North Tees and Hartlepool NHS
NHS Foundation Trust

Virtual Board of Directors Meeting

Thursday, 28 May 2020
at 12 noon

a Front sheet

b BoD Agenda 28 May 2020

c Glossary of Terms - Strategic Aims 2020

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item 2 - CE Report May 2020

Item 3 - Integrated Compliance report May 20 cover sheet

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Item 3.2 Corporate Dashboard PDF

Item 4 - Annual Report and Accounts Cover sheet

Item 5 - Annual Self Certification May 2020

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Item 6 - Executive Summary LfD Report Q4 2019-20

Item 6.1- Learning from Deaths Board Report Q4 2019-20 Final

item 7 - Guardian of Safe Working Hours Report

item 8 - Documents Executed Under Seal

Item 9 - Adult Vulnerability Annual Report Cover sheet May 2020

Item 9.1 - Adult Vulnerability Annual Report FINAL May 2020

Item 10 - DIPC Annual Report cover sheet

Item 10.1 - Annual report DIPC - May 2020

NHS
North Tees and Hartlepool
NHS Foundation Trust

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PG/SH

21 May 2020

Dear Colleague

A shortened meeting of the **Board of Directors** will be held virtually via video conferencing on **Thursday, 28 May 2020** at 12 noon. Dial in details will be circulated separately.

Yours sincerely

Paul Garvin
Chairman

Agenda

			Led by
1.	(12 noon)	Summary of the virtual meeting held on, 30 April 2020 **(enclosed)**	Chairman
2.	(12 noon)	Report of the Chief Executive incl. COVID-19 Briefing **(enclosed)**	J Gillon
3.	(12.20pm)	Integrated Compliance and Performance Report **(enclosed)**	L Taylor
4.	(12.30pm)	Annual Report and Accounts and Quality Accounts 2019/20 **(to follow)**	B Bright N Atkinson & J Lane
5.	(12.40pm)	Annual Plan Self-Certifications **(enclosed)**	L Taylor
6.	(12.50pm)	Learning from Deaths Report **(enclosed)**	D Dwarakanath
7.	(12.55pm)	Guardian of Safe Working Hours Report **(enclosed)**	D Dwarakanath
Items to Receive:			
8.	(1.05pm)	Retrospective Approval of Deed Executed under Seal **(enclosed)**	J Gillon
9.	(1.05pm)	Annual Report 2019-20 of the Vulnerability Unit, Safeguarding Adults, Children & Young People **(enclosed)**	J Lane
10.	(1.05pm)	Director of Infection Prevention and Control Report 2019-20 **(enclosed)**	J Lane
12.	(1.10pm)	Any Other Notified Business	Chairman
13.	Date of Next Meeting		

(Thursday, 30 July 2020, Boardroom, University Hospital of North Tees)

Paul Garvin
Chairman

Julie Gillon
Chief Executive

Glossary of Terms

Strategic Aims and Objectives

Putting Our Population First

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

Valuing People

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

Transforming Our Services

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

Health and Wellbeing

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

North Tees and Hartlepool NHS Foundation Trust

Video-conference meeting of the Board of Directors

Thursday, 28 May 2020 at 12:20

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

These minutes represent a formal record of the video-conferencing meeting.

The electronic pack of papers was circulated to the full Board

Attendance via video conferencing: -

Paul Garvin, Chairman*	Chairman
Steve Hall, Vice-Chair/Non-Executive Director*	SH
Ann Baxter, Non-Executive Director*	AB
Philip Craig, Non-Executive Director*	PG
Jonathan Erskine, Non-Executive Director*	JE
Kevin Robinson, Non-Executive Director*	KR
Neil Schneider, Associate Non-Executive Director	NS
Rita Taylor, Associate Non-Executive Director	RT

Attendance in the Boardroom: -

Julie Gillon, Chief Executive*	CE
Neil Atkinson, Director of Finance*	DoF
Barbara Bright, Director of Corporate Affairs and Chief of Staff	DoCA&CoS
Levi Buckley, Chief Operating Officer*	COO
Lynne Taylor, Director of Performance and Planning	DoP&P

In attendance: -

Samantha Sharp, Personal Assistant (note taker)
BoD/4254 &4255: Deepak Dwarakanath, Medical Director/Deputy Chief Executive MD

In attendance via audio calling: -

John Edwards, Elected Governor for Stockton
Dominic Johnson, Appointed Governor: Newcastle University

BoD/4249 Summary of the Virtual Meeting held on, Thursday, 30 April 2020

Resolved: that, the summary of the meeting held on Thursday, 30 April 2020 be confirmed as an accurate record.

BoD/4250 Report of the Chief Executive including COVID-19 Briefing

The CE provided an update in respect to the latest position regarding COVID-19 and the plans for the next phase of the response including planning for the restoration of activity and any future peaks of COVID-19 presentation. The Trust was committed to resuming its focus on treating the health care needs of communities and further developing partnerships toward a new operational model in addition to reinstating services across care pathways.

The North East Nightingale Hospital officially opened on 5 May 2020 and would provide the North East and North Cumbria with a level of capacity and resilience, if required, to manage

* voting member

the continuing challenges of COVID-19 and seasonal pressures as we approach winter of 2020/21. The Trust would be represented at scheduled workshops to reflect on the proposed clinical model for this hospital and the way forward.

The Trust's current COVID-19 admissions to date indicated the following: -

- 407 patients had been admitted with COVID-19 symptoms
- 61% of admissions had been discharged from hospital
- 27% of COVID-19 patients had died in hospital
- 12% were still in hospital
- The Trust peaked at 57 patients in a bed at any one time, with the highest number of Critical Care beds occupied by COVID-19 patients reporting at 22
- The Trust currently had 46 in-patients with confirmed COVID-19

A support offer had been developed in collaboration with system partners including Tees Valley CCG, Stockton and Hartlepool Local Authorities, Tees and Esk and Wear Valley NHS Foundation Trust to support timely access to clinical advice for care home staff and residents. This offer included the arrangements for testing of care home residents and staff and access to infection prevention and control support and guidance.

A number of refreshes to the guidance in respect to PPE had been made since the initial guidance which had 'enhanced' the PPE to front line staff. The Trust continued to meet demand by managing regular local supplies during national shortages

The CE reported that the Government had introduced a test and trace service to help control the rate of reproduction and reduce the spread of infection. Following testing, those reporting positive would be contacted by the test and trace service and asked to share details of those they had been in close and recent contact with. The 14-day isolation period and the impact this may have on staff absence was highlighted.

The Trust had ensured that the wellbeing of staff had been central to the response to the COVID-19 pandemic, recognising the physical, emotional and mental impact that staff faced. A cohesive approach would be adopted whereby staff would be supported to recognise symptoms of mental illness early and learn how to manage their symptoms and wellbeing. It was noted that the Vans for Bands bus had now left the North Tees site and an alternative recharge hub was being sought for both North Tees and Hartlepool.

A COVID-19 information hub had been developed on the Trust website to provide updates with the latest advice and guidance in addition to details of any restrictions/changes that had been implemented to services and hospital sites. Traffic to and engagement with the Trust's social media channels had continued to increase significantly over the past month.

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

- Consultant appointments: Dr Anilkumar Sreedhara Panicker, Consultant Paediatrician, Mr Khaled Aneiba, Consultant Spinal Surgeon, Dr Victor Chew, Consultant Physician in Respiratory and General Medicine and Dr Randeep Hunjan, Consultant Cardiologist;
- Work continued on the development of the governance arrangements that would support the proposals for a Group Structure between the three Trusts in the Tees Valley. An inaugural meeting was held on 27 May 2020 involving the Chairs and Chief Executives from the three organisations where discussions focussed on partnership working, strategic rationale and intent, work programme, governance and stakeholder engagement;

- Working with the local authorities, NHS Trusts, police and fire services, as well as shop workers and pharmacies, the Trust had launched a campaign to encourage social distancing which described what two metres might mean to a Teessider;
- The Billingham lodge of the Durham Freemasons had donated 20 electronic tablet devices to support virtual visiting for patients and their relatives during the current pandemic and were keen to continue fundraising for the Trust post COVID-19.
- The Trust were exploring opportunities to roll out a wellbeing model in localities with an emphasis on community driven services. Exploring community payback and fund raising options for the future was now a priority for the Trust.

In response to a query from RT, the CE provided an update on the return of maternity services to Hartlepool highlighting that the service would be reinstated at the site by September 2020 but stressing that prenatal and post-natal and community care was still provided for Hartlepool community mothers and babies . Further service changes were also planned for Hartlepool with changes to the estate being made to support this.

SH congratulated the CE and the Executive Team in continuing to support staff and manage the crisis locally and sought assurance on how plans were progressing to recover the backlog. The CE explained that there was a lot of work being undertaken to ensure that waiting lists were reduced and to understand what proportion of the waiting list was delayed due to COVID-19. The DoP&P added that significant planning was taking place supported by the Project Management and Improvement Office and new ways of working were being considered, including the use of technology to support virtual appointments. KR, Chair of Performance, Planning and Compliance Committee provided assurance that progress was being monitored though the committee.

In response from a query from PC, the CE advised that as part of the recovery to respond to multiple surges of COVID-19, a programme of refresher training would be developed for those staff who had been retrained to provide essential support to key services during the current pandemic.

In response to a query from JE, the CE highlighted that the health and wellbeing of staff remained a key priority for the Trust with a particular focus on mental wellbeing, acknowledging that some staff may exhibit signs of post-traumatic stress disorder in the future. A workstream had commenced to consider the resources needed and the impact of staff's mental health going forward.

Resolved: that, the contents of the report and the pursuance of strategic objectives amongst the COVID-19 pandemic crisis be noted.

BoD/4251 Integrated Compliance and Performance Report

The DoP&P presented the Integrated Compliance and Performance Report for the month of April 2020. The Trust had experienced unprecedented pressures as a result of the COVID-19 pandemic which had ultimately impacted upon a number of indicators. Patient pathways had remained open in relation to RTT, cancer and diagnostics. Close collaboration across the regional network in relation to cancer management was ongoing through the South cancer 'cell', implemented to manage cancer treatment through the available capacity across all provider organisations, including the independent sector.

Key points were: -

- Single Oversight Framework: The Trust recovered the cancer 62-day position in March despite pressures faced from the impact of COVID-19 with the final validated position

reporting at 87.3% though this was insufficient to recover the quarter reporting at 79.3%. The median RTT wait had increased, however, the Trust remained one of the top reporting organisations in the region. Recovery plans were currently being developed to ensure any delayed pathways were kept to an absolute minimum as the COVID-19 situation allowed and in line with national guidance. Routine diagnostics had been put on hold during the COVID-19 pressures, however with 2-week rule and urgent tests still carried out wherever appropriate in line with national guidance. This had resulted in an increase in over 6 week diagnostic waits. Diagnostics were being reinstated, however once again working within the constraints of COVID-19 and non COVID-19 pathways.

- Operational Efficiency and Productivity Standards: The Trust had maintained a positive position in relation to DTOCs and super-stranded patients. Occupancy remained below standard. Due to reduced elective activity, performance against a number of efficiency indicators had not been reported this month due to small numbers which would have impacted upon the relevance of the KPIs, which would be reviewed going forward for future performance reporting;
- Quality and Safety: HSMR and SHMI rates remained within the expected range. The Trust had reported five Trust attributable cases of Clostridium Difficile in April, an increase from the two cases reported in March. No trajectory had yet been set for 2020/21 but the Trust were monitoring against the previous year's position. The majority of complaints were being managed through the stage 1 process. 100% compliance had been maintained against dementia standards. No falls with fracture had been reported since February 2020. Due to COVID-19, the Trust was no longer required to produce their 2019/20 Quality Accounts or have them audited by an external auditor. However, as the work to produce the report was already nearing completion, the Trust would publish it on their website and NHS Choices as per usual;
- Workforce: Sickness absence continued to be the key pressure within workforce and remained above the 4% target. There had been a decrease in the long-term sickness rate with an increase in short-term sickness when compared to the previous month. Anxiety/stress/depression/other psychiatric illnesses' continued to account for the highest proportion of all sickness absence at 40%, an increase when compared to February (39%). During April, there were 583 cases of COVID-19 related absences reducing to a current position of circa 300. The Workforce Department continued to manage the staff COVID-19 absence call-in line and the co-ordination of swab tests. The Trust were providing dedicated psychological support to staff currently absent due to COVID-19 related anxiety, stress and depression. A Listening in Action application had been developed for smart phones to enable staff to air concerns or anxieties and seek support if required. Turnover and attrition rates remained within expected levels. Mandatory training and appraisals had now been reinstated following suspension due to the current pandemic. Mandatory training compliance had dropped by 3% to 87% and appraisal compliance remained consistent at 86%. The volunteer service had been significantly impacted by the COVID-19 pandemic. Contact had been maintained with all volunteers with a significant number committing to return in the future. Staff from Middlesbrough College and Bloodrun were supporting the Trust in volunteering activities with many having offered continued support in the longer term;
- Financial position: The Trust were currently working under a financial block contract arrangement as set out by NHSI/E with the Trust applying the same national arrangements underpinned by an Interim Financial Management Framework. At Month 1, the Trust was showing a breakeven position, largely due to the Trust operating within run rates. The year to date contributions from Optimus and the LLP were £37k and £78k respectively. The Group cash balance was £44.8m which was £28.1m favourable to the NHSI plan, driven by cash received in advance from the Centre for May activity. Debtor days had worsened by two days and creditor days had improved by five days in comparison to April 2019/20.

In response to a query from SH, the DoP&P reported that the Trust continued to encourage partners to refer patients to the hospital though it was noted that GP attendances had dropped and that this was a cause for concern. The Trust continued to work with the national team to encourage patients to visit their GP should they have any health concerns during this time

In response to a query from JE, the DoP&P explained how the Trust managed the 'red' and 'green' workstreams throughout the hospital. Patient flow was being reviewed to consider the maximum number permitted in the Outpatients Department. Due to the use of virtual appointments, there was currently reduced footfall at the hospital. Planning continued and changes made in response to COVID-19 were being communicated to patients coming into hospital. The DoP&P highlighted that a significant amount of resource was required to manage this appropriately.

Resolved: (i) that, the performance against the key operational, quality, finance and workforce standards during April in light of the impact of the COVID-19 pandemic be noted; and
(ii) that, the on-going financial pressures be recognised; and
(iii) that, the on-going operational monitoring and system risks to regulatory key performance indicators and the intense mitigation work that was being undertaken to address these going forward be acknowledged.

BoD/4252 Annual Report and Accounts and Quality Accounts 2019/20

The DoCA&CoS presented the Annual Report and Accounts 2019/20, and Quality Accounts 2019/20 explaining that the documents had been prepared in accordance with statutory guidance, the Foundation Trust Annual Reporting Manual (FT ARM), The Department of Health and Social Care Group Accounting Manual (GAM) and the revised guidance issued by NHS Improvement (NHSI) in response to the escalation of the pandemic crisis

The DoCA&CoS reported that revised timelines had been issued by NHSI and that the Annual Report and Accounts were required to be submitted to NHS Improvement by 25 June 2020 and would be laid before parliament following this (date to be confirmed).

The Trust was no longer required to produce their 2019/20 Quality Accounts or have them audited by an external auditor. However, as the work to produce the report was already nearing completion, the Trust would publish it in the Annual Report, on their website and to NHS Choices as per usual. There had been full involvement of Governors and third parties in production and review of the report and third party declarations had been received from a number of key stakeholders.

The Annual Report and Accounts had been audited and reviewed by the Trust's external auditors, PricewaterhouseCoopers (PwC) to ensure they were fully compliant with the requirements of the FT ARM, GAM and other guidance and had subsequently been presented to the Audit Committee on 21 May 2020.

External publication of the information could take place once the information was laid before parliament and would be published on the Trust website, NHSI website and be formally presented at the Trust's Annual General Meeting in August.

PC, Chair of the Audit Committee confirmed that PwC and the Audit Committee were satisfied that the 2019/20 Annual Report and Accounts were prepared in-line with the guidance issued.

Resolved: (i) that, the Board of Directors review the report and note the work

undertaken to produce this within the timelines; and

(ii) that, the scrutiny on compliance by the external auditors be noted; and

(iii) that, submission in line with the guidance to NHS Improvement in readiness for submission to Parliament be noted; and

(iv) that, the finalised report be published on the Trust's website and formally presented at the Trust's Annual General Meeting in August.

BoD/4253 Annual Plan Self-Certification

The DoP&P presented the Trust's Annual Plan Self-Certification of Compliance which was in-line with licencing conditions and provided an overview of the requirements and the Trust's position against each declaration. Key risks highlighted were the consistent delivery of the cancer 62-day referral to treatment standard, the impact of COVID-19 and delivery of the 2020/21 financial plan and the impact that COVID-19 may have on this.

Due consideration had been given against each of the self-certifications based on the performance and forecast pressures for 2020/21. The individual self-certifications had been completed providing evidence of assurance where necessary, with the aim to declare compliance against each of the declarations for the periods of 2019/20 and 2020/21 as applicable.

Resolved: (i) that, due diligence had been paid by the Board of Directors in assessing on-going compliance with governance requirements 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.

BoD/4254 Learning from Deaths Report

The MD/DCE provided an update in respect of performance against Learning from Deaths guidance. Key points included:

- Mortality: The Trust's HSMR value had decreased to 91.30 (December 2018 to November 2019), the SHMI was currently 98.53 (November 2018 to October 2019); both were within the 'as expected' range;
- Compulsory case reviews: For 2018/19, 94% of the cases identified in the Trust's policy had been reviewed. During 2019/20, by the end of Quarter 3, 48% of compulsory reviews had been completed. During 2019/20, by the end of Quarter 4, 39% of compulsory reviews had been completed;
- A business case to support the introduction of the Medical Examiners role had been agreed with Dr Jean McLeod being appointed as the interim lead.

In response to a query raised by the Chairman, the MD/DCE highlighted that much of the population the Trust served had a significant number of comorbidities and that the Trust had got much better at reporting these taking the number of comorbidities from an average of 4 to an average of 6 or 7. The MD/DCE reported that consideration was always given to ensuring that the Trust did not over report on comorbidities or have excess deaths. The CE added that robust governance was in place and that the Trust had commissioned an independent audit a number of years ago on depth of coding and had made changes in respect to this. It was agreed that a summary paper on comorbidity reporting and management would be presented at a future Patient Safety and Quality Standards Committee.

Resolved: (i) that, the content of the report be noted and the information provided

in relation to the identification of trends to assist learning lessons from mortality reviews in order to maintain the reduction in the Trust's mortality rates be noted; and

(ii) that, the on-going work programme to maintain the mortality rates within the expected range for the organisation be noted; and

(iii) that, a summary paper on comorbidity reporting and management be presented at a future Patient Safety and Quality Standards Committee.

BoD/4255 Guardian of Safe Working Hours Report

The MD/DCE presented the Guardian of Safe Working Report for the period December 2019 to March 2020 highlighting that NHS Employers and the BMA had published a joint statement on the application of the 2016 contract limits for the duration of pandemic providing guidance on where working hours limits and rest requirements outlined in the contract could be flexible

A total of 52 exceptions were submitted, mainly by foundation year one trainees for additional hours worked. No fines had been levied by the Guardian. There were no exception reports submitted in April.

As a result of COVID-19, the April 2020 training rotation had been postponed by Health Education England. This was scheduled to restart in August 2020.

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

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

BoD/4256 Retrospective Approval of Deed Executed Under Seal

The DoF provided clarity and the CE requested retrospective approval for the following document executed under seal:

Document	Date Signed	By
Deed of Surrender Between: 1) AC Blandford, S Laloo, KS Sidhu and R Hussain and 2) North Tees and Hartlepool NHS Foundation Trust Relating to premises at Morven, Hesleden Road, Blackhall, Peterlee	26 March 2020	Neil Atkinson, Director of Finance Barbara Bright, Director of Corporate Affairs and Chief of Staff

Resolved: that, the retrospective approval for the signing of the document be granted

BoD/4257 Annual Report 2019/20 of the Vulnerability Unit, Safeguarding Adults, Children and Young People

The Annual Report 2019/20 of the Vulnerability Unit, Safeguarding Adults, Children and Young People was provided for information.

Resolved: (i) that, the Annual Adult, Children & Young People Vulnerability 2019/20 Report be received; and
(ii) that, the sustained improvements for vulnerable and at risk people using Trust services be noted; and
(iii) that, the key priorities for 2020/21 be noted.

BoD/4258 Director of Infection Prevention and Control Report 2019/20

The Director of Infection Prevention and Control Report 2019/20 was provided for information.

Resolved: that, the Annual Director of Infection Prevention and Control Report 2019/20 be received and published on the Trust's website.

BoD/4259 Any Other Notified Business

a. Governor Representation

The Chairman asked John Edwards, Elected Governor for Stockton whether he would like to comment. John thanked the Chairman for the opportunity to join the meeting via audio conferencing and placed on record his thanks to the team for how the COVID-19 pandemic had been managed.

Resolved: that, the verbal update be noted.

BoD/4260 Date and Time of Next Meeting

Resolved: that, the next meeting be held on Thursday, 30 July 2020.

