emphasis on the role of the Dementia Champions and have compiled a list of expectations which outline their responsibilities following the course.

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

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

Priority 1: Patient safety

Mental Health

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

Overview of how will measure it

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

Overview of how we will report it

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

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

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

Will aim to:

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

To achieve the 3 aims the objective will be to:

- Foster positive attitudes towards integrated mental and physical health, combatting stigma
- Improve recognition and support for both the mental and physical health needs of patients
- Assist staff to access support and resources for working with mind and body
- Ensure that mind and body care is addressed at all levels of healthcare
- Engage local partners in improving mind and body training and subsequently care
- Through Treat as One, develop a 1 day, tier 2 course to ensure that appropriate staff has a more in-depth understanding of how mental health and physical health are linked.

2021 Update

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

As at February 2022, 90.76%% of staff have now completed this training which is a significant achievement and demonstrates the willingness of staff to engage with mind and body care for patients.

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

An update around the work on **embedding integrated mind and body care as common practice, joining up and delivering excellent mental and physical health care, research and education** so that we treat the whole person (one of the stated aims within the *Mental Health* priority).

The trust signed up the 'Time to Change' national initiative and continuers to embed this within the Trust.

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

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

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

Priority 1: Patient safety

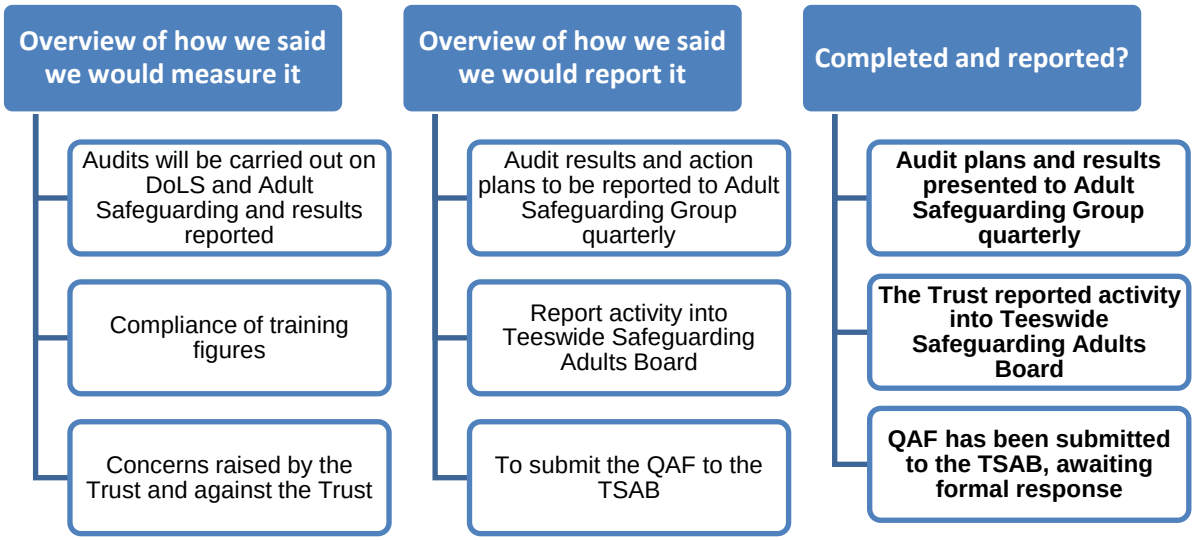
Safeguarding (Adults & Children's)

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

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

Overview of how we said we would do it

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



Safeguarding Adults

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

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

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

Training Figures 2021-22	
Level 1	93%
Level 2	95%
Level 3	70%

*Data obtained from the Trust workforce for March 2022.

Trust Reporting

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

Additionally, the importance of two way communications are recognised as vital to ensure safeguarding adult activity is embedded within practice across adult health and social care. Therefore, this report highlights areas of good practice within all service areas requiring development as well as providing actions agreed from discussion within the group.

The data contained in the reports includes:

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

Number of Concerns / Enquiries raised within the Trust

The Trust has moved to Datix to manage and record safeguarding concerns. This helps to collate, trend and theme the data. The data produced is governed through the quarterly Safeguarding Vulnerable Adults Steering Group to Patient Safety & Quality Standards Committee (PS & QS).

There have been **564** concerns the Trust has been involved with in 2021-22, the Trust raised **392** of these concerns. This trend demonstrates that there has been an increase in concerns in 2021-22.

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

***Data as of 31 March 2021

Types of Concerns

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

Type of Concern	Q1	Q2	Q3	Q4	Total
Discriminatory	0	1	1	1	**3**
Domestic Abuse	18	17	16	18	**69**
Financial or Material	14	12	10	18	**54**
Modern Day Slavery	0	1	0	0	**1**
Neglect and Acts of Omission	74	58	67	69	**268**
Organisational	3	4	5	7	**19**
Physical	22	9	15	28	**74**
Psychological	13	10	6	9	**38**
Self-Neglect	34	33	33	40	**140**
Sexual Abuse	4	2	4	3	**13**
Sexual Exploitation	1	0	0	0	**1**
Total	**183**	**147**	**157**	**193**	**680**

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

Alerting Care Group

Care Group	Q1	Q2	Q3	Q4	Total
Care Group 1 - Healthy Lives	43	48	48	54	**193**
Care Group 2 - Responsive Care	57	28	36	37	**158**
Care Group 3 - Collaborative Care	6	7	9	13	**35**
Corporate Group	1	6	4	6	**17**
North Tees & Hartlepool Solutions (Estates & Facilities)	0	0	0	0	**0**
Total	**107**	**89**	**97**	**110**	**403**

Number of concerns against the Trust

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

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

Themes of Alerts against the Trust

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

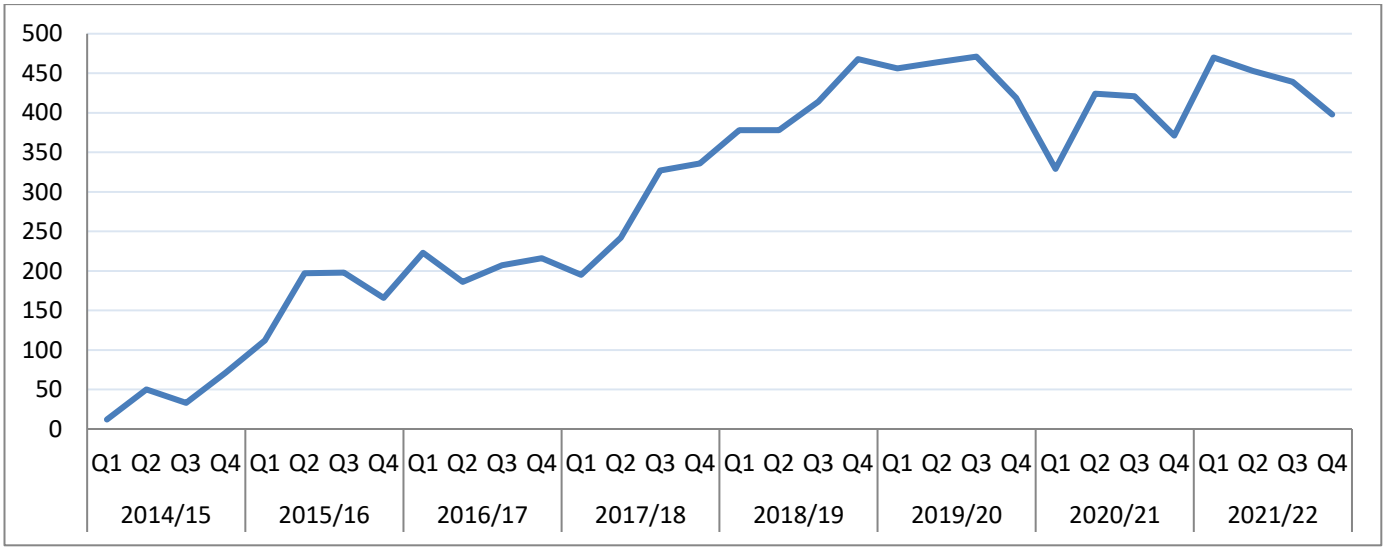
*To note: one concern can cover multiple themes

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

Deprivation of Liberty Safeguards (DoLS)

Provision of specialist advice relating to implementation of The Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS) and the Human Rights Act provides added assurance that the Trust remains compliant with legislation. The Trust continues to provide education regarding the awareness of DoLS; improvements have been made to the paperwork to assist staff in its completion.

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



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

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

***Data as of 31 March 2021

Trust Adult Safeguarding Governance Arrangements

The Associate Director of Nursing –Patient Safety, Risk & Governance is the executive lead for safeguarding adults with the Named Nurse Adult Safeguarding holding operational responsibility.

Directorate management teams are responsible for practices within their own teams and individual clinicians are responsible for their own practice.

The Trust Adult Safeguarding Committee has been combined with Childrens so that there is a joint strategic safeguarding Committee, this reports to Patient Safety and Quality Standards Committee (PS & QS), including representatives from key Trust clinical and non-clinical directorates and partners from Local Authority and Harbour who are experts in domestic abuse.

The Trust is represented at the Tees-wide Adult Safeguarding Board, and its subgroups.

The Trust Strategy groups for adult safeguarding, learning disability and dementia, have now been amalgamated to ensure reciprocal standard agenda items and membership. This supports sharing of information and lessons learnt so that they can be incorporated into relevant work streams relating to the most vulnerable groups.

Adult Safeguarding - Prevent

Throughout 2021-22 Adult Safeguarding has continued to make positive strides towards its objectives.

The aim of PREVENT is to stop people from becoming terrorists or supporting terrorism.

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

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

The 'Named Nurse' for Adult Safeguarding represents the Trust at a multi-disciplinary meeting (Silver command) around PREVENT. During this year **1** Prevent concern has been raised.

Training Figures 2021-22	
PREVENT	92%
WRAP	90%

Children's Safeguarding and Looked After Children (LAC)

A child/young person is defined as anyone who has not yet reached their 18th birthday.

North Tees and Hartlepool NHS Foundation Trust has a duty in accordance with the Children Act 1989 and Section 11 of the Children Act 2004 to ensure that its functions are discharged with regard to the need to safeguard and promote the welfare of children and young people. The Trust recognises the importance of partnership working between children/young people, parents/carers and other agencies to prevent child abuse, as outlined in Working Together to Safeguard Children and their Families, 2018. In addition, arrangements to safeguard and promote the welfare of children must also achieve recommendations set out by the CQC Review of Safeguarding: A review of arrangements in the NHS for safeguarding children, 2009 and give assurance as outlined in the National Service Framework for Children, Young People and Maternity Services, 2004 (Standard 5). The Trust continues to demonstrate robust arrangements for safeguarding and promoting the welfare of children.

Children & Young People Governance Arrangements

The Trust has maintained a robust board level focus on Safeguarding and Children in Our Care (formerly LAC) led by the Chief Nurse/Director of Patient Safety and Quality. A monthly Adult and Childrens Safeguarding Committee, chaired by a Non-Executive Director maintains responsibility for the performance monitoring of the Children's Safeguarding work program. The Committee also brings together commissioners and providers with representation from Tees Valley CCG (Designated Doctor and Designated Nurse for Safeguarding and Looked after Children) and Designated Nurse Safeguarding and Looked after Children from Durham, Darlington, Easington & Sedgefield.

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

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

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

- Tees Procedures and Policy group
- HSSCP (Hartlepool and Stockton Children's Partnership) Strategic - Engine room
- DSCP (Durham Safeguarding Children's Partnership) Strategic Board
- VEMT (Vulnerable Exploited and Trafficked) Strategic Group and MACE Board
- MARAC (Multi Agency Risk Assessment Conference)
- MATAC (Multi Agency Tasking and Co-ordination)
- County Durham Safeguarding Health Leads
- County Durham Child Exploitation Group (CEG)

Representatives from across all directorates take a lead role to act as champions for the safeguarding of children and through the safeguarding operational professional group meets on a bi-monthly basis. Key professionals for example from Emergency Department and Women's and Children's services are brought together to ensure momentum of the Safeguarding and Children's Health in Care agenda and work program remains paramount. This governance framework provides safeguarding assurance to the trust and its partners through a Safeguarding Strategic Committee.

Children's Safeguarding Work Program

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

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

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

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

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

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

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

Part 2 - Development Work

Children Not Brought for Appointments by Parents/Carers' Policy

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

Safeguarding Children's Policy

The Safeguarding Children's Policy ensures that Trust staff understand their responsibility under current legislation to safeguard and promote the welfare of children and to enable the Trust to meet its statutory duties in this regard. This policy has been recently reviewed and agreed by members of the Children's Safeguarding Professionals and Steering group at the end of 2020 now the Safeguarding Committee.

Safeguarding Children Supervision

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

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

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

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

North of Tees Children's Hub

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

Child Sexual Exploitation (CSE) and Child Criminal Exploitation (CCE)

CSE and CCE continue to be a growing concern. The Stockton and Hartlepool VEMT (Vulnerable, Exploited, Missing Trafficked) practitioners group and the Child Exploited group (CEG) in County Durham identifies those children and young people at risk, allows for the sharing of information between practitioners and helps to put safety measures in place to attempt to reduce risk. A CSE risk assessment is completed on all LAC children over the age of 10 years and on all children who attend unscheduled care within the Trust if they fit within an agreed criteria of risk.

Domestic Violence & Abuse

The Trust is represented at Multi Agency Risk Assessment Conferences (MARAC) in Hartlepool and Stockton where high risk victims of domestic abuse are identified and safety plans put in place and the Trust also contribute to Multi Agency Tasking and Coordination (MATAC) where response to high risk perpetrators are managed.

A Domestic Abuse Policy is in place across the Trust to support staff in responding to indicators that are suggestive of Domestic Abuse, how to address these safely with the child or other vulnerable adult's paramount to the assessment of an appropriate response including what to do if a colleague discloses Domestic Abuse. The policy is presently under review to ensure it reflects guidance to staff on recent changes in response to the Domestic Abuse Bill (2021). Safeguarding training updates include updated advice.

Local Authority Designated Officer (LADO)

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

Voice of the Child

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

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

Bruising in Immobile Babies Policy

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

Joint working with Adult Safeguarding

Children's Safeguarding trainers continue to support joint working across the Vulnerability Unit in providing training for both children and adult safeguarding across the Trust including Female Genital Mutilation (FGM), Prevent, Forced Marriage and Modern Slavery and Trafficking. The Adult Vulnerability Committee and Children's Steering Group have been brought together into the Safeguarding Committee to facilitate the 'Think Family' approach at a Strategic level.

Audit

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

Adult Risky Behaviours A&E Audit	**Medical Audits:** • **Child Protection Medical Assessment** • **Haematological investigations in Non Accidental Injuries (Initial and re audit)** • **Impact of Pandemic on Abusive Head Trauma** • **Fabricated or Induced Illnesses**
Section 11 Audit	**Safer Referral Audit**
NICE Guideline 89 Audit	**Looked After Children Review Health Assessment Audit**
Midwifery Quality Assurance Record Audit	**Immobile Baby Pathway Audit**
Paediatrics Child Protection Medical Quality Assurance Record Audit	**Children Not Brought for Appointments by Parents/Carers Policy Audit**

Children's Safeguarding Key Achievements 2021/2022

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

Children's Safeguarding Key Priorities 2022/2023

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

Safeguarding Children Training Programme

Throughout 2021 the Trust's in-house Safeguarding Children Training Programme has continued to provide mandatory foundation and update single agency training for all staff employed within the organisation. The training is in-line with the requirements of Safeguarding Children and Young people: roles and competences for health care staff, Intercollegiate Document (2019) and the Trust's Safeguarding Children Training Policy. This includes:

- **Level 1** – All non-clinical staff working in health care settings. For example, receptionists, administrative, porters
- **Level 2** – All clinical staff who have any contact with children, young people and/or parents/carers. This includes health care students, clinical laboratory staff, pharmacists, adult physicians, surgeons, anaesthetists, radiologists, nurses working in adult acute/community services, allied health care practitioners and all other adult orientated secondary care health care professionals, including technicians

- **Level 3** – All clinical staff working with children, young people and/or their parents/carers who could potentially contribute to assessing, planning, intervening and evaluating. The needs of a child or young person and parenting capacity where there are safeguarding/child protection concern. This includes paediatric allied health professionals, all hospital paediatric nurses, hospital based midwives, accident and emergency/minor injuries unit staff, urgent care staff, obstetricians, paediatric radiologists, paediatric surgeons, children's/paediatric anaesthetists, and paediatric dentists.

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

Level 3 Safeguarding training content has been refreshed and now includes scenario based training with the elements of effective referrals and information sharing.

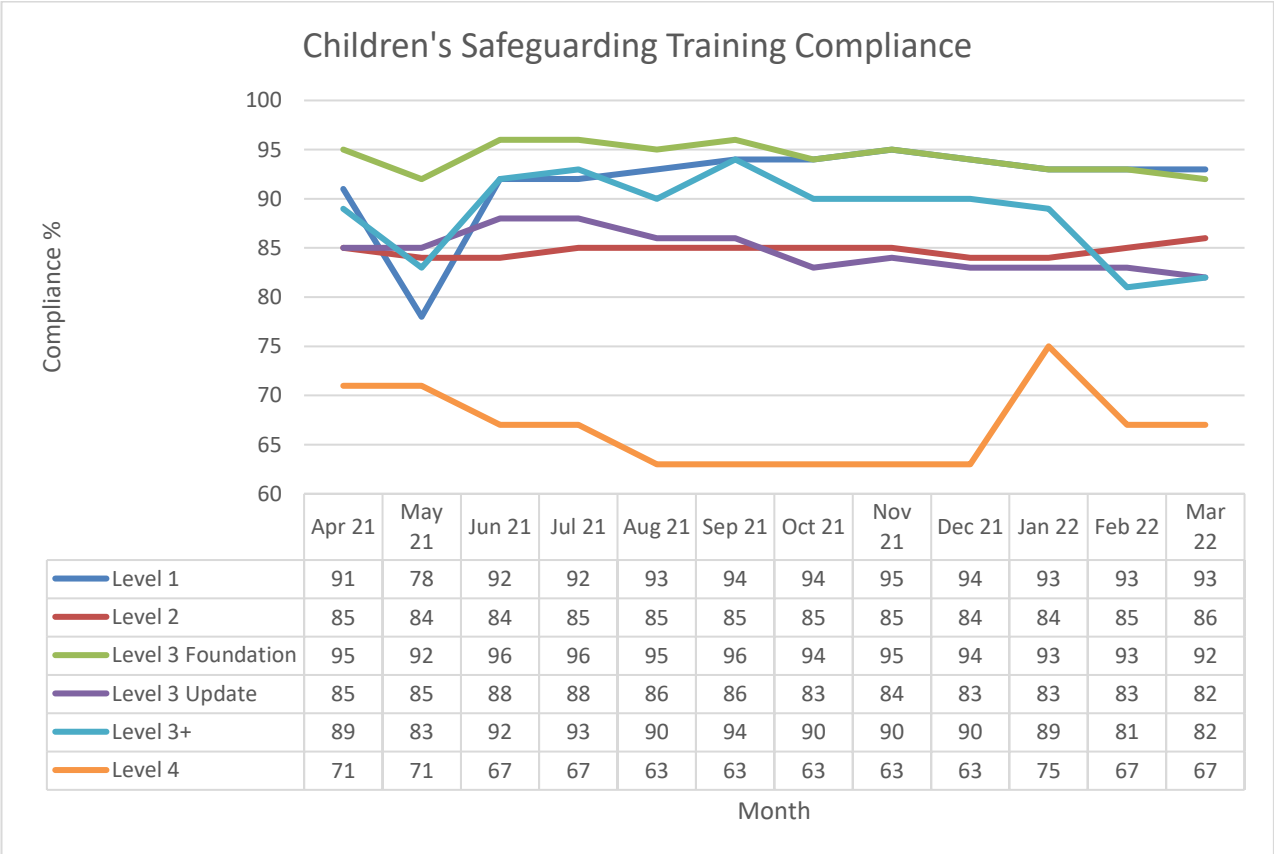
Where appropriate staff are required and supported to attend multi-agency training provided by the Safeguarding partnerships and other external providers and is strongly recommended for those staff groups identified as requiring Level 3 plus competencies.

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

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

Overall Trust Compliance for Safeguarding Children Training

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



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

Looked After Children (LAC)

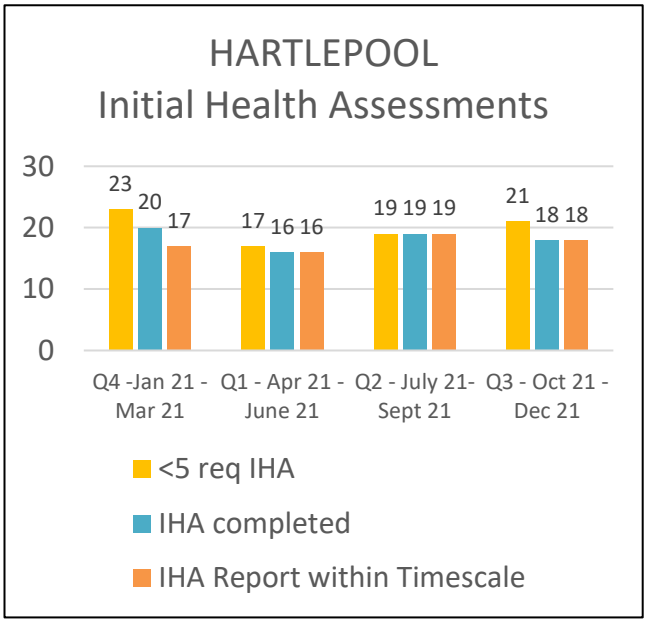
The services and responsibilities for LAC are underpinned by legislation, Statutory guidance and good practice guidance which include: *Statutory Guidance on Promoting the Health and Well-being of Looked After Children* (DH, 2015) and *Looked After Children and Young People* (NICE, Oct 2021). The importance of the health of children and young people in care cannot be overstated; many children in care are likely to have had their health needs neglected prior to coming into care. The health of looked after children is everyone's responsibility, so partnership working is essential to ensure optimum health for each individual child and young person.

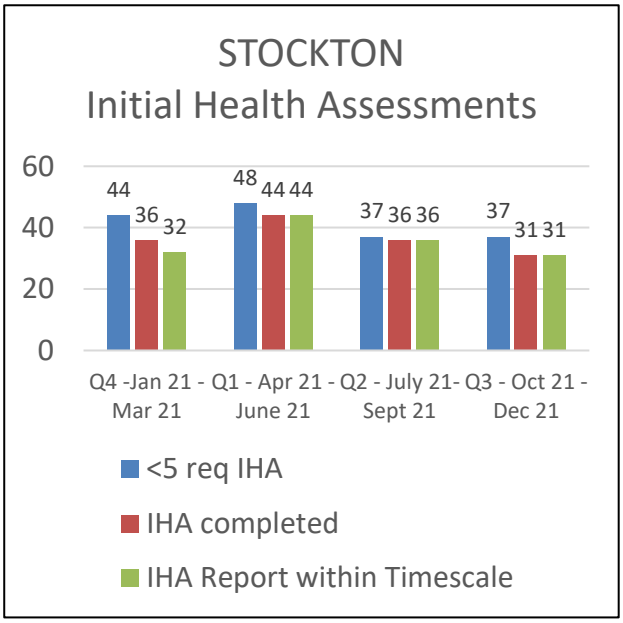
- LAC health provision over the last year has been an integral part of the Trust Safeguarding work programme which reports to the Trusts Safeguarding Committee and Patient Safety Committee.
- The Trust continues to be represented and is an active member of the Children in Our Care Council in Stockton and Corporate Parenting Group in Hartlepool.