The meeting closed at 13:45 pm

Signed:  Date: 30 July 2020

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

	Chief Executive Report														
Date:	28 May 2020														
Prepared by:	Julie Gillon, Chief Executive Barbara Bright, Director of Corporate Affairs and Chief of Staff														
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 Improvement, NHS England, Care Quality Commission and the Department of Health and Social Care.

In addition, information is provided on strategic delivery and positioning and operational issues not covered elsewhere on the agenda.
Key issues for Information:

- Coronavirus (COVID-19) update
  - Nightingale Hospital
  - Resumption of non-urgent elective activity
  - Care Home Support
  - Personal Protective Equipment (PPE)
  - Infection Prevention and Control Board Assurance Framework
  - COVID-19 Communications
- Consultant appointments
- Integrated Care System/Integrated Care Partnership (ICS/ICP) Update
- Tees Valley Acute Hospitals Group
- Chief Executives Group – 22 April 2020
- North East and Yorkshire Leaders Events MP engagement
- Social distancing – a collaborative campaign
- Billingham Lodge of Durham Freemasons

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

Consideration will be given to the information contained within this report as to the potential impact on existing or new risks.

Committees/groups where this item has been discussed	Items contained in this report will be discussed at Executive Team and other relevant committees within the governance structure to ensure consideration for strategic intent and delivery.
Recommendation	The Board of Directors is asked to receive and note the content of this report and the pursuance of strategic objectives.

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

28 May 2020

Report of the Chief Executive

1. Introduction

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

2. Key Issues and Planned Actions

2.1 Strategic Objective: Putting our Population First

2.1.1 Coronavirus (COVID-19) Current Position

The Trust continues to respond to the COVID-19 pandemic under the Civil Contingencies Act and the focus remains on how best to protect patients, staff and visitors at this very difficult time. I would like to put on record my thanks to all staff for the tremendous amount of work they have been doing, and will continue to do, to help contain the spread of this virus and continue to provide high quality services.

The Executive Team continues to oversee key decision making and to maintain leadership through the current crisis. The Executive Team ensures a broad, holistic view of both challenges and opportunities, maintaining well directed management. The long view and anticipating risks and recovery into the future enables support and guidance based on experience and expertise. The governance structure enables responsive delegated leadership in the incident command and control infrastructure, whilst uniting all efforts as a cohesive clinical, operational and strategic approach.

The Trust is committed to resuming its focus on treating the health care needs of communities and further developing partnerships toward a new operational model in addition to reinstating services across care pathways. It has been noted that 'switching' on normal service provision is more complex than simply reinstating services as the Trust develops clinical models that balance treating COVID-19 patients and retaining surge capacity to deal with further outbreaks alongside reintroducing commissioned services. There will be additional challenges in meeting unmet demand from people who are unable, or chose not to access services they may have required over the last 10 weeks.

Nightingale Hospital North East and North Cumbria

The Nightingale North East was officially opened by the Countess of Wessex on 5 May 2020. The Hospital will provide the North East and North Cumbria with a level of capacity and resilience, if required, to manage the continuing challenges of COVID-19 and seasonal pressures as we approach the winter of 2020/21.

To support the future provision of care the North East and North Cumbria Integrated Care System (ICS) is holding workshops to reflect on the proposed clinical model for this hospital and the way forward. The workshops will consider the significant challenges in restoring cancer screening and diagnostic programmes, combined with the likely winter pressures of disease exacerbation and influenza.

The Trust will be represented at these workshops by the Medical Director and Chief Nurse with the Chief Executive providing strategic coordination at ICS level.

Planning for the next phase of COVID-19 and non-COVID-19 response

It is clear that rather than experiencing a short but intense peak of COVID-19 hospital admissions, the Trust can expect a prolonged period of relatively small levels of COVID-19 related activity. The Care Groups, supported by the Project Management and Improvement Office, have been modelling future bed configuration with a particular focus on maintaining 'red' and 'green' areas that can support the safe management of inpatient activity.

To this end the Trust has agreed a next phase configuration plan that locates both the receiving area for suspected COVID-19 cases and the beds for the care of confirmed COVID-19 cases at North Tees. Further planning is being undertaken to support services at Hartlepool Hospital with a particular focus on restoring and increasing elective capacity.

The modelling, planning and delivery of elective activity continues at pace with the continued provision of cancer surgery, emergency trauma list and the clinical prioritisation of patients on waiting lists to ensure the prioritisation of those patients with the greatest clinical need.

Care Home Support

A support offer has been developed in collaboration with system partners including Tees Valley CCG, Stockton and Hartlepool Local Authorities, Tees, Esk and Wear Valley NHS Foundation Trust. The objective is to support timely access to clinical advice for care home staff and residents and to ensure proactive support for people living in care homes. This offer includes the arrangements for testing of care home residents and staff and access to Infection Prevention and Control support and guidance.

Personal Protective Equipment (PPE)

The safety of patients and staff remains paramount and therefore the appropriate supply of PPE is critical to preventing the transmission of the virus and ensuring the confidence of patients and staff.

There have been a number of refreshes to the guidance by Public Health England which has 'enhanced' the PPE to front line staff from the initial guidance. This has required a significant uplift in PPE supplies to meet demand which the organisation has been able to fulfil to date, by managing regular local supplies during national shortages.

Infection Prevention and Control Board Assurance Framework

As understanding of COVID-19 has developed, Public Health England has published related guidance on infection prevention and control measures, which has been regularly updated to reflect the learning and to enable appropriate response in an evidence based way to maintain the safety of patients, services users and staff.

To support this work NHS England and NHS Improvement has developed the Infection Prevention and Control Board Assurance Framework self-assessment tool. Identification of areas of risk and corrective actions to provide assurance to the Board that organisational compliance has been systematically reviewed.

Completion of the assessment has demonstrated a high level of compliance and evidence in support of each of the indicators. Areas of improvement have been identified and will be progressed in the coming weeks. This package of evidence and on-going action will be challenged through the governance route in the organisation.

COVID-19 Communications

A COVID-19 Information Hub has been developed on the Trust website to provide updates with the latest advice and guidance in addition to details of any restrictions/changes that have had to be implemented to services and hospital sites.

Traffic to and engagement with the Trust's social media channels has continued to increase significantly over the past month. This includes an increase in new followers, engagement and views, for example, a story about a patient cheered out of Critical Care had 22,000 estimated people reached, attracting 400 comments on Facebook. It is clear that there is a real appetite for stories of hope in the current climate, as well as the factual information reported.

2.2 Strategic Objective: Valuing our People

2.2.1 Consultant appointments

Interviews have taken place over the last month for a Consultant position with a successful appointment being made as follows:

Consultant Paediatrician Dr Anilkumar Sreedhara Panicker

Further interviews will take place on 21 May for Consultants in Cardiology, Respiratory and General Medicine and Spinal Surgery services.

2.3 Strategic Objective: Transforming our Services

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

Whilst work on developing the decision making and governance framework for the ICS has been limited during the COVID period, work is recommencing on the key work streams to support the strategic intent of the ICS.

The ICS is currently concentrating on coordinating COVID-19 recovery with partners across health and social care, planning for further resilience options in the advent of anticipated multiple peaks and winter pressures, moving into phase 3 planning, recovery of access standards and financial performance, including management of the 2020/21 capital envelope.

The ICP, again, is focused on planning for the next phase of COVID-19 management including demand modelling and service mapping, capitalising on transformation achieved during the initial phases of COVID-19 response and supporting care homes.

2.3.2 Tees Valley Acute Hospitals Group

During COVID-19 the three acute trusts in the Tees Valley have responded, at pace, to the unprecedented challenge with clearly demonstrable innovation and collaborative working for the benefit of patients. To deliver health care that reflects the ever changing needs of the population and to support a greater partnership approach, work has continued in the development of governance that will support the proposals for a Group Structure between the three Acute Trusts in the Tees Valley.

The governance arrangements will be formulated in order to clearly articulate the purpose, functions and responsibilities of any Group arrangement and clarify the alignment and relationship with the Tees Valley Health and Care Partnership. To support this development a facilitator/chair has been appointed, on an interim basis, who will support and enable development of a Group approach, working closely with all three Trusts.

An inaugural meeting was held on 27 May 2020 involving the Chairs and Chief Executives from the three organisations where discussions focussed on partnership working; strategic rationale and intent; work programme; governance; and stakeholder engagement.

KPMG has been commissioned to undertake a review of ICP activity to date in relation to the Clinical Services Strategy. This piece of work has commenced and is being facilitated by a desk top review of evidence and interviews, held virtually, with key stakeholders. A report from this exercise is expected by the end of May and this will act as a catalyst to strengthen direction, worth of Managed Clinical Networks and developing design principles in readiness for future capital investment.

2.3.3 Chief Executives Network

A Chief Executive Network Group meeting facilitated by the NHS Confederation was held virtually on 22 April 2020. During the course of the meeting Chief Executives provided positive reports in relation to the rapid implementation of innovation, transforming service provision, staff 'stepping up' to the challenge and leadership capacity. Debate centred around the strengths of local leadership, the challenge of care home resilience and social care in the future and the future financial model for the NHS.

2.3.4 North East and Yorkshire Leaders Event

Several events have been held in May with NHSI/E Chief Executive and Chief Operating Officer and with the Regional Director to explore policy direction and guidance, recovery and best practice in the COVID-19 battle.

2.3.5 MP engagement

The Trust continues to work with all of the local MPs to understand the questions / concerns or queries from within their respective constituencies. On the whole, political colleagues are being helpful in supporting the Trust with its ambitions as work progresses in managing the pandemic. The Trust is working consistently to manage the messages to both the MPs and the wider media that best reflects the work it is delivering at both of hospital sites and in the community.

2.4 Strategic Objective: Health and Wellbeing

2.4.1 Social distancing – a collaborative campaign

The communications and marketing team have worked across the Tees Valley in a bid to send a message out to Teessiders to stay home and stay safe. Working with the local authorities, NHS Trusts, police and fire services, as well as shop workers and pharmacies – the campaign reminded the population that COVID-19 is not yet over.

The campaign was launched, accompanied by a social and local media campaign which described what two metres might mean to a Teessider by working as a collaborative the message will resonate across communities with a major impact on behaviour.

2.4.2 Billingham Lodge of Durham Freemasons

Mark Davies from the Billingham Lodge of Durham Freemasons visited on 14 May 2020 to present the Trust with a donation of 20 electronic Tablet devices to support virtual visiting for patients and their relatives during the current pandemic. The Trust has been overwhelmed by the generosity of the local communities and the donation of electronic equipment has proved invaluable in providing a resource to be used by patients, enhancing their personal experience whilst being in hospital and helping in small ways to address some of the challenges they face.

2.4.3. Population Health

The COVID-19 challenge and future planning has once again highlighted the required focus for population health management. The Trust is exploring opportunities to roll out a wellbeing model in localities with an emphasis on community driven services in the first instance. Exploring community payback and fund raising options for the future is now a priority for the Trust.

3. Recommendations

The Board of Directors is asked to note the content of this report and the pursuance of strategic objectives amongst the COVID-19 Pandemic crisis.

Julie Gillon
Chief Executive

Board of Directors

Title of report:	Integrated Compliance and Performance Report										
Date:	28 May 2020										
Prepared by:	Lindsey Wallace, Head of Planning, Performance and Development										
Executive Sponsor:	Lynne Taylor, Director of Planning and Performance										
Purpose of the report	The report provides an overview of the integrated performance for compliance, quality, finance and workforce for April 2020.										
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		Well Led	x	

Executive Summary and the key issues for consideration/ decision:

- The report outlines the Trust's compliance against key access standards in April including quality, workforce and finance in accordance with the Single Oversight Framework.
- The Trust has experienced significant pressures across many standards this month including the impact of COVID-19 with most key indicators impacted upon.
- Quality standards indicate positive performance against a number of key indicators, including HSMR/SHMI, C-difficile, Dementia standards and level 1 and 2 pressure ulcers.
- Sickness absence remains the key pressure within the Workforce standards, however with multiple actions implemented to understand the underlying reasons. This is compounded by the additional COVID-19 self-isolation pressures

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.
Staff self-isolation as a result of COVID-19.

Committees/groups where this item has been discussed	Executive Team Meeting Audit and Finance Committee Planning, Performance and Compliance Committee
Recommendation	The Board of Directors is asked to note the performance against standards within compliance, quality, finance and workforce whilst recognising on-going pressures.

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

28 May 2020

Integrated Compliance and Performance Report

Report of the Director of Planning and Performance, Chief Nurse/Director of Patient Safety and Quality, Chief People Officer and Director of Finance

Strategic Aim and Strategic Objective: Putting our Population First

1. Introduction/Purpose

1.1 The integrated Compliance and Performance Report highlights performance against a range of indicators against the Single Oversight Framework (SOF) and the Foundation Trust terms of licence for the month of April 2020.

1.2 The Integrated Dashboard is attached in Appendix 1- 5, with additional commentary provided against key metrics, providing month on month trend analysis. Appendix 1 outlines the trend analysis against the key Compliance indicators, Appendix 2 outlines Operational Efficiency and Productivity, Appendix 3 demonstrates Quality metrics, Appendix 4 Workforce and Appendix 5 relates to Finance.

1.3 The Trust has experienced significant pressures across many standards during April as a result of Covid-19 pressures and the continued period of government 'Lockdown' initiatives.

1.4 As reported to the Board in April, the Trust implemented robust resilience plans to enable the delivery of key services during the COVID-19 pressures, including new ways of working to ensure patient pathways can commence safely during the pandemic period. Patient pathways have remained open in relation to RTT, Cancer and Diagnostics, with patients being treated in order of 'clinical category' and 'clinical prioritisation' rather than access 'treat by dates', with some patient's conditions allowing a 12 week 'pause' alongside regular clinical review. Close collaboration across the regional network in relation to cancer management is on-going through the South cancer 'cell', implemented to manage cancer treatment through the available capacity across all provider organisations, including the independent sector.

1.5 The impact of the revised pathways, including the need to treat both COVID-19 and non COVID-19 patients through designated 'green' and 'red' areas, is evident across a number of key standards.

2. Performance Overview

2.1 Compliance

2.1.1 The Trust recovered the Cancer 62 day position in March, despite pressures faced from the impact of COVID-19 with a final validated position reporting at 87.3%, not sufficient to recover the quarter reporting at 79.3%.

2.1.2 The pressure of Covid-19 has inevitably impacted on the delivery of routine electives, which has resulted in longer waits reported across the RTT performance standards. However, the Trust remains one of the top reporting organisations in the region, with no patients waiting more than 52 weeks at this stage. Recovery plans are underway to ensure any delayed pathways are kept to an absolute minimum as the COVID-19 situation allows and in line with national guidance.

2.1.3 Routine diagnostics have been put on hold during the COVID-19 pressures, however with 2-week rule and urgent tests still carried out wherever appropriate, in line with national guidance. This has resulted in an increase in over 6 week diagnostic waits, reflected in the April performance. Diagnostics are now being re-instated, however once again working within the constraints of COVID-19 and non- COVID-19 pathways.

2.1.4 The Trust has continued to work with NHS England in the 'testing' of the revised emergency care standards.

2.1.5 Emergency activity across the organisation has seen a decrease of 48.02% (n=1860) in April compared to the same period last year, with emergency activity including 512 who were treated via Ambulatory Care, equating to 25.43% of total emergency admissions.

2.1.6 The Trust has maintained a positive position in relation to DTOCs and super stranded patients in April.

2.1.7 Reduced elective activity during April has resulted in the performance against a number of the efficiency indicators changing significantly, due to small numbers, changes in pathways and reduced capacity due to the use of appropriate personal protective equipment (PPE). This has therefore impacted on the relevance of a number of the current KPIs, which will be reviewed going forward for future performance reporting.

2.2 **Quality**

2.2.1 The Trust continues to remain within the expected range for both HSMR and SHMI values. The latest HSMR value is now 92.15 (January 2019 to December 2019), this has increased from the previously reported 91.30 (December 2018 to November 2019). The latest SHMI value is now 97.75 (November 2018 to October 2019), this has decreased from the previously reported value of 98.53 (November 2018 to October 2019).

2.2.2 For April 2020 the Trust is reporting 5 Trust attributed cases of Clostridium difficile (C.diff), (4 HOHA - Hospital Onset Healthcare Acquired) and (1 COHA - Community Onset Healthcare Acquired). The 5 cases have increased from the 2 cases reported in March 2020. No trajectory has yet been set for 2020-21, once it has, this will be reflected in future reports.

2.2.3 For April 2020 the Trust is reporting 14 Trust attributed cases of Catheter-associated Urinary Tract Infections (CAUTI), this has decreased from the 33 in March 2020.

2.2.4 The Trust is reporting 2 stage 3 (Formal Letter) complaints for April 2020. This has decreased from the 7 stage 3 complaints in March 2020.

2.2.5 The Trust is reporting zero falls resulting in a fracture for April 2020. This has remained the same from the previous period.

2.2.6 The Trust continues with its excellent performance in relation to dementia standards maintaining 100% compliance.

2.2.7 The Unify Registered Nurse/Midwife night shift fill rates submission has been suspended until further notice due to COVID-19.

2.2.8 Due to COVID-19, the Trust is no longer required to produce their 2019-20 Quality Accounts or even have them audited by an external auditor. However, as the work to produce the 2019-20 was already nearly complete we will still publish it onto the Trust website and NHS Choices as per usual.

2.3 **Workforce/Volunteers**

2.3.1 The sickness absence rate for March 2020 is reported at 5.43%, which is 1.43% above the revised Trust target of 4.0%. When comparing to the previous months' sickness absence rate of 4.52%, there has been an increase of 0.91%. 1.4. The long term sickness absence rate is reported at 3.07%, a reduction of 0.14% when compared to the previous month (3.21%). The short-term sickness absence rate for is reported at 1.93%, an increase of 0.26% when compared to the previous month (1.67%).

2.3.2 The cost of sickness absence is reported as £350,111 for the month of March 2020. This has increased by £129, 049 compared to February 2020 (£221, 062).

2.3.3 'Anxiety/stress/depression/other psychiatric illnesses' continues to account for the highest proportion of all sickness absence reasons at 40% for March 2020, which is an increase of 1% compared to February 2020 (39%).

2.3.4 During the month of April 2020 there were 583 cases of COVID-19 related absences. These are separated into 3 categories; 400 Staff members who were absent for 7 days, 157 who self-isolated for 14 days and 26 who are shielding for 12 weeks.

2.3.5 The Workforce Department are managing and coordinating a Cov-19 Absence call-in line which is operating Monday to Friday 8am-8pm and 9am-5pm on Saturday and Sunday. Due to a slight reduction in demand from Trust employees, with effect from 1 May 2020 the operating hours for the call-in line will be 8am to 5pm Monday to Friday and 8am to 12pm Saturday and Sunday.

2.3.6 The Workforce Department is also coordinating the arrangement of swab tests. The manning of the POD is being coordinated by the Health and Wellbeing Service and the POD is operating 8am-8pm Monday to Friday and 9am-5pm Saturday and Sunday. The testing commenced as an essential service for staff and index cases but has expanded to provide a service for pre-assessment patients, local GP Practices, Care Homes, NEAS and TEWV. Although there has been a reduction in demand from Trust employees, as anticipated the demand from external agencies has increased, specifically requests from Care Homes. With effect from 4 May 2020 the operating hours for the POD will be 10am to 6pm Monday to Friday and 10am to 2pm Saturday and Sunday.

2.3.7 A dedicated team was identified to support the continued management of urgent/high risk employee relation issues following national guidance that non-essential HR activity be paused. This is ongoing and consideration is being given on an individual basis to on-going cases taking into consideration impact on the individual, the trust and statutory requirements.

2.3.8 Consideration is to be given to provide dedicated support to staff currently absent due to COVID-19 related anxiety stress and depression to understand the context of the absence and provide advice.

2.3.9 The Wellbeing bus has been on site for a number of weeks and is facilitated by members from Organisation Development, Employee Engagement and Health and Wellbeing, providing support to employees and enabling staff to relax and get some time away from the workplace.

2.3.10 Health & Wellbeing and Psychology departments are providing support for staff throughout COVID-19 through a number of combined initiatives ensuring that all staff have access to someone to speak to if they experience any problems.

2.3.11 A Listening in Action application has been developed for Smartphones to enable staff to air concerns or anxieties and seek support if required.

2.3.12 The turnover rate for April 2020 is reported at 9.56% which has increased by 0.14% when compared to the previous month (9.42%), with the attrition figure for April 2020 is reported at 1.30%, which has reduced by 0.03% when compared to the previous month (1.33%).

2.3.13 The overall compliance for mandatory training for April 2020 is 87%, which has reduced by 3% when compared to the previous month (90%). Appraisal compliance is reported at 86% for April 2020, which has remained consistent with the previous month.

2.3.14 The volunteer Service has been significantly impacted by the COVID-19 pandemic with 39 volunteers in the Trust, 12 of which are drivers as at 30 April 2020. This is in comparison to the 223 internal volunteers and 117 external volunteers that were in place in early March 2020. The external volunteer partners, (RVS, Radio Stitch, Bookbase and League of Friends) continue with their suspension of activities.

2.3.15 For 'existing' volunteers who are unable to support the Trust during this unprecedented period, contact has been maintained by phone and the latest newsletter. Feedback to date has been positive with a significant number committing to return in the future. Proposals going forward include using technology to host virtual briefing sessions and meetings.

2.3.16 Interest in supporting the Trust continues to be high and there are currently 84 further applications in the pipeline being worked through with support from the Resourcing Team. The NHSE/I recruitment guidance, which was recently introduced, is working well, with minimum impact on the service and existing processes.

2.3.17 Effective working relationships have been developed with both Middlesbrough College and Bloodrun, whose staff are supporting the Trust in volunteering activities. A number of these volunteers have offered continued support to the organisation in the long term and not just during this current period. This is mirrored with other volunteers who have joined the Trust since 23 March, with an estimation that a third will continue as volunteers once the initial phases of lockdown are lifted.

2.3.18 Some of the activities being undertaken during this period include: -

- the responder role, which has been developed to ensure the needs of the Trust, staff and patients are met in a reactive and timely way.
- volunteers who are supporting non COVID-19 wards by befriending patients, providing support at mealtime and generally offering a helping hand.
- Collection and distribution of parcels dropped off by patient relatives and friends.

- Volunteer drivers, who are less involved in the discharge of patients and more involved in the delivery of medications for those outpatients who have experienced 'virtual' consultations. Also they have been involved in the delivery of essential preparations for those patients with endoscopy appointments.
- Volunteers have been involved in staff transport as a result of the capacity restrictions on the Shuttle bus service.

3. Finance Overview

3.1 NHSI/E issued guidance setting out the revised financial arrangements for 1st April to 31st July 2020 with the main aims to ensure; that the NHS has sufficient money to do what it is needed during this period, that the costs of dealing with COVID-19 are captured and funded, and that financial governance is maintained.

3.2 As a Trust, we are applying the same internal arrangements to match the national arrangements which aim to fund providers for cost based run rates and this is underpinned by an Interim Financial Management Framework which has been agreed at the Executive and Care Group Director meetings.

3.3 At the end of Month 1 the Trust is showing a breakeven position which includes a £36k contribution from Optimus and a £78k contribution from the LLP. Reporting a breakeven position at the end of Month 1 in light of the uncertain external environment we are currently operating in, is largely due to the Trust operating within run rates. It is essential that we continue to operate within run rates for the remainder of the 4 month period to 31st July 2020 to deliver a break-even position.

3.4 The Group cash balance at April is £44.8m which is £28.1m favourable to the NHSI plan, driven to cash received in advance from the Centre for May activity.

3.5 Debtor days have worsened by 2 days in comparison to April 2019/20 and creditor days have improved by 5 days in comparison to April 2019/20.

4. Key Challenges

4.1 The management of the COVID-19 pressures alongside the delivery of 'business as usual' service provision in the longer term. This will include new ways of operational delivery to ensure patient pathways, and the associated standards, can be recovered at the earliest point.

4.2 Situation reporting has significantly increased adding to the Trusts pressures, resulting in the requirement to deliver 7-day corporate support within the staffing resource available.

4.3 Financial impact of COVID-19 on the in-year recovery.

5. Conclusion/Summary

5.1 The Trust has experienced significant pressures as a result of the COVID-19 pandemic, inevitably impacting on the delivery of access standards however recovery plans are being developed.

5.2 Robust governance and monitoring of patients' pathways has been adapted to align with national and local guidance. In addition to this, the Trust has continued with 'business as usual' daily sitrep reports, including field testing of the emergency care standards, alongside multiple additional Covid Sitrep reports.

5.3 The impact of COVID-19 ‘self- isolation’ for staff has contributed to the overall resource pressures,

6. Recommendations

The Board of Directors is asked to note:

- The performance against the key operational, quality and workforce standards during April in light of the impact of the COVID-19 pandemic.
- Recognise the on-going financial pressures.
- Acknowledge the on-going operational performance and system risks to regulatory key performance indicators and the intense mitigation work that is being undertaken to address these going forward.

Lynne Taylor, Director of Planning and Performance
Julie Lane, Chief Nurse/Director of Patient Safety and Quality
Alan Sheppard, Chief People Officer
Neil Atkinson, Director of Finance

North Tees and Hartlepool NHS
NHS Foundation Trust

Integrated Performance and Compliance Report

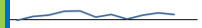
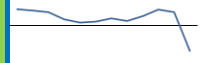
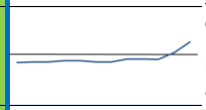
April 2020

Integrated Performance & Compliance

Developed by: Performance Team
Development lead: Lindsey Wallace

Integrated Performance and Compliance Dashboard - April 2020

SINGLE OVERSIGHT FRAMEWORK

Measure *(click on measure for trend graphs)*	Reporting period	Target	Actual	Q4	Trend	Details
Emergency Care Activity	Apr-20					2020/21 dashboard will see the introduction of a standard that considers a patients total waiting time in Emergency Care which will replace the 4 hour standard.
New Cancer 31 days subsequent Treatment (Drug Therapy)	Mar-20	98.0%	**98.9%**	**99.1%**		The Trust achieved these standards for the month of March and Q4
New Cancer 31 days subsequent Treatment (Surgery)	Mar-20	94.0%	**95.2%**	**95.7%**		
New Cancer 62 days (consultant upgrade)	Mar-20	85.0%	**90.5%**	**90.7%**		
New Cancer 62 days (screening)	Mar-20	90.0%	**92.0%**	**92.0%**		
New Cancer GP 62 Day (New Rules)	Mar-20	85.0%	**87.3%**	**79.3%**		Pressures across the system continued in the first two months of the quarter resulting in the Trust under achieving in January and February, similar trends to national and regional positions. However the Trust recovered the position in March despite pressures faced from the impact of COVID-19 with a validated position reporting at 87.3%, not sufficient to recover the quarter reporting at 79.3%.
New Cancer Current 31 Day (New Rules)	Mar-20	96.0%	**97.8%**	**98.5%**		The Trust achieved these standards for the month of March and Q4
New Cancer Two week Rule (New Rules)	Mar-20	93.0%	**93.3%**	**93.5%**		
Breast Symptomatic Two week Rule (New Rules)	Mar-20	93.0%	**95.8%**	**96.1%**		
RTT incomplete pathways wait (92%)	Apr-20	92.00%	**88.44%**	**93.79%**		The disruption to services as a result of the COVID-19 pandemic, has inevitably impacted upon performance however the Trust remains one of the highest performers across the region. No patient has yet been waiting more than 52 weeks. A slight increase to the median waiting is noted however a reduction of 4.3% (n=535) is noted to the overall waiting list size (April 2020 compared to January 2020) as clinicians have been reviewing patients and providing advice and guidance back to the care of the GP where appropriate to do so based on clinical need and priority. This, together with a reduction in routine referrals, has seen a reduced waiting list size. However the Trust anticipates some delays moving into Q1 of 2020/21 in keeping within national guidance, which stipulates that pathways remain open, acknowledging that Trusts will not be penalised as a result of RTT breaches as a result of COVID-19. Recovery plans are currently being developed.
RTT incomplete pathways wait (92nd percentile)	Apr-20	28.00	**20.40**	**16.60**		
RTT incomplete pathways wait (Median)	Apr-20	7.20	**10.10**	**6.60**		
RTT incomplete pathways >52 week wait	Apr-20	0	**0**	**0**		

Integrated Performance and Compliance Dashboard - April 2020

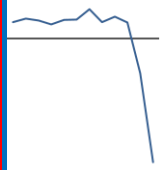
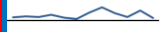
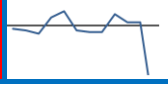
SINGLE OVERSIGHT FRAMEWORK

Measure *(click on measure for trend graphs)*	Reporting period	Target	Actual	Q4	Trend	Details
Number of patients waiting less than 6 weeks for diagnostic procedures	Apr-20	99.00%	43.26%	91.67%		Diagnostic waiting list has seen a significant increase in patients waiting over 6 weeks as routine procedures were paused as a result of Covid-19. Emergency, urgent and cancer diagnostics continues. The main pressure is seen within non obstetric ultrasound.
CIDs -Referral information	Mar-20	50.00%	100.00%	95.89%		The Trust continues to perform well against the Community Information Datasets, with all standards reporting above the 50% targets.
CIDs- Referral to Treatment information	Mar-20	50.00%	97.09%	96.94%		
CIDs- Treatment Activity Information	Mar-20	50.00%	100.00%	95.89%		

Performance Overview / Key Highlights	The Trust has experienced significant pressures as a result of the COVID-19 pandemic generally with all access standards affected. Robust governance and monitoring of patients pathways has been adapted to fit in alignment with national and local guidance with recovery plans under development.

Integrated Performance and Compliance Dashboard - April 2020

EFFICIENCY AND PRODUCTIVITY

Measure *(click on measure for trend graphs)*	Reporting period	Target	Actual	Q4	Trend	Details
New to Review ratio (cons led)	Mar-20	1.45	**1.41**	**1.41**		The Trust is realigning baseline targets for all operational efficiency standards in 2020/21.
Outpatient DNA (new)	Apr-20	7.20%	**5.17%**	**7.87%**		The introduction of non face to face appointments appear to have had a positive impact on DNA rates with one of the lowest rates noted.
Outpatient DNA (review)	Apr-20	9.00%	**6.54%**	**9.37%**		The Trust has maintained outpatient activity however delivered successfully via telephone and video links .
Revised Occupancy Trust	Apr-20	95.00%	**56.71%**	**86.65%**		The Covid pandemic saw bed occupancy reduce towards the end of March as the Trust prepared to escalate ITU capacity. This involved the cancellation of all elective procedures including cancers and closing a number of elective and medical beds across the Trust (including UHH) in an attempt to co-hort appropriately trained staff, ensure skill mix therefore being able to support the emergency pressures of Covid-19 . Beds occupied reduced with the latest position showing 123 beds closed. Low occupancy reflects the accommodation of red and green areas to support the Covid pressures. A recovery programme is underway.
Number of ambulance handovers between ambulance and A&E waiting more than 30 minutes	Apr-20	0	**7**	**60**		The North East (NEAS) average handovers greater than 30 minutes reported an unvalidated position of 57 (range 26-115), with the average over 60 minutes reporting at 3 (range 0 – 7). NEAS report the Trust at 26 delays >30 minutes and 0 >60 minutes whereas internal validated reports the Trust at 7 >30 minutes and 0>60 minutes.
Number of ambulance handovers between ambulance and A&E waiting more than 60 minutes	Apr-20	0	**0**	**6**		
Diabetic Retinopathy Screening	Apr-20					In keeping with national guidance on trusts being asked to prioritise 2 week rules and urgent referrals only this service has been temporarily paused during the Coovid-19 pandemic
Delayed Transfers of Care	Apr-20	3.50%	**0.50%**	**1.77%**		The Trust has maintained a positive position in relation to DTOCs and super stranded in the start of the new year, despite Covid-19 pandemic pressures.
Super Stranded Reduction (per day average)	Apr-20	64	**13**	**68**		

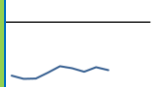
Integrated Performance and Compliance Dashboard - April 2020

EFFICIENCY AND PRODUCTIVITY

Measure *(click on measure for trend graphs)*	Reporting period	Target	Actual	Q4	Trend	Details
Performance Overview / Key Highlights	The Hospital Evaluation Data (HED) within the main report provides a summary of the Trusts benchmark position against a number of performance indicators covering clinical quality, operational efficiency, patient safety and finance. The Trust has demonstrated a positive performance against a number of the key operational indicators, supported by the Health Evaluation Data (HED) benchmarking data available in the main menu. The report indicates the Trust is performing above or within expected for the majority of indicators and also demonstrates improvement in indicators where performance has previously been below the national average.					

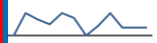
Integrated Performance and Compliance Dashboard - April 2020

QUALITY AND SAFETY

Measure *(click on measure for trend graphs)*	Reporting period	Target	Actual	Trend	Details
HSMR Mortality Rates (Rolling 12 month value)	Dec-19	108.00			The latest HSMR value is now 92.15 (January 2019 to December 2019), this has decreased from the previously reported 91.30 (December 2018 to November 2019). The value of 92.15 continues to remain inside the 'as expected' range; the national mean is 100. When benchmarked against the same period last year (January 2018 to December 2018) this has decreased from 97.79 to 92.15.
SHMI Mortality rate (Rolling 12 month value)	Nov-19	109.00			The latest SHMI value is now 97.75 (December 2018 to November 2019), this has decreased from the previously reported value of 98.53 (November 2018 to October 2019). When benchmarked against the same period last year (December 2017 to November 2018) this has decreased from 100.82 to 97.75.
Dementia - % of patients aged 75 and over, admitted as emergencies, stayed more than 72 hours and were asked the dementia case finding question	Apr-20	90.00%	**100.00%**		The Trust is reporting that 100% of patients aged 75 and over, who were admitted as emergencies, stayed more than 72 hours were asked the dementia case finding question.
Dementia - % of patients undergone a diagnostic assessment	Apr-20	90.00%	**100.00%**		The Trust is reporting that 100% of patients identified as potentially having dementia underwent a diagnostic assessment.
Dementia - % of those that received a diagnostic assessment that were referred onto another service or back to GP	Apr-20	90.00%			The Trust is reporting that 100% of those that received a diagnostic assessment were referred onto another service or back to GP.
Complaint Stage 1 - Informal	Apr-20	61			The Trust is reporting 44 stage 1 complaints for April 2020. This has decreased from the 64 stage 1 complaints in March 2020. When benchmarked against the same period last year (April 2019) this has decreased from 61 to 44.
Complaint Stage 2 - Formal Meeting	Apr-20	7			The Trust is reporting 3 stage 2 complaint for April 2020. This has decreased from the 1 stage 2 complaints in March 2020. When benchmarked against the same period last year (April 2019) this has decreased from 7 to 3.
Complaint Stage 3 - Formal Chief Executive Letter	Apr-20	13	**2**		The Trust is reporting 2 stage 3 complaints for April 2020. This has decreased from the 7 stage 3 complaints in March 2020. When benchmarked against the same period last year (April 2019) this has decreased from 13 to 2.
Never Events	Apr-20	0	**0**		There has been no Never Events reported in this period.

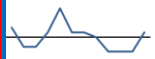
Integrated Performance and Compliance Dashboard - April 2020

QUALITY AND SAFETY

Measure *(click on measure for trend graphs)*	Reporting period	Target	Actual	Trend	Details
Category 2 Pressure Ulcers (In-Hospital)	Mar-20	15	**20**		The Trust is reporting 20 category 2 pressure ulcers for March 2020. This has decreased from 33 category 2 ulcers reported for February 2020. When benchmarked against the same period last year (March 2019) this has increased from 15 to 20 cases.
Category 3 Pressure Ulcers (In-Hospital)	Mar-20	5	**0**		The Trust is reporting zero category 3 pressure ulcers for March 2020. This has decreased from the 4 cases reported in February 2020. When benchmarked against the same period last year (March 2019) this has decreased from 5 to zero cases.
Category 4 Pressure Ulcers (In-Hospital)	Mar-20	0	**0**		The Trust is reporting zero category 4 pressure ulcer for March 2020. This has remained the same from the previous reporting period. When benchmarked against the same period last year (March 2019) this has remained the same at zero cases.
Fall - No Injury (In-Hospital)	Apr-20	74	**59**		The Trust is reporting 59 falls resulting in no injury for April 2020. This has increased from the 52 falls reported for March 2020. When benchmarked against the same period last year (April 2019) this has decreased from 74 to 65.
Fall - Injury, No Fracture (In-Hospital)	Apr-20	19	**15**		The Trust is reporting 15 falls resulting in an injury, but no fracture for April;2020. This has increased from the 13 falls resulting in an injury reported for March 2020. When benchmarked against the same period last year (April 2019) this has decreased from 19 to 15.
Fall - With Fracture (In-Hospital)	Apr-20	1	**0**		The Trust is reporting zero falls resulting in a fracture for April 2020. This has remained the same at zero falls resulting in a fracture from March 2020. When benchmarked against the same period last year (April 2019) this has decreased from 1 to zero.
VTE Risk Assessment	Apr-20	95.00%	**95.44%**		The Trust is reporting that 95.44% of patients admitted to hospital were risk assessed for venous thromboembolism (VTE) during April 2020. This has decreased from 96.98% reported in March 2020.
Hand Hygiene Compliance	Apr-20	95.00%	**100.00%**		The overall Trust compliance score for hand hygiene is 100% for April 2020; this has remained the same from the previous reporting period.

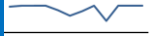
Integrated Performance and Compliance Dashboard - April 2020

QUALITY AND SAFETY

Measure *(click on measure for trend graphs)*	Reporting period	Target	Actual	Trend	Details
Clostridium difficile (C.diff)	Apr-20	4	5		For April 2020 the Trust is reporting 5 Trust attributed cases of Clostridium difficile infection (4 HOHA - Hospital Onset Healthcare Acquired an 1 COHA - Community Onset Healthcare Acquired), this has increased from the previous reporting period when 2 cases were reported. The Trust has not been set a trajectory for 2020-21 yet, so no targets can be aligned for each month. This will be updated when the trajectory has been set.
Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia	Apr-20	0	0		The Trust is reporting zero Trust attributed cases of MRSA bacteraemia in April 2020. This remains the same from previous reporting period and the target of zero cases.
Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia	Apr-20	0	1		The Trust is reporting 1 Trust attributed case of MSSA bacteraemia for April 2020. This has decreased from the 3 cases reported in the previous period of March 2020. When benchmarked against the same period last year (April 2019) this has increased from zero to 1 case.
Escherichia coli (E.coli)	Apr-20	3	0		The Trust is reporting zero Trust attributed cases of E coli bacteraemia in April 2020. This has decreased from the 4 reported cases in March 2020. When benchmarked against the same period last year (April 2019) this has decreased from 3 to zero cases.
Klebsiella species bacteraemia (Kleb sp)	Apr-20	2	0		The Trust has reported zero Trust attributed cases of Klebsiella species bacteraemia in April 2020. This has remained the same from the previous period. When benchmarked against the same period last year (April 2019) this has decreased from 2 to zero cases.
Pseudomonas aeruginosa bacteraemia (Ps a)	Apr-20	0	0		The Trust has reported zero Trust attributed cases of Pseudomonas aeruginosa bacteraemia in April 2020. This has remained the same from the previous reporting period. When benchmarked against the same period last year (April 2019) this has remained the same at zero cases.
CAUTI	Apr-20	28	14		For April 2020 the Trust is reporting 14 Trust attributed cases of a catheter-associated urinary tract infection (CAUTI), this has decreased from the 33 cases reported in the previous reporting period. When benchmarked against the same period last year (April 2019) this has decreased from 28 to 14 cases.

Integrated Performance and Compliance Dashboard - April 2020

QUALITY AND SAFETY

Friends & Family - (Ward) [National Score based on % 'Very Good' & 'Good']	Apr-20	70.00%			The in-patient Friends and Family position for the new method of rating the service 'Very Good or Good' was 95% for April 2020. The National FFT upload to NHS Digital has been suspended until further notice due to COVID-19.
Friends & Family - (A&E/Urgent Care) [National Score based on % 'Very Good' & 'Good']	Apr-20	70.00%			The Emergency Care (Accident & Emergency and Urgent Care) Friends and Family position for the new method of rating the service 'Very Good or Good' was 90% for April 2020. The National FFT upload to NHS Digital has been suspended until further notice due to COVID-19.
Friends & Family - (Birth) [National Score based on % 'Very Good' & 'Good']	Apr-20	70.00%			The Maternity (Delivery) Friends and Family position for the new method of rating the service 'Very Good or Good' was 100% for April 2020. The National FFT upload to NHS Digital has been suspended until further notice due to COVID-19.
Registered Nurse/Midwife day shift fill rates	Apr-20	>=80% and <=109.99%			The Unify Registered Nurse/Midwife night shift fill rates submission has been suspended until further notice due to COVID-19. NHS Digital have stated the following: "In view of the on-going response to COVID-19, it has been agreed to pause the Rota Fill Rates and CHPPD (Safe Staffing) Collection at this time with immediate effect."
Registered Nurse/Midwife Night shift fill rates	Apr-20	>=80% and <=109.99%			The Unify Registered Nurse/Midwife night shift fill rates submission has been suspended until further notice due to COVID-19. NHS Digital have stated the following: "In view of the on-going response to COVID-19, it has been agreed to pause the Rota Fill Rates and CHPPD (Safe Staffing) Collection at this time with immediate effect."
Care Staff day shift fill rates	Apr-20	>=80% and <=109.99%			The Unify Registered Nurse/Midwife night shift fill rates submission has been suspended until further notice due to COVID-19. NHS Digital have stated the following: "In view of the on-going response to COVID-19, it has been agreed to pause the Rota Fill Rates and CHPPD (Safe Staffing) Collection at this time with immediate effect."
Care Staff Night shift fill rates	Apr-20	>=110% and <=125.99%			The Unify Registered Nurse/Midwife night shift fill rates submission has been suspended until further notice due to COVID-19. NHS Digital have stated the following: "In view of the on-going response to COVID-19, it has been agreed to pause the Rota Fill Rates and CHPPD (Safe Staffing) Collection at this time with immediate effect."