Looked After Arrangements and Provision

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

Table 1 below demonstrates compliance when Children's Health in Care service are notified by the Local Authority when children have come into care





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

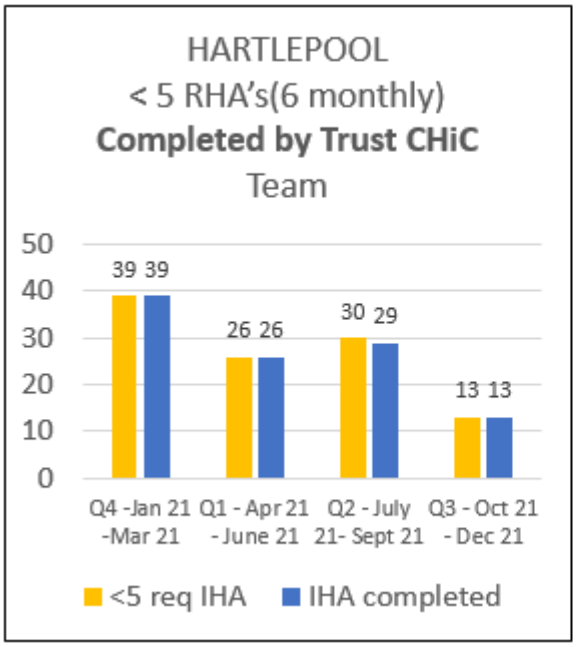
- Not receiving timely and appropriate consent for IHAs affects the overall compliance rate
- Cancellations by carers continue to affect the rates of compliance. These issues are addressed with partner agencies and carers at the time

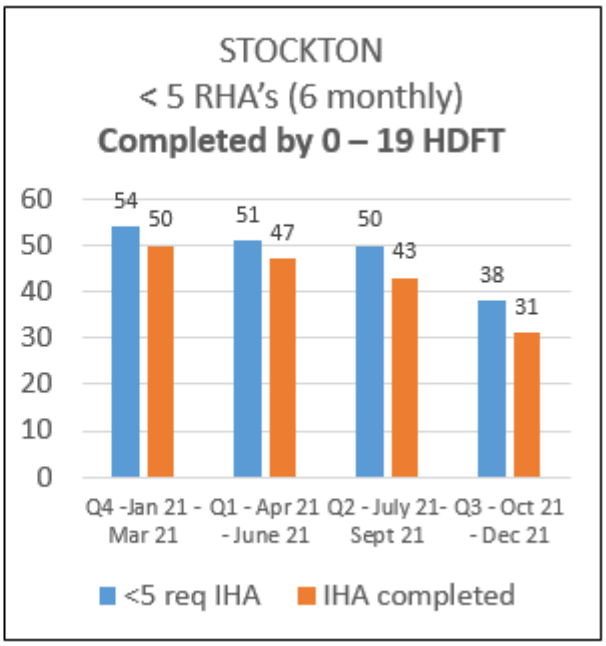
The completion of Initial Health Assessment will remain with the Trust however notification and coordination of Initial Health Assessments will now come from Harrogate and District NHS Foundation Trust as part of their commissioning responsibilities alongside completion of Review Health Assessments across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

Review Health Assessments

Review Health Assessments must be undertaken at six monthly intervals for children under five years and annually for those over five up until they turn 18 years old.

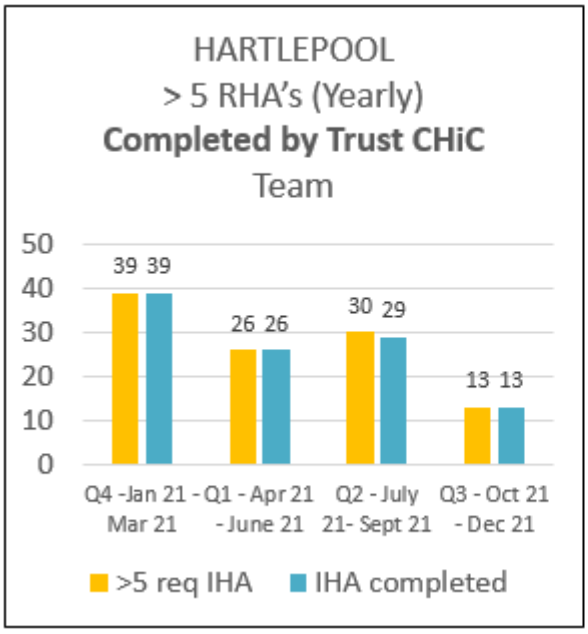
Reviews are designed to identify and monitor health needs of the looked after child and are a statutory obligation. In Stockton the service model includes Health Visitors and dedicated School Nurses who undertake the RHA for those LAC accessing universal services. Health Visiting and School Nursing are a Public Health commissioned service. In Hartlepool the RHA's are undertaken by the Trust's Children's Health in Care (CHiC) team. To support this activity additional staff nurses have been recruited.

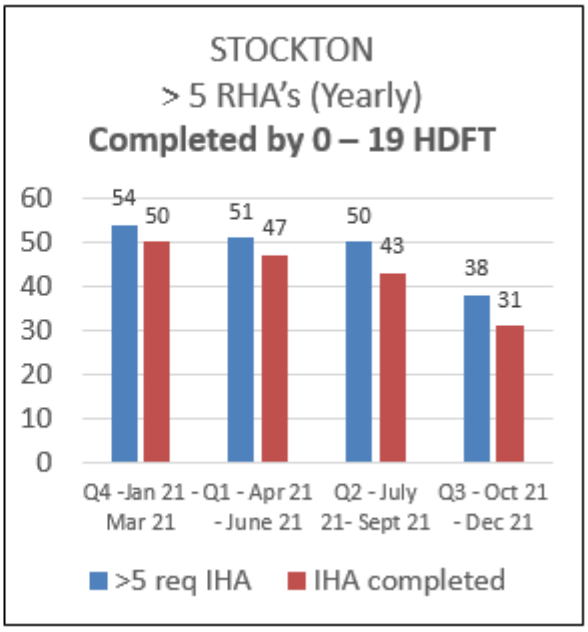




The tables above represent compliance to completion of Review Health Assessments for our under five year olds.

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





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

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

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

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

Sensory Loss

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

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

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

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

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

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

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

Identifying Patients with Sensory loss

Significant changes have been made to Core Admission Documentation to identify, more clearly, patients who have a sensory loss / impairment. The planning of care document has also been improved to include recording in relation to any reasonable adjustments required to support the patient during their hospital stay. This is followed by the provision and application of associated care plans; these are reviewed and evaluated as part of daily assessments and rounding by the Matrons. Work has also been undertaken to update current electronic systems used in the community settings to ensure inclusion of the requirements of the Accessibility Standards i.e. identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents where their needs relate to a disability, impairment or sensory loss.

Patient Experience

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

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

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

Specialist Equipment

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

Following the audit, the portable hearing loops were removed from the wards and stored in the medical equipment library so they are available to all when needed on a 24 hour basis. A Portable hearing loop is also kept in the resilience offices on both sites for emergency use.

Priority 1: Patient safety

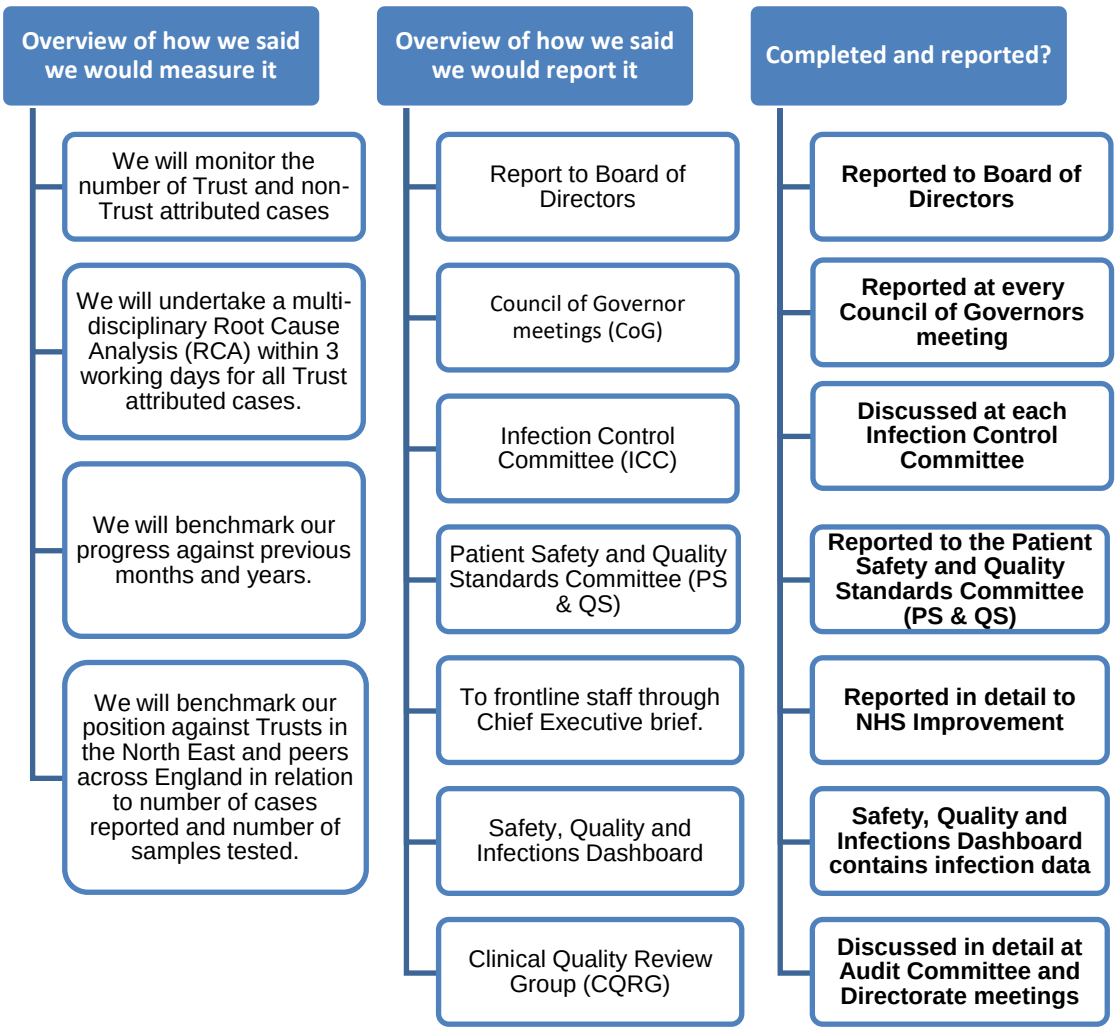
Infections

Rationale: The Trust continues to report on infections of:

- Clostridioides difficile (C.diff),
- Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia;
- Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia; and
- Escherichia coli (E.coli)
- Klebsiella species (Kleb sp) bacteraemia; and
- Pseudomonas aeruginosa (Ps a) bacteraemia.
- Catheter-associated urinary tract infection (CAUTI)
- COVID-19

Overview of how we said we would do it

- We will closely monitor testing regimes, antibiotic management and repeat cases and ensure we understand and manage the root cause wherever possible.



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

Clostridioides difficile (C.difficile)

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

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

Our staff continue their efforts to control and reduce opportunities for infections to spread, whether we treat people in our clinical premises or in their own homes. The Trust has maintained a consistent approach to cleanliness across all areas of our environment including enhanced decontamination with hydrogen peroxide vapour, and the provision of a hygienist team to support additional cleaning. The focus on antimicrobial stewardship has continued and is led by a Consultant Microbiologist and Antimicrobial Pharmacist. The importance of adherence to high standards of hand hygiene has continued to be a core element of our strategy.

Actions to reduce C difficile are within an integrated HCAI improvement plan covering all infections and practices and is reviewed monthly. Progress against the plan is reported to the Healthcare Associated Infection Operational Group and Infection Control Committee and is regularly shared and discussed with commissioners.

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

Data reporting using the new requirements

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

***Trust Cdiff cases 2019-22**

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

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

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

	2021 22
Healthcare-associated	0
Community-associated	1

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

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

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

Methicillin-Sensitive Staphylococcus Aureus (MSSA)

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

In 2021-22 we currently report **38** cases of healthcare-associated MSSA bacteraemia to date. This is an increase from 2020-21 where we reported 25 hospital-onset cases. Each case is subject to a root cause analysis and the analysis of these investigations has shown that there are no apparent trends in terms of linked cases or frequently seen sources of infection. In many cases the source has been a chest or skin infection which would have been difficult to prevent.

However, the Trust recognises that further improvement can be achieved in this infection and increased emphasis on clinical practices continues to be a focus of our work to reduce the number of MSSA bacteraemia. A reduction in the number of community-associated cases is noted and this is likely due to the new reporting criteria. An increase in healthcare-associated cases is due to an increase in activity, compared to 2020-21 and increased length of stay.

	2021 22
Healthcare-associated	29
Community-associated	9

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

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

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

Escherichia coli (E.coli)

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

The numbers of E coli bacteraemia (blood stream infection) reported across by the Trust for previous years are shown in the table below. The reported healthcare-associated cases to date are 67, against a trajectory of 117. As the majority of these cases remain those that are identified within the first 48 hours of hospital admission, work is required across all healthcare settings to achieve improvements. A national objective to reduce gram-negative blood stream infections (E coli, Klebsiella and Pseudomonas) by 50% by 2023 is in place and within this to reduce E coli bacteraemia by 10% each year. The recent publication of the Commissioning for Quality and Innovation (CQUIN) in January 2022 for 2022-23 also addresses the need for appropriate antibiotic prescribing for urinary tract infections, which remains the leading cause for gram –negative bloodstream infections.

Root cause analysis is completed for cases deemed to have been hospital-onset and healthcare-associated and action plans are developed where actions are identified. In many cases these infections are related to urine infections and are thought to be not preventable with only a very small percentage of cases being in patients with a urinary catheter where there may be potential for improved practices.

	2021 22
Healthcare-associated	35
Community-associated	43

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

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

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

Klebsiella species (Kleb sp) bacteraemia

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

	2021 22
Healthcare-associated	9
Community-associated	6

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

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

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

In 2021-22 the Trust reported **15** Klebsiella species bloodstream infections as healthcare-associated, against a trajectory of 24 cases. There is no reduction target associated with this infection currently. Enhanced data collection is carried out on each case to understand if there are any common themes to the infections. This allows us to target our efforts effectively to reduce the number of cases further.

Pseudomonas aeruginosa (Ps a) bacteraemia

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

	2021 22
Healthcare-associated	9
Community-associated	5

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

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

In 2020-21 the Trust reported **14** healthcare-associated cases of Pseudomonas aeruginosa bloodstream infections against a target of 11 cases. Many of these cases are considered unpreventable, as with Klebsiella, there is no reduction target assigned and enhanced data collection continues to better understand the sources of these infections.

Catheter-associated urinary tract infection (CAUTI)

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

	2019-20	2020-21	2021 22
Hospital Onset	**360**	**211**	**265**

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

Coronavirus disease

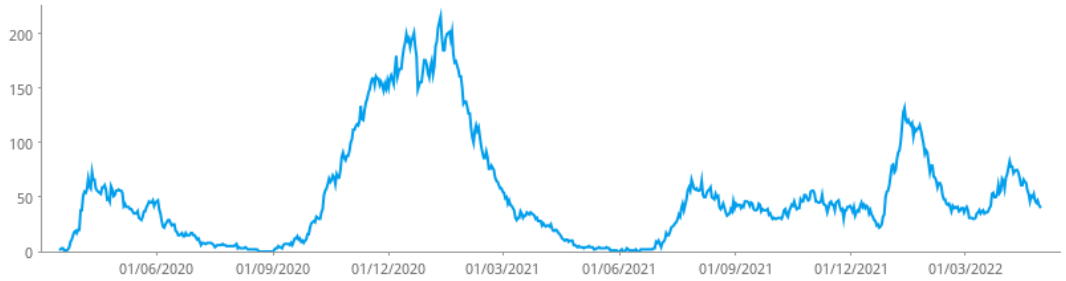
Coronavirus disease (COVID-19) is an infectious disease caused by a newly discovered coronavirus.

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

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

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

COVID-19 Positive Patients in the Trust



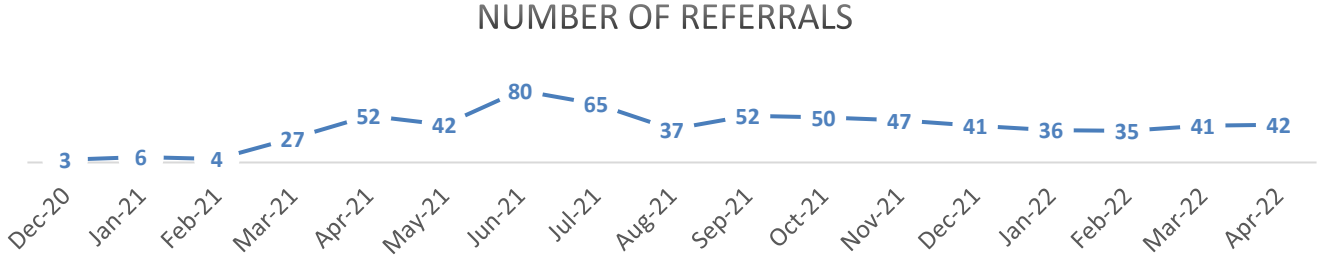
The peak of COVID-19 patients in the Trust was 216, this was in January 2021 (during Lockdown 3). Omicron has put further pressure on the NHS with high case numbers seen from December 2021, although it is noted that ITU admissions and deaths have decreased. Staff cases remain high, with January 2022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

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

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

Long Covid Clinic

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



Priority 2: Effectiveness of Care

Learning from Deaths

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

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

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

During **April 2021 to March 2022**, **1,357** of North Tees and Hartlepool NHS Foundation Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

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

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

In **4** cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:
1 in the first quarter;
2 in the second quarter;
0 in the third quarter.
1 in the fourth quarter.

0 representing **0%** of the patient deaths during the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient. To date, one investigation remains ongoing, there are some cases from 2021-22 which are also awaiting information from Coronial review.

In relation to each quarter, this consisted of:
0 representing **0%** for the first quarter;
0 representing **0%** for the second quarter;
0 representing **0%** for the third quarter;
0 representing **0%** for the fourth quarter;

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

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

- **Medical Examiner**

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

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

- **Learning Disabilities Mortality Reviews (LeDeR)**

The Trust has continued to undertake LeDeR reviews alongside the internal mortality review process. The LeDeR reviews are undertaken for all deaths of patients who have diagnosed learning disability from the age of 4; the reviews are not only undertaken by the trust but by all services who have been involved in the patients care during their lifetime. Deaths in patients with a learning disability (LD) in our care; are thankfully rare, however, this makes it even more important to take every opportunity to learn. Information from the reviews is shared with the Teeswide LeDeR team who then collate the information for shared learning across all health and social care services. If necessary for individual cases, this can lead to a full multiagency review meeting to assist in identifying any shared learning.

Over 2021-22, the Trust has received some positive feedback from these multiprofessional reviews, in particular around the reasonable adjustments put into place and the involvement of the Trusts Nurse Advisor for LD alongside the Community LD staff. Positive feedback has also been received from families, an example relates to experiences from patient and families who have been through a screening programme in the Trust. The Trust had previously identified areas of learning from mortality reviews which resulted in some quality improvement activity; the recent positive feedback provides supportive evaluation for the screening team involved and also the Trust.

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

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

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

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

The aim of the pathway is to:

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

- **Deteriorating Patient Group**

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

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

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

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

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

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

- **Maternity Stillbirth update**

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

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

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

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

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

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

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

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

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

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

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

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

- **Risk assessment**

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

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

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

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

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

- **Smoking**

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

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

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

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

- **Reduced fetal movements**

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

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

- **Paediatric reviews**

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

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

- **Community Services**

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

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

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

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

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

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

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

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

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

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

- **Surgical Mortality Reviews**

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

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

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

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

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

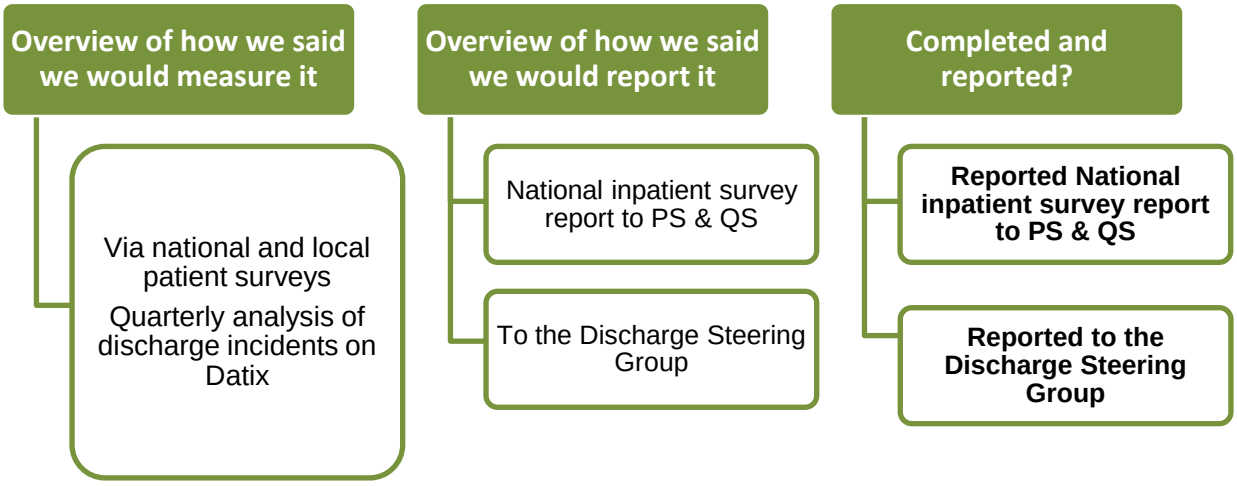
- A number of the surgical mortality cases reviewed continue to identify the need for broader discussions across other specialist services to support shared learning and collaborative improvements. In 2021, the Vascular Lead from South Tees virtually attended the surgical Clinical Governance meeting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

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

Priority 2: Effectiveness of Care

Discharge Processes

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



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

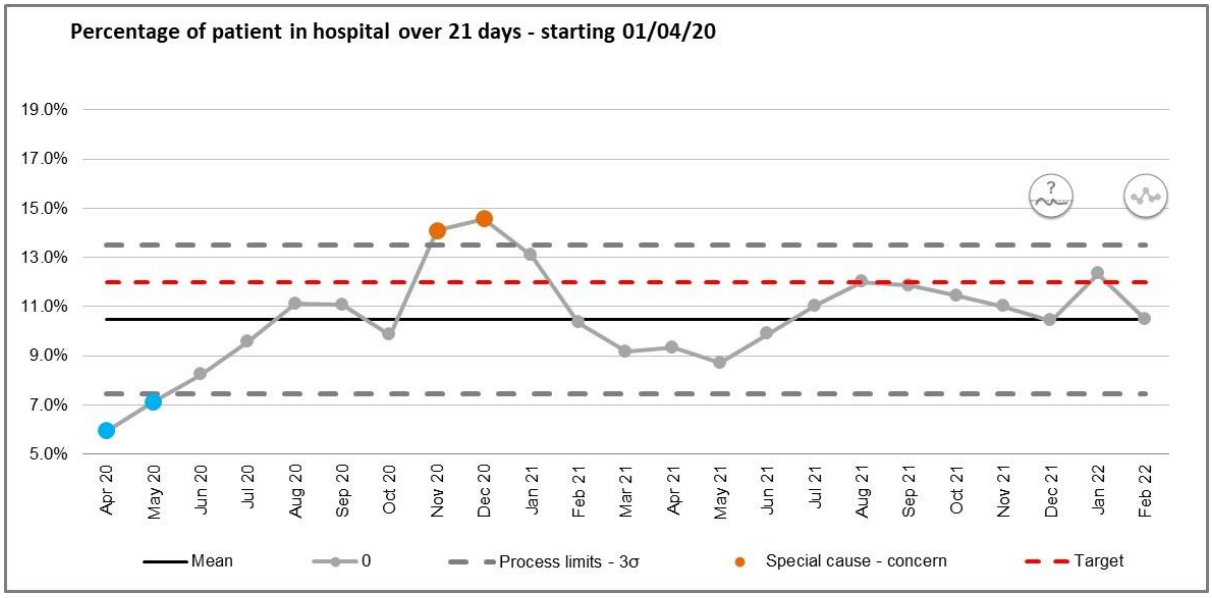
The Trust and our partners in social care have worked together to implement the discharge policy and continue to reduce delayed transfers of care. The Trust interagency discharge policy is to be reviewed for implementation May 2022.