Integrated Performance and Compliance Dashboard - April 2020

QUALITY AND SAFETY

Measure *(click on measure for trend graphs)*	Reporting period	Target	Actual	Trend	Details
Performance Overview / Key Highlights					The latest data for the Trusts HSMR is 92.15; this has increased from the previous reported value of 91.30, with the Trusts latest SHMI at 97.75, this has decreased from the previously reported position of 98.53. For April 2020 the Trust is reporting 5 Trust attributed cases of Clostridium difficile infection (4 HOHA - Hospital Onset Healthcare Acquired and 1 COHA - Community Onset Healthcare Acquired), this has increased from the previous reporting period when 2 cases were reported. There has been no trajectory set for 2020-21 as of yet, when it has been set, this will be cascased.
Conclusion and recommendation					The Board of Directors is asked to note the content of the report; current performance and work to continuously improve. The Board are asked to note the excellent HSMR and SHMI values which continue to remain within the expected range, along with the on trajectoy position for Cdiff.

Integrated Performance and Compliance Dashboard - April 2020

WORKFORCE

Measure *(click on measure for trend graphs)*	Reporting period	Target	Actual	Q4	Trend	Details
Sickness	Mar-20	4.00%	**5.43%**	**5.01%**		The sickness absence rates for April 2020 are not yet available. The sickness absence rate for March 2020 is reported at 5.43%, which is 1.43% above the revised Trust target of 4.0% The long term sickness absence rate for March 2020 is reported at 3.07%, a reduction of 0.14% when compared to the previous month (3.21%). The short-term sickness absence rate for March 2020 is reported at 1.93%, an increase of 0.26% when compared to the previous month (1.67%). The cost of sickness absence is reported as £350,111 for the month of March 2020. This has increased by £129, 049 compared to February 2020 (£221, 062). Benchmarking The latest national sickness absence data available is for the month of December 2019 and supplied by NHS Digital. The sickness rate for North Tees and Hartlepool is 5.46%, which is 0.02% above the regional average and 0.59% above the NHS average. Four North East Trust's report a rate lower than the regional average; none report a rate lower than the national average (though Gateshead is the same rate). The highest sickness absence rate in the North East region for December 2019 is reported by Tees, Esk and Wear Valleys NHS Foundation Trust at 6.22%.
Turnover (12 months rolling data)	Apr-20	10.00%	**9.56%**	**9.42%**		The turnover rate for April 2020 is reported at 9.56% which has increased by 0.14% when compared to the previous month (9.42%).
Mandatory Training	Apr-20	80%	**87%**	**90%**		The overall compliance for mandatory training for April 2020 is 87%, which has reduced by 3% when compared to the previous month (90%).
Appraisals	Apr-20	95%	**86%**	**86%**		Appraisal compliance is reported at 86% for April 2020, which has remained consistent with the previous month

Performance Overview / Key Highlights	North Tees & Hartlepool NHS Foundation Trust When comparing March 2020 to the previous months' sickness absence rate of 4.52%, there has been an increase in the Trust's sickness absence rate of 0.91%. 'Anxiety/stress/depression/other psychiatric illnesses' continues to account for the highest proportion of all sickness absence reasons at 40% for March 2020, which is an increase of 1% compared to February 2020 (39%).
Conclusion and recommendation	The Board is asked to note the contents within the workforce report and positive performance against standards together with the on-going work to integrate performance reporting.

Integrated Performance and Compliance Dashboard - April 2020

APPENDIX 1 - SINGLE OVERSIGHT FRAMEWORK

Measure	KPI	Period	Jan-20	Feb-20	Mar-20	Q4	Apr-20	May-20	Jun-20	Q1	Jul-20	Aug-20	Sep-20	Q2	Oct-20	Nov-20	Dec-20	Q3	Jan-21	Feb-21	Mar-21	Q4
A&E	*Target*		200.00	200.00	200.00	200.00	200.00															
	Total Time in Department (Mean) Type 1 & 3	Apr-20	97.26	99.82	103.50	100.20	120.29															
Cancer	*Target*		98.0%	97.7%	98.0%	97.9%																
	New Cancer 31 days subsequent Treatment (Drug Therapy)	Mar-20	98.9%	**90.4%**	98.9%	99.1%																
	Target		94.0%	94.0%	94.0%	94.0%																
	New Cancer 31 days subsequent Treatment (Surgery)	Mar-20	100.0%	**92.3%**	95.2%	95.7%																
	Target		85.0%	85.0%	85.0%	85.0%																
	New Cancer 62 days (consultant upgrade)	Mar-20	88.2%	93.8%	90.5%	90.7%																
Cancer	*Target*		90.0%	90.0%	90.0%	90.0%																
	New Cancer 62 days (screening)	Mar-20	**82.9%**	100.0%	92.0%	92.0%																
	Target		85.0%	85.0%	85.0%	85.0%																
	New Cancer GP 62 Day (New Rules)	Mar-20	**76.1%**	**73.9%**	87.3%	**79.3%**																
Cancer	*Target*		96.0%	96.0%	96.0%	96.0%																
	New Cancer Current 31 Day (New Rules)	Mar-20	98.5%	99.2%	97.8%	98.5%																
	Target		93.0%	93.0%	93.0%	93.0%																
	New Cancer Two week Rule (New Rules)	Mar-20	93.2%	93.8%	93.3%	93.5%																
	Target		93.0%	93.0%	93.0%	93.0%																
Cancer	Breast Symptomatic Two week Rule (New Rules)	Mar-20	95.5%	96.9%	95.8%	96.1%																

Integrated Performance and Compliance Dashboard - April 2020

APPENDIX 1 - SINGLE OVERSIGHT FRAMEWORK

Measure	KPI	Period	Jan-20	Feb-20	Mar-20	Q4	Apr-20	May-20	Jun-20	Q1	Jul-20	Aug-20	Sep-20	Q2	Oct-20	Nov-20	Dec-20	Q3	Jan-21	Feb-21	Mar-21	Q4
RTT	*Target*		92.00%	92.00%	92.00%	92.00%	92.00%															
	RTT incomplete pathways wait (92%)	Apr-20	93.28%	94.19%	93.84%	93.79%	**88.44%**															
	Target		28.00	28.00	28.00	28.00	28.00															
	RTT incomplete pathways wait (92nd percentile)	Apr-20	16.60	16.00	17.10	16.60	20.40															
	Target		7.20	7.20	7.20	7.20	7.20															
	RTT incomplete pathways wait (Median)	Apr-20	6.10	6.00	**7.60**	6.60	**10.10**															
	Target		0	0	0	0	0															
	RTT incomplete pathways >52 week wait	Apr-20	0	0	0	0	0															
Diagnostics	*Target*		99.00%	99.00%	99.00%	99.00%	99.00%															
	Number of patients waiting less than 6 weeks for diagnostic procedures	Apr-20	**88.73%**	**95.63%**	**90.19%**	**91.67%**	**43.26%**															
CIDS	*Target*		50.00%	50.00%	50.00%	50.00%																
	CIDs -Referral information	Mar-20	93.33%	95.10%	100.00%	95.89%																
	Target		50.00%	50.00%	50.00%	50.00%																
	CIDs- Referral to Treatment information	Mar-20	96.48%	97.35%	97.09%	96.94%																
	Target		50.00%	50.00%	50.00%	50.00%																
	CIDs- Treatment Activity Information	Mar-20	94.22%	94.08%	100.00%	95.89%																

Integrated Performance and Compliance Dashboard - April 2020 (2019-2020 against target)

APPENDIX 2 - EFFICIENCY AND PRODUCTIVITY

Measure	KPI	Period	Jan-20	Feb-20	Mar-20	Q4	Apr-20	May-20	Jun-20	Q1	Jul-20	Aug-20	Sep-20	Q2	Oct-20	Nov-20	Dec-20	Q3	Jan-21	Feb-21	Mar-21	Q4
	Target		1.45	1.45	1.45	1.45																
New to review	New to Review ratio (cons led)	Mar-20	1.41	1.32	1.41	1.41																
	Target		7.20%	7.20%	7.20%	7.20%	7.20%															
DNA	Outpatient DNA (new)	Apr-20	**7.40%**	**7.50%**	**7.78%**	**7.87%**	5.17%															
	Target		9.00%	9.00%	9.00%	9.00%	9.00%															
	Outpatient DNA (review)	Apr-20	**9.52%**	**9.14%**	**9.43%**	**9.37%**	6.54%															
	Target		4.50%	4.50%	4.50%	4.50%																
	Pre - Op Stays	Apr-20	1.56%	1.20%	1.21%	1.42%																
	Target		85.00%	85.00%	85.00%	85.00%	95.00%															
Occupancy	Revised Occupancy North Tees	Apr-20	**91.93%**	**90.77%**	73.93%	**86.89%**	56.71%															
	Target		85.00%	85.00%	85.00%	85.00%	95.00%															
	Revised Occupancy Hartlepool	Apr-20	**89.52%**	76.63%	79.44%	82.46%	Closed															
	Target		85.00%	85.00%	85.00%	85.00%	95.00%															
	Revised Occupancy Trust	Apr-20	**91.79%**	**89.97%**	74.20%	**86.65%**	56.71%															
	Target		0.00%	0.00%																		
Readmissions *	Readmission rate 30 days (Elective admission)	Feb-20	**3.72%**	**4.17%**																		
	Target		9.73%	9.73%																		
	Readmission rate 30 days (Emergency admission)*	Feb-20	**13.40%**	**12.66%**																		
	Target		7.70%	7.70%																		
	Readmission rate 30 days (Total)	Feb-20	**9.19%**	**8.79%**																		
	Target		95.00%	95.00%	95.00%	95.00%	95.00%															
EDS	Electronic Discharge Summaries within 24 hours (incl. A&E)	Apr-20	**93.04%**	**92.84%**	**91.99%**	**92.65%**	**91.96%**															
	Target		15.60%	15.60%	15.60%	15.60%																
C-sections	Emergency c-section rates	Apr-20	14.01%	15.13%	11.47%	13.44%																
	Target		72.86%	72.86%	72.86%	72.86%																
Theatres	Operation Time Utilisation	Mar-20	**70.77%**	74.29%	72.92%	**72.65%**																
	Target		87.07%	87.07%	87.07%	87.07%																
	Run Time Utilisation	Mar-20	**86.40%**	87.51%	**86.88%**	**86.92%**																

Integrated Performance and Compliance Dashboard - April 2020 (2019-2020 against target)

APPENDIX 2 - EFFICIENCY AND PRODUCTIVITY

Measure	KPI	Period	Jan-20	Feb-20	Mar-20	Q4	Apr-20	May-20	Jun-20	Q1	Jul-20	Aug-20	Sep-20	Q2	Oct-20	Nov-20	Dec-20	Q3	Jan-21	Feb-21	Mar-21	Q4
	Target		92.50%	92.50%	92.50%	92.50%																
	Planned Session Utilisation *	Mar-20	**91.67%**	92.86%	**76.23%**	**84.62%**																
	Target		0.80%	0.80%	0.80%	0.80%																
	Cancelled procedures (Non medical)	Apr-20	0.19%	0.24%	0.66%	0.50%																
	Target		0	0	0	0																
	Readmission within 28 days of non medical cancelled operation	Apr-20	**1**	0	**4**	**5**																
	Target		0	0	0	0																
	Cancelled Urgent Operations for second time	Apr-20	0	0	0	0																
	Target		8.80%	8.80%	8.80%	8.80%																
	Cancelled on day of operation	Mar-20	6.48%	7.58%	**9.31%**	8.44%																
	Target		33.11%	33.11%	33.11%	33.11%																
	Late Start %	Mar-20	**43.01%**	**41.39%**	**44.53%**	**42.93%**																
	Target		46.13%	46.13%	46.13%	46.13%																
	Early Finishes %	Mar-20	**47.20%**	**47.62%**	40.08%	45.16%																
	Target		12.89%	12.89%	12.89%	12.89%																
	Session overruns (>30 minutes)	Mar-20	**16.78%**	12.82%	**18.62%**	**16.00%**																
	Target		5.00%	5.00%	5.00%	5.00%	5.00%															
	A&E unplanned returns within 7 days - Type 1	Apr-20	1.81%	1.64%	0.90%	1.46%	0.49%															
	Target		5.00%	5.00%	5.00%	5.00%	5.00%															
	A&E left without being seen - Type 1	Apr-20	2.57%	3.04%	2.34%	2.65%	1.61%															
	Target		15	15	15	15.00	15															
	Time to Initial Assessment (mean) Type 1 & 3	Apr-20	9.08	9.42	8.59	9.03	9.40															
A&E	*Target*		0	0	0	0	0															
	Number of ambulance handovers between ambulance and A&E waiting more than 30 minutes	Apr-20	**21**	**10**	**29**	**60**	**7**															
	Target		0	0	0	0	0															
	Number of ambulance handovers between ambulance and A&E waiting more than 60 minutes	Apr-20	**1**	**1**	**4**	**6**	0															
	Target		0	0	0	0	0															

Integrated Performance and Compliance Dashboard - April 2020 (2019-2020 against target)

APPENDIX 2 - EFFICIENCY AND PRODUCTIVITY

Measure	KPI	Period	Jan-20	Feb-20	Mar-20	Q4	Apr-20	May-20	Jun-20	Q1	Jul-20	Aug-20	Sep-20	Q2	Oct-20	Nov-20	Dec-20	Q3	Jan-21	Feb-21	Mar-21	Q4
	A&E 12 Hour Trolley waits - Type 1	Apr-20	0	0	0	0	0															
	Target		95.00%	95.00%																		
Screening	Diabetic Retinopathy Screening	Apr-20	98.34%	98.45%																		
	Target		17.00%	17.00%	17.00%	17.00%	17.00%															
TCS	TCS 19 - % of Community Patients that have had an unplanned admission LOS <=2 days (Defined set of conditions)	Apr-20	9.38%	8.13%	7.75%	8.44%	6.06%															
	Target		93.50%	93.50%	93.50%	93.50%	93.50%															
	TCS 24 - % of Patients achieving improvement using a EQ5 validated assessment tool	Apr-20	97.96%	96.70%	98.10%	98.90%	98.90%															
	Target		5.00%	5.00%	5.00%	5.00%																
	TCS35b - % of wheelchair referrals not completed within 8 weeks but completed within 18 weeks	Mar-20	4.90%	1.35%	**15.76%**	**8.00%**																
	Target		95.00%	95.00%	95.00%	95.00%	95.00%															
Audiology	The % patients treated within 18 weeks of referral to audiology (Hpool site)	Apr-20	100.00%	100.00%	100.00%	100.00%	100.00%															
	Target		18.30	18.30	18.30	18.30	18.30															
	Audiology non admitted wait (92nd percentile)	Apr-20	4.00	5.00	6.00	6.00	10.00															
	Target		50.00%	50.00%	50.00%	50.00%																
Patient identifier	Patient Identifier Indicator	Mar-20	94.22%	94.08%	100.00%	95.89%																
	Target		50.00%	50.00%	50.00%	50.00%																
EOL	End of Life measure	Mar-20	87.18%	86.96%	84.04%	86.07%																
	Target		3.50%	3.50%	3.50%	3.50%	3.50%															
DTOC	Delayed Transfers of Care	Apr-20	1.75%	1.84%	1.70%	1.77%	0.50%															
	Target		65	65	64	65	64															
Super Stranded	Super Stranded Reduction (per day average)	Apr-20	**72**	**67**	**66**	**68**	13															

Integrated Performance and Compliance Dashboard - April 2020 (2019-2020 against target)

APPENDIX 2 - EFFICIENCY AND PRODUCTIVITY

Measure	KPI	Period	Jan-20	Feb-20	Mar-20	Q4	Apr-20	May-20	Jun-20	Q1	Jul-20	Aug-20	Sep-20	Q2	Oct-20	Nov-20	Dec-20	Q3	Jan-21	Feb-21	Mar-21	Q4
Unplanned	*Target*		199.7	199.7	199.7	199.7																
	Emergency admissions for acute conditions that should not usually require hospital admission	Mar-20	159.3	137.5	106.3	135.3																
	Target		21.51	21.51	21.51	21.51																
	Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	Mar-20	**30.03**	21.13	13.35	21.51																
	Target		73.3	73.3	73.3	73.3																
	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)	Mar-20	**78.5**	64.5	49.5	60.1																
	Target		44.49	44.49	44.49	44.49																
	Unplanned hospitalisation for respiratory tract infections in under 19s	Mar-20	**55.62**	12.24	26.70	31.52																
Stroke	*Target*		80.00%	80.00%	80.00%	80.00%																
	Stroke admissions 90% of time spent on dedicated Stroke unit	Mar-20	89.74%	90.48%	86.67%	88.89%																
	Target		75.00%	75.00%	75.00%	75.00%																
	High risk TIAs assessed and treated within 24 hours	Mar-20	**60.00%**	100.00%	100.00%	84.62%																

Integrated Performance and Compliance Dashboard - April 2020 (2019-2020 against target)

APPENDIX 4 - WORKFORCE

Measure	KPI	Period	Jan-20	Feb-20	Mar-20	Q4	Apr-20	May 20	Jun-20	Q1	Jul 20	Aug-20	Sep-20	Q2	Oct 20	Nov 20	Dec 20	Q3	Jan-21	Feb-21	Mar-21	Q4
Staff	*Target*		4.00%	4.00%	4.00%	4.00%																
	Sickness	Mar-20	**4.98%**	**4.52%**	**5.43%**	**5.01%**																
	Target		10.00%	10.00%	10.00%	10.00%	10.00%															
	Turnover (12 months rolling data) - revised methodology from Nov-18 *	Apr-20	9.71%	9.38%	9.42%	9.42%	9.56%															
	Target		80.0%	80.0%	80.0%	80.0%	80.0%															
	Mandatory Training	Apr-20	89.0%	89.0%	90.0%	90.0%	87.0%															
	Target		95.0%	95.0%	95.0%	95.0%	95.0%															
	Appraisals	Apr-20	**85.0%**	**86.0%**	**86.0%**	**86.0%**	**86.0%**															

Integrated Performance and Compliance Dashboard - April 2020 (2019-2020 against target)

APPENDIX 3 - QUALITY AND SAFETY

Measure	KPI	Period	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Q4	Apr-20	May-20	Jun-20	Q1	Jul-20	Aug-20	Sep-20	Q2	Oct-20	Nov-20	Dec-20	Q3	Jan-21	Feb-21	Mar-21	Q4
HMSR	*Target*		108.00	108.00																				
	HSMR Mortality Rates (Rolling 12 month value)	Dec-19	91.30	92.15																				
SHMI	*Target*		109.00	109.00	109.00																			
	SHMI Mortality rate (Rolling 12 month value)	Nov-19	97.75	98.80	98.11																			
Dementia	*Target*		90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%															
	Dementia - % of patients aged 75 and over, admitted as emergencies, stayed more than 72 hours and were asked the dementia case finding question	Apr-20	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%															
	Target		90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%															
	Dementia - % of patients undergone a diagnostic assessment	Apr-20	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%															
	Target		90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%															
	Dementia - % of those that received a diagnostic assessment that were referred onto another service or back to GP	Apr-20	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%															
Complaints			49	50	73	64	60	197	61															
	Complaint Stage 1 - Informal	Apr-20	75	66	97	88	64	**249**	44															
			9	6	5	13	8	26	7															
	Complaint Stage 2 - Formal Meeting	Apr-20	7	7	8	3	1	12	3															
			20	12	14	30	10	54	13															
	Complaint Stage 3 - Formal Chief Executive Letter	Apr-20	16	9	16	11	7	34	2															
Risks			10	8	9	7	7	23	6															
	Corporate & Departmental Risks (Red)	Apr-20	7	6	5	4	5	14	7															
Never Events			0	0	0	0	0	0	0															
	Never Events	Apr-20	0	0	0	0	0	0	0															
Pressure Ulcers	*Target*		6	8	8	6	8	22	7															
	Catergory 1 Pressure Ulcers (In-Hospital)	Mar-20	3	4	8	7	3	18	4															
	Target		19	15	15	28	15	58	23															
	Category 2 Pressure Ulcers (In-Hospital)	Mar-20	19	21	29	33	20	82	28															
	Target		2	1	3	4	5	12	4															
	Category 3 Pressure Ulcers (In-Hospital)	Mar-20	1	2	2	4	0	6	0															
	Target		0	0	0	1	0	1	1															
	Category 4 Pressure Ulcers (In-Hospital)	Mar-20	0	0	1	0	0	1	0															
Falls			79	79	84	72	80	236	74															
	Fall - No Injury (In-Hospital)	Apr-20	67	69	57	64	52	173	59															

Integrated Performance and Compliance Dashboard - April 2020 (2019-2020 against target)

APPENDIX 3 - QUALITY AND SAFETY

Measure	KPI	Period	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Q4	Apr-20	May-20	Jun-20	Q1	Jul-20	Aug-20	Sep-20	Q2	Oct-20	Nov-20	Dec-20	Q3	Jan-21	Feb-21	Mar-21	Q4
			21	23	28	20	16	64	19															
	Fall - Injury, No Fracture (In-Hospital)	Apr-20	22	21	15	20	13	48	15															
			3	4	2	3	4	9	1															
	Fall - With Fracture (In-Hospital)	Apr-20	0	0	0	9	0	9	0															
	Target		95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%															
VTE	VTE Risk Assessment	Apr-20	97.39%	97.08%	97.66%	97.36%	96.98%	97.53%	95.44%															
	Target		95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%															
Hand Hygiene Compliance	Hand Hygiene Compliance	Apr-20	98.00%	99.00%	99.00%	99.00%	100.00%	96.00%	100.00%															
	Target		5	4	5	5	5	15	4															
Infections	Clostridium difficile (C.diff)	Apr-20	6	4	2	2	2	6	5															
	Target		0	0	0	0	0	0	0															
	Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia	Apr-20	0	0	0	0	0	0	0															
			1	4	1	3	1	5	0															
	Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia	Apr-20	2	2	0	1	3	4	1															
			3	2	2	1	3	6	3															
	Escherichia coli (E.coli)	Apr-20	6	2	1	6	4	11	0															
			3	1	1	2	1	4	2															
	Klebsiella species bacteraemia (Kleb sp)	Apr-20	1	0	3	0	0	3	0															
			1	2	1	0	0	1	0															
	Pseudomonas aeruginosa bacteraemia (Ps a)	Apr-20	1	0	0	0	0	0	0															
									28															
	CAUTI	Apr-20	21	32	31	27	33	91	14															
	Target		70.00%	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%															
FFT	Friends & Family - (Ward) [National Score based on % 'Very Good' & 'Good']	Apr-20	96.00%	98.00%	93.00%	91.00%	90.00%	97.00%	95.00%															
	Target		70.00%	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%															
	Friends & Family - (A&E/Urgent Care) [National Score based on % 'Very Good' & 'Good']	Apr-20	82.00%	100.00%	86.00%	78.00%	87.00%	89.00%	90.00%															
	Target		70.00%	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%															
	Friends & Family - (Birth) [National Score based on % 'Very Good' & 'Good']	Apr-20	94.00%	100.00%	83.00%	100.00%	100.00%	99.00%	100.00%															
	Target		>=80% and <=109.99%	>=80% and <=109.99%	>=80% and <=109.99%	>=80% and <=109.99%		>=80% and <=109.99%																
Workforce	Registered Nurse/Midwife day shift fill rates	Apr-20	86.08%	86.17%	83.67%	83.57%		86.84%																
	Target		>=80% and <=109.99%	>=80% and <=109.99%	>=80% and <=109.99%	>=80% and <=109.99%		>=80% and <=109.99%																

Integrated Performance and Compliance Dashboard - April 2020 (2019-2020 against target)

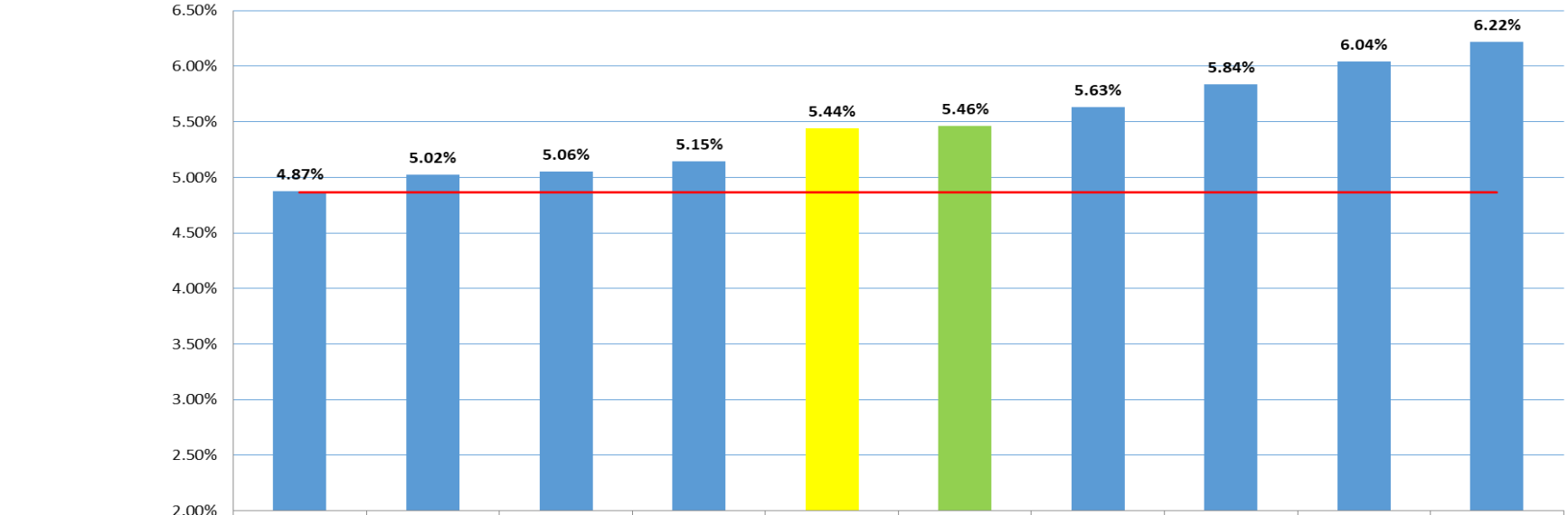
APPENDIX 3 - QUALITY AND SAFETY

Measure	KPI	Period	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Q4	Apr-20	May-20	Jun-20	Q1	Jul-20	Aug-20	Sep-20	Q2	Oct-20	Nov-20	Dec-20	Q3	Jan-21	Feb-21	Mar-21	Q4
	Registered Nurse/Midwife Night shift fill rates	Apr-20	91.44%	91.53%	93.01%	92.62%		93.77%																
	Target		>=80% and <=109.99%	>=80% and <=109.99%	>=80% and <=109.99%	>=80% and <=109.99%		>=80% and <=109.99%																
	Care Staff day shift fill rates	Apr-20	98.97%	99.05%	99.05%	100.82%		90.12%																
	Target		>=110% and <=125.99%	>=110% and <=125.99%	>=110% and <=125.99%	>=110% and <=125.99%		>=110% and <=125.99%																
	Care Staff Night shift fill rates	Apr-20	138.41%	138.69%	149.66%	144.91%		122.22%																

Integrated Performance and Compliance Dashboard - April 2020 Benchmark Regional

Measure	National	North East	North Tees & Hartlepool	S Tyneside & Sunderland	N Cumbria	Gateshead	Newcastle	Northumbria	S Tees	Durham & Darlington
RTT March 20										
Incomplete Pathways waiting <18 weeks	**79.7%**		**93.8%**	**88.6%**	**N/A**	**82.4%**	**83.9%**	**91.2%**	**76.2%**	**82.0%**
Half of patients wait less than										
Half of admitted patients wait less than										
19 out of 20 patients wait less than										
Half of Non admitted Pathways waited less than										
19 out of 20 patients wait less than										

Cancer 62 Day Standard March 20	National	North East	North Tees & Hartlepool	S Tyneside and Sunderland	N Cumbria	Gateshead	Newcastle	Northumbria	S Tees	Durham & Darlington
Breast		92.03 (138.5/150.5)	100 (25.5/25.5)	50 (0.5/1)	81.82 (9/11)	91.23 (26/28.5)	82.86 (14.5/17.5)	97.18 (34.5/35.5)	93.1 (13.5/14.5)	88.24 (15/17)
Lung		65.61 (62/94.5)	73.91 (8.5/11.5)	83.33 (12.5/15)	70.59 (6/8.5)	76.92 (5/6.5)	57.89 (11/19)	85.71 (6/7)	40 (5/12.5)	79.31 (8/14.5)
Gynae		75 (39/52)	100 (1.5/1.5)	100 (3/3)	69.23 (4.5/6.5)	76 (9.5/12.5)	75 (3/4)	88.24 (7.5/8.5)	50 (4.5/9)	92.86 (5.5/7)
Upper GI		48.44 (31/64)	75 (3/4)	52.63 (5/9.5)	57.14 (4/7)	71.43 (2.5/3.5)	34.48 (5/14.5)	69.23 (4.5/6.5)	33.33 (5.5/16.5)	60 (1.5/2.5)
Lower GI		70.48 (74/105)	83.33 (7.5/9)	81.48 (11/13.5)	71.43 (10/14)	58.33 (7/12)	37.5 (6/16)	100 (15/15)	62.96 (8.5/13.5)	83.33 (9/12)
Uro (incl testes)		75.83 (182/240)	87.8 (18/20.5)	77 (38.5/50)	58.06 (18/31)	75.76 (12.5/16.5)	67.11 (25.5/38)	71.74 (16.5/23)	86.89 (53/61)	0 (0/0)
Haem (incl AL)	**Data not available**	80.2 (40.5/50.5)	33.33 (1/3)	82.61 (9.5/11.5)	100 (6/6)	70 (3.5/5)	90 (4.5/5)	75 (6/8)	69.23 (4.5/6.5)	100 (5.5/5.5)
Head & Neck		63.46 (33/52)	100 (2/2)	80 (6/7.5)	100 (3/3)	0 (0/0)	78.05 (16/20.5)	0 (0/0)	31.25 (5/16)	33.33 (1/3)
Skin		97.8 (178/182)	100 (0.5/0.5)	100 (5/5)	100 (14/14)	0 (0/0)	95.24 (60/63)	100 (8/8)	97.47 (38.5/39.5)	100 (52/52)
Sarcoma		66.67 (1/1.5)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	66.67 (1/1.5)	0 (0/0)	0 (0/0)	0 (0/0)
Brain/CNS		0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)
Children's		0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)
Other		77.78 (7/9)	100 (1/1)	100 (1.5/1.5)	50 (1/2)	100 (1/1)	50 (0.5/1)	100 (1/1)	100 (1/1)	0 (0/0.5)
All		78.52 (786/1001)	87.26 (68.5/78.5)	78.72 (92.5/117.5)	73.3 (75.5/103)	78.36 (67/85.5)	73.5 (147/200)	88 (99/112.5)	73.16 (139/190)	85.53 (97.5/114)



	Gateshead Health F	Newcastle-Upon-Tyne F	Northumbria F	South Tees F	Regional Trust Average	North Tees & Hartlepool F (Note 3)	South Tyneside & Sunderland F	County Durham & Darlington F	Northumberland Tyne & Wear F	Tees Esk & Wear F
Absence Rate (Note 1)	4.87%	5.02%	5.06%	5.15%	5.44%	5.46%	5.63%	5.84%	6.04%	6.22%
NHS in England (Note 2)	4.87%	4.87%	4.87%	4.87%	4.87%	4.87%	4.87%	4.87%	4.87%	4.87%

North East Region Trusts - Sickness Rates December 2019 (*latest available)

The chart above shows the sickness absence figures for Acute and Mental Health Trust's in the North East region for December 2019. North Tees and Hartlepool NHS Foundation Trust is represented by the green column. The average rate for all North East Acute and Mental Health Care Trust's is shown by the yellow column. The red line is the average rate for the whole of the NHS in England.

Gateshead Health NHS Foundation Trust report the lowest sickness absence rate for December 2019 at 4.87%.

The sickness rate for North Tees and Hartlepool is 5.46%, which is 0.02% above the regional average and 0.59% above the NHS average.

Four North East Trust's report a rate lower than the regional average; none report a rate lower than the national average (though Gateshead is the same rate).

The highest sickness absence rate in the North East region for December 2019 is reported by Tees, Esk and Wear ValleysNHS Foundation Trust at 6.22%.

Integrated Performance and Compliance Dashboard - April 2020 Benchmark HED

Standard Indicator Set: Operational Efficiency	Trust Performance			Benchmarking			
Indicator	Current	Previous	Change	Peer	National	Position	Module Link
30-day PbR emergency readmission rate (12 mth rolling) HES Inpatients (Dec 2019)	9.25% (Sep 2018 - Aug 2019)	9.23% (Aug 2018 - Jul 2019)	0.02 ↑	7.46%	7.48%		
2-day emergency readmission rate (12 mth rolling) HES Inpatients (Dec 2019)	2.07% (Sep 2018 - Aug 2019)	2.03% (Aug 2018 - Jul 2019)	0.04 ↑	1.95%	1.94%		
7-day emergency readmission rate (12 mth rolling) HES Inpatients (Dec 2019)	5.08% (Sep 2018 - Aug 2019)	5.03% (Aug 2018 - Jul 2019)	0.05 ↑	4.45%	4.16%		
14-day emergency readmission rate (12 mth rolling) HES Inpatients (Dec 2019)	7.52% (Sep 2018 - Aug 2019)	7.48% (Aug 2018 - Jul 2019)	0.04 ↑	6.53%	5.94%		
28-day emergency readmission rate (12 mth rolling) HES Inpatients (Dec 2019)	10.49% (Sep 2018 - Aug 2019)	10.49% (Aug 2018 - Jul 2019)	No Change	9.12%	8.09%		
Outpatient DNA rate (12 mth rolling) HES Outpatients (Dec 2019)	8.47% (Oct 2018 - Sep 2019)	8.44% (Sep 2018 - Aug 2019)	0.03 ↑	7.74%	7.45%		
Outpatient New to Follow-up ratio (12 mth rolling) HES Outpatients (Dec 2019)	2.31 (Oct 2018 - Sep 2019)	2.31 (Sep 2018 - Aug 2019)	No Change	2.37	2.14		
Outpatient cancellation rate (12 mth rolling) HES Outpatients (Dec 2019)	0.00% (Oct 2018 - Sep 2019)	0.00% (Sep 2018 - Aug 2019)	No Change	8.48%	8.11%		
DTOC - Proportion of delayed bed days (12 mth rolling) DTOC (Dec 2019)	2.21% (Nov 2018 - Oct 2019)	2.24% (Oct 2018 - Sep 2019)	-0.03 ↓	2.37%	4.13%		
RTT - Referral within 18 weeks (admitted pathway) (12 mth rolling) RTT (Dec 2019)	89.04% (Nov 2018 - Oct 2019)	89.05% (Oct 2018 - Sep 2019)	-0.01 ↓	76.39%	70.03%		
RTT - Referral within 18 weeks (non-admitted pathway) (12 mth rolling) RTT (Dec 2019)	96.22% (Nov 2018 - Oct 2019)	96.44% (Oct 2018 - Sep 2019)	-0.22 ↓	91.29%	86.42%		
RTT - waiting less than 18 weeks (incomplete pathway) (12 mth rolling) RTT (Dec 2019)	93.73% (Nov 2018 - Oct 2019)	93.88% (Oct 2018 - Sep 2019)	-0.15 ↓	89.26%	83.95%		
Day case realisation rate (12 mth rolling) HES Inpatients (Dec 2019)	97.07% (Oct 2018 - Sep 2019)	97.05% (Sep 2018 - Aug 2019)	0.02 ↑	95.20%	95.82%		
Day case rate (12 mth rolling) HES Inpatients (Dec 2019)	86.33% (Oct 2018 - Sep 2019)	86.02% (Sep 2018 - Aug 2019)	0.31 ↑	83.44%	71.29%		

Integrated Performance and Compliance Dashboard - April 2020 Benchmark HED

Average excess length of stay (12 mth rolling) HES Inpatients (Dec 2019)	0.10 (Oct 2018 - Sep 2019)	0.09 (Sep 2018 - Aug 2019)	0.01 ↑		0.36	0.46	
Average length of stay (12 mth rolling) HES Inpatients (Dec 2019)	3.30 (Oct 2018 - Sep 2019)	3.27 (Sep 2018 - Aug 2019)	0.02 ↑		4.15	4.52	
Average elective length of stay (12 mth rolling) HES Inpatients (Dec 2019)	2.10 (Oct 2018 - Sep 2019)	2.03 (Sep 2018 - Aug 2019)	0.07 ↑		3.34	4.40	
Average non-elective length of stay (12 mth rolling) HES Inpatients (Dec 2019)	3.42 (Oct 2018 - Sep 2019)	3.40 (Sep 2018 - Aug 2019)	0.02 ↑		4.29	4.53	
Average pre-operative length of stay (12 mth rolling) HES Inpatients (Dec 2019)	0.20 (Oct 2018 - Sep 2019)	0.20 (Sep 2018 - Aug 2019)	No Change		0.24	0.23	
Average elective pre-operative length of stay (12 mth rolling) HES Inpatients (Dec 2019)	0.01 (Oct 2018 - Sep 2019)	0.01 (Sep 2018 - Aug 2019)	No Change		0.03	0.03	
Average non-elective pre-operative length of stay (12 mth rolling) HES Inpatients (Dec 2019)	0.34 (Oct 2018 - Sep 2019)	0.34 (Sep 2018 - Aug 2019)	No Change		0.47	0.46	
Average post-operative length of stay (12 mth rolling) HES Inpatients (Dec 2019)	0.82 (Oct 2018 - Sep 2019)	0.82 (Sep 2018 - Aug 2019)	No Change		0.99	0.89	
Average elective post-operative length of stay (12 mth rolling) HES Inpatients (Dec 2019)	0.21 (Oct 2018 - Sep 2019)	0.21 (Sep 2018 - Aug 2019)	No Change		0.35	0.29	
Average non-elective post-operative length of stay (12 mth rolling) HES Inpatients (Dec 2019)	1.27 (Oct 2018 - Sep 2019)	1.27 (Sep 2018 - Aug 2019)	-0.01 ↓		1.72	1.63	
Non-elective zero-day spells (12 mth rolling) HES Inpatients (Dec 2019)	35.20% (Oct 2018 - Sep 2019)	34.96% (Sep 2018 - Aug 2019)	0.24 ↑		32.14%	33.44%	
Elective stranded rate (12 mth rolling) HES Inpatients (Dec 2019)	5.98% (Oct 2018 - Sep 2019)	5.82% (Sep 2018 - Aug 2019)	0.16 ↑		11.25%	11.97%	
Emergency stranded rate (12 mth rolling) HES Inpatients (Dec 2019)	16.06% (Oct 2018 - Sep 2019)	15.98% (Sep 2018 - Aug 2019)	0.08 ↑		19.03%	19.43%	
Elective super-stranded rate (12 mth rolling) HES Inpatients (Dec 2019)	0.90% (Oct 2018 - Sep 2019)	0.86% (Sep 2018 - Aug 2019)	0.04 ↑		2.13%	3.06%	
Emergency super-stranded rate (12 mth rolling) HES Inpatients (Dec 2019)	3.40% (Oct 2018 - Sep 2019)	3.38% (Sep 2018 - Aug 2019)	0.02 ↑		4.77%	5.14%	
Elective zero-day pre-op length of stay (12 mth rolling) HES Inpatients (Dec 2019)	91.97% (Oct 2018 - Sep 2019)	92.06% (Sep 2018 - Aug 2019)	-0.09 ↓		78.80%	78.47%	
Elective pre-op length of stay >3 days (12 mth rolling) HES Inpatients (Dec 2019)	0.40% (Oct 2018 - Sep 2019)	0.41% (Sep 2018 - Aug 2019)	-0.01 ↓		0.88%	0.83%	
Relative risk length of stay (12 mth rolling) HES Inpatients (Dec 2019)	82.66 (Oct 2018 - Sep 2019)	82.15 (Sep 2018 - Aug 2019)	0.50 ↑		105.35	98.99	Low (>95%)

Integrated Performance and Compliance Dashboard - April 2020 Finance

APPENDIX 5 - FINANCE

REPORTS FOR INCLUSION IN THE INTEGRATED PERFORMANCE REPORT MONTHLY

Statement of Comprehensive Income (SoCI)

Current Month £000's

	Actual (£'000s)
Income exc. PSF/FRF/MRET and donated asset income	27,981
Pay	18,844
Operating Non Pay	7,081
Pass through drugs and devices	1,022
Total Operating Costs	26,947
EBITDA	1,034
Interest, Depreciation and PDC	1,034
Surpus/Deficit before PSF	(0)
Impairments	0
Capital donations / grants I&E impact	0
Surplus/(Deficit) for the year	(0)

Statement of Financial Position

	Actual (£'000s)
Assets, Non Current	115,685
Assets, Current	67,423
Total Assets	183,108
Liabilities, current	(76,188)
Net current assets (current assets less current liabiitiess)	(8,765)
Liabilities, non current	(25,894)
Total Assets Employed	81,026
Taxpayers Equity	81,026

Commentary

NHSI/E issued guidance setting out the revised financial arrangements for 1st April to 31st July 2020 with the mains aims to ensure; that the NHS has sufficient money to do what it is needed during this period, that the costs of dealing with COVID-19 are captured and funded, and that financial governance is maintained.

As a Trust, we are applying the same internal arrangements to match the national arrangements which aim to fund providers for cost based run rates and this is underpinned by an Interim Financial Management Framework which has been agreed at the Executive and Care Group Director meetings.

At the end of M1 the Trust is showing a breakeven position which includes a £36k contribution from Optimus and a £78k contribution from the LLP. Reporting a breakeven position at the end of M1 in light of the uncertain external environment we are currently operating in, is largely due to the Trust operating within run rates. It is essential that we continue to operate within run rates for the remainder of the 4 month period to 31st July 2020 to deliver a break-even position.

The Group cash balance at April is £44.8m which is £28.1m favourable to the NHSI plan, driven to cash received in advance from the Centre for May activity.

Debtor days have worsened by 2 days in comparison to April 2019/20 and creditor days have improved by 5 days in comparison to April 2019/20.