The government provided funding until the end of March 2022, to help cover the cost of post-discharge recovery and support services, rehabilitation and reablement care following discharge from hospital through the discharge to assess funding. The Trust has established the trusted assessor pathways during 2020 to meet this requirement and ensure the processes are fully embedded for all people aged 18+. The trusted assessors work with patients, their families and staff on the wards to transfer patients in a safe and timely manner. The trusted assessor model has reduced the time it takes from referral to transfer. The model is fully supported by our Partners in Hartlepool & Stockton Borough Council and will be reviewed once new policy and guidance is published.

Acute hospitals must discharge all persons who no longer meet the criteria to reside in hospital as developed with the Academy of Medical Royal Colleges, as soon as they are clinically safe to do so. Daily morning ward huddles to review every person take place and a decision, informed by the criteria to reside, are the foundation for avoiding delay and improving outcomes for individuals. As a trust the daily reviews have been integrated into the electronic patient information systems; this ensures that tracking list is available for all agencies to work from and includes those patients suitable for discharge. We have progressed to a web based tool that enables all agencies to view the discharge patient tracking list to ensure that patient discharge plans are in place and carried out in a timely manner. We continue to produce data of the numbers of patients that no longer meet the criteria to reside and those that are discharged by 5pm by the national sitrep report. We have developed a new Discharge Flow Facilitator role within the Trust who provide operational support across the discharge team and the Trust patient flow teams to ensure information is continually available to the bed managers to support discharge activity and manage bed capacity.

Reduction length of stay in hospital

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



Help Force Home but not alone scheme

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

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

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

7 day working focus on weekend discharges

There have been a range of developments to support discharge over the weekend as well as out of hours. Many services provide a level of service at weekends such as pharmacy, physiotherapy, occupational therapy, district nurses and community matrons and there is equipment provision for basic items. There is availability of diagnostics required for discharge or to make decisions 7 days a week.

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

Changes in medical training impact on the available hours for doctors in training working clinically on medical wards. Therefore, the out of hour workload and associated increased admissions between 11-7pm has led to some rota amendments to support increasing numbers of staff out of hours and at peak times to improve the resilience for more timely patient assessments and discharge planning. Alternative workforce models with Physician Associates and Advanced Practitioners have also been used to support this. Different ways of working have been explored and capacity prioritised to ensure best use of resources, e.g. “weekend working teams”, 'Home First' principles and huddle/board rounds. There is also 8 medical consultants on site over the weekend to ensure timely decision making supporting management of care and discharging.

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

Integrated single point of access pilot (ISPA)

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

The service manages a broad set of pathways and the work currently delivered in iSPA has a range of complexity, which is all delivered through a multi professional group of staff, which include nursing, therapy and social care and will include mental health services form May 2022. The ISPA has demonstrated effectiveness in the triage and clinical assessment of those patients requiring urgent response to remain in the community and avoid unnecessary acute admissions. The team within the ISPA have a broad knowledge of community health and social care services as well as the voluntary sector and are able to make decisions on appropriate pathways of care, ensuring patients receive the right care in the right place at the right time by the right professional. Primary Care Networks are also key partners in the development of the iSPA through our System Design and Delivery Groups. Since 2020 ISPA has developed integrated pathways of care with PCN’s to support delivery of the Enhanced Health in Care Homes framework. Each PCN, iSPA and other professionals meet weekly to collaborate and deliver on appropriate individual care plans to ensure system based support to manage frail elderly patients within a community setting and reduce non-elective admissions.

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

District nursing in reach project

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

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

Frailty Coordinators

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

A pilot to enhance Huddles and Board Rounds at front of house with more staff that are senior, including the Emergency Department and the Emergency Assessment Unit, has been introduced. The objective of these are to employ an MDT approach with the medical teams, the Frailty Team and community services, to identify more patients on admission who could be treated/cared for on pathways in the community. This work is ongoing and results of this are due for evaluation

Home First Pilot

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

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

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

Priority 2: Effectiveness of Care

Accessibility

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

Aim

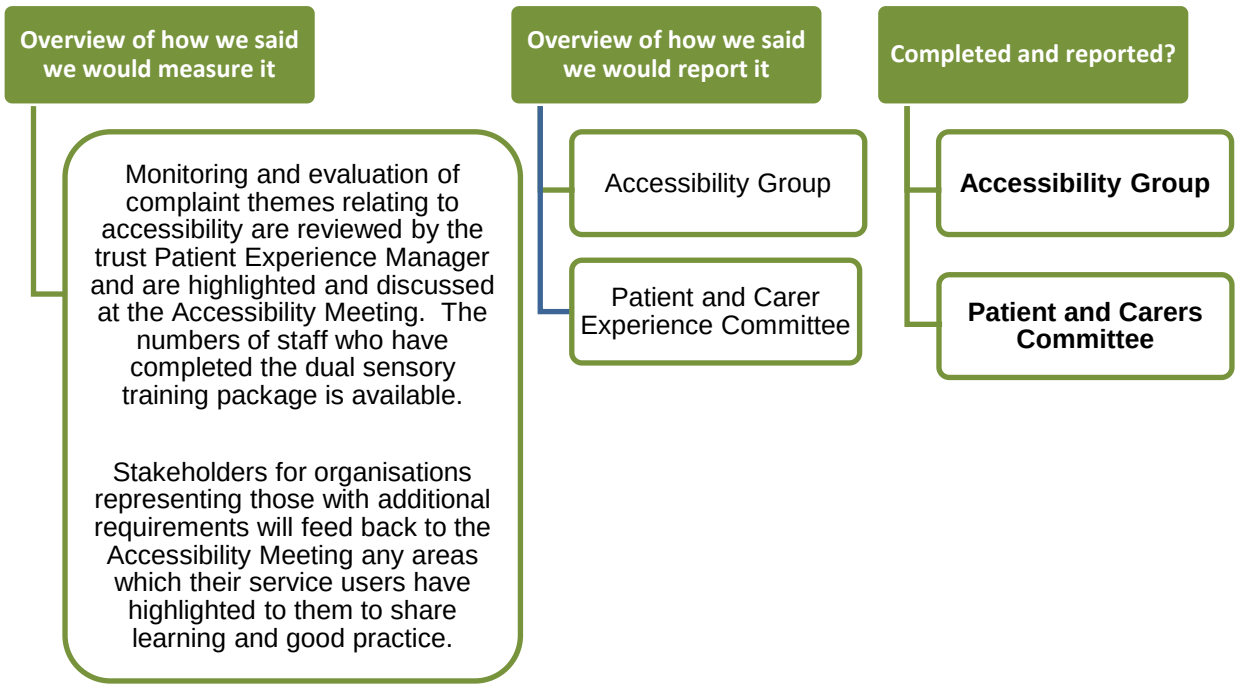
The aim is to develop a culture which learns from service user/stakeholder feedback. To provide a forum for service users/stakeholders to participate in accessibility projects and groups to ensure that their voices can be heard and that their views make a difference to the work in the trust. To ensure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

Overview of how we will do it

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

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

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



Developments and improvements 2021/2022:

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

Priority 2: Effectiveness of Care

Violent Incidents

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

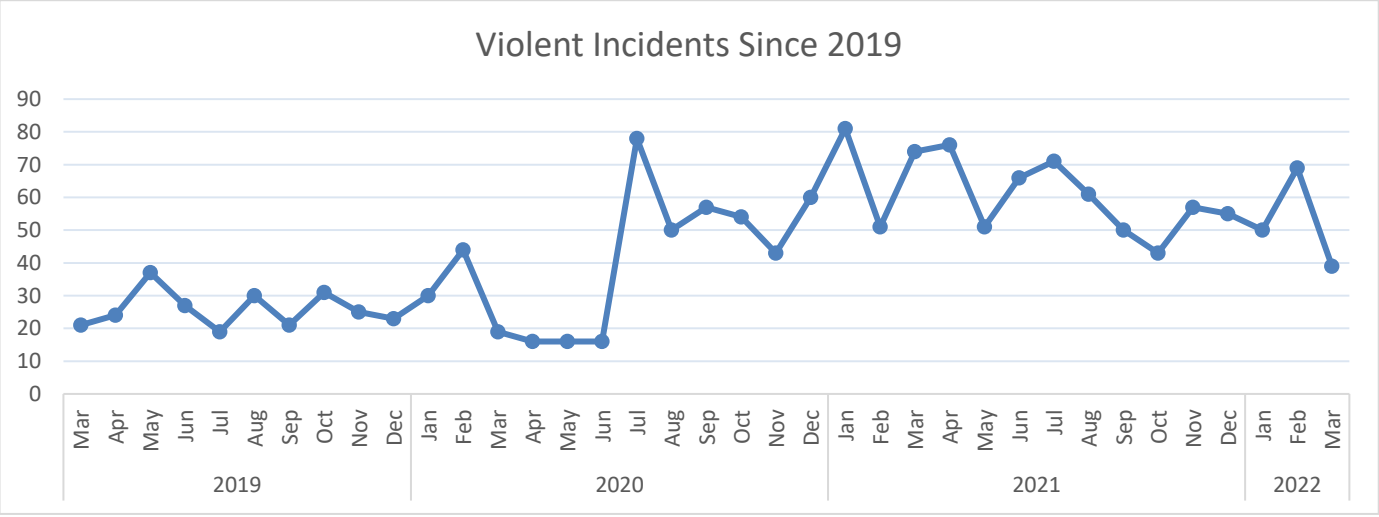
Overview of how we will do it
Utilise the Violent Incidents data held within the Trusts incidents reporting software (Datix).

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

Year Comparison

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

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



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

Priority 2: Effectiveness of Care

Safety and Quality Dashboard

Rationale: The Safety and Quality Dashboard will support close monitoring of nurse sensitive patient indicators on a day-to-day basis. It will support sharing of best practice and speedy review of any potential areas of concern.

Overview of how we said we would do it

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

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

The areas covered by the dashboard are:

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

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

Senior Clinical Professionals Weekly Huddle

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

Priority 3: Patient Experience

Palliative Care and Care For the Dying Patient

Rationale: The Trust used the Care For the Dying Patient (CFDP) and Family's Voice. Stakeholders and the Trust believe that this needs to remain a priority in 2021-22 both in hospital and in the community.

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

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

Overview of how we said we would do it

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

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

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

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

Specialist Palliative Care

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

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

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

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

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

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

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

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

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

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

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

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

Care For the Dying Patient (CFDP)

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

Between April 2021 and March 2022, the Trust has had returned **107** diaries, currently the average score has decreased to **20.30** from the previous average of 20.40. The Trust has endeavoured to improve the uptake of the CFDP with greater support from the chaplains who review every patient on the Care of the Dying Document. If the document has not been given out, it is pointed out and the next occasion they offer to accompany the staff in giving it out.

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

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021 22
Number of Patients	167	171	147	134	139	48	**92**
Average Daily Score (Max 24.00)	20.80	20.40	20.60	20.51	20.11	20.40	**20.30**

*Data obtained from the Trusts Family's Voice database

Quotes from family members/carers for the dying patient

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

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

In March 2015, the NHS England published NHS Chaplaincy Guidelines. The guidelines recognise the development of chaplaincy in a range of specialties including General Practice and in areas such as Paediatrics and Palliative care, describing the importance of spiritual and religious support to patients approaching end of life. The guidelines support and promote the approach that our Trust has taken since July 2009 to meet the needs of patients and families when faced with the knowledge that end of life is near.

Actions taken by the Trust:

The Trust has routinely referred patients on the end of life care pathway to the chaplaincy team. During 2021-22, **333** patients were referred by our staff to this pioneering service provided by the Trust chaplains. They provide **spiritual, pastoral and emotional support** to patients, families and staff. **2** patients declined support during the reporting year. **168** patients welcomed and received multiple visits. This service offers added value to the quality of overall care provided to patients and their loved ones and has highlighted the importance of this aspect of support to the dying patient.

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

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

Chaplain Referrals, Received more than 1 visit and Declined Support

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

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

*data from the Trusts chaplain service

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

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

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

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

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

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

Patient Experience Surveys

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

National Surveys

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

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

Local Surveys

Survey	Survey results compiled	Number of Patients Surveyed
Endoscopy Patient Survey 2021	August 2021	163 patients
Colposcopy Survey 2021/22	March 2022	110 patients
Family Health Counselling Survey	December 2021	23 patients
Cancer Care Coordinator Survey (cycle 1)	April 2022	40 patients

National Surveys

We take part in the national survey programme. This is a mandatory Care Quality Commission (CQC) requirement for all acute NHS trusts. Each question is nationally benchmarked so we can understand how we scored when compared with other trusts. The coloured bars below show how the trust scored.

Better than expected	About the same	Worse than expected

CQC National Inpatient Data 2020 Key results

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

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

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

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

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

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

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

CQC National Emergency Survey Key results

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

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

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

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

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

CQC National Childrens and Young People's Survey Key results

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

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

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

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

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

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

CQC National Maternity Survey Key results

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

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

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

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

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

Action plans

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

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

Priority 3: Effectiveness of Care

Friends and Family Test

Rationale: The Department of Health require Trusts to ask the Friends and Family recommendation questions from April 2013. Stakeholders agreed that this continues to be reported in the 2021-22 Quality Accounts.

Overview of how we said we would do it

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

Overview of how we said we would measure it	Overview of how we said we would report it	Completed and reported?
We analyse feedback from all Friends and Family questionnaires	Report to Board of Directors	**Reported to Board of Directors**
	Report at every Council of Governors meeting	**Reported at every Council of Governors meeting**
	On the Safety, Quality and Infections Dashboard	**Reported on the Safety, Quality and Infections Dashboard**

> “Service was excellent doctor and nurses were brilliant well done Hartlepool Hospital” [sic]

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

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

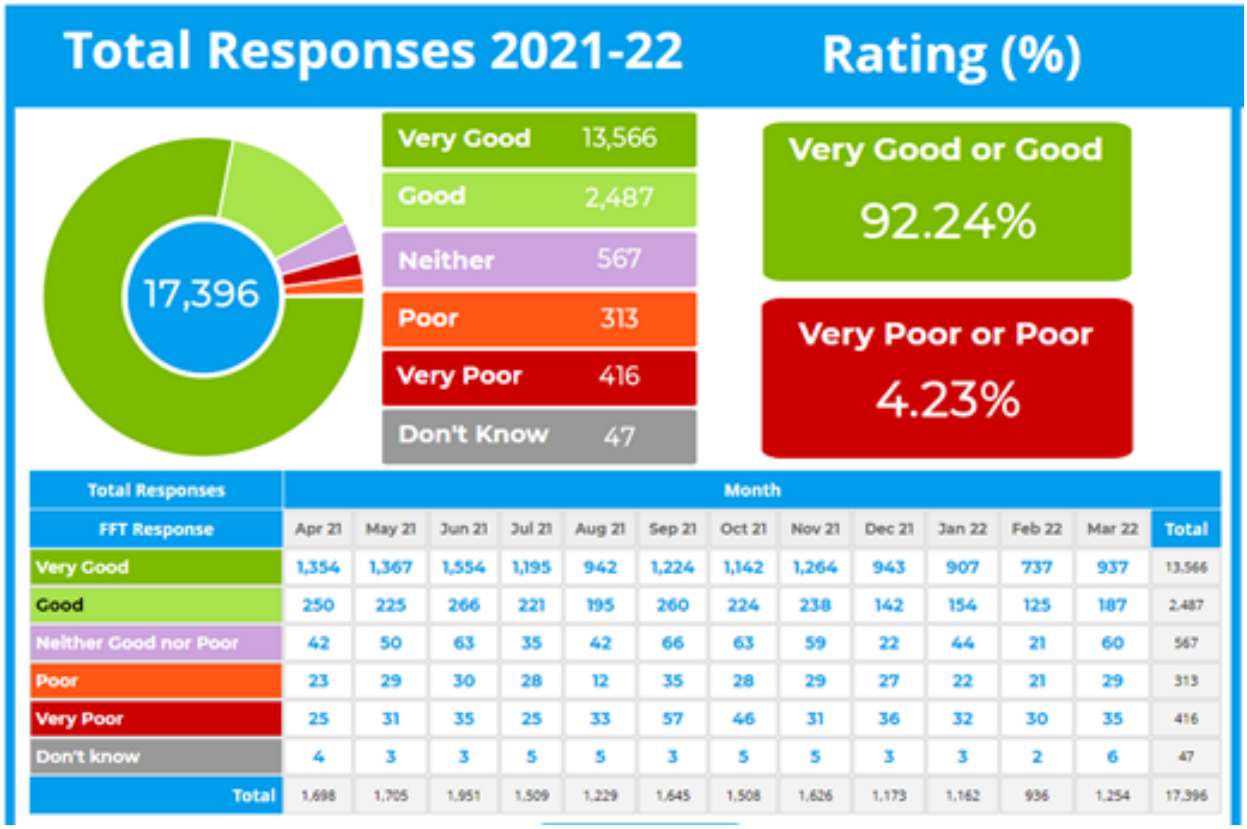
The Friends and family data can be found at:
https://www.england.nhs.uk/fft/friends-and-family-test-data/

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

North Tees and Hartlepool NHS Foundation Trust

Returns for April 2021 to 14 March 2022

The Trust continuously monitors the positive and negative comments on a weekly basis to ensure that any similar issues or concerns can be acted upon by the ward matrons. This helps in reducing the reoccurrence of similar issues in the future.



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

*Data from Trusts Friends and Family database and Inhealthcare

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

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

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

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

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

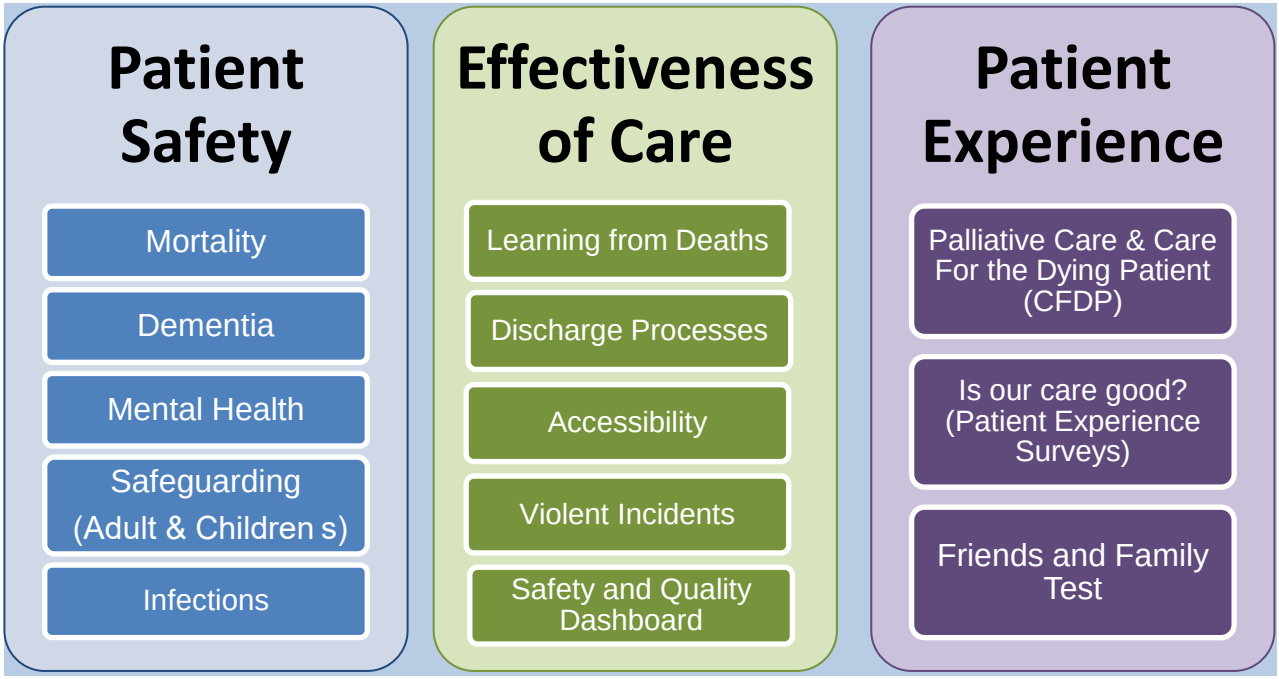
Part 2b: 2022-23 Quality Improvement Priorities

Introduction to 2022-23 Priorities

Due to COVID-19, the key priorities for improvement for 2022-23 have been rolled over from 2021-22. This has been discussed and agreed with governors, Healthwatch colleagues, commissioners, local health scrutiny committees, healthcare user group and the Board of Directors.

Stakeholder Priorities for 2022-23

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



Rationale for the selection of priorities for 2022-23

Through the Quality Accounts stakeholder meetings and other engagement events we provided an opportunity for stakeholders, staff and patients to suggest what they would like the Trust to prioritise in the 2022-23 Quality Accounts.

We then chose indicators from each of the key themes of Patient Safety, Effectiveness of Care and Patient Experience. The Trust will continuously monitor and report progress on each of the above indicators throughout the year by reporting to the Board.

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

Patient Safety

Priority 1 - Mortality

To reduce avoidable deaths within the Trust

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

We will use the Healthcare Evaluation Data (HED) benchmarking tool to monitor and interrogate the data to determine areas that require improvement. We will also review/improve existing processes involving palliative care, documentation and coding process.

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

Overview how we will monitor it
Monitored by the Mortality Dashboard

Overview of how we will report it
Report to Board of Directors meeting
Report to Council of Governors meeting
Report quarterly to the Commissioners

Priority 2 - Dementia

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

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

We will make it mandatory that all patients over 65 receive an Abbreviated Mental Test (AMT) and are, where appropriate, referred for further assessment.

Patients with dementia will be appropriately assessed and referred on to specialist services if needed.

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

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

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

The percentage of patients who receive the Abbreviated Metal Test and, where appropriate, further assessment will be reported monthly via UNIFY.
We will continue with the prevalence audit for the number of patients that have cognitive screening over the age of 75 admitted as an emergency that are reported as having a known diagnosis of dementia, or have been asked the dementia case finding questions.

We will continue to undertake the National Audit for dementia.

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

Overview of how we will report it
Vulnerability Committee
Monthly UNIFY

Priority 3 – Mental Health

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

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

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

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

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

Priority 4 – Safeguarding

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

Overview of how we will do it
Provision of specialist advice relating to implementation of The Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS) and the Human Rights Act provides added assurance that the Trust remains compliant with legislation.

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

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

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

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

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

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

Priority 5 – Infections

Key stakeholders asked us to report on infections in 2020-21 due to the increase in Ecoli infections and scrutiny towards Cdifficile.

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

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

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

Overview of how we will report it
Board of Director Meetings, Council of Governor Meetings (CoG), Infection Control Committee (ICC), Patient Safety and Quality Standards Committee (PS & QS), To frontline staff through Chief Executive brief, Safety and Quality Dashboard and Clinical Quality Review Group (CQRG).