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

	Annual Report and Accounts 2019/20 including the Quality Accounts 2019/20											
Date:	28 May 2020											
Prepared by:	Neil Atkinson, Director of Finance Barbara Bright, Director of Corporate Affairs and Chief of Staff Julie Lane, Chief Nurse/Director of Patient Safety and Quality											
Executive Sponsor:	Barbara Bright, Director of Corporate Affairs and Chief of Staff											
Purpose of the report	It is a statutory requirement for the Trust to produce an annual report and accounts which is required to be in the format as laid down within the NHS Foundation Trust Annual Reporting Manual (ARM). In addition, trusts are also required to follow the Department of Health Group Accounting Manual 2019/20 (DH GAM 2018/19) for detailed requirements for their accounts. The Trust's Annual Report and Accounts 2019/20, including the Quality Accounts 2019/20 have been developed in preparation for submission to NHS Improvement within agreed timelines, following which they will be laid before Parliament at a date to be confirmed.											
Action required:	Approve	X	Assurance	X	Discuss		Information					
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 document is provided in accordance with the requirements as detailed within the NHS Foundation Trust Annual Reporting Manual 2019/20 (FT ARM) and the revised guidance issued by NHS Improvement (NHSI) in response to the escalation of the pandemic crisis. The revised guidance aims to reduce the burden on providers, however, the Trust has prepared all the reports working to the original deadlines.

As previously reported the following changes have been made for this year by NHSI:

- Final Audited accounts will be due on 25 June
- Annual Report will be due on 25 June
- Quality Accounts will not be subject to the June deadline specified in the regulations – further amendments to the process from DHSC are awaited
- Auditor assurance work on Quality Accounts and Quality Reports should cease for 2019/20
- The Quality Accounts is not required to be included in the Annual Report

- Providers will no longer be required to submit hard copy documents to NHSI for annual report and accounts
- The date for submission to Parliament is to be confirmed

The attached document provides compliance with the guidance and Annual Reporting Manual and consists of: -

- Shortened opening statement from Chair and Chief Executive;
- Overview of the Trust's strategic direction;
- Performance Summary (Headlines only);
- Accountability Report (Table form with summary narrative);
- Staff report (Highlights only);
- Quality Report and Accounts, which will also be published separately;
- Auditors report;
- Foreword to the accounts; and
- 4 Primary financial statements of comprehensive income, financial position, changes in taxpayers' equity and cash flows, and notes to the accounts

The annual report and annual accounts are subject to a full and robust audit process which has been undertaken over the last couple of months. The external auditors PricewaterhouseCoopers have worked with key leads in the trust to ensure that all of the information contained within the report and accounts complies fully with requirements of the FT ARM and other guidance.

The external auditors have scrutinised information, and all information was presented at the Audit Committee on 21 May 2020.

In respect to the Quality Accounts and Report for 2019/20 there is no requirement for an external audit assurance review, however, there has been full involvement of governors and third parties in production and review of the report. Third party declarations are received from the CCGs, Healthwatch in Hartlepool and Stockton, Stockton Adult Services and Health Select Committee, Hartlepool Borough Council Audit and Governance Committee, Council of Governors and the Healthcare User group

Once the report has been laid before parliament it will be presented to the Council of Governors at the Annual General Meeting in August 2020 and made publically available.

How this report impacts on current risks or highlights new risks:
The areas within the Annual Report and Accounts are covered within the Board Assurance Framework in respect to quality, safety, performance, finance and leadership, therefore are managed through this process.

Committees/groups where this item has been discussed	Executive Team Audit Committee Board of Directors
Recommendation	The Board of Directors is invited to review the attached document, note the work undertaken to produce this within the timelines, note the scrutiny on compliance by the external auditors, and note submission in line with guidance to NHS Improvement in readiness for submission to Parliament in June.

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Annual Plan – Self Certifications										
Date:	28 May 2020										
Prepared by:	Neil Atkinson, Director of Finance Barbara Bright, Director of Corporate Affairs and Chief of Staff Lynne Taylor, Director of Planning and Performance										
Executive Sponsor:	Lynne Taylor, Director of Planning and Performance										
Purpose of the report	In line with NHS Improvement Annual Planning requirements, NHS Foundation Trusts and NHS Trusts are required to complete annual self-certifications of compliance against a number of governance requirements, in line with Licencing conditions. This summary report provides an overview of the requirements and the Trust's position against each declaration.										
Action required:	Approve	x	Assurance	x	Discuss		Information				
Strategic Objectives supported by this paper:	Putting our Population First	x	Valuing People		Transforming our Services		Health and Wellbeing				
Which CQC Standards apply to this report	Safe		Caring		Effective		Responsive		Well Led	x	

Executive Summary and the key issues for consideration/ decision:

NHS Foundation Trusts are required to make the following declarations to NHS Improvement;

- Systems for compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence (Appendix 1, section 1&2)
- Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Appendix 1, section 3)
- Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Appendix 2)
- Corporate Governance Statement (Appendix 3 FT4 declaration)

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

One area highlighted at risk within the Annual Operating Plan for 2020/21 includes the consistent delivery of the Cancer 62-day referral to treatment standard, due to the continuous impact of patient choice, complexity of pathways and system pressures outside the organisation's control, however recognising the robust governance structure the Trust has in place to monitor and manage pathways.

The Covid-19 pandemic, initially impacting in March 2020 and continuing into 2020/21, is recognised as a key risk to on-going delivery of both non-elective and elective pathway delivery. The Trust has developed and implemented resilience plans to mitigate the risks, with further recovery plans underway to ensure sustainable delivery of the Trust's services. However, the significant impact has, and is predicted to continue to, affect performance against key access standards in 2020/21.

The Trust reported a surplus position in 2019/20 (after the inclusion of PSF and FRF) which was ahead of the plan / control total agreed with NHSE/I. Due to the COVID-19 pandemic the financial arrangements for 2020/21 cover the first four months of the financial year only. The Trust anticipates achieving a break-even position during the four months. The Trust is awaiting further guidance as to the arrangements for the remainder of the financial year.

Committees/groups where this item has been discussed	
Recommendation	The Board of Directors is asked to note: • Due diligence has 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 • the requirement for the Board of Directors to delegate responsibility to the Chairman to sign the statements of self-certification contained within the enclosed attachments on behalf of the Board.

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

28 May 2020

Annual Plan – Self Certifications

Report of the Director of Planning and Performance

1. **Introduction/ Purpose**

1.1 In line with NHS Improvement Annual Planning requirements, NHS Foundation Trusts and NHS Trusts are required to complete annual self-certifications of compliance against a number of governance requirements, in line with Licencing conditions.

1.2 This summary report provides an overview of the requirements and the Trust's position against each declaration.

2. Key Highlights/ Issues/ Risks

2.1 NHS Foundation Trusts are required to make the following declarations to NHS Improvement;

- Systems for compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence (Appendix 1, section 1&2)
- Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Appendix 1, section 3)
- Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Appendix 2)
- Corporate Governance Statement (Appendix 3 FT4 declaration)

2.2 General Condition 6 requires the Board to review and declare that, in the financial year most recently ended, the Trust (Licensee) took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution. See Appendix 1.

2.3 Condition 7, Continuity of Services, requires that the Board have a reasonable expectation that the Trust (Licensee) will have the required resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to within the declaration, 2020/21. See Appendix 1.

2.4 Certification on training of Governors requires the Board to review and declare compliance that it is satisfied that during the financial year most recently ended, 2019/20, that the Trust (Licensee) has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role. See Appendix 2, Training of Governors.

2.5 The Corporate Governance Statement requires the Board to review and declare that it is satisfied that the Trust (Licensee) applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. The Corporate Governance Statement requires evidence of compliance against a number of key criteria, to support assurance of self-certification. See Appendix 3, FT4 declaration.

3. Key Challenges

3.1 One of the key areas highlighted at risk within the Annual Operating Plan for 2020/21 includes the consistent delivery of the Cancer 62-day referral to treatment access standard, due to the continuous impact of patient choice, complexity of pathways and system pressures outside the organisation's control, however recognising the robust governance structure the Trust has in place to monitor and manage pathways.

3.2 The Covid-19 pandemic, initially impacting in March 2020 and continuing into 2020/21, is recognised as a key risk to on-going delivery of both non-elective and elective pathway delivery. The Trust has developed and implemented resilience plans to mitigate the risks, with further recovery plans underway to ensure sustainable delivery of the Trust's services. However, the significant impact has, and is predicted to continue to, affect performance against key access standards in 2020/21.

3.3 The Trust reported a surplus position in 2019/20 (after the inclusion of PSF and FRF) which was ahead of the plan / control total agreed with NHSE/I. Due to the COVID-19 pandemic the financial arrangements for 2020/21 cover the first four months of the financial year only. The Trust anticipates achieving a break-even position during the four months. The Trust is awaiting further guidance as to the arrangements for the remainder of the financial year.

3.4 The Board of Directors is aware of internal and external risks which pose a threat to quality, service performance and financial balance, within the agreed NHS Improvement plan, and whilst mitigation is in place supported by enhanced accountability and governance frameworks, will continue to assess service delivery options and radical efficiency gains to mitigate and maintain assurance.

4. Conclusion

4.1 Due consideration has been given against each of the Self-Certifications, based on the 2019/20 performance and the forecast pressures for 2020/21, taking into account the on-going financial pressures, however alongside the mitigating actions that have been put in place to improve the position in 2020/21.

4.2 The individual Self Certifications have been completed, providing evidence of assurance where necessary, with the aim to declare compliance against each of the declarations for the periods of 2019/20 and 2020/21, as applicable.

5. Recommendations

The Board of Directors is asked to note:

- Due diligence has 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
- the requirement for the Board of Directors to delegate responsibility to the Chairman to sign the statements of self-certification contained within the enclosed attachments on behalf of the Board.

Prepared by:

Neil Atkinson	**Director of Finance**
Barbara Bright	**Director of Corporate Affairs and Chief of Staff**
Lynne Taylor	**Director of Planning and Performance**

Appendix 1

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates 2019-20

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Confirmed — OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

Confirmed

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

The Board of Directors has identified key risks to financial, clinical and operational sustainability. The Board has declared concerns with regards to the consistent delivery of the 62 day cancer referral to treatment access standard, due to the continuous impact of patient choice, complexity of pathways and system wide pressures and challenges outwith its influence and control.

The Covid-19 pandemic, initially impacting in March 2020 and continuing into 2020/21, is recognised as a key risk to on-going delivery of both non elective and elective pathway delivery. The Trust has developed and implemented resilience plans to mitigate the risks, with further recovery plans underway to ensure sustainable delivery of the Trust's services. However, the significant impact has, and is predicted to continue to, affect performance against key access standards in 2020/21.

The Trust reported a surplus position in 2019/20 (after the inclusion of PSF and FRF) which was ahead of the plan / control total agreed with NHSE/I. Due to the CoVID pandemic the financial arrangements for 2020/21 cover the first four months of the financial year only. The Trust anticipates achieving a break-even position during the four months. The Trust is awaiting further guidance as to the arrangements for the remainder of the financial year.

Governance, mitigatory actions and assurance processes have been appropriately escalated within the Board Assurance Framework.

The Board of Directors is aware of internal and external risks which pose a threat to quality, service performance and financial balance, within the agreed NHS Improvement plan, and whilst mitigation is in place supported by enhanced accountability and governance frameworks, will continue to assess service delivery options and radical efficiency gains to mitigate and maintain assurance.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Paul Garvin	**Name**	Julie Gillon
Capacity	Chairman	**Capacity**	Chief Executive
Date	28 May 2020	**Date**	28 May 2020

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

Appendix 2

Worksheet "Training of governors"

Financial Year to which self-certification relates 2019-20 Please Respond

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		Signature	
Name	Paul Garvin	Name	Julie Gillon
Capacity	Chairman	Capacity	Chief Executive
Date	28 May 2020	Date	28 May 2020

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

Appendix 3

Worksheet "FT4 declaration"

Financial Year to which self-certification relates **2019-20**

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Board of Directors certifies on-going compliance with the governance condition, via the Corporate Governance Statement, using performance against governance indicators, financial performance, exception reports and third party information to test the certification. The Board of Directors effectively planned and assessed risks for 2019/20, with the risk of underachievement against the 62 day referral to treatment cancer standards anticipated by the Board of Directors and acknowledged in the returns to NHS Improvement via the Annual Operating Plan. The Trust has recognised the consistent delivery of cancer standards continues to present a risk and as such has declared this within the Annual Plan for 2020/21. The risk of financial delivery is on-going, this was declared in 2019/20 and has been declared within the 2020/21 Annual Plan, however with the Trust working closely, alongside NHSI representatives, to ensure continued delivery of robust financial plans. The delivery of these plans will continue to be given appropriate scrutiny and oversight by the Board. The original plan currently contained risk associated with delivery of CIP, and the plan is aligned with commissioner assumptions; however, it does include identified system risk. CCGs have agreed to provide a contract baseline which is commensurate with the trading position which would be expected under National Tariff arrangements. This baseline is unaffordable to the commissioner and the wider system. In order to address the system affordability gap, the Trust and the Commissioner have agreed to work collaboratively to address these financial pressures and will work closely to identify system solutions that will enable both provider and commissioner to meet their financial obligations for 2020/21. This demonstrates the commitment of the Trust to work collaboratively within the Integrated Care Partnership and support the wider system returning to financial balance. In contractual terms, the contract baseline is overlaid with a system risk sharing agreement. This agreement ensures both parties play an equal part in returning the wider health economy to financial balance whilst limiting the exposure of each organisation to a financial risk of £3m (£6m across the system). This plan has been subsequently suspended following the COVID-19 pandemic with a national interim financial arrangement in place. The Board of Directors gains assurance from a number of sources and assurance mechanisms as follows: Internal and external audit plans which cover a full range of audits; Annual Governance Statement; Head of Internal Audit Opinion; Integrated performance report to the Board of Directors covering quality, performance, workforce and finance; Board Assurance Framework reported quarterly to the Board of Directors' Risk Management Strategy.
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	There are no risks identified with this statement, the Trust has due regard to guidance when issued by NHS Improvement.
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	The Trust has a robust governance structure with a locally agreed committee structure under the Board of Directors which are over and above those required in statute. This ensures that members of the Board are more closely involved in the governance of the organisation and are closer to assurance on the quality of services (clinical and non-clinical). Each committee has terms of reference which clearly articulate the purpose, responsibilities, accountabilities, reporting lines and delegated authority they have been given by the Board to carry out work on its behalf. Minutes of the individual sub-committees are reviewed within the Board of Directors meeting. The Board agenda focuses on the key areas of quality, strategy, performance and governance; reports, along with minutes of committee meetings are presented on a regular basis. The terms of reference are reviewed on a regular basis to ensure effectiveness and this will continue in 2020/21. Significant work has been undertaken during 2019/20, which will continue in 2020/21, in order to create the capacity, capability and leadership required to fulfil the future ambitions with the introduction of a new Care Group Operating Model, with robust support from corporate services and functions. This new way of working will make the Trust sustainable and an enabler to drive the vision, deliver the strategy and the Long Term Plan. A number of documents outline the accountabilities, responsibilities and reporting lines including: Well led external review CQC Inspection reports The Trust's Constitution Standing Financial Instructions Scheme of Delegation Sub-Committee terms of reference
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	During the year the Trust has further strengthened its governance in respect to financial decision-making in order to support the management, grip and control of expenditure, this will continue in 2020/21. The Trust was placed into segment 3 within the Single Oversight Framework risk assessment in 2018, with enforcement actions in place aligned to the Trust's financial deficit position. The Trust remains in segmentation 3, however has made significant inroads into reducing the overall financial deficit and the subsequent removal of the financial enforcement undertakings. In 2019/20 the Trust reported a £0.6m surplus which was £0.6m ahead of ahead of the year end control total. The operational delivery of financial commitments is overseen by the dedicated Executive Financial and Performance Management Group (EFPMG) on a monthly basis, with appropriate scrutiny and challenge across the individual Care Groups / Directorates. The Board has timely and effective oversight receiving monthly/quarterly reports via the Corporate Dashboard and reporting framework which was reviewed and redesigned in 2018 to adopt an integrated approach across Compliance, Quality, Workforce and Finance, reflecting the NHSI Single Oversight Framework, Lord Carter Model Hospital review, contract metrics, and internal reporting requirements, together with key objectives. Due consideration is given to both positive and negative variances and progress against monthly, annual and in year improvement targets. Additional commentary is provided within the reports against key metrics, providing month on month trend analysis. The Board is also provided with sufficient information in respect to the Single Oversight Framework and the Trust position in relation to segmentation and use of resources. The Trust has a robust Risk Management process in place, which is supported through a standardised Board Assurance Framework, with each Corporate risk monitored through the individual Board sub committees and the overall Trust governance structure. The Board and its sub-committees receive timely information in accordance with its scheduled cycle of business and will scrutinise performance. Performance is also reported to the Council of Governors and Governors are provided with an opportunity of holding the Non-Executive directors to account for the performance of the Board. Following a Care Quality Commission (CQC) inspection in November 2017, the Trust received an overall rating of 'Good' across all elements (previously rated as 'Requires Improvement). The Trust is now progressing to an 'Outstanding' rating and there is a strong focus on continuous learning and quality improvement at all levels throughout the organisation. Internally the focus is on 'Excellence as our Standard'. The trust proactively supports a culture of innovation and improvement with a number of initiatives being driven from the frontline staff. An independent external Well Led review was undertaken by the Good Governance Institute and reported to the Board in October 2018. The review concluded that the organisation is a well-led Trust, with Executive Directors complemented by a number of experienced Non- Executive Directors who work well as a team. There are effective governance arrangements and a satisfactory system of internal control in place, both of which are fit for purpose and operating effectively. The review observed cohesive leadership from the Chief Executive and Chair, and a professionally run Board with high potential. There was evidence of the Trusts investment in leadership and the strong Board-level visibility and access across the Trust.
			The review highlighted a positive and patient centred culture, which was well embedded throughout the organisation and at Board level, with clear vision and values. There was strong recognition of the unified, patient focussed, governance and leadership embedded within the organisation. As part of the review ten recommendations based on findings against the key lines of enquiry was identified, with the Board agreeing actions to be taken forward in order to address these. A Board development programme took place in May 2019 to review and address all recommendations. The Trust has a robust Business Planning cycle in place, which supports the development and delivery of Directorate Business Plans, and in year service delivery. The Business Planning process has been reviewed by internal audit and received 'Good Assurance'. Operational delivery of business plans is monitored through the Care Group Director's meetings in-year, with appropriate oversight and scrutiny by the Chief Operating Officer and the Director of Planning and Performance. Financial performance delivery is monitored though the EFPMG, as outlined above. Governance of compliance with Licence conditions is managed through the Board of Directors and Council of Governors, with assurance provided through the reporting structure outlined above. Evidence to support this statement include: Well led external review Constitutional documents Internal Audit plans, reports and opinion Risk Management Processes Board and Sub-Committee meetings cycle Safer staffing reports Financial performance reports to the Board and Sub-Committees Performance monitoring process and review by the Care Groups Annual Report, Quality Report, Annual Accounts and Annual Governance Statement Leadership Walkarounds
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	The Trust has continued to review and focus its attention on the management of strategic risks, which is supported by the Risk Management Strategy and Board Assurance Framework, which drives the Board's agenda. Board sub-committees and other high-level groups who have defined responsibilities and accountabilities for risk management are in place for the escalation of risks from the front line, through governance channels, to the Board of Directors. Overall decisions in relation to prioritisation of corporate risk issues and resource allocation are taken by the Board of Directors, with delegation of decisions relating to specific risks to sub-committees or the Executive Team as appropriate. This features highly in the planning round to deliver the Annual Operating Plan and the Board of Directors ability to self-certify. In 2019/20 the Board of Directors further reviewed the strategic direction in line with the North East and North Cumbria Integrated Care System objectives and the alignment of operational delivery. This included a refresh, reframe and development of the Corporate Strategy to ensure it is fit for the future and incorporates system wide integration and financial delivery, reflecting all external influences accordingly. The Board of Directors has a range of skills, experience, maturity and expertise to deliver the key objectives. The appointment of a Chief Operating Officer, voting member of the Board, was made in November 2019 along with the introduction of Associate Non-Executive Director posts to provide additional leadership capacity and capability in support of the evolving and challenging agenda. In April 2019 a new operating model was introduced, with Care Groups replacing the traditional acute services model providing a new and innovative approach to pathway delivery outside the historical specialty level management. This has provided the opportunity to review how services are delivered through collaborative working both internally and across the community with local authority partners. This is supported by three executive team members taking on the role of 'Locality Director' for the local authority areas served by the Trust, with a focus on delivering the strategic objectives, partnership opportunities and place based planning. Where capacity is a risk an infrastructure of support has been considered and agreed. The Board of Directors has a track record of making intelligent decisions and tackling risks to clinical, operational and financial stability in a proactive and timely manner. The Well Led principles have been reassessed throughout the Trust and key areas of development supported to fit the strategic agenda.

6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**Confirmed**	A number of changes took place during 2019/20 in the need to support the challenging and changing environment in which the Trust is operating, with consideration given to the senior level structure going forward to ensure the organisation has the necessary capacity and capability to deliver whilst also ensuring continuity and stability of service provision. The most significant was the development of a Care Group structure and implementation of a new operating model, which reflects the direction of travel and acknowledges a radical shift away from a traditional acute hospital model in its ambition and responsibilities. Changes implemented included the: • Appointment to the role of Chief Operating Officer with effect 4 November 2020; • Introduction of 3 new Care Groups, led by a Care Group Director and supported by a Care Group Clinical Lead; • Interim Director of Planning and Performance appointed to the post substantively from 1 April 2019; • A further 3-year term agreed for the Medical Director from 1 June 2019. • Chief Information and Technology Officer (CITO) continued for a further 12 months in the role of Chief Digital Officer (CDO) for the Integrated Care System (ICS) for the North East and North Cumbria region, whilst maintaining his CITO role within the Trust. Appointments to a number of posts were through internal organisational change processes, so have the benefits of maintaining significant organisational knowledge and familiarity. This has meant a broad knowledge, experience and intelligence has been retained and transition has been easier to initiate in practice. The Chief Operating Officer was an external appointment, which provides opportunity for new insight and perspective to be brought into practice, whilst recognising and learning from experience and expertise gained from the wider health sector. To ensure capacity, capability and continuity of service provision, the Board of Directors and Executive Team have been supported in 2019/20 by a robust programme of development, which will continue into 2020/21. The Board recognises the benefits of development and taking the time to debate and discuss the impact of governance, legislative matters and future challenges, from both a national, system-wide and local perspective. At Non-Executive level the term of office of a number of postholders came up for review in 2019/20. The tenure of the Chairman and two Non-Executive Directors were extended for a further term of 1 year. In addition, the Council of Governors agreed the creation of three Associate Non-Executive Director roles, who would be non-voting members of the Board and would support the wider healthcare developments, creating capacity and succession planning, ensuring a period for shadowing and transition. Appointment to these posts were made from 1 July 2019.
			The Trust ensures that on appointment and thereafter on an annual basis it undertakes assessment of continued fitness for the role by completion of the fit and proper person test and declaration. This applies to Non-Executive and Executive Directors, as well as other senior staff. In addition, for senior staff that require registration with a professional body, this information is checked on an annual basis to ensure on-going validation. There remains a challenge to the organisation with the recruitment of staff to some specialities, however recruitment plans continue to be developed in order to address any gaps and discussions are continuing are taking place across the Integrated Care System and Integrated Care Partnership in looking at collaboration and network approaches.

Signature **Signature**

Name Paul Garvin **Name** Julie Gillon

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

NHS
North Tees and Hartlepool
NHS Foundation Trust

Board of Directors

Title of report:	Learning from Deaths Report, Quarter 4, 2019-20										
Date:	28 May 2020										
Prepared by:	Janet Alderton, Head of Patient Safety										
Executive Sponsor:	Deepak Dwarakanath, 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		Information				
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 Trusts HSMR value in the latest period has decreased to **91.30** (December 2018 - November 2019), the SHMI is currently **98.53** (November 2018 to October 2019).
2. There has been a sustained improvement in the level of care being documented which has helped sustain the current reported national mortality statistics.
3. For 2018-19, 94% of the compulsory mortality reviews identified using the Trust Learning from Deaths policy have been reviewed. During 2019-20, by the end of quarter 4, 39% of compulsory reviews have been completed.
4. There are a number of workstreams in place, to support ongoing clinical and service improvements. There is an updated information within this report from two areas of work, due to the Covid-19 pandemic other updates and information have been delayed and will be added in future reports along with any nationally required monitoring in relation to the pandemic.

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
Recommendation	1. The Board of Directors is asked to note the content of this report and to derive assurance that there is continued focus to ensure in depth multidisciplinary learning being is obtained from mortality review processes. 2. The Board is asked to recognise the continued sustained improvement in the national mortality statistics.

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

28 May 2020

Learning from Deaths Report

Report of the Medical Director

1. Introduction/Background

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

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

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

1.4 During the Covid-19 pandemic clinical teams have not been able to provide all of the updates that would generally be included in this report. It is planned that these updates will be obtained over the next 2 quarters and these will also take into account any national requirements introduced in relation to mortality reviews during and following the pandemic.

2. Mortality Data

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

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

2.2 The latest HSMR value is now **91.30** (December 2018 to November 2019), this has decreased from the previously unreported 92.17 (November 2018 to October 2019). The value of 91.30 continues to remain inside the 'as expected' range.

2.3 The Trust currently has the 33rd lowest HSMR value from the 137 Trusts nationally, and the lowest value out of the 8 North East Trusts.

2.4 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

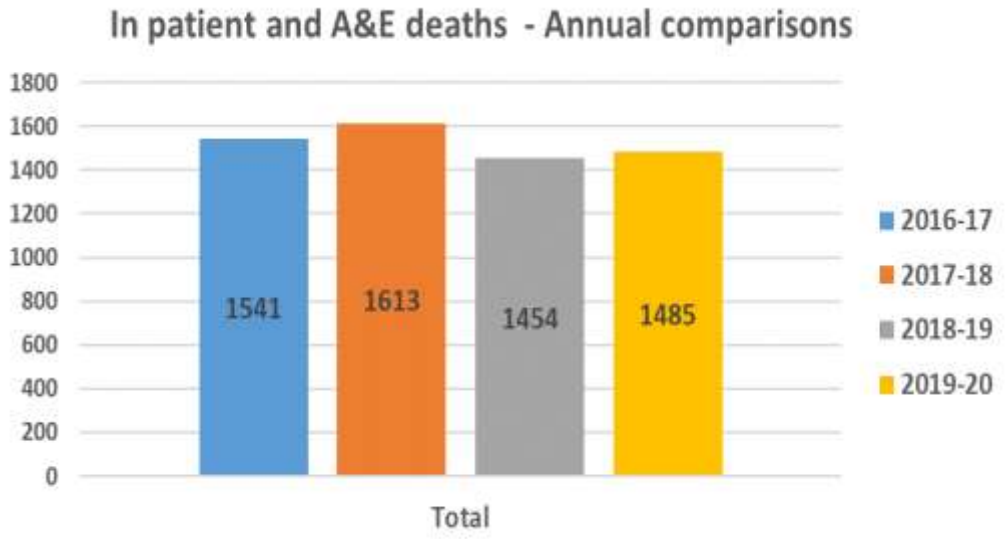
gender, age, admission method, admissions in the last year and diagnosis being treated for the last admission.

2.5 The latest SHMI value is now **98.53** (November 2018 to October 2019), this has decreased from the previously reported value of 99.02 (October 2018 to September 2019).

2.6 The Trust currently has the 51st lowest SHMI value from the 137 Trusts nationally, and 2nd lowest value out of the 8 North East Trusts.

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

2.8 During 2019-20 the Trust recorded 1,485 deaths in Accident and Emergency and also in-patient areas. The table below provides a comparison with the previous 3 years; with a slight increase occurring from 2018-19 but with less than the previous 2 years. There is ongoing monitoring of mortality rates during the Covid-19 pandemic, the impact of which will be outlined in future reports.

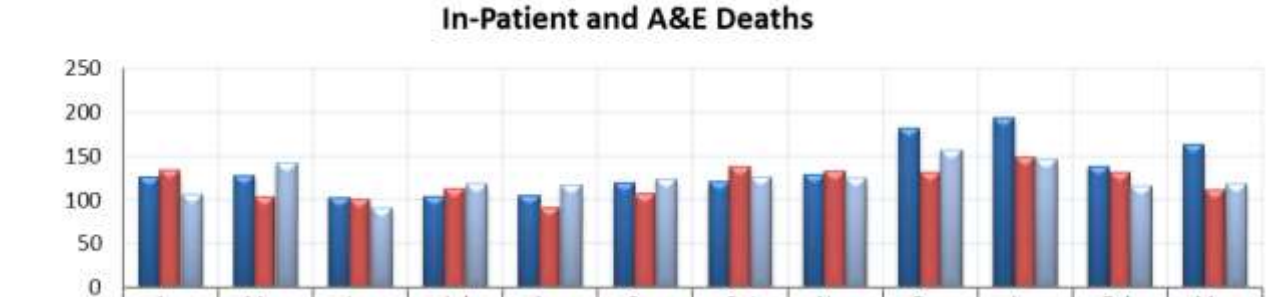


2.7 The increased focus on this should allow the Trust to maintain clearer clinical records but also maintain the current statistical mortality rates during the Covid-19 pandemic when there are nationally more deaths occurring.

3. Mortality reviews

3.1 The Trust uses an electronic system to record mortality case reviews that are undertaken; this system is also used by other trusts in the region and is based on the “PRISM” methodology, one of the review tools recommended in the national guidance. This is a structured review of a case record, carried out by clinicians not involved in the patient’s care, to determine whether there were any problems in care. Case record review is undertaken routinely to learn and improve in the absence of any concerns, with all directorates undertaking their own specialty based mortality and morbidity meetings. This is because it can help identify issues where there are no initial concerns. It is also used where concerns exist, such as when bereaved families or members of staff raise issues about care.

3.2 The Trust policy identifies that all in-patient deaths and those in the Accident and Emergency department are included in the scope of the mortality reviews. Since April 2017 the Trust has reported the following deaths:



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	126	128	103	104	105	120	121	129	182	194	138	163
2018/19	135	104	102	114	92	108	139	134	132	149	132	113
2019/20	106	142	90	118	117	124	126	125	157	146	116	118

3.3 The following charts shows the monthly trend and fluctuations in mortalities since April 2016.

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

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

Compulsory case reviews are also undertaken for the following cases, which are linked to specific national review processes, some of these reviews are not yet recorded in the Trust mortality system and this is an area of ongoing development:

- All deaths where a patient has a registered Learning Disability (LD) – in conjunction with the Learning Disability Mortality Review Programme (LeDER).
- All maternal deaths – in conjunction with M-BRRACE-UK.

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

There are also additional reviews that are undertaken either as a random selection or in response to requests internal or external to the Trust.

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

During quarter 1, 2019-20, there were 8 cases identified to be investigated as serious incidents, all of these were prior to mortality reviews being completed. Five of these remain under review, requiring information from the Coroner to complete the investigations, the overall outcome will be reported in future reports.

During quarter 2, there have been 2 cases reported and investigated as serious incidents, both were identified prior to mortality reviews being completed. One was identified as having a Hogan score of 4 which is "probably preventable".

During quarter 3, there have been 5 cases reported and investigated as serious incidents, all were identified prior to mortality reviews being completed. Four remain under review and require information from the Coroner to complete the investigations, the overall outcome will be reported in future reports.

During quarter 4, there have been 5 cases reported and investigated as serious incidents, all were identified prior to mortality reviews being completed. All remain under review and require information from the Coroner to complete the investigations, the overall outcome will be reported in future reports.

At this time, as a result of the Covid-19 pandemic the Coroner has suspended inquests. The Trust will continue to ensure cases are reviewed and learning obtained; overall outcomes will be included in future reports.

3.5 The data presented in the appendix provides detail of all case reviews undertaken since April 2018. There are cases that may not have been identified immediately but have come to light as a result of the receipt of complaints and family requests through the Trust Bereavement survey; as a result, there are some reviews pending completion and details may change slightly for each report.

3.6 The following table provides a summary of the data by financial quarters, to date, for 2018-19; a more detailed monthly breakdown is included in appendix 1.

2018-19	Q1	Q2	Q3	Q4	Total
Total deaths in scope	342	317	406	397	**1462**
Deaths in compulsory criteria	46	44	41	45	**176**
Compulsory case reviews completed (no.)	46	43	38	39	**166**
Compulsory case reviews completed (%)	100%	98%	93%	87%	**94%**
Compulsory reviews pending	0	1	3	6	**10**
Additional reviews completed	51	51	37	41	**180**
Total of reviews completed (no.)	97	94	75	80	**346**
Total of reviews completed (%)	28%	30%	18%	20%	**24%**
Reviewed Deaths considered avoidable (no.)	0	0	0	0	**0**
Reviewed Deaths considered avoidable (%)	0%	0%	0%	0%	**0%**
Reviewed Deaths considered not preventable (no.)	97	94	75	80	**346**
Reviewed Deaths considered not preventable (%)	100%	100%	100%	100%	**100%**

The following table provides a summary of the data by financial quarters, to date, for 2019-20; a more detailed monthly breakdown is included in appendix 2.

2019-20	Q1	Q2	Q3	Q4	Total
Total deaths in scope	338	359	408	380	**1485**
Deaths in compulsory criteria	39	36	47	36	**158**
Compulsory case reviews completed (no.)	26	27	9	0	**62**
Compulsory case reviews completed (%)	67%	75%	19%	0%	**39%**
Compulsory reviews pending	13	9	38	36	**96**
Additional reviews completed	3	8	0	1	**12**
Total of reviews completed (no.)	29	35	13	1	**78**
Total of reviews completed (%)	9%	10%	3%	0.3%	**6%**
Reviewed Deaths considered avoidable (no.)	0	1	0	0	**1**
Reviewed Deaths considered avoidable (%)	0%	3%	0%	0%	**1%**
Reviewed Deaths considered not preventable (no.)	29	34	13	1	**77**
Reviewed Deaths considered not preventable (%)	100%	97%	100%	100%	**99%**

3.7 The numbers of mortality reviews undertaken by the Trust is lower during winter periods; this is usually resolved during quarter 4 each year. However, as a result of the Covid-19 pandemic the clinical staff have not been able to undertake the numbers of mortality reviews to reflect a significant improvement in the analysis given above. There is ongoing work to ensure all cases identified as compulsory are reviewed as required.

3.8 **Medical Examiners**

Over recent years a national Coronial review has been completed; this review identified a variety of recommendations one of which relates to the introduction of a “Medical Examiners” (ME) role that is responsible for reviewing deaths and speaking with families in relation to any concerns they may have.

A business case to support implementation of this role has been approved to provide 6 sessions and some additional funding will be available from NHS England to provide this as a 6-day service. Due to the Covid-19 pandemic formal appointments have not yet been made, however an interim lead has been appointed. It is envisaged that as this role is implemented, there will be changes to the mortality review processes already in place; however, it is considered that this will only improve the overall analysis of mortalities.

4. Learning and actions from reviews

4.1 Bereavement surveys

The Trust has had a bereavement survey in place for several years; this survey is provided as a part of a pack of information given to families when they meet with the Trust bereavement team.

The survey is providing with a self-addressed envelope and invites families to provide feedback on the care of their relative leading up to and also following their death; this also includes how the family were treated during this time and also offers them an opportunity to request a review the care and management provided. A number of families have taken up this offer, in several cases the families have been very complimentary about care despite their request. None of the reviews completed to date have been identified as avoidable deaths.

During the Covid-19 pandemic, the survey has been continued to ensure that families continue to have the opportunity to request a review or to raise any queries with the Trust about the care of their loved one. In order to get the maximum benefit from returned surveys are reviewed, the overall information, positive and negative, is collated; and then shared with various committees and groups in the Trust to ensure learning is identified and actions implemented as needed. Where concerns are raised about the care of a patient these are linked to the relevant team of staff involved and the Patient Experience Team so that direct action can be taken and where necessary families contacted to respond to their concerns or questions.

4.2 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. Information is then shared with this multiprofessional group to obtain an overall picture of the patient and their care; this allows all the opportunity to recognise if any different care or management may have delayed the patient's death. The overarching reviews are led by the Trusts commissioners with learning and actions taken being linked into the national LeDeR process.

The Trust has, from these reviews, identified areas for improvement within the organisation. One of these relates to the use of the hospital "passport"; this document is developed, by any care provider, with families and carers in order to provide clear information about the patient and what their specific needs are when in hospital. There was one review where we identified that the passport was not available in the hospital records; however, having one available for all other cases was felt to be positive. The Trust has this year introduced learning disability training for all staff; as part of this training the importance of using the passport is a key area of focus.

Another opportunity for families and carers, of patients with learning disabilities (LD), to be involved in the care of the patients whilst they are in hospital is by the use of "Johns Campaign". This is a national campaign highlighting the role of informal carers in contributing to the provision of safe and responsive care to their relatives and friends. The Trusts has this year introduced its own local guidance for staff. By implementing the principles of John's Campaign it is anticipated that vulnerable patients will suffer the least disruption to aspects of their everyday life during their stay in hospital. Additional benefits of this are that this group of patients will have their experience enhanced through greater involvement of their informal carers. The campaign itself is also covered in the mandatory training mentioned earlier, and the overall impact of implementation will be monitored through family feedback surveys. As result are received then any relevant actions will be initiated; the improvements identified will be shared in future reports.

In order to ensure staff, providing care for any patients with LD, have direct access for advice from the Trusts LD Specialist Nurse; the trust is developing a procedure identifying how to make a referral to this service and when this may be required. This will alert the LD Specialist nurse and allow for early contacts to be made to support planning for the care and management of a patient; and also to support in the provision of any reasonable adjustments that need to be made.

The following are a few good practice points noted from the reviews:

- Reasonable adjustments made to enable a patient to become engaged with and attend cancer screening services.
- Good communication with other services to support personalised end of life care.
- Clear multidisciplinary communication and working across organisations.
- Detailed plans for transition from children to adult services.

In order to widely share learning from the reviews across the organisation; summaries of all are to be presented at the Trusts Vulnerability Committee.

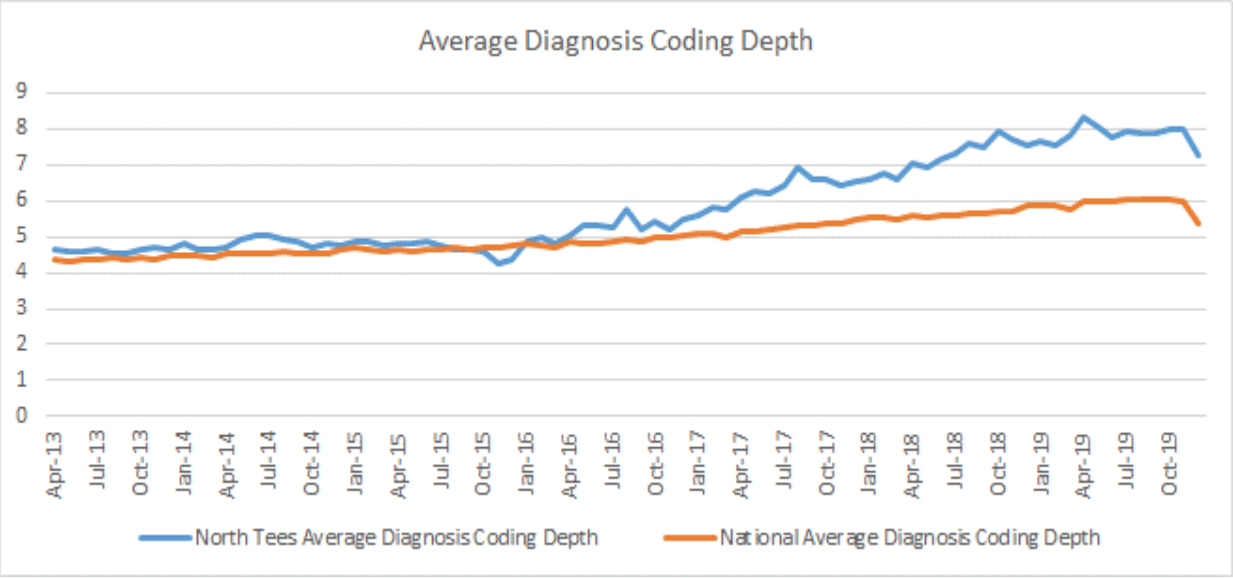
4.3 Clinical documentation and coding

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

The Trust has in the past been reported as having increased Hospital Standardised Mortality Rates (HSMR) and Standardised Hospital Mortality Indices (SHMI). These are both nationally agreed figures that use some areas of healthcare data (Charlson co-morbidities) to assist in benchmarking Trusts nationally. As a result of the mortality reviews it was recognised that records may not fully reflect all a patient's individual health problems (co-morbidities) or that the records may not clearly identify the diagnosis of the problems being treated. Making improvements in overall record keeping impacts on inter-professional communication of management plans, assisting in providing seamless care across primary and secondary areas, but can also impact on the healthcare data collected for national statistical analysis.

The Trust is continuing, during training and update multi-disciplinary sessions to raise awareness around the importance of accurately and comprehensively recording co-morbidities. The information covers the background to the mortality indicators and demonstrates the positive impact good documentation and record keeping can have on the Trusts HSMR and SHMI rates when the resultant coding can provide an accurate clinical picture of the patients who are treated in hospital.

The following chart shows the improvement in the Trusts recording of co-morbidities over the last 7 years to December 2019, the data shows the average number of comorbidities recorded for each of our patients, the last month is at this time only <u>partially</u> completed and will be finalised when future uploads are received:



As a result of the ongoing work examining areas where quality and safety of care can be enhanced; and also because of the improvements in clinical documentation and consequently the clinical coding; the Trusts HSMR and SHMI rates have been within the national "as expected" range for the last 16 consecutive quarters.

5. Conclusion/Summary

5.1 The Trusts HSMR value in the latest period is **91.30** (December 2018 to November 2019), the SHMI is currently **98.53** (November 2018 to October 2019).

5.2 There has been a sustained improvement in clinical documentation to support multidisciplinary working but also to support the increased data the Trust are able code and subsequently provide for the national mortality statistics.

5.3 Of the compulsory case reviews identified in the Trusts policy 94% have been reviewed during 2018-19, an overall 24% of all deaths. During 2019-20 to date 39% of compulsory reviews have been completed to date, an overall 5% of all deaths. This percentage is less than expected as a result of the impact of winter and the current Covid-19 pandemic, both of which reduce the clinical staff's ability to complete the reviews. There is ongoing data collection in relation to Covid-19 deaths and this will be examined further in future reports.