Effectiveness of Care

Priority 6 – Learning from Deaths

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

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

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

Overview how we will monitor it
Monitored by the Mortality Dashboard

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

Priority 7 – Discharge Processes

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

Overview of how we said we would do it

All patients should have a safe and timely discharge.
All concerns and/or incidents raised onto the Trust's Datix system.

Overview of how we said we would measure it

Via national and local patient surveys.
Quarterly analysis of discharge incidents on the Datix system.

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

Overview of how we said we would report it

National inpatient survey report to PS & QS.
To the Discharge Steering Group.

Priority 8 – Accessibility

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

Aim

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

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

Overview of how we will do it

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

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

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

Overview of how we will measure it

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

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

Overview how we will monitor it

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

Overview of how we will report it

Accessibility Group
Patient and Carers Committee

Priority 9 – Violent Incidents

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

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

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

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

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

Priority 10 – Safety and Quality Dashboard – Business Intelligence

The Safety and Quality Dashboard will support close monitoring of nurse sensitive patient indicators on a day-to-day basis. It will support sharing of best practice and speedy review of any potential areas of concern.

Overview of how we will do it
Training will be undertaken and each department will evidence that their results have been disseminated and acted upon.

Ward matrons will present their analysis on a public area of the ward for patients and staff to see. The results will be discussed at ward meetings.

Overview of how we will measure it
The dashboard will be used during the weekly Quality Reference Group meetings with the wards/areas. Quarterly meetings with wards/areas will be held to ensure that data is up to date, accurate and displayed in public areas.

Overview how we will monitor it
Monthly dashboard analysis to the Chief Nurse/Director of Patient Safety and Quality

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

Patient Experience

Priority 9 – Palliative Care and Care For the Dying Patient (CFDP)

The Trust has continued to use the Care for the Dying Patient (CFDP) and Family's Voice. Stakeholders and the Trust believe that this still needs to remain a priority in 2020-21.

Overview of how we will do it
We will continue to embed the use of the Family's Voice in hospital and monitor use in community.

Overview of how we will measure it
We will evaluate feedback in relation to pain, nausea, breathlessness restlessness, care for the patient and care for the family.

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

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

Priority 10 – Is our care good? (Patient Experience Surveys)

Trust and key stakeholders believe that it is important to ask the Friends and Family question through internal and external reviews.

Overview of how we will do it
We will ask every patient interviewed in the Patient and Staff Experience reviews. We will also ask the question in all Trust patient experience surveys, along with monitoring patient feedback from national surveys.

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

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

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

Priority 11 – Friends and Family Test

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

Overview of how we will do it
We currently ask patients to complete a questionnaire on discharge from hospital for in-patients, Accident & Emergency, Urgent Care and Maternity as well as Outpatients, Day Case Units, Community Clinics, Community Dental, Radiology and Paediatrics.

Overview of how we will measure it
We will analyse feedback from patient surveys and discharge questionnaires.

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

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

Part 2c: Statements of Assurance from the Board

Review of Services

During 2021-22 the North Tees and Hartlepool NHS Foundation Trust provided and/or subcontracted **64** relevant health services. The majority of our services were provided on a direct basis, with a small number under sub-contracting or joint arrangements with others.

The North Tees and Hartlepool NHS Foundation Trust has reviewed all the data available to them on the quality of care in **64** of these relevant health services.

The income generated by the relevant health services reviewed in 2021-22 represents **100%** of the total income generated from the provision of relevant health services by the North Tees and Hartlepool NHS Foundation Trust for 2021-22.

Participation in clinical audits

All NHS Trusts are audited on the standards of care that they deliver and our Trust participates in all mandatory national audits and national confidential enquiries.

The Healthcare Quality Improvement Partnership (HQIP) provides a comprehensive list of national audits which collected audit data during 2021-22 and this can be found on the following link:

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

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

During 2021-22, North Tees and Hartlepool NHS Foundation Trust participated in **96%** of national clinical audits and **100%** of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

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

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

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

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

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

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

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

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

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

The national clinical audits and national confidential enquires that North Tees and Hartlepool NHS Foundation Trust participated in, and for which data collection was completed during 2021-22, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

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

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

National Clinical Audits

The reports of **19** national clinical audits were reviewed by the provider in 2021-22 and North Tees and Hartlepool NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

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

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

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

All national audit reports are considered by the Audit and Clinical Effectiveness (ACE) Committee which reports to the Patient Safety and Quality Standards (PS & QS) committee, PS & QS reports directly to the Board of Directors.

National Confidential Enquiries (NCEPOD):

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

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

Local Clinical Audits

The reports of **63** local clinical audits were reviewed by the provider in 2021-22 and North Tees and Hartlepool NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Audit title	Actions taken/in progress
Anaesthetics: Volatile Anaesthetic Gas Use	Minimise the use of Desflurane, Nitrous Oxide and Entonox, as these have significant impact on the environment.
Emergency Care: Correct Prescribing in Acute Alcohol Withdrawal	Departmental education and TrakCare development to improve use of CIWA (Clinical Institute Withdrawal Assessment for Alcohol), and resulting correct prescribing of chlordiazepoxide therapy.

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

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

Commissioning for quality and innovation (CQUIN)

A proportion of North Tees and Hartlepool NHS Foundation Trust income in 2020-21 was conditional upon achieving quality improvement and innovation goals agreed between North Tees and Hartlepool NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

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

In 2020-21 and 2021-22However for 2020-21 there was no CQUIN in line with national arrangements re COVID.

Care Quality Commission (CQC)

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

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

The Care Quality Commission (CQC) has not taken enforcement action against North Tees and Hartlepool NHS Foundation Trust during 2020-21. North Tees and Hartlepool NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

The Trust was inspected by the Care Quality Commission (CQC) under the new regime of inspection at the end of 2017. The new inspection includes an unannounced inspection which took place from 21 to the 23 November 2017 and a planned well-led inspection which took place from the 19 to the 21 December 2017.

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

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

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

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

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

2017-18 - Overall ratings for the Trust

Overall rating for this Trust	Good

Are services at this Trust safe?	Good
Are services at this Trust effective?	Good
Are services at this Trust caring?	Good
Are services at this Trust responsive?	Good
Are services at this Trust well-led?	Good

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

Rating for Acute Services/Acute Trust

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

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

It is important to highlight the Trust has recently launched the Quality Improvement Strategy which is aligned to several key sub-strategies and the Trusts Vision, mission and values. It underpins continuous improvement in patient care and services by developing effective leaders, engaging

support and participation by all relevant staff with an emphasis on team work, innovation and sustainability. Fundamentally `Putting Patients First` is the Trust`s main objective and it is important as a Trust we create a person-centred approach across the organisation, embedding a culture which engages and enables staff to add value to patient experience and that can be demonstrated through patient safety, high quality and effective delivery of care.

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

CQC Contact and Communication

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

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

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

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

Seven Day Hospital Services

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

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

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

Duty of Candour

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

The Trust policy has been in place, and reviewed as required, since the regulations were introduced. The policy details for staff how application of the regulations should be communicated to patients and their families/carers and then recorded. This is supported by the

provision of a healthcare document to be completed and stored in the patients records, full completion of this records sheet will ensure all of the necessary regulatory points are recorded.

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

There are continuing training and update sessions available to all staff in relation to Duty of Candour and details of any external seminars are shared to enhance wider knowledge of the regulations. Duty of Candour training has been mandated for all staff grade 6 and above since 2018; the training is provided as e-learning with training levels are monitored monthly through the Trusts mandatory training reports.

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

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

Commissioners Assurance

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

Freedom to Speak Up (FTSU)

Background to the Freedom to Speak Up Guardian (FTSUG)

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

The Francis Report raised 290 recommendations. One of the recommendations was to have a designated person who was impartial and independent working in every Trust. This role would facilitate staff to speak to in confidence about concerns at work including any public interest disclosure. It was acknowledged that staff should be listened to, taken seriously and would not suffer detriment for speaking up.

Philosophy

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

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

The Trust positively encourages all employees to speak up if they have a concern about risk, malpractice or wrongdoing. Moreover, if there are any behaviours or acts which harm the services the Trust delivers, we have both a duty and right to speak up. Examples may include (but are by no means restricted to):

- unsafe patient care
- unsafe working conditions
- inadequate induction or training for staff
- professional malpractice
- lack of, or poor, response to a reported patient safety incident
- suspicions of fraud (which can also be reported to our local counter-fraud team)
- an inappropriate culture (e.g. bullying within a team or service)
- suspicion that a bribe has been either offered, promised, agreed, requested or accepted
- conduct which is likely to damage the reputation of the Trust;
- breach of the Trust's policies and procedures
- a criminal offence has been, or is being committed, or is likely to be committed
- any misrepresentation of the true state of affairs of the Trust
- the environment has been, is being or is likely to be damaged
- deliberate concealment of any of the above matters or information which has been or may be deliberately concealed.
- anything that gets in the way of doing a great job.

Trust progress 2021 - 2022

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Case Data

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

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

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

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

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

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

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

Staff Feedback

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

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

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

Final Comments

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

NHS number and general medical practice validity

North Tees and Hartlepool NHS Foundation Trust submitted records during 2021-22 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episodes Statistics (HES) which are included in the latest published data.

The percentage of records in the published data:

Which included the patient's valid NHS number was:	%	Which included the patient's valid general medical practice code was:	%
Percentage for admitted patient care**	**99.92%**	Percentage for admitted patient care	**100%**
Percentage for outpatient care	**99.98%**	Percentage for outpatient care	**100%**
Percentage for accident and emergency care	**99.66%**	Percentage for accident and emergency care	**100%**

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

Information governance (IG)

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

In order to further strengthen existing Trust policy and to prevent repeat incidents in areas where incidents have occurred during 2021-22 the following key actions were undertaken:

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

Assurance continues to be provided to the Board of Directors that systems and processes are being constantly assessed and improved to ensure that information is safe. The Data Security and Protection Standards for health and care are set out in the National Data Guardian's (NDG) ten standards and are measured though the completion of the Data Security Protection Toolkit (DSPT). All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practicing good data security and that personal information is handled correctly.

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

Freedom of Information (FOI)

The Trust continues to respond to Freedom of Information requests from members of the public on a range of topics across all services and departments, complying with the 20 working day limit to do so. The act is regulated and enforced by the Information Commissioners Office (ICO). The ICO hold powers to enforce penalties against the Trust when it does not comply with the Act, including but not limited to monetary fines. For the year 2021-22 the Trust received 507 requests with a compliance level, as of 31 March 2022, of 97% with complete compliance data available after 30 April 2022. This was achieved despite Trust services experiencing significant pressure during the Covid-19.

Clinical coding error rate

Clinical coding translates medical terms written by clinicians about patient diagnosis and treatment into codes that are recognised nationally.

North Tees and Hartlepool Foundation Trust was *not subject* to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

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

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

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

The errors include both coder and documentation errors of which the coding errors will be fed back to the coders as a group and individually. The documentation errors will be taken to directorate meetings.

Depth of coding and key metrics is monitored by the Trust in conjunction with mortality data. Targeted internal monthly coding audits are undertaken to provide assurance that coding reflects clinical management. Any issues are taken back to the coder or clinician depending on the error. The clinical coders are available to attend mortality review meetings to ensure the correct coding of deceased patients.

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

Specific issues highlighted within the audit will be fed back to individual coders and appropriate training planned where required. **North Tees and Hartlepool NHS Foundation Trust** will be taking the following actions to improve data quality. The coding department has undergone a re-structure in order to facilitate coding medical episodes from case notes.

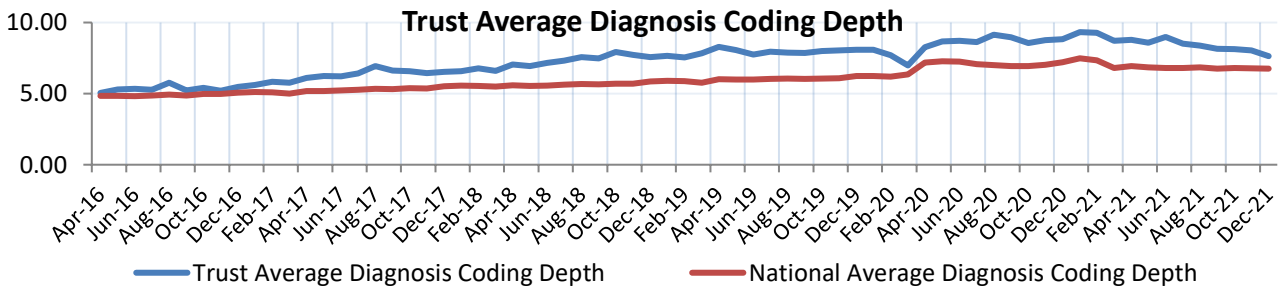
Unfortunately, due to the impact of COVID and losing three WTE coders, the department has failed to code the episodes within the required time scales. This has resulted in a backlog of workload and the difficult decision was taken to pull back from coding all medical episodes from case notes and use the discharge summary as the source documentation. There were exceptions, however, to minimise the impact on the mortality indicators and all long stay and deceased patients continue to be coded from the case notes. A contract coder has also been employed to help to reduce the backlog. There is a recovery plan in place and it is hoped the deadlines will be introduced again in the summer. The HSMR and SHMI mortality indicators are constantly being reviewed and so far, the change in coding practice, has not had a negative impact on them. When the medical coding does return to the case notes EAU and ambulatory will still be coded from the discharge summary as the increase in daily workload coupled with the imbalance in the team dynamic means that maintaining coding accuracy while continuing to achieve 100% of coding within the mandatory time deadlines is increasingly challenging. In order to improve the flow of medical case notes being sent to the coding department a temporary red sticker has been piloted on the medical base wards. The sticker instructs whoever has the case notes at that time to send them to the coding department. The pilot was deemed a success, and the system was rolled out to all wards across the Trust.

In July 2020 the Trust went live with Active Clinical Notes (ACN). Active Clinical Notes allows traditional paper-processes and pathways to be made available digitally. This means the clinical details of patient's diagnoses and treatments are now added directly to the patient's Electronic Patient Record (EPR). Nursing pathways are currently not available electronically and are still manually completed and filed within the patient's case notes. As a result of this change it has allowed the coding department to introduce an opportunity for some of the coders to work from home. In June 2021 the Coding Department started a twelve week homeworking trial period. After the initial trial period the homeworkers coding was audited and the results showed the quality of coding carried out at home was on a level with the coding carried out within the trust. As a result the home working was made permanent. Continuous audits will be carried out to ensure the levels of accuracy are maintained.

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

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

The Trust has continued to make great strides in improving the accuracy and depth of patient coding, the following chart demonstrates the increase (blue) against the national average (red). The Trust has improved the quality of discharge documentation and actively engaged clinicians to work closely with Clinical Coding. The latest depth of coding shows the Trust having an Average Diagnosis Depth of **7.63** (December 2021) compared with the National average of **6.76.**



Part 2d: Core set of Quality Indicators

	The data made available to the trust by NHS Digital with regard to — the value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period **July 2020 – August 2021**.	NHS DIGITAL

SHMI Definition

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

Summary Hospital-level Mortality Indicator (SHMI) – Deaths associated with hospitalisation, England, **September 2020 – August 2021**

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

SHMI Regional – September 2020 – August 2021

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

The **North Tees and Hartlepool NHS Foundation Trust** considers that this data is as described for the following reason. SHMI mortality data when reviewed against other sources of mortality data including Hospital Standardised Mortality Ratio (HSMR) and when benchmarked against other NHS organisations will provide an overview of overall mortality performance either within statistical analysis or for crude mortality.

The **North Tees and Hartlepool NHS Foundation Trust** has taken the following actions to improve this indicator and so the quality of its services. The Trust continues to undertake mortality reviews over two sessions each week, this is in line with the Secretary of State for health requirements for all Trusts to undertake mortality reviews; this continues to be supported by the CQC. This has been supported by the inclusion of the mortality reviews in the quality work

undertaken by all consultant staff as part of their annual appraisal. The information is input directly onto a dedicated database; this is then used to extract data for reporting.

The clinical reviews undertaken provide the organisation with the opportunity to assess the quality of care being provided as this will continue to be the priority over and above the statistical data. The Trust's review process is linked closely with the work being undertaken regionally and the Trust is working jointly with local Trusts to utilise a web based system to store mortality reviews that can be linked into the national system once this is agreed and in place. All Trusts in the region are undertaking reviews and Trust staff meet with them on a regular basis to share best practice and to also consider areas of focus across the region as well as locally.

The awareness, work and engagement has been delivered during 2020-21, this continues to make an impact on the HSMR and SHMI values, and have led to both of these statistics being reported as being "within expected" ranges. Whilst the Trust recognises that the values have maintained an excellent position over a number of months, the actions already initiated are being followed to completion and there are further areas being identified for review, and potential improvement work, from the analysis of a wide variety of data and information sources on a regular basis.

Measure	Measure Description	Data Source
1b	The data made available to the trust by NHS Digital with regard to — The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust – **Jul 2020 – Aug 2021**	NHS DIGITAL

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

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

Latest Time Period benchmarking position – September 2020 – August 2021

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

The **North Tees and Hartlepool NHS Foundation Trust** considers that this data is as described for the following reason. The use of palliative care codes within the Trust is now a fully embedded practice. The processes and procedures are continuously reviewed to ensure that the Specialist Palliative Care team are reviewing patients in a timely manner.

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

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

The Trust continues to work with commissioners to review pathways of care and support patient choice of residence at end of life wherever possible. Further work is also on-going with GPs to try and reduce inappropriate admissions to the Trust.

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

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

Apr 20 to Mar 21, Data from NHS Digital

April 19 to March 20	*Groin hernia	*Varicose vein	Hip replacement – Primary	Hip replacement – Revisions	Knee replacement – Primary	Knee replacement – Revisions
Trust Score	No data	No data	0.468	No data	0.394	No data
National Average	No data	No data	0.459	0.307	0.335	0.295
Highest National	No data	No data	0.468	0.338	0.394	0.394
Lowest National	No data	No data	0.409	0.307	0.312	0.295

Apr 19 to Mar 20, Data from NHS Digital

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

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

The Trust continues to use the telephone review clinics, thus ensuring that communication remains open with the patient listening and acting upon any issues/concerns that they may have.

Measure	Measure Description	Data Source
3	The data made available to the trust by NHS Digital with regard to the percentage of patients aged— (i) 0 to 15; and (ii) 16 or over. readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.	NHS DIGITAL

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

The **North Tees and Hartlepool NHS Foundation Trust** considers that this data is as described for the following reasons. The Trust monitors and reports readmission rates to the Board of Directors and Directorates on a monthly basis. The December 2019 position (latest available data) indicates the Trust has an overall readmission rate of 10.01% against the internal stretch target of 7.70%, indicating the Trust's readmission rates have slightly decreased by 0.95% from the same period in the previous year (10.96% - December 2018).

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

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

Period of Coverage	National Average	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST (out of 100)
2021 22	Not Available	Not Available
2020 21	Not Available	Not Available
2019-20	67.10	62.60
2018-19	67.20	65.20
2017-18	68.60	68.70
2016-17	68.10	67.20
2015-16	69.60	67.70
2014-15	68.90	68.10

*2019-20 & 2020-21 data not available at the time of print

Benchmarked against over North East Trusts for 2019-20;

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

NB: Average weighted score of 5 questions relating to responsiveness to inpatients' personal needs (Score out of 100)

The scores are out of 100. A higher score indicates better performance: if patients reported all aspects of their care as "very good" we would expect a score of about 80, a score around 60 indicates "good" patient experience. The domain score is the average of the question scores within that domain; the overall score is the average of the domain scores. The Trust has worked hard in order to further enhance its culture of responsiveness to the personal needs of patients.

The **North Tees and Hartlepool NHS Foundation Trust** considers that this data is as described for the following reasons. The Trust has developed its Patients First strategy and understanding patient views in relation to responsiveness; and personal needs helps us to understand how well we are performing.

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

Measure	Measure Description	Data Source
5	The data made available to the trust by NHS Digital with regard to the percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	NHS DIGITAL

All NHS organisations providing acute, community, ambulance and mental health services are now required to conduct the Staff Friends and Family Test each quarter.

The aim of the test is to:

- "Encouraging improvements in service delivery" – by "driving hospitals to raise their game"

The Trust believes that the attitude of its staff is the most important factor in the experience of patients. We will continue to work with staff to develop the leadership and role modeling required to further enhance the experience of patients, carers and staff.

National NHS Staff Survey

Question: If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust

	Survey Year				
Trust Name	**2017**	**2018**	**2019**	**2020**	**2021**
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	77	83	88	87	84
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	58	59	61	66	60
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	**67**	**71**	**72**	**74**	**70**
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	89	90	91	91	85
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	69	71	64	76	76
GATESHEAD HEALTH NHS FOUNDATION TRUST	81	81	82	80	75
SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST			70	71	65
North East	72	74	75	78	74
England	70	70	71	74	68
National High	**86**	**95**	**-**	**92**	**-**
National Low	**47**	**41**	**-**	**48**	**-**

Peoples Pulse – Staff

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

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

*Oct 21 information taken from the NHS National Staff Survey

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

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

*Oct 21 information taken from the NHS National Staff Survey

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

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

*Oct 21 information taken from the NHS National Staff Survey

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

The **North Tees and Hartlepool NHS Foundation Trust** has taken the following actions to further improve this percentage, and so the quality of its services, by involving the views of the staff in developing a strategy for care. We have a range of opportunities for staff to be involved in develop changes across the organisation which ensures we each have a voice that counts with clear linkage to the NHS People Plan.

National Staff Survey

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

2015	2016	2017	2018	2019	2020	*2021	2021 National Average
19.90%	16.10%	18.90%	16.60%	15.90%	15.70%	**15.20%**	**19.50%**

*2021 released In March 2022

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

2015	2016	2017	2018	2019	2020	*2021	2021 National Average
90.50%	90.60%	93.2%	91.10%	88.90%	88.10%	**86.30%**	**82.50%**

*2021 released In March 2022

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

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

Two year reporting trend

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

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

North East Trust benchmarking 2019-20

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

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

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

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

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

The Trust ensures that each Directorate clinical lead is responsible for monitoring and audit of compliance of NICE VTE guidelines and this is presented yearly to the Audit and Clinical Effectiveness (ACE) Committee.

Venous thromboembolism (VTE) mandatory training 2021-22	93%

*Data obtained from the Trust training department

Measure	Measure Description	Data Source
7	The data made available to the trust by NHS Digital with regard to the rate per 100,000 bed days of cases of C difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.	NHS DIGITAL

	Rate per 100,000 bed-days for specimens taken from patients aged 2 years and over				
Reporting Period	Trust C difficile cases	*Trust Rate	*National Average	*Highest National rate	*Lowest National rate
Apr 2020 Mar 2021	**49**	**16.38**	**12.27**	**41.53**	**0.00**
Apr 2019 – Mar 2020	53	13.20	10.71	64.61	0.00
Apr 2018 – Mar 2019	31	16.40	12.20	79.97	0.00
Apr 2017 – Mar 2018	35	17.90	13.70	91.00	0.00
Apr 2016 – Mar 2017	39	18.80	13.20	82.70	0.00

* 2020-21 numbers as of 30 March 2022, additional detail not available at the time of print

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

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

- Enhanced ward cleaning and decontamination of patient equipment, including the use of steam, hydrogen peroxide and Ultraviolet (UV) light.
- Exploration of new patient products such as commodes to ensure they are easy to clean and fit for purpose.
- The continued use of the mattress decontamination service to reduce the risk of infection and improve quality of service to patients.
- Raised awareness and audit of antimicrobial prescribing and stewardship including the identification of antibiotic champions for each directorate and the introduction of competency assessments for prescribers. The Trust again participated in European Antibiotic Awareness day with displays for staff around prudent prescribing. Awareness has also been raised via the CQUIN scheme to reduce overall antibiotic consumption and ensure that prompt review of antibiotics takes place.
- Continued emphasis on high standards of hand hygiene for staff and patients, utilising hand hygiene champions and a monthly RAG report.
- Monitoring of the management of affected patients to support ward staff and ensure guidance is being adhered to.
- The continuation of annual update training in infection prevention and control for all clinical staff.
- Review of all hospital onset cases by an independent panel to ascertain whether the infection was avoidable and to ensure all learning has been identified.
- Collaborative working with partner organisations to standardise guidance and promote seamless care for patients who move between care providers.

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

Measure	Measure Description%	Data Source
8	The data made available to the trust by NHS Digital with regard to the number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	NHS DIGITAL

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

Provider: Acute (Non Specialist) – Organisational incident data by organisation in 6-month period, **October 2019 – March 2020**

	Based on occurring dataset (Degree of Harm – All)		National			Our Trust	
			Degree of harm Severe or Death			Degree of harm Severe or Death	
Report period	Number of incidents occurring	Rate per 1000 Bed Days	Average %	Highest %	Lowest %	Number of incidents	%
Oct 19 Mar 20	**3,820**	**41.60**	**0.16**	**0.49**	**0.01**	**26**	**0.30**
Oct 18 – Mar 19	1,580	16.90	0.16	0.49	0.01	15	0.16
Oct 17 – Mar 18	4,582	44.80	0.15	0.55	0.00	18	0.18
Oct 16 – Mar 17	3,087	29.80	0.15	0.53	0.01	5	0.05

Regional Benchmarking

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

*Data for Oct 19 – Mar 20

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

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

positive safety culture is associated with increased reporting and as such, the Trust continuously monitors the frequency of incident reporting and strives to increase reporting in all areas. The Trust is targeting the reporting of no and low harm incidents, which can provide valuable insights into preventing future incidents of patient harm. In relation to frequently occurring incidents such as falls and pressure damage, the Trust have developed templates within the incident reporting system to identify contributory factors of incidents, identify trends, develop improvements and evaluate the impact of these.

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

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

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

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

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

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

Part 3a:

Additional Quality Performance measures during 2020-21

This section is an overview of the quality of care based on performance in 2020-21. In addition to the three local priorities outlined in Section 2, the indicators below further demonstrate that the quality of the services provided by the Trust over 2020-21 has been positive overall.

The following data is a representation of the data presented to the Board of Directors on a monthly basis in consultation with relevant stakeholders for the year 2020-21. The indicators were selected because of the adverse implications for patient safety and quality of care should there be any reduction in compliance with the individual elements.

Patient Safety

Falls

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

A post falls checklist is completed and is used to help categorise the fall into the classification of No Harm, Low Harm, Moderate Harm, Severe Harm or Death.

Falls with No Harm

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

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

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

Falls with Low Harm

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

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

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

Falls with Moderate Harm

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

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

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

Falls with Severe Harm

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

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

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

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

Falls with Death

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

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

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

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

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

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

Never Events

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

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

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

Since 2015 the Trust has had **9** Never Events and they are broken down as follows:

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

The NHS England report can be accessed via:

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

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

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

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

Effectiveness of Care

Medication Errors

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

In **2020-21** there were **540** medicines incident reports via Datix. In **2021-22** there has been **617** incident reports. A small number of these incidents originate from external organisations such as GPs and care homes.

Type of incidents	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021 22
Prescribing	147	224	138	141	172	162	**141**	**155**
Administration	314	321	413	386	468	376	**305**	**345**
Dispensing	43	48	72	78	61	83	**42**	**56**
Other	50	16	62	65	74	57	**52**	**61**
Total	**554**	**609**	**685**	**670**	**775**	**713**	**540**	**617**

* Data from the Trusts Datix system

Medicines Safety Committee (MSC)

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

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

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

Pharmacy service improvements in promoting medicines safety

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

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

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

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

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

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

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

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

Clinical Effectiveness Indicators

These indicators for Clinical Effectiveness are covered under the section of Effectiveness of Care. The Trust has decided to include more detail around some of the Clinical Effectiveness indicators; this will be built on year on year, including more detailed data around the Monitor Compliance Framework.

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

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

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

*Data from Trust Clinical Effectiveness Team

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

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

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

Patient Experience

Complaints

The Trust continues to work hard to improve customer satisfaction through patient experience.

We do recognise that we don't always get things right and this is why we have a dedicated **patient experience team** to listen to and ensure concerns and complaints are investigated.

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

Number of Complaints – 2021-22

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

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

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

2021-22 Complaints by complaint type:

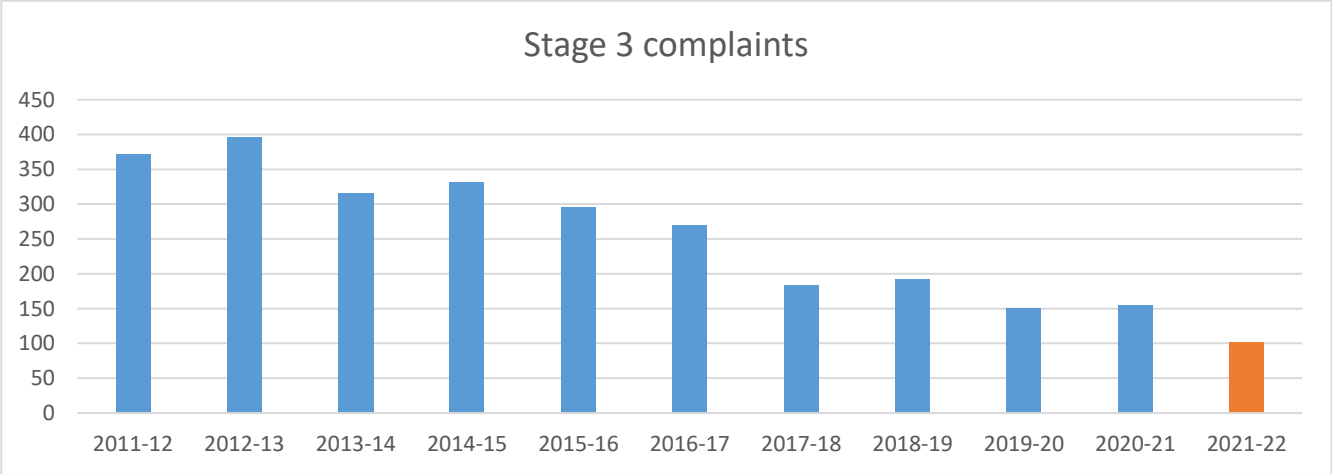
Please see the following breakdown for the Top 12 primary complaint themes from the **92 Stage 3** complaints received in 2021-22

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

*Data obtained from Datix as end of March 2022

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

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



*Data obtained from Datix upto March 2022

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

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

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

Number of complaints

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

Complaints upheld by Trust

The number of Stage 3 complaints upheld is below:

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

Referred to PHSO

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

Complaints upheld by PHSO

During 2021-22 there were no cases upheld during this financial year.

Action taken to improve services

The Trust takes all complaints raised seriously and actions are taken to improve service issues identified. The most common theme identified for 2020-21 was staff attitude. Civility Training has been rolled out within the Trust from Autumn 2020-21. Additionally, where specific staff are identified, their attitude/communication with service users and relatives is investigated and raised with staff directly, via their line manager. The staff are then supported to reflect on the concerns raised; in order to consider any individual areas of improvements that can be made.

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

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

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

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

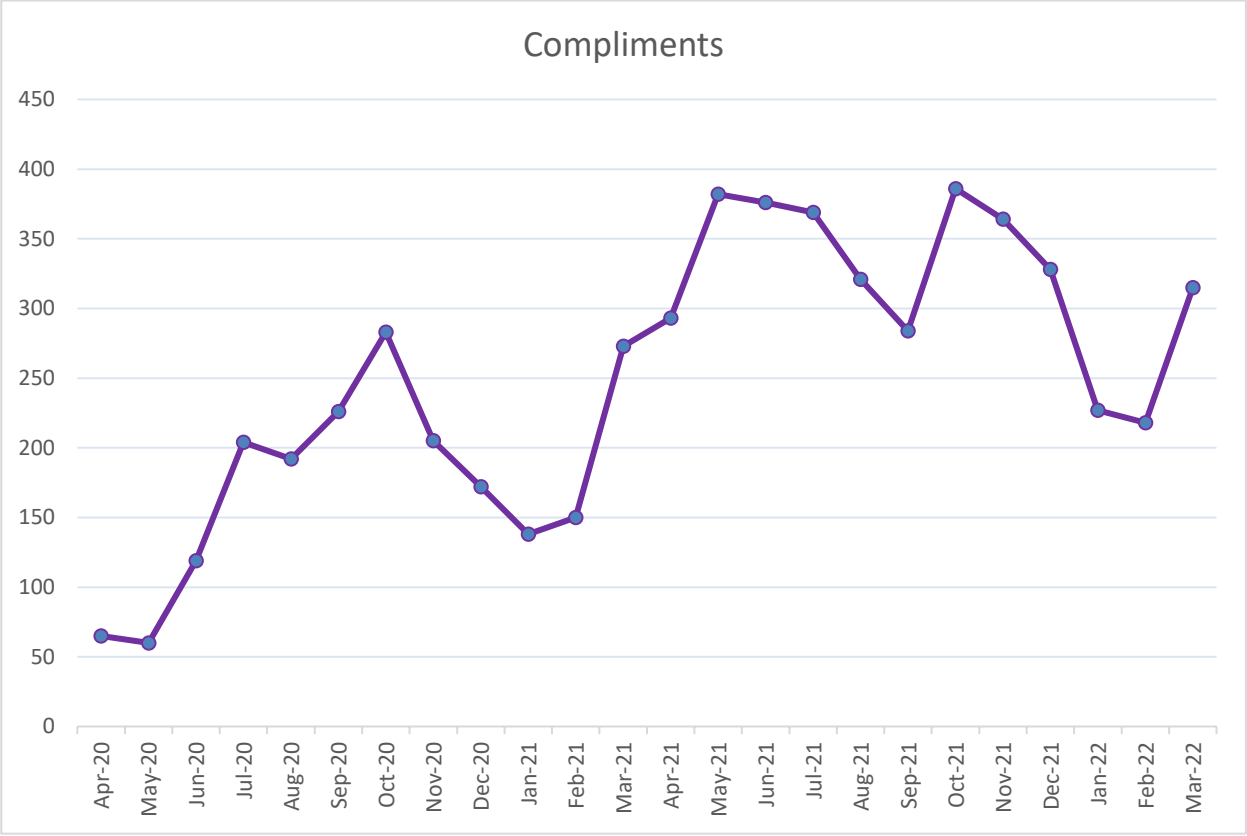
A new letter template for responding to Stage 3 complaints has been introduced and resulted in a reduction in the number of further contacts received, this will continue to be monitored.

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

Compliments

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

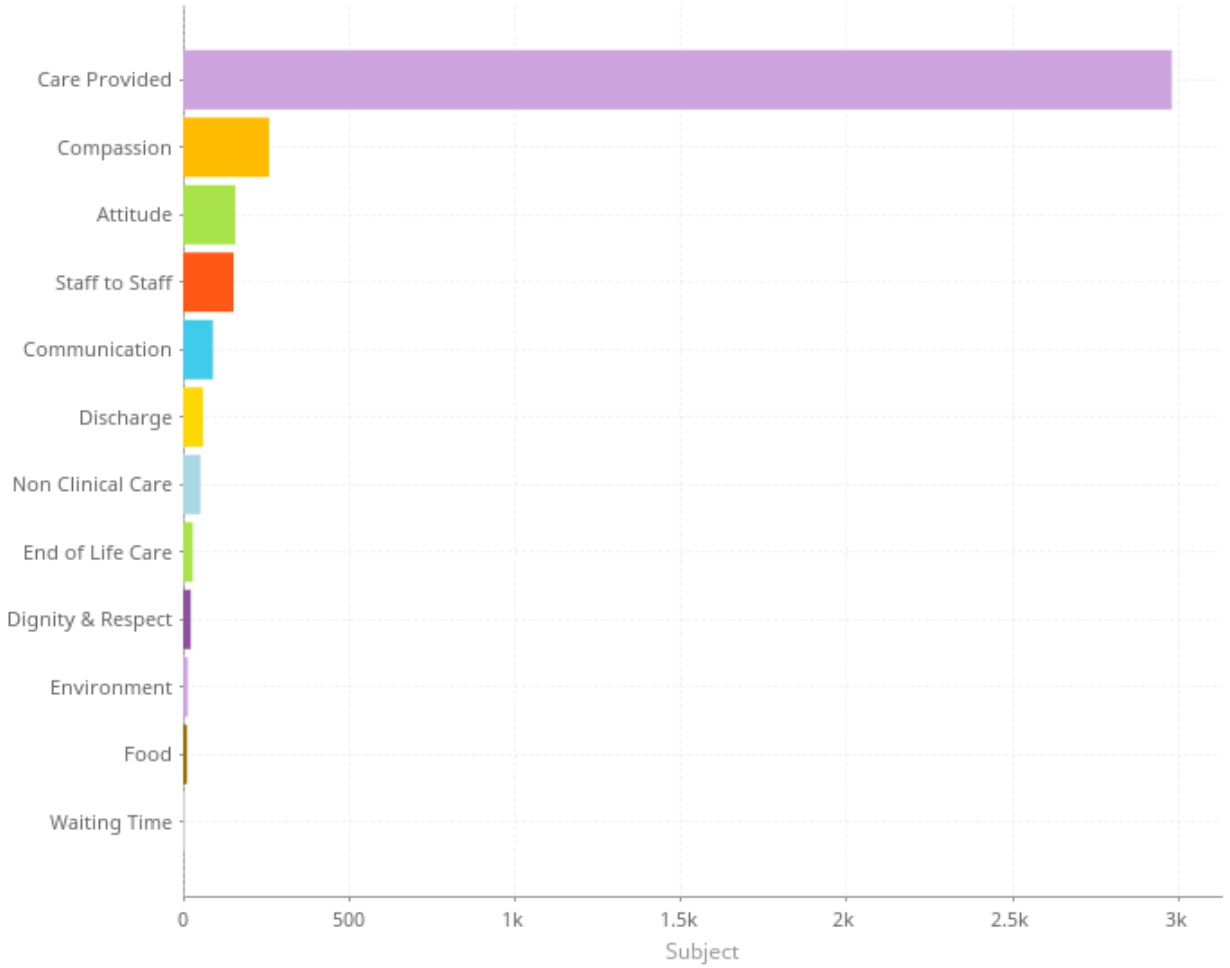
Financial Year	Number of Compliments
2020-21	2,087
2021-22	**3,863**



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

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

Compliment Subject



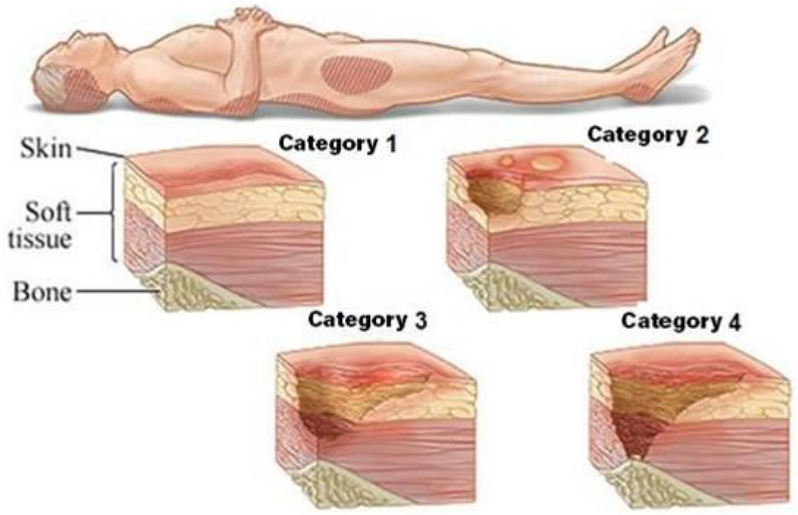
To improve the numbers and qualitative data around compliments, the Trust has established a Greatix system within the existing incidents platform to capture the relevant data.

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

> Just wanted to say thank you for the care and support given to the family member. [sic]

Pressure Ulcers

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



Year on Year Comparison – In-*Hospital Acquired*

Reporting Period	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021 22
Category 1	78	39	38	54	92	64	48
Category 2	258	128	189	198	299	233	272
Category 3	12	9	20	35	34	14	16
Category 4	1	1	2	2	3	3	2
Total	**349**	**177**	**249**	**289**	**428**	**314**	**338**

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

Year on Year Comparison – Out of Hospital *Acquired*

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

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

Actions taken by the Trust:

Pressure damage is one of the top five reported incidents within the Trust; with risk assessment, prevention and management being guided through the application of NICE guidelines and quality standards. The incidents are reported via datix and the Trust has developed a checklist within the system to capture the overall data in relation to pressure ulcer incident reporting. The checklist also supports colleagues reviewing such incidents by providing a consistent approach towards decision making in relation to the level of investigation required. All incidents are quality checked, after reporting, by the Tissue Viability Nurses. The numbers of pressure ulcer incidents are discussed at the Senior Clinical Professionals Huddle each week and monitored through the Tissue Viability Operational Group, Quality Reference Group which informs the integrated professional Board meeting.

The Tissue Viability Operational Group has the remit of reviewing the Trust's functioning programs of improvement, Trust policies and guidelines. Quarterly audits by the directorates are undertaken and the TVN and quality teams are looking at enhancing the use of internal audit data, presented on the Trust dashboards, to continue to improve quality. An annual pressure ulcer prevalence audit is also undertaken for patients on the community nurse caseload and patients in hospital in-patient beds. Following the moderation of results, an improvement plan is negotiated with the Directorate Leads to provide assurance that there is evidence of continuous improvement and performance. The Trust continues with "Our Journey to Outstanding" and the Quality Improvement Strategy aims to place quality improvement at the heart of everything the Trust does, with a focus on the needs of our patients, families and carers. Therefore, as part of this journey the Trust has developed a Pressure Ulcer Assurance Framework which aims to give assertion of progression of excellent practice within pressure ulcer prevention as well as identifying any areas of improvement needed. During the COVID-19 pandemic staff have continued to be educated and empowered through ongoing support to reduce unwarranted variation and provide the very best care to every patients, every day. The agenda for pressure ulcer prevention is underpinned by evidence, research and best practice with measurable outcomes ensuring we do the right thing at the right time.

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

Communication between services continues to be improved in order to provide seamless holistic care for our patients moving between hospital and community. A key element of this is ensuring wound care information is passed onto the next care provider. The Tissue Viability service have developed their SystmOne functionality to allow those that are able to access the patients' health care record to see the input of the TVN team regardless of which clinical area the patient is in when they are seen by the TVN team. This has already helped with continuity of care for these patients that move between services. The TVN team are exploring further ways of enhancing communication between services.

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

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

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

Section 3b:

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

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

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

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

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

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

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

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

Additional Assurance:

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

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

Annex A: Third party declarations

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

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

NHS Tees Valley CCG commissions healthcare services for the population of Darlington, Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton-On-Tees. The CCG take seriously their responsibility to ensure that the needs of patients are met by the provision of safe, high quality services and therefore welcome the opportunity to submit a statement on the Annual Quality Account for North Tees and Hartlepool NHS Foundation Trust (NTHFT).

The quality of services delivered, and associated performance measures are the subject of debate and discussion at the Clinical Quality Review Group (CQRG) meetings. The meetings are well attended and provide an opportunity to gain assurance that there are robust systems in place to support the delivery of safe, effective and high-quality care.

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

Commissioners are pleased to note from the 2021/22 Quality Account that the Trust continues to be a strong performer in relation to the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) mortality values. The values continue to report within the 'as expected' range and below the national average. Furthermore, the utilisation of national and regional agreed tools to ensure that this position is upheld is acknowledged. The Commissioners would like to express gratitude to staff who continue to contribute towards maintaining this position in challenging times. Commissioners will continue

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

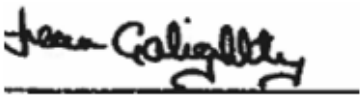
Unfortunately, in 2021/22 the Trust reported three 'Never Events'. All serious incidents are managed through the serious incident process and the Commissioners will continue to work with the Trust to identify and share learning and appropriate improvement actions.

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

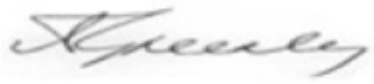
The CCGs can confirm that to their best knowledge the information provided within the NTHFT 2021/22 Annual Quality Account is an accurate and fair reflection of the Trust's performance. It is clearly presented in the format required and the information it contains accurately represents the Trust's Quality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

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

Yours sincerely



Jean Golightly
Director of Nursing & Quality
NHS Tees Valley CCG



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

Hartlepool Healthwatch – 17 June 2022

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

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

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

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

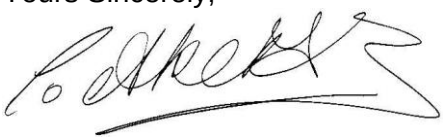
In respect of accessibility, we would welcome intervention by Estates when considering the reconfiguration of services at Hartlepool hospital. A prime example is the location of the lung clinic, which is difficult to access given the physical journey through the hospital that may exacerbate a patient's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

Communication could be improved around patient leaflets and equality of access to patients who may be Deaf/ Blind /Visually impaired or with dual sensory loss. There is a need for appropriate & improved signage for patients especially those living with a disability. Access routes should be clearly identified and appropriate signage displayed / use of plain English and easy read where possible; accessible toilets/changing places conveniently located to promote dignity and independence.

Finally patient care to be considered for dementia sufferers who are admitted with another diagnosis as the primary reason for hospitalisation. Following on from this delayed discharge data should be collected for patients with communication/other support needs. Information at discharge should always be accessible (i.e. Deaf patients not given telephone number to call ward for advice post discharge). There should always be communication support at discharge to ensure patients understand the outcome of the treatment, future appointments as well as patients understanding what prescribed medication is for, how to take correctly and known side effects etc.

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

Yours Sincerely,



Christopher Akers-Belcher

Chief Executive - Healthwatch Hartlepool

Stockton Healthwatch – 16 June 2022

Healthwatch Stockton-on-Tees are pleased to report back on the 2021/22 Quality Accounts and note the significant achievements and the clear useful data explaining how North Tees and Hartlepool NHS Foundation Trust is performing against other Trusts in the region and nationally. The report is comprehensive and provides an excellent overview of how the Trust demonstrates quality of healthcare, its general performance and how it manages its services. It was pleasing to note that the Trust has maintained ongoing involvement with Healthwatch Stockton-on-Tees and taken account of our thoughts and recommendations where they were helpful.

We noted the Covid-19 pandemic having had a considerable impact on the management and staffing across the Trust and we share our sincere condolences with the families and friends of the 716 people across the Borough who have died in hospital since March 2020. We also note the setting up of the Long Covid Clinic with 660 patients referred so far showing the impact Covid continues to have.

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

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

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

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

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

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

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

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

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

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

The Trusts Council of Governors – 17 June 2022

Council of Governors

(third party declaration)

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

Governors also have the opportunity to review the draft Quality Account to provide general comments regarding its content and design, and to highlight any areas where it is felt further scrutiny or greater assurance is required. The Council of Governors is kept fully appraised in respect of the Trust's priority areas and future developments through a number of forums which include the formal Council of Governor meetings; development sessions; pre-Council of Governor meetings and the sub-committee structure. During 2021/22, the ongoing presence of the COVID-19 pandemic meant that some of the Trust's key meetings were undertaken on a virtual basis as well as reduced capacity in order to adhere to statutory guidelines. Development sessions were facilitated for Governors and included the People Plan, Estates Strategy, Stroke Services, Special Care Baby Unit and Community Diagnostic Centres.

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

Within the sub-committee structure the Strategy and Service Development Committee reviews new developments and strategic plans. At this Committee presentations were provided in respect of the Yellowfin Business Intelligence tool, the COVID-19 Vaccination Hub, in addition to being presented with the Integrated Performance Report at every meeting. These meetings provide the opportunity for detailed debate and interaction with the Governors to seek their views and knowledge.

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

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

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

Audit and Governance Committee – Third Party Declaration 2021/22

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

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

Patient Safety;
Effectiveness of care; and
Patient Experience.

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

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

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

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

Yours faithfully
STATUTORY SCRUTINY MANAGER

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Healthcare User Group (HUG) – 16 May 2022

Third Party Statement from the Healthcare User Group (HUG)

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

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

2020 was a year "like no other" but 2021 too, had many other pressures to exert upon the NHS, as the Alpha, Beta and Delta variants and lately, the Omicron variant had swept through the country and our region. So, 2021 - 22 was another year when there were no HUG visits to inpatient wards or outpatient clinics, but those members of our group who were able to attend meetings remotely continued to do so.

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

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

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

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

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

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

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

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

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

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

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

Healthcare User Group

May 2022

Annex B: Quality Report Statement

Statement of Directors' Responsibilities in Respect of the Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust boards should put in place to support data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

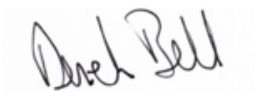
- the content of the Quality Report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2021-22* and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2021 to April 2022
  - papers relating to Quality reported to the Board over the period April 2021 to April 2022
  - feedback from commissioners dated xx *2022*
  - feedback from governors dated 17 *2022*
  - feedback from local Healthwatch organisations dated 16 June *2022&* 17 June *2022*
  - feedback from the Adult Services and Health Select Committee and Audit and Governance Committee dated 17 June *2022 &* 21 *2022*
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated *Q4 2021-22*
  - the latest national patient survey *2019*
  - the latest national staff survey *2020*
  - the Head of Internal Audit's annual opinion over the Trust's control environment dated 16 *May 2019*
  - CQC Quality Report – Inspection Report 14 March 2018
  - the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered;
  - the performance information in the Quality Report is reliable and accurate;
  - there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
  - the data underpinning the measures of performance in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
  - the Quality Report has been prepared in accordance with NHS Improvements annual reporting guidance (which incorporates the Quality Accounts Regulations) as well as the standards to support data quality for the preparation of the quality report

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board

Date 31 May 2022 Date 31 May 2022

Chief Executive



Chairman

Annex C: Independent Auditors' Limited Assurance Report

Independent Auditors' Limited Assurance Report to the Council of Governors of North Tees and Hartlepool NHS Foundation Trust on the Annual Quality Report

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

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

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

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

Patient Experience Team

North Tees & Hartlepool NHS Foundation Trust

Hardwick Road

Stockton-on-Tees

Cleveland

TS19 8PE

.....

Thank you for your time.

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

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

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

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

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

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Alternatively you can email us at: **nth-tr.PatientExperience@nhs.net** with the Subject **Quality Accounts**

Glossary

A&E	Accident and Emergency
ACE Committee	Audit and Clinical Effectiveness Committee – the committee that oversees both clinical audit (i.e. monitoring compliance with agreed standards of care) and clinical effectiveness (i.e. ensuring clinical services implement the most up-to-date clinical guidelines)
ACL	Anterior Cruciate Ligament – one of the four major ligaments of the knee
AKI	Acute Kidney Injury
AHP	Allied Health Professional
AMT	Abbreviated Mental Test
AquA	Advancing Quality Alliance
BI	Business Intelligence
CAB	Citizens Advice Bureau
CABG	Coronary Artery Bypass Graft (or “heart bypass”)
CAUTI	Catheter-associated urinary tract infection
CFDP	Care For the Dying Patient
CCG	Clinical Commissioning Group
CCOT	Critical Care Outreach Team
CDI	Clostridium difficile Infection
CHKS	Comparative Health Knowledge System
CIAT	Community integrated assessment team (CIAT)
Clostridium Difficile (infection)	An infection sometimes caused as a result of taking certain antibiotics for other health conditions. It is easily spread and can be acquired in the community and in hospital
CLRN	Comprehensive Local Research Network
CMR	Crude Mortality Rate
CNS	Clinical Nurse Specialist
COHA	Community onset Healthcare Associated
COPD	Chronic Obstructive Pulmonary Disease
CLIP	Complaints Litigation Incidents Performance
CPIS	Child Protection Information System
CPMS	Central Portfolio Management System
CSE	Child Sexual Exploitation
CSP	Co-ordinated System for gaining NHS Permission
CQC	The Care Quality Commission – the independent safety and quality regulator of all health and social care services in England

CQRG	Clinical Quality Review Group
CQUIN	Commissioning for Quality and Innovation – a payment framework introduced in 2009 to make a proportion of providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care
DAHNO	Data for Head and Neck Oncology (Head and Neck Cancer)
DARs	Data Analysis Reports
Datix	Datix is the Trust incident reporting system
DH	Department of Health
DLT	Discharge Liaison Team
DNA	Did Not Arrive
DNACPR	Do Not Attempt Cardio Pulmonary Resuscitation
DoLS	Deprivation of Liberty Safeguards
DSCP	Durham Safeguarding Children Partnership
DSPT	Data Security Protection Toolkit
DToC	Delayed Transfer of Care
DVLA	Driver and Vehicle Licensing Agency
EAU	Emergency Assessment Unit
E coli (infection)	Escherichia coli – An infection sometimes caused as a result of poor hygiene or hand-washing
ED	Emergency Department
EMSA	Eliminating mixed sex accommodation
EPMA	Electronic Prescribing and Medication Administration
EPR	Electronic Patient Record
EOL	End of Life
ESR	Electronic Staff Record
EWS	Early Warning Score – a tool used to assess a patient's health and warn of any deterioration
FCE	Finished Consultant Episode – the complete period of time a patient has spent under the continuous care of one consultant
FGM	Female Genital Mutilation
FICM	Faculty of Intensive Care Medicine
FOI (act)	The Freedom of Information Act – gives you the right to ask any public body for information they have on a particular subject
FFT	Friends and Family Test
FSCO	First Stop Contact officer

FTSU	Freedom To Speak Up
FTSUG	Freedom To Speak Up Guardian
Global trigger tool (GTT)	Used to assess rate and level of potential harm. Use of the GTT is led by a medical consultant and involves members of the multi-professional team. The tool enables clinical teams to identify events through triggers which may have caused, or have potential to cause varying levels of harm and take action to reduce the risk
GCP	Good Clinical Practice
GM	General Manager
HCAI	Health Care Acquired Infection
HED	Healthcare Evaluation Data (A major provider of healthcare information and benchmarking)
HEE	Health Education England
HENE	Health Education North East
HES	Hospital Episode Statistics
HLSCB	Hartlepool Local Safeguarding Children Board
HMB	Heavy Menstrual Bleeding
HOHA	Hospital Onset Healthcare Associated
HQIP	Healthcare Quality Improvement Partnership
HRG	Healthcare Resource Group – a group of clinically similar treatments and care that require similar levels of healthcare resource
HSCB	Hartlepool Safeguarding Children Boards
HSMR	Hospital Standardised Mortality Ratio – an indicator of healthcare quality that measures whether the death rate in a hospital is higher or lower than you would expect
HSSCP	Hartlepool and Stockton Safeguarding Children Partnership
HUG	Healthcare User Group
IBD	Inflammatory Bowel Disease
ICC	Infection Control Committee
ICE	
ICNARC	Intensive Care National Audit and Research Centre
ICO	Information Commissioners Office
ICS	Intensive Care Society
IG	Information Governance
IHA	Initial Health Assessment
IMR	Intelligent Monitoring Report tool for monitoring compliance with essential standards of quality and safety that helps to identify where risks lie within an organisation

LD	Learning Difficulties
ICE	Integrated Clinical Environment
IG	Information Governance
Intentional rounding	A formal review of patient satisfaction used in wards at regular points throughout the day
IPB	Integrated Professional Board
IPC	Infection Prevention and Control
ISPA	Integrated Single Point of Access
Kardex (prescribing 154ardex)	A standard document used by healthcare professionals for recording details of what has been prescribed for a patient during their stay
KEOGH	Sir Bruce Keogh
Kleb sp	Klebsiella Species (type of infection)
KPI	Key Performance Indicator
LAC	Looked After Children
LADO	Local Authority Designated Officer
LAR	Looked After Review
LD	Learning disabilities
LeDeR	Learning Disabilities Mortality Review
Liverpool End of Life Care Pathway	Used at the bedside to drive up sustained quality of care of the dying patient in the last hours and days of life
LMS	Local Maternity System
LPMS	Local Portfolio Management Systems
LPS	Liberty Protection Systems
LQR	Local Quality Requirements
LSCB	Local Safeguarding Children's Board
MARAC	Multi Agency Risk Assessment Conferences
MATAC	Multi Agency Tasking and Co-ordination
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK
MCA	Mental Capacity Act
MDT	Multidisciplinary Team
ME	Medical Examiner
MEG	Missing Exploited Group
MHA	Mental Health Act
MHRA	Medicines and Healthcare products Regulatory Agency
MIU	Minor Injuries Unit

MINAP	The Myocardial Ischaemia National Audit Project
MRSA	Methicillin-Resistant Staphylococcus Aureus – a type of bacterial infection that is resistant to a number of widely used antibiotics
MSSA	Methicillin-Sensitive Staphylococcus Aureus
MUST	Malnutrition Universal Screening Tool
NCEPOD	The National Confidential Enquiry into Patient Outcome and Death
NCPES	National Cancer Patient Experience Survey
NCRN	National Cancer Research Network
NDG	National Data Guardian
NEAS	North East Ambulance Service
NEEP	North East Escalation Plan
NEPHO	North East Public Health Observatory
NEQOS	North East Quality Observatory System
NEWS	National Early Warning Score
NHS Improvements	The independent regulator of NHS foundation Trusts
NICE	The National Institute of Health and Clinical Excellence
NICOR	The National Institute for Cardiovascular Outcomes Research
NIHR	National Institute for Health Research
NNAP	National Neonatal Audit Programme
NQB	National Quality Board
NRLS	National Learning and Reporting System
NTHFT	North Tees and Hartlepool Foundation Trust
OD Banding	Overdispersion (statistical indicators)
OFSTED	The Office for Standards in Education
PalCall	Palliative care, out-of-hours telephone helpline for patients and carers registered with our services
PALS	Patient Advice and Liaison Service
PAS	Patient Administration System
Patient Safety and Quality Standards (Ps&Qs) Committee	The committee responsible for ensuring provision of high quality care and identifying areas of risk requiring corrective action
PET	Patient Experience Team
PHE	Public Health England
PIC	Patient Identification Centre
PICANet	Paediatric Intensive Care Audit Network
PMRT	Perinatal Mortality Review Tool
PREVENT	the government's counter-terrorism strategy
PROMs	Patient Reported Outcome Measures
Psa	Pseudomonas Aeruginosa (Type of Infection)

Pseudonymisation	A process where patient identifiable information is removed from data held by the Trust
QAF	Quality Assessment Framework
Quality Improvement	
R&D	Research and Development
RA	Recruitment Activity
RAG	Red, Amber, Green chart denoting level of severity
RCA	Root Cause Analysis
RCOG	The Royal College of Obstetricians and Gynaecologists
RCPCH	The Royal College of Paediatric and Child Health
REPORT-HF	International Registry to assess Medical Practice with longitudinal observation for Treatment of Heart Failure
RESPECT	"Responsive, Equipped, Safe and secure, Person centered, Evidence based, Care and compassion and Timely" – a nursing and midwifery strategy developed with patients and governors aimed at promoting the importance of involving patients and carers in all aspects of healthcare
RHA	Review Health Assessments
RMSO	Regional Maternity Survey Office
SBAR	Situation, Background, Assessment and Recommendation – a tool for promoting consistent and effective communication in relation to patient care
SCM	Senior Clinical Matron
SCMOoH	Senior Clinical Matron Out-of-Hours
SCR	Serious Case Review
SEPSIS	Life-threatening reaction to an infection
SHA	Strategic Health Authority
SHMI	Summary Hospital Mortality-level Indicator – a hospital-level indicator which reports inpatient deaths and deaths within 30-days of discharge at Trust level across the NHS
sic	The Latin adverb ***sic*** ("thus"; in full: *sic erat scriptum*, "thus was it written"), inserted immediately after a quoted word or passage, indicates that the quoted matter has been transcribed exactly as found in the source text, complete with any erroneous or archaic spelling, surprising assertion, faulty reasoning, or other matter that might otherwise be taken as an error of transcription.
SINAP	Stroke Improvement National Audit Programme
SLSCB	Stockton Local Safeguarding Children Board
SMPG	Safety Medical Practices Group
SOF	Single Oversight Framework
SOP	Standard Operating Procedures
SPA	Single Point of Access
SPC	Specialist Palliative Care
SPCT	Specialist Palliative Care Team

SPEQS	Staff, Patient Experience and Quality Standards
SPICT	Supportive & Palliative Care Indicator Tools
SPOC	Single point of contact
SSKIN	Surface inspection, skin inspection, keep moving, incontinence and nutrition
SSU	Short Stay Unit
STAMP	Screening Tool for the Assessment of Malnutrition in Paediatrics
STEIS	Strategic Executive Information System
STERLING	Environmental Audit Assessment Tool
SUS	Secondary User Service
TEWV	Tees, Esk and Wear Valleys NHS Foundation Trust
TIA	Transient Ischemic Attack
TNA	Training Needs Analysis
Tough-books	Mobile computers aim to ensure that community staff has access to up-to-date clinical information, enabling them to make speedy and appropriate clinical decisions
TRAKCARE	Electronic Patient Record System
TSAB	Tees-Wide Safeguarding Board
UCC	Urgent Care Centre
UHH	University Hospital of Hartlepool
UHNT	University Hospital of North Tees
UKST	UK Sepsis Trust
UNIFY	Unify2 is an online collection system used for collating, sharing and reporting NHS and social care data.
UTI	Urinary Tract Infection
UV	Ultra Violet
VEMT	Vulnerable, exploited, missing, trafficked
VSGBI	The Vascular Society of Great Britain and Ireland
VTE	Venous Thromboembolism
WRAP	Workshop to Raise Awareness of PREVENT
WTE	Whole Time Equivalent - is a unit that indicates the workload of an employed person in a way that makes workloads or class loads comparable
4at delirium assessment tool	Bedside medical scale used to help determine if a person has positive signs for delirium

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Carbon Reduction Programme Performance Targets										
Date:	28th July 2022										
Prepared by:	Stuart Watkin (Head of Engineering and Complinace) Steven Taylor (Assistant Director Estates & Capital)										
Executive Sponsor:	Mike Worden (Managing Director										
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 Patients First	X	Valuing our 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:

- **Carbon Reduction Measures:** In 2021/22, the Trust's Carbon Footprint increased by 7% due in part to the recovery from COVID-19, increased heating due to open windows, the service developments of new departments, new CT Scanner, new Air Handling Units and Electric Vehicle charging.
- **Long Term Carbon Reduction Performance:** Against the government benchmark year of 2007/08, the Trust has reduced its Carbon Footprint by **over 30%** and now looks to be net-zero carbon by 2050. (80% reduction by 2030).
- **On-Site Solar Panels Generating "Green" Electricity**: Since installation the solar panels on the UHNT site have generated over 686,000 kWh's of green and free electricity. This is enough to power over 190 homes for 1 year. This has also saved the Trust circa £102,000 off its electricity bill to date.
- **Electric Vehicle Charging**: 52 vehicle charging positions have now been installed on Trust premises for transport vehicles, staff and the public.
- **Green / zero carbon imported electricity from 1 April 2020:** The Trust has purchased 100% green electricity for all imported electricity since 1 April 2020. This was mandated for all public bodies to be able to record zero-carbon for their electrical imports.
- **The Trust Green Plan was approved at Trust Board in 2021**: As part of the wider ICS strategic drive to net zero carbon. This has rightly raised the bar for the annual carbon reduction target to 5%.

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 Jun 22
Recommendation	To continue to support the Carbon Management Programme and the work of the new Sustainable Development Steering Group

Meeting of the Board of Directors

2022

Executive Summary

Carbon Reduction Programme

Report of the Managing Director of North Tees and Hartlepool Solutions LLP

Presented:	Levi Buckley
Reporting Period:	2021-2022
Agreed by:	Stuart Watkin / Steven Taylor

Strategic Aim
(The full set of Trust Aims can be found at the beginning of the Board Reports)

Maintain Compliance and Performance

Strategic Objective
(The full set of Trust Objectives can be found at the beginning of the Board Reports)

Maintain Compliance and Performance

1. Introduction

1.1 The NHS Sustainable Development Unit (SDU) reported in 2010 that the wider NHS community in England was responsible for more than 30 million tonnes of CO_2. 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.

1.2 The government has progressed these targets, with the aim of making public services net-zero carbon, and as such is prioritising the decarbonisation of heating within public buildings over the next 20 years.

1.3 The NHS, because of its significant impact, has been involved throughout; through a progressive Carbon Management Programme, and against a trend of increasing activity and associated energy increases, the Trust has made savings of 30% since 2010. In partnership with NTH Solutions, the Sustainability Development Management Group is planning a wide range of measures to reduce our carbon footprint still further and aspire to become net-zero by 2040.

2. Key Issues

2.1 NTS Solutions spent £2.17M on Gas and Electric during FY2021/22 on behalf of the Trust. This is a significant increase (38%) on previous years and was greatly influenced by price increases in Oct 21 and then the Ukraine Conflict starting in Mar 22. The cost impact will continue to be felt into FY2022/23 and beyond.

2.2 The initial period of the Carbon Management Programme was completed successfully in 2016 achieving carbon reductions of 20%. Since then, a further targeted reduction of 2% per year, has seen carbon reductions reach more than 30%. The past 2 years have been heavily influenced by the COVID-19 pandemic, but this year has seen a rise in the carbon footprint of 7.2% against FY2020/21. This has been as a result of:-

- Increased clinical activity across the Trust (during covid and the ongoing covid recovery).
- increased heating demands due to windows having been opened to aid air flow throughout COVID.
- Significant capital investment to provide new ventilation plant and equipment for new clinical services (A&E, Respiratory Support Unit and the third CT scanner being significant elements),
- And the introduction and utilisation of 52 electric vehicle charging points across the 3 main sites, which now accounts for 2.5% of Trust's electrical load.

2.3 NTH Solutions is working with Veolia Environmental Services on a feasibility study with the potential to significantly reduce the carbon footprint. The aim is to seek funding through the government's Public Service Decarbonisation Scheme (PSDS) and where possible seek Trust capital. The full report is due in July, but a high level investment summary has been presented to identify some early measures.

2.4 The Trust Green Plan was also developed and approved at Trust Board in 2021, as part of the wider ICS strategic drive to net zero carbon. This has rightly raised the bar for the annual carbon reduction target to 5%. In reality, the reductions are likely to be "step change" reductions as new renewable plant becomes operational and new technology solutions emerge rather than an a consistent annual 5% reduction.

2.5 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. This has avoided over £265,000 of costs on the annual gas bill.

3. Recommendation

The Board is requested to receive this report and note the key issues in driving down the carbon footprint; the need to minimise energy usage, invest in equipment and optimize the hospital sites for the long term to support government targets on carbon emissions and drive down operating costs.

Mike Worden
Managing Director
North Tees and Hartlepool Solutions LLP

Meeting of the Board of Directors

2022

Executive Summary

Carbon Reduction Programme

Report of the Managing Director of North Tees and Hartlepool Solutions LLP

1. Introduction / Background

1.1 To update Trust Board members of 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 Trust Board support for an on-going programme of works and to demonstrate that a focus on behavioural changes can drive down carbon usage across procurement, travel and the environment. Achieving a reduction in carbon emissions in the longer term will result in a reduction in energy costs and the avoidance of carbon tarrifs.

1.2 The NHS Sustainable Development Unit (SDU) reported in 2010 that the wider NHS community in England was responsible for more than 30 million tonnes of CO_2. 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.

1.3 The government has progressed these targets, with the aim of making public services net-zero carbon, and as such is prioritising the decarbonisation of heating within public buildings over the next 20 years.

1.4 The NHS, because of its significant impact, has been involved throughout; through a progressive Carbon Management Programme, and against a trend of increasing activity and associated energy increases, the Trust has made savings of 30% since 2010. In partnership with NTH Solutions, the Sustainability Development Management Group is planning a wide range of measures to reduce our carbon footprint still further and aspire to become net-zero by 2040 (80% reduction by 2030).

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.

Over the past 2 years, a further £580k of Trust capital has been spent on LED lighting and upgrades to the building management system and air conditioning to improve energy efficiency and reduce the carbon impact with a return on investment of 3 years. Further funding has seen more energy efficient lifts and air handling units installed as part of the capital investment in backlog maintenance.

The next stage for the Board will be to support a business case to seek Public Sector Decarbonisation Scheme (PSDS) funding in late 2022 for a major carbon reduction scheme at Hartlepool and where possible, Trust funding for schemes presented for North Tees as a direct result of the ongoing feasibility study in support of the Trust's Heat Decarbonisation Plan.

Hartlepool

The study has revealed that it would be possible to use ground source heat pumps, utilising the water table under the hospital, to generate heating and hot water, rather than use the gas-fuelled boilers. Electric power for this would be generated from large-scale Solar Photo-Voltaic (PV) arrays installed across the site.

North Tees

Due to the restrictions on the qualification for PSDS funding, the new energy centre precludes the trust from applying at this time. However, the study has revealed that there is a distinct early advantage to increasing self-generation through Solar PV, and upgrading the heat distribution network to provide greater efficiency. The use of blended natural gas /hydrogen in the gas network would also yield carbon reductions over the next 5-10 years.

The feasibility study works would likely provide a significant part of the Trust's overall 80% carbon reduction target by 2030.

2.2 **Carbon Implications**

The ongoing implementation of the Carbon Management Programme continues to make a significant impact on the carbon footprint. Against a trend of increasing activity and associated energy increases, the Trust has made carbon reduction savings of 30% since 2010 in support of the government's 2050 targets (Appendix 1).

There has been a distinct change in focus within government policy, and that focus is now upon decarbonising the heat used in our buildings. Currently most of the heating and hot water is raised by steam from the gas-fired boilers or from waste heat from the gas-fired CHP. Gas being a fossil fuel is carbon heavy, so any move away from this will reduce our carbon emissions. Our Heat Decarbonisation Plan provided a high-level assessment of what is required over the next 5-10 years, and now the feasibility study will direct how best to start to address and prepare for the changes required.

Building planners are now assessing the societal impact of energy usage in public buildings in that different fuels have different impacts on society and the local environment in terms of carbon impact, supply costs, pollutants and air quality.

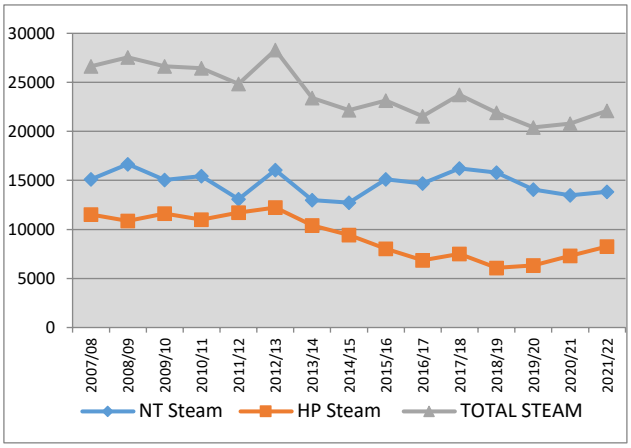
The trust's Sustainability Development Management Group is also developing a wide range of measures to reduce our carbon footprint still further, challenge and change behaviours, and aspire for North Tees and Hartlepool NHS Foundation Trust to become net-zero by 2040.

Notwithstanding all the good work and investment, the carbon footprint for FY2021/22 increased by 7.2% [using the 2010 benchmark system] to 11,034 TonnesCO_2e.
In trying to evaluate the issues, it is clear that both steam and electrical demands have risen as a result of:

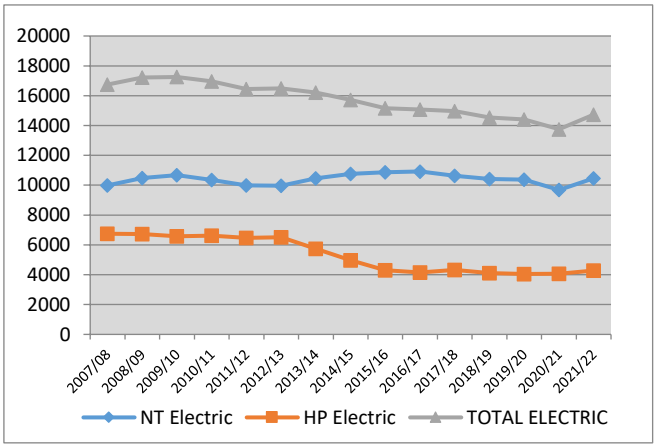
- Increased clinical activity

- Increased heating demands as windows have been opened to aid air flow throughout COVID
- Significant capital investment in department upgrades that have introduced additional air handling plant and equipment.
- Introduction of electric vehicle charging which now accounts for 2.5% of site electrical load.

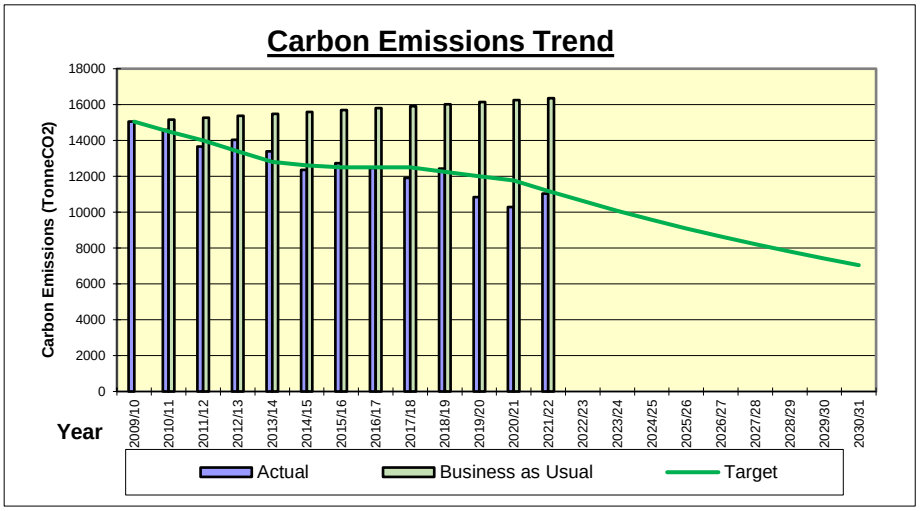
TOTAL STEAM DEMAND (MWh)



TOTAL ELECTRICAL DEMAND (MWh)



Nonetheless the trend in carbon reduction is still on target and, subject to approval, new schemes will help advance further reductions.



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) satisfy the requirements.

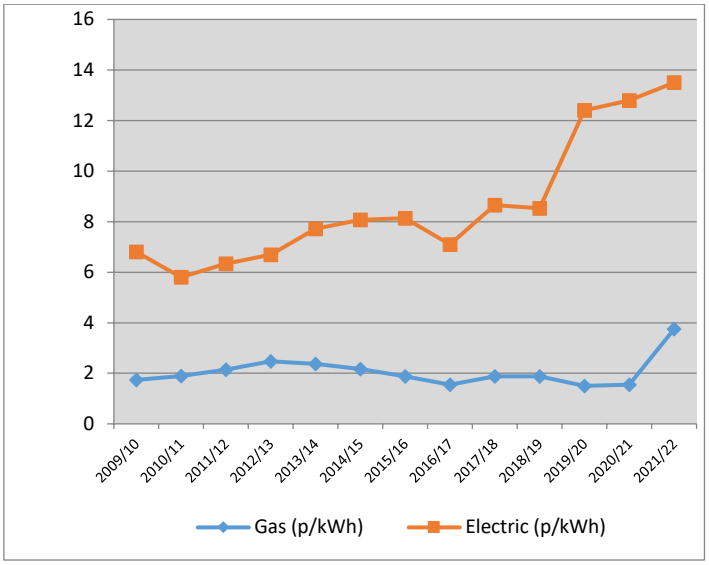
2.3 Finance Implications

NTS Solutions spent £2.17M on Gas and Electric during FY2021/22 on behalf of the Trust. This is a significant increase on previous years and was greatly influenced by world-wide price increases in Oct 21 and then the Ukraine Conflict starting in Mar 22.

Gas is traded in cost/therm and then sold to users based on p/kWh:

- Apr 21 - gas was being traded at 50-60p/therm,
- Oct 21 - prices hit £3/therm before dropping back to £1/therm in Feb
- Mar 22 – prices initially rose above £6/therm ending about £2.50/therm.

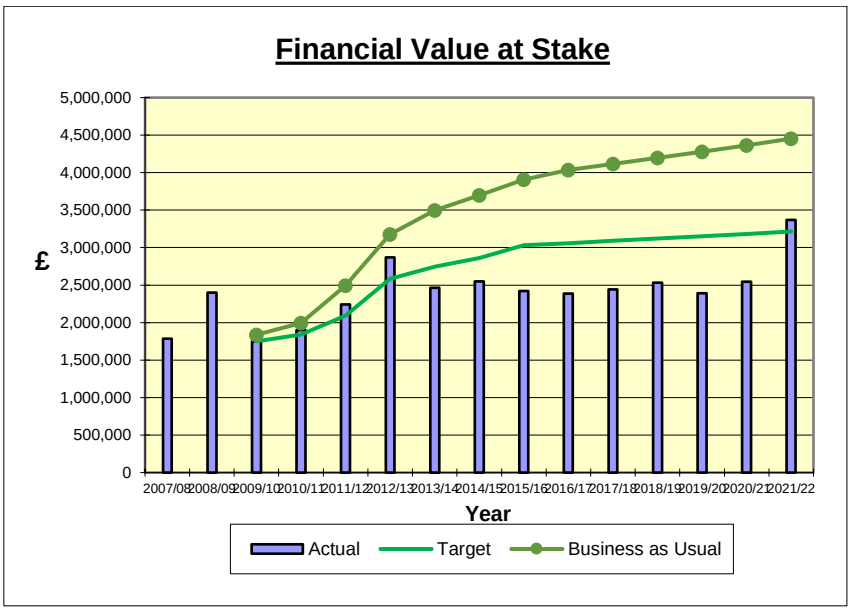
The following plot demonstrates the <u>average</u> annual prices for each commodity:



The impact of gas price increases is clear, and is likely to continue upwards in FY2022/23. Gas commodity prices have stayed at near 2p/kWh for much of the past decade, but in March 22, our bills saw prices of 4.6p/kWh and a single month gas invoice at North Tees was £208,000.
Electrical per unit cost increases over the past 3 years have been due to increasing non-commodity charges and taxes. The impact of the gas increases has yet to be felt in electrical costs.

Given these increases, it imperative to reduce our electrical and steam demands wherever possible. Investment in self-generation through Solar PV now makes more economic sense, and despite the current carbon impact of CHP, financially it is still the best option financially for the next 5-10 years.

The Financial Value at stake is presented here to show the step up in costs, but note the Business as Usual and Target trends were based on a 2% increase year-on-year on the benchmark elements and cannot account for the 38% in-year increase in gas & electric.



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. This has avoided over £265,000 of costs on the annual gas bill.

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, travel and 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.

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, tax avoidance, seeking ways to drive down energy consumption and promoting investment in key infrastructure (such as the new Energy Centre at North Tees), and 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 (and NHS Target of 2040), with the establishment of the Sustainable Development Management Group.

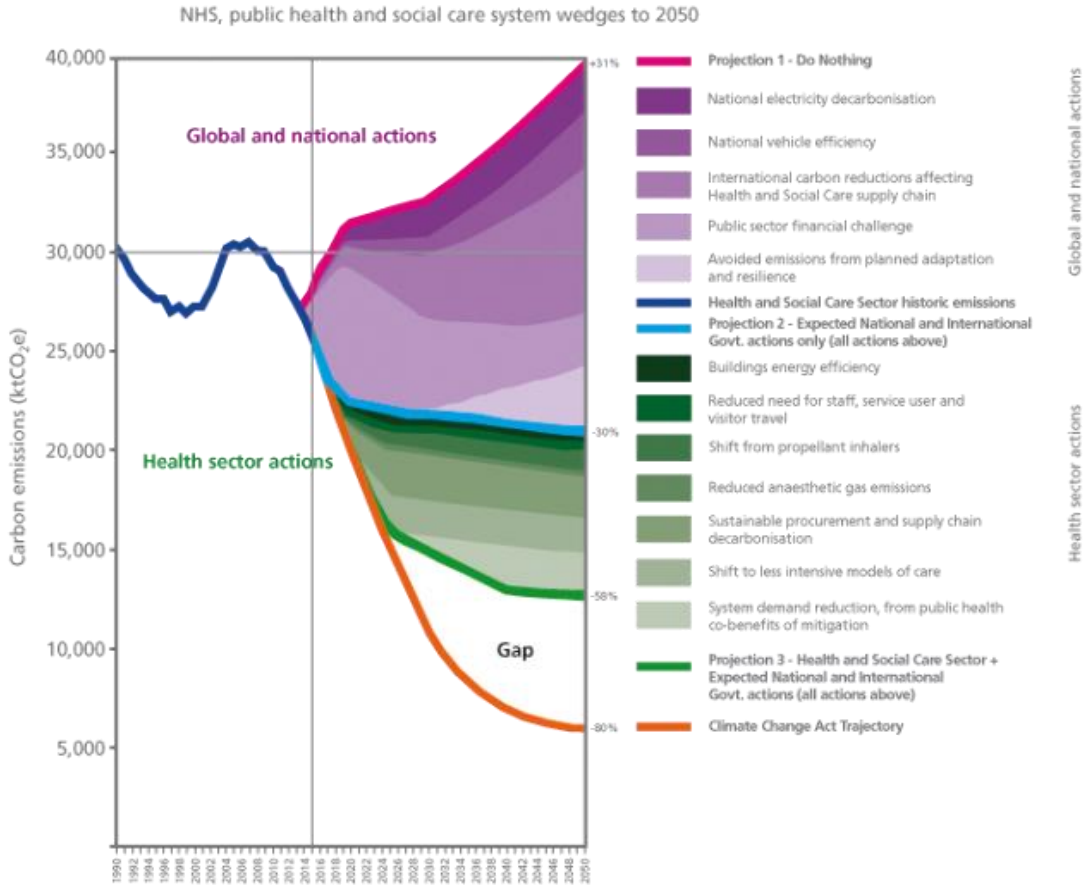
3.3 The next phase has started with the ongoing feasibility study into decarbonising the buildings; the follow-up will be to seek innovation, investigate novel technologies and drive through the recommendations made having sought appropriate funding mechanisms.

4. Recommendation

The Board is requested to receive this report and note the key issues in driving down the Carbon Footprint; the need to minimise energy usage, invest in equipment and optimize the hospital sites for the long term to support government targets on carbon emissions and drive down operating costs.

Mike Worden
Managing Director
North Tees and Hartlepool Solutions LLP

Appendix 1


NHS, public health and social care system wedges to 2050
Carbon emissions (ktCO2e)
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
Global and national actions
Health sector actions
Gap
+31%
-30%
-58%
-80%
Projection 1 - Do Nothing
National electricity decarbonisation
National vehicle efficiency
International carbon reductions affecting Health and Social Care supply chain
Public sector financial challenge
Avoided emissions from planned adaptation and resilience
Health and Social Care Sector historic emissions
Projection 2 - Expected National and International Govt. actions only (all actions above)
Buildings energy efficiency
Reduced need for staff, service user and visitor travel
Shift from propellant inhalers
Reduced anaesthetic gas emissions
Sustainable procurement and supply chain decarbonisation
Shift to less intensive models of care
System demand reduction, from public health co-benefits of mitigation
Projection 3 - Health and Social Care Sector + Expected National and International Govt. actions (all actions above)
Climate Change Act Trajectory
Global and national actions
Health sector actions

Appendix 2

Greenhouse Gas Emissions

Area		Non-Financial Data			Financial Data		
		2019/20	2020/21	2021/22	2019/20	2020/21	2021/22
Finite Resources	Electricity	1003.8 MWh	1595.8 MWh	1694.3 MWh	£441,846	£320,616	£285,704
		278.1 tCO2	0 tCO2 (1)	0 tCO2			
	Gas	56,551 MWh	56,027 MWh	57,257 MWh	£1,169,273	£1,249,039	£1,887,627
		10179.2 tCO2	10309 tCO2	10535 tCO2			
	Oil	239,069 kWh	102,924 kWh	174,060 kWh	£58,000	£12,434	£40,000
		63.4 tCO2	27.3 tCO2	44.6 tCO2			
Waste	Total Waste	1567 t	1435 t	1448 t	£814,290	£372,431	£399,277
Hazardous Waste	Clinical waste to alternative treatment of incineration	196 t	408 t	298 t			
		44.3 tCO2	92.2 tCO2	67.3 t			
Non-hazardous Waste	Landfill	0 t	51 t	63 t			
		0 tCO2	22.8 tCO2	37.0 t			
	Re-used / Recycled	360 t	285 t	258 t			
	Incinerated with Energy Recovery	951 t	681 t	810 t			
	Electrical Waste (WEEE)	5 t	10 t	20 t			
Travel	Commercial Vehicles Diesel	541,574 miles	0 (2)	0	£97,641	£0	£0
		97.5 tCO2	0 tCO2	0 tCO2			
	Lease Vehicles Petrol	23,971 miles	191,234 miles	222,326 miles	£4,576	£36,506	£59,450
		4.3 tCO2	34.4 tCO2	59.8 tCO2			
	Lease Vehicles Diesel	0	95,519 miles	32,820 miles	£0	£22,533	£10,840
		0 tCO2	17.2 tCO2	9.1 tCO2			
	Business Miles	1,178,594	1,000,823	1,115,121	£212,490	£180,440	£281,465
		212.1 tCO2	184.0 tCO2	314.0 tCO2			
Water	Water Consumption	132,944 m3	138,894 m3	142,623 m3	£350,097	£362,736	£370,310
		53.7 tCO2	56.1 tCO2	49.1 tCO2			

Notes:

1. Electricity is now from Green Tariff so no Carbon Footprint
2. Finance now report Business miles and lease mileage directly.

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Health, Safety & Security Annual Report 2021/2022										
Date:	28th July 2022										
Prepared by:	Katie Joyce, (Health and Safety Manager) Sharon Mee, Assistant Director Governance, Compliance & Company Secretary										
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 Health, Safety and Security Annual Performance for 2021/22										
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 health and safety performance over the FY 2021-2022 as well the achievements, key issues / future activity for 2022-2023.

Key Issues:

- 31 RIDDOR incidents reported to the HSE;
- There were a total of 859 incidents in the Abuse, Violent, Disruptive, Self Harming Behavior category;
- A total of 163 (19%) physical assaults (malicious/unintentional) were committed on staff by patients or visitors during the year April 2021 to March 2022, compared to 141 the previous year, an increase of 16% per cent;
- Of the reported physical assaults 156 occurred within North Tees, 5 occurred at Hartlepool and 2 in the community, 141 of the physical assault occurred in Care Group 2;
- The majority are non-intentional and were caused by the patient's medical condition;
- 88 of the 163 incidents were committed by those patients aged 60+;
- It is important to note that out of 163 assaults, 152 were unintentional and were due to lack of capacity, and 11 were categorised as malicious. Only 7 were reported to the police;
- 80 fire alarm incidents reported – 2 actual fire and 78 unwanted alarms;
- 21% of waste produced was clinical, there was a 27% decrease in clinical waste from what was
- reported last year;
- 79% of waste produced was domestic;
- There was a 29% increase in sharps incidents;
- 43 safety alerts disseminated and reported via CAS site, 42 complete within deadline and 1 on-going within deadline;
- 492 Inspections were undertaken by the Health and Safety team.

16 fire warden sessions delivered training 71 fire wardens	
How this report impacts on current risks or highlights new risks:	
This report does not raise any new risks.	
Committees/groups where this item has been discussed	Health, Safety & Security Committee - 19/07/2022 NTH Solutions LLP Management Board - 21/07/2022
Recommendation	Note the content of the report.

Health, Safety & Security Annual Report

FINANCIAL YEAR 2021 / 2022

Presented: 07/06/2022

Reporting period:	FY2021/22
Author:	Katie Joyce : 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: 01-04-2021 to 31-03-2022. It should be noted that the information recorded in bi-monthly 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

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 2021/22

The following key performance indicators are part of the Master Services Agreement with the Trust, the tables overleaf indicates performance through 2021-22.

2.1 North Tees & Hartlepool Solutions Performance Indicators

Performance indicators have been developed for the Health and Safety service and these are shown in the Appendix 1. The main areas for performance review include:

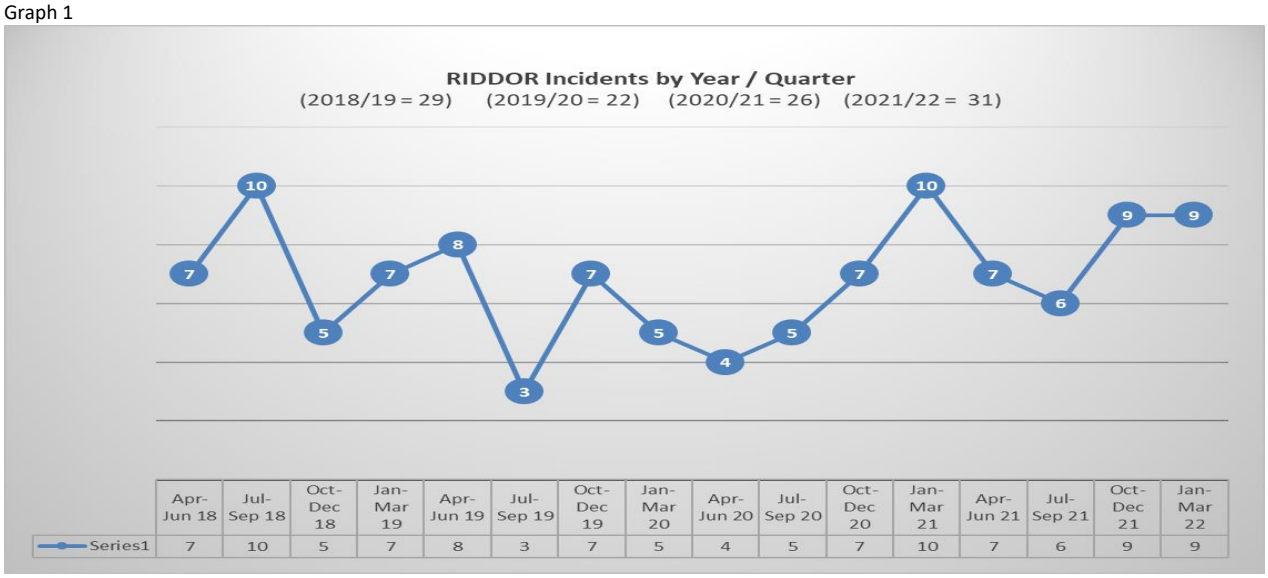
- RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations)
- Reportable incidents
- Inspections
- Enforcement Notices
- Physical assault against staff incidents Malicious & unintentional
- Fire : Actual Fire Alarm - Fire Brigade attended, Unwanted (False) Fire Alarm - Fire Brigade attended, Unwanted (False) Fire Alarm - NIL Brigade attendance
- Central Alerting System compliance statistics

- Number of high/ moderate risks and number of out of date risks.

2.2 RIDDOR Reportable Incidents

A total of 31 RIDDOR incidents were reported to the HSE during 2021-22 compared to 26 reported in 2020-21, which is an 18% increase in RIDDOR reportable incidents since the previous year.

Graph 1



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, as follows:

- slips trip and falls (16)
- trap or struck incidents (4)
- collisions (3)
- manual handling incidents (3),
- abuse incidents (2)
- Strain (2).
- scalding incidents (1),

Of the 31 reported incidents 22 were in the over 7-day category for reporting and the remanding 9 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 563.5 lost days due to RIDDOR accidents at work shared between 23 employees. This is **322.5** days more compared to the previous year of 2021-22 (241).

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 = **£57,379.77**

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.

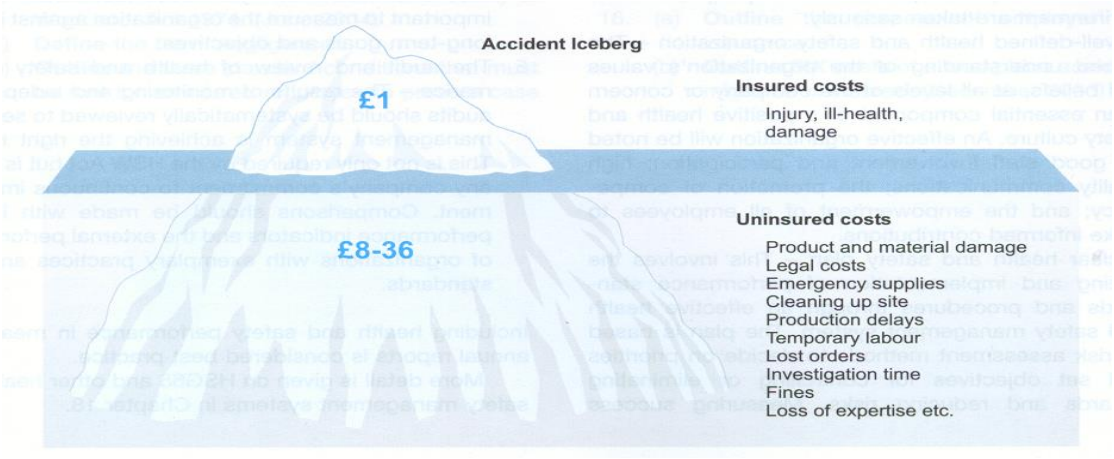


Figure 1 Iceberg model

Based on this equation, the calculated hidden cost accrued by the Trust for RIDDOR reportable accidents, equates to ***£459,038.16*** **(*as a minimum*) and *£2,065,671.72* (*as a maximum*).**

These figures are for accidents, which occurred within the financial year of 2021 – 22.

2.3 Security

North Tees and Hartlepool NHS Foundation Trust comprises of two acute sites located in residential areas and an Integrated Community Service. There are 24-hour Accident and Emergency facilities on the North Tees site and a 24-hour Urgent Care Centres located on both sites.

The security issues are typical of those associated with the NHS and primarily consist of:

- violence and aggression
- theft of personal property
- damage to and theft of organisational property

The Trust has a legal duty under section 2 of the Health and Safety at Work Act 1974 to ensure the health and safety of employees, and under section 3 to ensure, so far as is reasonably practicable, that person not in his employment who may be affected thereby are not thereby exposed to risk to their health.

Security management is concerned with the provision of safeguards to protect property and the safety of those who work in and use the Trust's premises. Security is the responsibility of all staff, not only protecting their own wellbeing, but that of patients, visitors etc. The safeguarding of the Trust property and private property against crime is of paramount importance.

In total there were 119 Incidents logged on DATIX, in the category for Security, when compared to the incidents for the previous year 2020/21 it demonstrates a small decrease of 1.65% in the category of security.

Analysis of the incidents showed Care Group areas where incidents occurred (see Table 1).

Table 1

Locations	No
Care Group 1 – Healthy Lives	13
Care Group 2 – Responsive Care	49
Care Group 3 – Collaborative Care	13
Trust Corporate	4
NTH Solutions	40
Total	**119**

It was necessary to involve the police with 17 of the security incidents.

2.4 Incidents of Physical Assault against Staff

North Tees and Hartlepool NHS Foundation Trust and North Tees and Hartlepool Solutions continue to regard violence and aggression towards staff as a primary priority area for action.

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.

There were a total of 859 incidents in the Abuse, Violent, Disruptive, Self Harming Behavior category. A total of 163 (19%) physical assaults (malicious/unintentional) were committed on staff by patients or visitors during the year April 2021 to March 2022, compared to 141 the previous year, an increase of 16% per cent. Of the reported physical assaults 156 occurred within North Tees, 5 occurred at Hartlepool and 2 in the community.

The range of staff assaults as evidenced in table 2.

Table 2

Type of Physical Assault on staff	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total
Punch / thump	17	13	5	7	42
Grab	11	8	10	5	34
Scratch	6	6	2	2	16
Weapon / Object	6	2	4	1	13
Kick	2	2	5	3	12
Slap	4	3	1	2	10
Push	3	3	2	1	9
Hit	2	0	2	2	6
Bite	4	0	0	1	5
Twist/Touch to part of body	0	0	0	3	3
Spit	1	2	0	0	3
Head butt	0	0	0	3	3
Hair Pulled	0	1	0	0	1
Stomped	1	0	0	0	1
Unknown	0	0	2	3	5
Total	**57**	**40**	**33**	**33**	**163**

The exact location where the physical assaults occurred as evidenced in table 3; the Care Group where these occurred is evidenced in table 4**.**

Table 3

Location	Qtr 1	Qtr 2	Qtr 3	Qtr 4	TOTAL
A&E	5	7	6	12	**30**
Ward 42	12	7	0	1	**20**
Ward 36 - SSU short stay unit	14	2	0	1	**17**
Ward 27	2	4	4	1	**11**

EAU / Amb Care (EAU)	1	2	5	1	**9**
Ward 26	6	0	2	1	**9**
Ward 38	1	3	0	4	**8**
Ward 40	2	2	2	2	**8**
Acute Cardiology Unit	7	1	0	0	**8**
Ward 28	1	2	2	1	**6**
Ward 25	1	2	2	0	**5**
ITU / Critical Care/Theatres	1	1	1	0	**3**
Ward 37	1	1	1	0	**3**
Ward 31	0	3	0	0	**3**
Ward 41	0	0	0	3	**3**
Ward 30/ SDU	0	0	3	0	**3**
Patient own home/Care Home	0	0	2	0	**2**
Ward 32	1	0	1	0	**2**
Ward 24	0	0	0	2	**2**
Paediatric A & E / OPD	0	1	1	0	**2**
Theatres	0	2	0	0	**2**
Ward 9 Hartlepool	0	0	0	2	**2**
Phlebotomy	1	0	0	0	**1**
Main Reception	1	0	0	0	**1**
Ward 33	0	0	1	0	**1**
UHNT Estates	0	0	0	1	**1**
Joint Replacement Unit UHH	0	0	0	1	**1**
MONTH TOTAL	**57**	**40**	**33**	**33**	**163**

Table 4

Physical Assaults on staff	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total
Care Group 1	0	0	2	0	2
Care Group 2	54	33	25	29	141
Care Group 3	3	7	6	3	19
Corporate	0	0	0	0	0
Estate	0	0	0	1	1
Total	**57**	**40**	**33**	**33**	**163**

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 163 assaults, it was necessary to involve the police with 24 incidents. 8 of these were in the malicious category and 16 in the unintentional category. The malicious unintentional were related to alcohol and drugs but the patients did not have capacity at this point.

Malicious Incidents

- W142794 – Q1 - Patient assaulted staff member trying prevent her from self-harming, scratching and biting hands and wrist. Patient then assessed by Psychiatry team to have capacity. Following discharge discussions with Liaison Psychiatry the patient spat in staff members face before leaving the ward and smashing 3 fire points in corridor. Police informed ref cvp-21-094496 – no outcome received;

- W142034 – Q1 - Call for assistance at security office by passing staff member, who reported that a female in the main entrance/reception area was being verbally aggressive toward him, screaming and swearing. Police not involved.

- W14746 – Q2 - Patient told they were discharged home, whilst trying to arrange transport for them, patient became agitated and trying to get back down the major corridor, whilst being encouraged to go back into the waiting room the patient become aggressive and physically assaulted the nurse – Police arrested male for assault - no outcome.

- W147263 – Q2 - HCA reported that after asking patient to sit on the chair to get a better saturation reading from him. This patient grabbed her with both hands by her neck and said if he saw her round town, he will ??? kill her. This HCA pushed him away and walked away – Police not involved.

- W148078 – Q3 - Patient admitted due to sudden onset of confusion. It turned out it was due to low BM's. Went to get a cup of orange juice and a sandwich, upon return to room the patient's husband was in her room. Staff member asked him to give her the orange juice as she refused to take it from staff member. The patient lashed out at this point and the orange juice went all over the floor and over the husband, the husband became very angry at this and grabbed hold of patient's right arm and staff member's left arm, he twisted staff member's arm round and threw their arm out to the side. Police arrested male for assault;

- W150028 – Q3 - Patient is hoist for all transfers, as we were rolling the patient towards myself to place the hoist sling underneath, he grabbed my right breast very hard and aggressively - no police involved.

- W155271 – Q4 - Female attacked 3 members of staff pulled cannula out and tried to spray blood on staff, restraint used several times to calm the situation down without success - police involved – no outcome.

- W155716 – Q4 - Called to escort a male patient from the department. After escorting the male out, he tried to return to the department, but was stopped by security. As security escorted the male out, again he became very aggressive. The male tried to head butt one of the security team and struck the other member of the team on the nose - police involved – no outcome.

- W152322 – Q4 - Patient transferred to XR escorted by HCA, patient taking her mask off, patient reminded that she needed to keep mask on, patient hit member of staff in the face. Patient brought back to department. Police not involved staff member did not want to take further action.

Table 5

Physical Assaults on staff	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total
Unintentional	55	38	31	28	152
Malicious Intention	2	2	2	5	11
Reported to Police	1	1	1	4	7
Total (Includes weapon)	**57**	**40**	**33**	**33**	**163**

The findings of violent incidents were that the majority of the patients committing assaults towards staff were elderly and not responsible for their actions due to their medical condition. Table 6 clearly demonstrates the age of all patient's responsible for assaulting our staff and professionals working at the

hospital. Analysis showed the upper age group 60 to 80+ were responsible for *54*% of all assaults towards staff.

Table 6

Assaults on staff by age of perpetrator	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total
Age 80+	5	15	11	2	**33**
Age 70 to 79	22	5	6	6	**39**
Age 60 to 69	4	7	2	3	**16**
Age 40 to 59	5	5	6	12	**28**
Age 17 to 39	16	4	2	7	**29**
Age 2 to 16	0	1	0	0	**1**
No age submitted	5	3	6	3	**17**
Total	**57**	**40**	**33**	**33**	**163**

Staff, are informed of their responsibility to report all violent incidents during their attendance at Trust induction, local induction and conflict resolution training.

The security officer's logbook reported 1039 responses throughout the year these included response to assistance requests and violent incidents.

The prevention of any untoward incident is better than cure. The Trust approaches the prevention of violence and aggression towards staff in many ways including conflict resolution training, policies and panic alarms fast response teams and poster campaigns. The challenges to a safety culture in the NHS is striking a balance of providing care with effort focussed on addressing associated clinical risks, whilst at the same time striving to address non-clinical safety risks.

2.5 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 most recent annual report received, it was noted that further progress has been made across the North Tees & Hartlepool NHS Foundation Trust. The installation of the new fire alarm systems has progressed with the new system at University Hospital of North Tees becoming live. Further work is being carried out on compartmentation and a further compartmentation survey is to be commissioned during 2022.

The Trust continues to have a mixture of assets, some ageing and built to differing standards that were relevant at the time of build. There is a desire to provide modern facilities and challenges are faced with regard to upgrading existing facilities. The Fire Safety Advisor is consulted at an early stage of proposed new works and alterations. Where possible the Trust 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.

From the evidence assessed, it continues to be the case that fire safety is taken seriously by the Trust with appropriate actions taken when required. A number of recommendations from last year's report (June 2021) have been included on in a work plan, which sits with the Fire Safety Advisor and is scrutinised by the interim Fire Safety Manager.

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, Levi Buckley is the Trust Board member responsible for Fire. Mike Worden is the Managing Director of the LLP and reports all issues through the Master Service Agreement Strategic Group and the Masters Service Agreement Operational Management Group meetings. Any issues are also reported via the Health, Safety and Security Committee meetings.

Overall, the standard of the strategies, policies and procedures reviewed were of a good quality, a number of which have been reviewed since the last report and are now published documents. Significant investment continues to be made and allocated to fire safety systems in times of stringent financial pressures. This demonstrates that the Trust takes the responsibility of keeping people safe from fire seriously and is of a high priority.

A Management of Fire Safety Policy is in place covering all properties within the Trust. The 'Fire Strategy University Hospital of North Tees' has been replicated for the University Hospital of Hartlepool. Both are useful documents. The documents are currently subject to a review.

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 4. The replacement fire alarm system at University Hospital of Hartlepool is due to be commissioned in the summer of 2022.

None of the Trusts' properties are subject to any form of enforcement action by the respective Fire Authorities.

It is important that fire risk assessments (FRA's) (in the form of PK1's and PK3 inspections) are reviewed frequently. The current process indicates that all fire risk assessments will be reviewed annually. This process will need close monitoring to ensure that the outcomes meet the demand. The completion of PK1's by local managers needs to be re-invigorated and this has been noted and forms part of an action plan.

A live play evacuation exercise has been carried out with another scheduled for the very near future.

The actions from previous reports have either been addressed or form part of a Fire Action Work Plan and are therefore not repeated within this report. The recommendations made within this report are intended to build on the work that is currently taking place within the Trust regarding matters relating to fire safety. The following recommendations have been put forward in this report to assist in further developing the fire safety arrangements across North Tees and Hartlepool NHS Foundation Trust. Previous recommendations that form part of on-going action plans are not repeated. Recommendations were made that:-

1. An audit of the process for conducting fire risk assessments (PK3's) is carried out with the Fire Safety Advisor to ensure that the current arrangements meet the requirements of the RR(FS)O.

2. A system is put in place for the Fire Safety Advisor to audit the commercial premises within the hospitals to ensure a fire risk assessment has been carried out by the responsible person for each area.

3. The revised Training Needs Analysis includes a programme of refresher training for Fire Wardens with a recommended time period of two yearly.

4. As the Covid-19 situation eases, it is suggested that a programme of Level 2 fire drills is established that includes closer working between wards and departments to ensure that, should a fire occur, all staff are aware of what to do not only in their own area but in also neighbouring areas.

Fire Incidents

There were 80 fire incidents recorded during 2021/22. This includes 2 actual fires and 78 false alarms, an increase in false alarms of 22% or 16 incidents on the previous year.

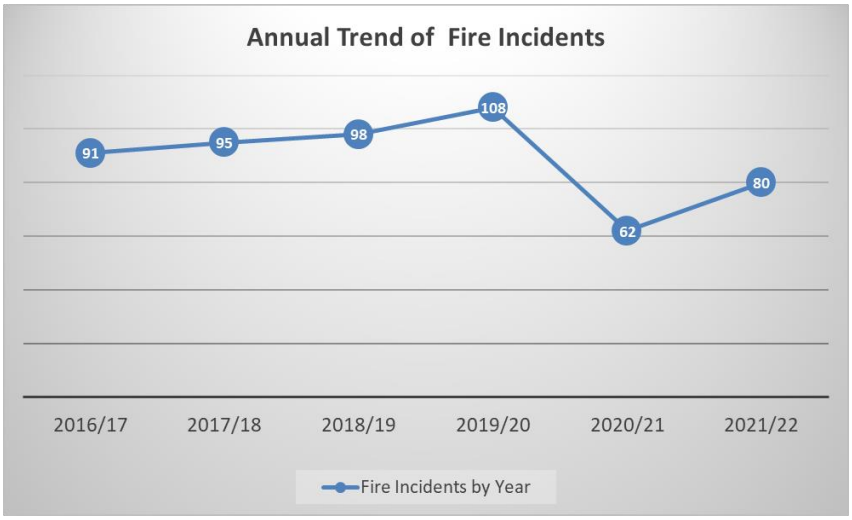
Both of the fires and 92% (72) of the false alarms occurred at University Hospital North Tees. The number of false alarms at University Hospital Hartlepool decreased from 21 in the previous year to 6 this year.

The two principal causes of false alarms were Environmental, including water or dust ingress into detector heads, birds tripping linear beam detectors and the use of aerosols beneath detector heads; and Management System faults, including contractors working near detector heads and failing to take necessary precautions.

These two causes accounted for 49% (38) of the false alarms. While incident numbers peaked in the second and third quarter of the year, they declined significantly in the final quarter despite a blip in March 2022, with only 2 incidents in each of January and February.

The Fire Service attended site on 7 occasions during this time. While this exceeds their threshold for number of attendances following which a charge will be levied, 4, this number includes attendance at one of the fires, and 3 attendances during an agreed amnesty period immediately after the new fire alarm system at University Hospital North Tees was commissioned. These attendances are discounted for charging purposes under the Brigade's Unwanted Fire Signals Policy, taking us below the charging threshold for the financial year.

Table 8 below provides a comparison to previous years and trend line of fire incidents.



2.6 Waste Management

Table 8 shows a breakdown of all wastes created within the Trust from 2016 to date. It shows a slight increase in overall waste of only 0.3% in 2021/22. A decrease in clinical waste of 31% for 2021/22 compared to the previous year.

Table 8

Period	Hazardous	Autoclave / waste to energy %	Pharm (Waste to energy)	Inert Landfill	Bulk Waste Transfer Station Potential Landfill	Waste to energy	Confidential	Metal	Cardboard	Mixed Recycling	Garden Waste	WEE	Furniture / Equipment	Total Waste	Total % Recycling
2016/17	**378**	**76**	**0**	**0**	**64**	**819**	**275**	**12**	**51**	**0**	**0**	**39**	**0**	**1714**	**22%**
2017/18	**265**	**85**	**0**	**0**	**51**	**893**	**293**	**8**	**41**	**0**	**0**	**10**	**0**	**1646**	**21%**
2018/19	**182**	**78**	**0**	**0**	**23**	**859**	**275**	**10**	**44**	**0**	**0**	**6**	**0**	**1477**	**28%**
2019/20	**196**	**107**	**0**	**0**	**0**	**951**	**231**	**14**	**32**	**18**	**13**	**5**	**0**	**1567**	**23%**
2020/21	**284**	**124**	**0**	**0**	**51**	**681**	**175**	**20**	**49**	**28**	**13**	**10**	**0**	**1435**	**23%**
2021/22	**196**	**87**	**15**	**0**	**61**	**810**	**146**	**21**	**66**	**19**	**5**	**14**	**1**	**1440**	**21%**

21% of waste produced was clinical whilst 79% was domestic/offensive. (It is difficult to quantify domestic/offensive split)

A decrease in clinical waste from 408 to 298 tonnes, as waste was directed from clinical to domestic/offensive due to reduction in Covid 19 patients.

Total Clinical Waste Disposal Costs 2021-2022 = £153,926.00 which equates to a 29.25% decrease £63,636.69 in costs from last year.

A decrease in overall recyclable waste of 2% for 2021 / 2022 compared to the previous year. The decrease is due to the reduction of confidential waste. (Although 31.11% of all domestic waste is recycled which is more than double the 14.8% figure of last year).

A decrease in clinical waste of 27% for 2021/2022 compared to the previous year, due to the Covid 19 patient reduction.

There is a decrease in confidential waste from 175 to 146 tonnes (29 tonnes or 17%), due to review of confidential waste bin activity on implementation of new confidential waste contract, as this stream is recycled the decrease does contribute to reduction of the overall recycling percentage. (It should be noted that confidential waste is not actually weighted but and industry average weight is used based on full bin weights). It is important to fully utilise the space in these containers. A review of confidential waste at the start of the new contract removed 10 bins from the weekly automatic list is these bin were not being filled.

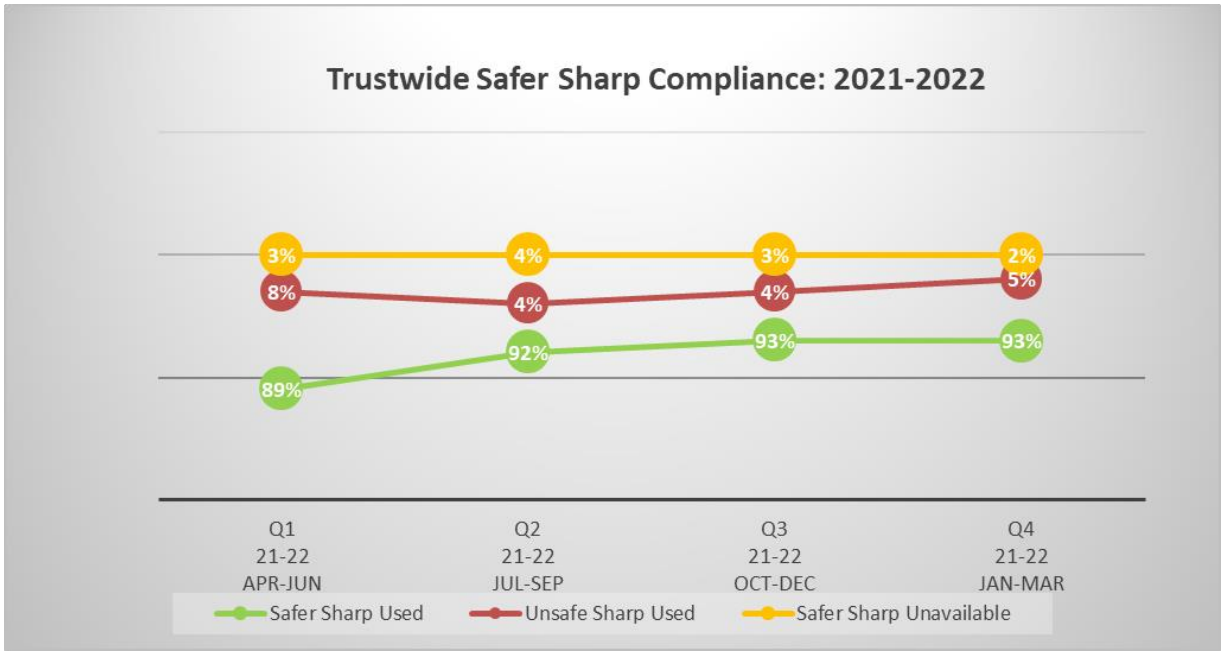
Offensive waste is included with the domestic figures, it is mixed with the domestic for waste to energy incineration, so difficult to quantify. Offensive waste is non-hazardous healthcare waste EWC 18-01-04.

A new column has been added this year to signify the amount of waste reused, A nominal 1 tonne has been used this year (although more than 1 tonne has probably been reused), it is hoped in years to come this can be measured more accurately and show an increase.

2.7 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. Their local risk assessment must identify 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. This information is communicated to the Medical Device Committee for discussion.

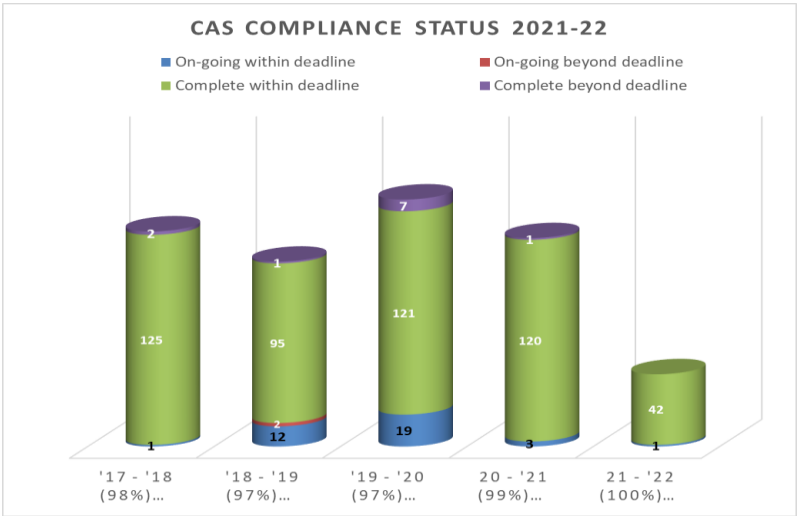


A total of 121 Sharp incidents were reported on the DATIX incident reporting system for the year. This is a 29% increase of the previous year.

2.8 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 below.



There were a total of 43 alerts received, 42 were completed within deadline, 1 are on-going within deadline and 0 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 bi-monthly 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 2021/22

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 (47 audits covering 335 self-assessment criteria over 5 domains). One of the domains covers Safety and is split into Safety Hard and Safety Soft;

- 137 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;

- 195 PK3 Fire safety inspections for individual areas and the production of summary reports for the Health, Safety and Security Committee;

- 123 PK7 Waste compliance inspections for individual areas and the production of summary reports for the Health, Safety and Security Committee;

- 21 Covid Environmental Safety risk assessments. Conducted by the team, initially in all areas then continued in communal areas across the hospital sites;

- 4 written Contractor Safety Inspections – not including visual inspections

- Audit for Containment level 3 pathogen processing in Pathology;

- 12 Union walkabout inspections, continuing monthly;

- Communication of 42 CAS alerts with collation of responses and sign off where applicable;

- Production and monitoring of bi-monthly non-clinical incident reports for Health, Safety and Security Committee and Health, Safety and Welfare Committee;

- Production and monitoring of bi-monthly 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 71 staff trained.

4. Key Issues/Future Activity

Continuous improvement in performance and service delivery is our aim. We will 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;

5. Recommendations

The Board is requested to receive this report and note the work undertaken in 2021/22 to support patient services across the Trust Estate.

Appendix 1

Key Performance Indicators 2021-22

Indicator		Performance Output Range			Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
		Green	Amber	Red	Actual											
01	Actual Fire Alarm - Fire Brigade attended per month < 1	<1	1-4	>5	0	0	0	0	0	0	1	0	0	0	0	0
02	Unwanted (False) Fire Alarm - Fire Brigade attended per month < 2	</=2	3-4	>/=5	0	0	0	0	3	0	1	1	0	0	0	1
03	Unwanted (False) Fire Alarm - NIL Brigade attendance per month < 2	</=2	3-4	>/=5	4	4	**5**	**5**	**7**	**9**	**10**	**10**	**5**	2	2	**11**
04	Number of Physical Assault (Malicious) on employees per month < 5	</=5	6-8	>/=9	0	1	1	0	0	2	1	1	0	1	0	4
05	Number of Physical Assaults (Unintentional) on employees per month < 12	</=12	13-20	>/=21	14	24	15	15	16	6	9	12	10	9	13	11
06	Number of RIDDOR incidents per month < 3	</=3	4-5	/=>6	3	1	3	2	3	1	3	2	4	4	4	1
07	Number of Enforcement Notices (All)	0	1	/=>2	0	0	0	0	0	0	0	0	0	0	0	0
08	Number of Health and Safety Inspections (Internal)	>/=20	14-19	</=13	33	50	59	30	36	24	47	77	46	26	27	35
09	Number of High / Moderate risks with no action plan	0	1-2	>/=3	0	0	0	0	0	0	0	0	0	0	0	0
10	Number of out of date risks	0	1-10	>/=11	0	0	0	0	0	0	0	0	0	0	0	0