5.4 There are twenty cases which were investigated as serious incidents, many of these remain under review and are awaiting Coroners inquests to complete these effectively. In all cases investigated as serious incidents Duty of Candour has been considered and applied appropriately.

5.5 Learning from the Trust Learning Disabilities mortality reviews is being shared regionally as part of an overall collaborative approach. The multidisciplinary review enables shared learning across all care sectors involved in a patients' care. There are some excellent examples of good quality supportive care being provided.

5.6 The Trust has approved a business case to support the introduction of the Medical Examiners role; this role is recommended from a recent national Coronial review. An interim lead has been appointed during the period of the Covid-19 pandemic.

5.7 During the Covid-19 pandemic clinical teams have not been able to provide all of the updates that would generally be included in this report. It is planned that these updates will be obtained over the next 2 quarters and these will also take into account any national requirements introduced in relation to mortality reviews during and following the pandemic.

6. Recommendations

6.1 The Board of Directors are asked to note the content of this report and the information provided in relation to the identification of trends to assist in learning lessons from the mortality reviews in order to maintain the reduction in the Trusts mortality rates.

6.2 The Board are asked to note the on-going work programme to maintain the mortality rates within the expected range for the organisation.

Dr D Dwarakanath
Medical Director

Appendix 1

North Tees and Hartlepool NHS Foundation Trust Mortality Review Data 2018-19												
Month of death	Total No of deaths	Deaths meeting inclusion criteria	Deaths reviewed meeting inclusion criteria		Pending Review	Additional Reviews	Total Reviewed	Overall % Reviewed	Death judged as avoidable (>50%		Deaths reviewed judged as not preventable	
		No.	No.	%	No.	No.	No.	%	No.	%	No.	%
Apr 18	135	13	13	100%	0	13	26	19%	0	0%	26	100%
May-18	105	18	18	100%	0	8	26	25%	0	0%	26	100%
Jun-18	102	15	15	100%	0	30	43	42%	0	0%	43	100%
Quarter 1	342	46	46	100%	0	51	97	28%	0	0%	97	100%
Jul-18	114	16	15	94%	1	7	22	19%	0	0%	22	100%
Aug-18	94	12	12	100%	0	10	22	23%	0	0%	22	100%
Sep-18	109	16	16	100%	0	34	50	46%	0	0%	50	100%
Quarter 2	317	44	43	98%	1	51	94	30%	0	0%	94	100%
Oct-18	139	19	18	95%	1	1	19	14%	0	0%	19	100%
Nov-18	135	13	13	100%	0	29	42	31%	0	0%	42	100%
Dec-18	132	9	7	78%	2	7	14	11%	0	0%	14	100%
Quarter 3	406	41	38	93%	3	37	75	18%	0	0%	75	100%
Jan-19	149	12	11	92%	1	8	19	13%	0	0%	19	100%
Feb-19	134	19	17	89%	2	26	42	31%	0	0%	43	100%
Mar-19	114	14	11	79%	3	7	18	16%	0	0%	18	100%
Quarter 4	397	45	39	87%	6	41	80	20%	0	0%	80	100%
Totals	**1462**	**174**	**164**	**94%**	**10**	**180**	**344**	**24%**	**0**	**0%**	**344**	**100%**

Appendix 2

NHS

North Tees and Hartlepool NHS Foundation Trust Mortality Review Data 2019-20

Month of death	Total No of deaths	Deaths meeting inclusion criteria	Deaths reviewed meeting inclusion criteria		Pending Review	Additional Reviews	Total Reviewed	Overall % Reviewed	Death judged as avoidable (>50% liklihood of avoidability)		Deaths reviewed judged as not preventable	
		No.	No.	%	No.	No.	No.	%	No.	%	No.	%
Apr 19	106	15	11	73%	4	1	12	11%	0	0%	12	100%
May-19	142	13	7	54%	6	2	9	6%	0	0%	9	100%
Jun-19	90	11	8	73%	3	0	8	9%	0	0%	8	100%
Quarter 1	338	39	26	67%	13	3	29	9%	0	0%	29	100%
Jul-19	118	11	7	64%	4	5	12	10%	0	0%	12	100%
Aug-19	117	18	14	78%	4	3	17	15%	1	7%	16	93%
Sep-19	124	7	6	86%	1	0	6	5%	0	0%	6	100%
Quarter 2	359	36	27	75%	9	8	35	10%	1	3%	34	97%
Oct-19	126	14	8	57%	6	0	8	6%	0	0%	8	100%
Nov-19	125	19	1	5%	18	1	2	2%	0	0%	2	100%
Dec-19	157	14	0	0%	14	3	3	2%	0	0%	3	100%
Quarter 3	408	47	9	19%	38	4	13	3%	0	0%	13	100%
Jan-20	146	16	0	0%	16	1	1	1%	0	0%	1	100%
Feb-20	116	13	0	0%	13	0	0	0%	0	NA	0	NA
Mar-20	118	7	0	0%	7	0	0	0%	0	NA	0	NA
Quarter 4	380	36	0	0%	36	1	1	0.3%	0	0%	1	100%
Totals	**1485**	**158**	**62**	**39%**	**96**	**12**	**78**	**5%**	**1**	**1%**	**77**	**99%**

Board of Directors

Title of report:	Guardian of Safe Working Hours Report										
Date:	May 2020										
Prepared by:	Mr Pud Bhaskar, Guardian of Safe Working hours										
Executive Sponsor:	Deepak Dwarakanath, Medical Director and Deputy Chief Executive Officer										
Purpose of the report	The New Junior Doctor Contract (2016) requests that the Guardian of Safe Working Hours (GOSW) prepares a quarterly report to the Board of Directors. These reports contain information relating to the safe working of doctors within the Trust. This report covers exception reports between December 2019 and March 2020, as well as feedback from the Doctors Forum in May 2020.										
Action required:	Approve		Assurance	✓	Discuss	✓	Information	✓			
Strategic Objectives supported by this paper:	Putting our Population First		Valuing our People	✓	Transforming our Services	✓	Health and Wellbeing	✓			
Which CQC Standards apply to this report	Safe	✓	Caring	✓	Effective	✓	Responsive	✓	Well Led	✓	

Executive Summary and the key issues for consideration/ decision:

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

NHS Employers and the BMA published a joint statement on 31st March 2020 on the application of the 2016 contract limits for the duration of pandemic. It provides guidance on where working hours limits and rest requirements outlined in the contract can be flexible.

In April we welcomed a cohort of 18 newly qualified doctors from Newcastle Medical School as part of a special national drive to support Trusts during this unprecedented time. These doctors have been deployed onto our medical wards.

Health Education England (HEE) has announced that rotations for doctors in training will restart in August, after being put on hold due to COVID-19. Some specialties will rotate later than August and HEE will be providing notice of placements when available. NHS Employers is working HEE, the National Association of Clinical Tutors and other stakeholders on questions around August induction.

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

Doctors in training have raised some concerns around the availability of scrubs and personal protective equipment, such as the size and type of face masks. These concerns have been referred to the relevant leads for review and any necessary action.

Overseas doctors in training appointed to start in August may be delayed as a result of the pandemic. The Lead Employer Trust (LET) will update Trusts on any potential risks to start dates.

Committees/groups where this item has been discussed	Patient Safety and Quality Standards Committee
Recommendation	The Board of Directors are asked to note the content of and accept this report.

Guardian of Safe Working Quarterly Report

Executive Summary

This report focuses on Doctors in Training and forms part of the reporting requirements of the 2016 contract for doctors and dentists in training. It aims to provide the Board of Directors with a summary on the working hours and practices during the reporting period, providing assurances on safe working and highlighting areas of concern.

It concludes that the organisation continues to meet the demands of the contract and that there is no evidence to suggest current working practices amongst trainees at the Trust are unsafe. However, doctors have reported difficulties in obtaining scrubs and personal protective equipment, mainly masks in sizes small or large.

Exception reports continue to be the mechanism used to highlight non-compliance with safe working hours, lack of support, and missed educational opportunities. A total of 52 exceptions were submitted between December 2019 and March 2020, mainly by foundation year one trainees for additional hours worked. Appendix one provides an exception report overview. No fines have been levied as there have been no reported breaches in the safety limits.

NHS Employers and the BMA published a joint statement on 31st March 2020 on the application of the 2016 contract limits for the duration of coronavirus pandemic. It provides guidance on where working hours limits and rest requirements outlined in the contract can be flexible. As the provisions are in place to ensure health and safety of trainees and patients, organisations are asked only to do this for a limited time as possible and for as short a time as possible. It should be done in discussion with trainees and the Guardian of Safe Working Hours.

As a result of the coronavirus pandemic the April 2020 training rotation was postponed by Health Education England. Rotas were also amended at short notice to reflect any temporary service changes and ensure back-up cover for COVID-19 related absences. Trainees were involved in rota discussions and have worked flexibly to support the Trust. No exception reports were submitted in April which suggests that safe working hours were maintained.

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

To ensure that doctors felt supported during this time and able to feedback concerns, the scheduled junior doctors' forum in May 2020 went ahead virtually utilising Microsoft Teams. The meeting was very well attended and positive feedback was received on the management and adjustments of rotas. However, concerns were expressed around availability of scrubs in certain areas and other areas being territorial over stock. They also felt that there was a shortage in mask sizes small and large, and where they were using FPP3 masks for swabs there had been some challenges from nursing staff.

The Trust continues to implement the recommendations from the fatigue and facilities charter. The doctors lounge is now fully refurbished and is well utilised, the additional rest room is now available but still requires some work.

Health Education England (HEE) has recently announced that rotations for doctors in training will restart in August 2020. Some specialties will rotate later than August and HEE will be providing notice of placements when available.

Overall there have been no significant exceptions resulting in any fines and there are no major concerns relating to safe working hours at present. Where concerns have been highlighted, work is on-going to ensure that they are addressed. The exception reporting process continues to enable the compensation of additional hours worked and ensures trainees are compensated appropriately.

The following new recommendations are made to the board:

1. Doctors should have access to scrubs in areas that would expect them to wear them.

2. Designated areas should store a sufficient amount of scrubs for doctors to access.

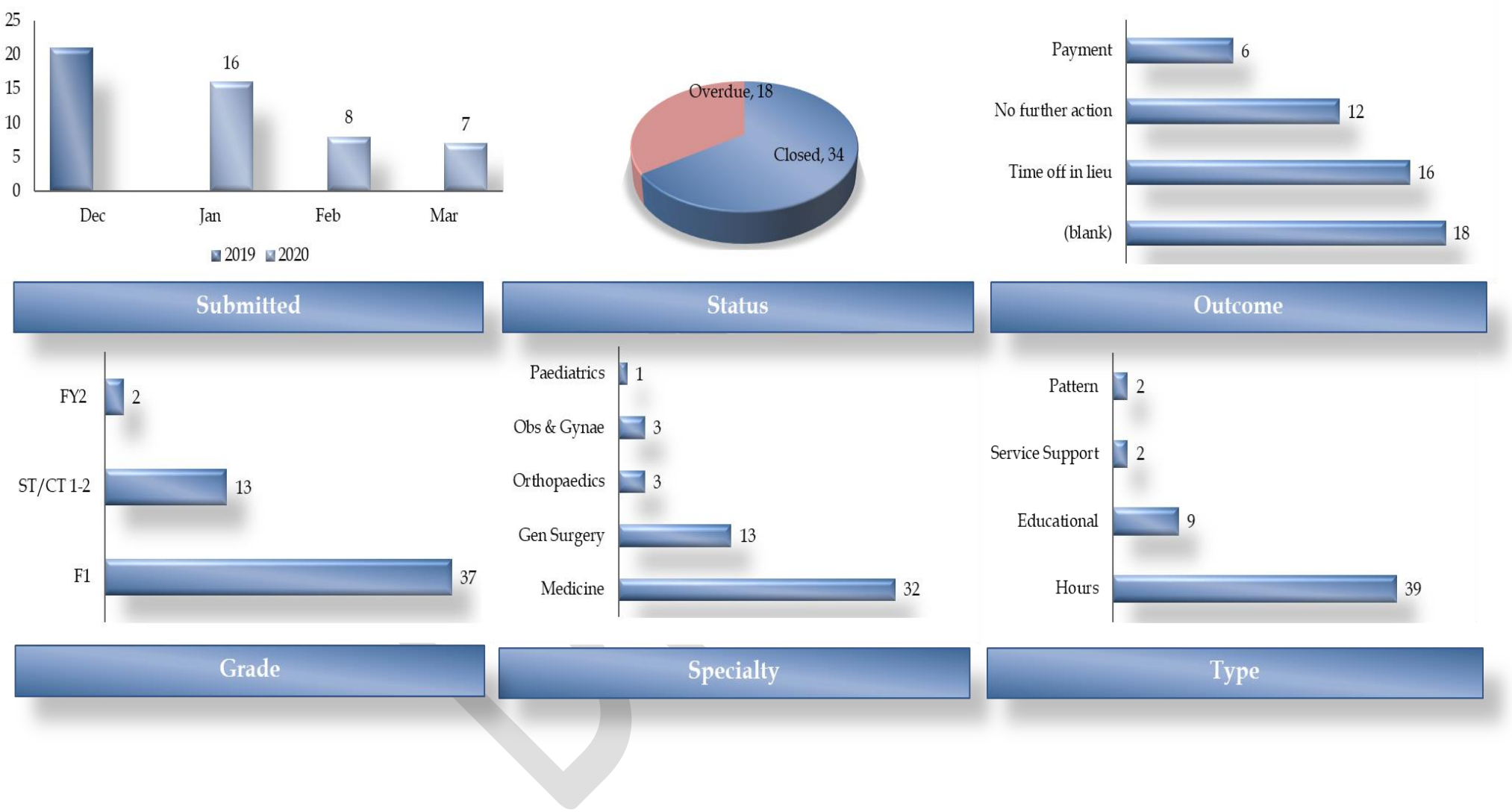
3. There should be clear instructions that if a doctor feels safe wearing an FFP3 mask whilst obtaining swab samples, they should be allowed to use them. These masks should be readily available to doctors.

The board is asked to note this report for information and assurance.

Mr Pud Bhaskar, Guardian of Safe Working Hours

May 2020

Appendix One: Exception Reporting Dashboard Screenshot – December 2019 to March 2020



52 Exception reports submitted by 20 doctors

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Retrospective Approval of Documents Executed Under Seal										
Date:	28 May 2020										
Prepared by:	Barbara Bright, Director of Corporate Affairs and Chief of Staff										
Executive Sponsor:	Julie Gillon, Chief Executive										
Purpose of the report	This report provides a details of a deed of surrender executed under seal, which requires Board of Directors approval.										
Action required:	Approve	✓	Assurance		Discuss		Information				
Strategic Objectives supported by this paper:	Putting our Population First	✓	Valuing People		Transforming our Services		Health and Wellbeing	✓			
Which CQC Standards apply to this report	Safe	✓	Caring		Effective	✓	Responsive		Well Led		

Executive Summary and the key issues for consideration/ decision:

The following document was executed under seal.

Document	Date Signed	By
Deed of Surrender Between: 1) AC Blandford, S Laloo, KS Sidhu and R Hussain and 2) North Tees and Hartlepool NHS Foundation Trust Relating to premises at Morven, Hesleden Road, Blackhall, Peterlee	26 March 2020	Neil Atkinson Director of Finance Barbara Bright Director of Corporate Affairs and Chief of Staff

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

No risks have been highlighted in respect to the report,

Committees/groups where this item has been discussed	
Recommendation	The Board of Directors is requested to grant retrospective approval for the signing of this document.

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Adult, Children and Young People Vulnerability Report 2019/20								
Date:	28 May 2020								
Prepared by:	Karen Sheard, Deputy Chief Nurse Safeguarding Team								
Executive Sponsor:	Julie Lane, Chief Nurse/Director of Patient Safety and Quality								
Purpose of the report	The report sets out the work carried out by the Vulnerability Team during 2019/20, including Adults, Children & Young People. It provides assurance as to how the Trust discharges its statutory responsibilities to those vulnerable patients who use Trust services.								
Action required:	Approve	☐	Assurance	☒	Discuss	☒	Information	☒	
Strategic Objectives supported by this paper:	Putting our Population First	☒	Valuing our People	☒	Transforming our Services	☒	Health and Wellbeing	☒	
Which CQC Standards apply to this report	Safe	☒	Caring	☒	Effective	☒	Responsive	☒	Well Led ☒

Executive Summary and the key issues for consideration/ decision:

Whilst the team operates as one resource with common work streams identified it is important to note that the legal responsibilities in relation to adults and children are discrete in application. Therefore, specialists within each area have been maintained within the team; for the purpose of this report the governance arrangements have been reported for the Vulnerability Team and subsequently separated into the specialist areas.

The report outlines and highlights key points in relation to the following: -

- Internal and external governance arrangements;
- Performance and training for 2019/20;
- Development and audits;
- Key achievements for 2019/20; and
- Key priorities for 2020/21.

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

The report outlines internal and external governance arrangements in relation to Adult, Children and Young People Safeguarding and those Children and Young People who are looked after.

Committees/groups where this item has been discussed	
Recommendation	The Board of Directors is asked to:- • note the sustained improvements for vulnerable and at risk people using Trust services; • note the performance and key achievements in 2019/20 across all specialist areas: and • note the key priorities identified for 2020/21.

Overall rating for North Tees and Hartlepool NHS Foundation Trust GOOD

North Tees and Hartlepool NHS Foundation Trust

Transforming our services - Putting patients first - Valuing our people - Health and wellbeing

Annual Report

April 2019 - March 2020

of the

Vulnerability Unit

Safeguarding Adults,
Children and Young People

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

Safeguarding Adults

Children & Young People

Introduction

Julie Lane
CHIEF NURSE/
DIRECTOR OF PATIENT
SAFETY AND QUALITY

This report sets out the work carried out by North Tees and Hartlepool NHS Foundation Trust (NTHFT), Vulnerability Team, including Adults, Children & Young People in providing assurance that the Trust discharges its statutory responsibilities to those vulnerable patients who use Trust services. Whilst the team operates as one resource with common work streams identified it is important to note that the legal responsibilities in relation to adults and children are discrete in application. Therefore, specialists within each area have been maintained within the team; for the purpose of this report the governance arrangements have been reported for the Vulnerability Team and subsequently separated into the specialist areas.

Rachel McLoughlin
NAMED NURSE

CHILDREN'S
SAFEGUARDING

Stuart Harper-Reynolds
NAMED NURSE

ADULT
SAFEGUARDING

Overall rating for North Tees and Hartlepool NHS Foundation Trust GOOD

North Tees and Hartlepool NHS Foundation Trust

Transforming our services - Putting patients first - Valuing our people - Health and wellbeing

Adult Safeguarding 'protecting our adults in need'

ADULT SAFEGUARDING

Stephen Nicholson
SAFEGUARDING ADVISOR AND DEMENTIA SPECIALIST

Carly Ogden
SAFEGUARDING ADVISOR AND LEARNING DISABILITIES SPECIALIST

Jenny Duthie
SENIOR NURSE

Liam Gates
ADULT SAFEGUARDING ADMINISTRATOR

Children's Safeguarding 'giving a voice to the child'

Transforming our services - Putting patients first - Valuing our people - Health and wellbeing

CHILDREN'S SAFEGUARDING WORK PROGRAMME

Lorraine Mulvey
SENIOR NURSE
Safeguarding Trainer

Terri Wells
SENIOR NURSE

Denise Hopkins
SENIOR NURSE

Catherine Flanagan
SENIOR NURSE
SPECIALIST MIDWIFE

Wendy Murdoch
SAFEGUARDING
CHILDREN'S TRAINER

1 Introduction

1.1 Safeguarding is a fundamental component of all care provided. The purpose of this Annual Report is to provide an overview of the work of the Vulnerability Team in relation to Safeguarding and Looked After Children activity across the Trust in the last 12 months ***(April 2019 – March 2020).***

This Annual Report demonstrates the Trust's commitment to delivering its statutory responsibilities in respect of safeguarding vulnerable children and adults.

2 Governance

2.1 The Chief Nurse, Director of Patient Safety and Quality has responsibility for Adult, Children & Young Peoples Safeguarding including Looked after Children with management of the operational team by the Deputy Chief Nurse, Patient Safety and Quality.

2.2 The adult vulnerability group combines safeguarding adults and includes learning disabilities and dementia. This group brings together key stakeholders who have responsibility for safeguarding adults with representation from Stockton and Hartlepool localities and maintains responsibility for the performance monitoring of the adult vulnerability work plan.

2.3 The Trust has maintained membership and has made active contributions at senior level on the 2 Safeguarding Partnerships and 1 Adult Safeguarding Board:

- Hartlepool and Stockton Safeguarding Partnership (HSSCP)
- Durham Safeguarding Children's Partnership.
- Teeswide Safeguarding Adult Board (TSAB)

The Trust has maintained representation and in some cases chaired a number of partnership and board subgroups.

Steering Group (is held bi-monthly) Responsibilities

- Performance Monitoring.
- Children's Safeguarding Work Programme including Looked After Children.

Members (Commissioners and Providers)

- Hartlepool and Stockton on Tees CCG
- Designated Doctor
- Designated Nurse Safeguarding and Looked After Children
- Designated Nurse Safeguarding and Looked After Children DURHAM, DARLINGTON, EASINGTON and SEDGEFIELD

3 Adult Safeguarding Performance

3.1

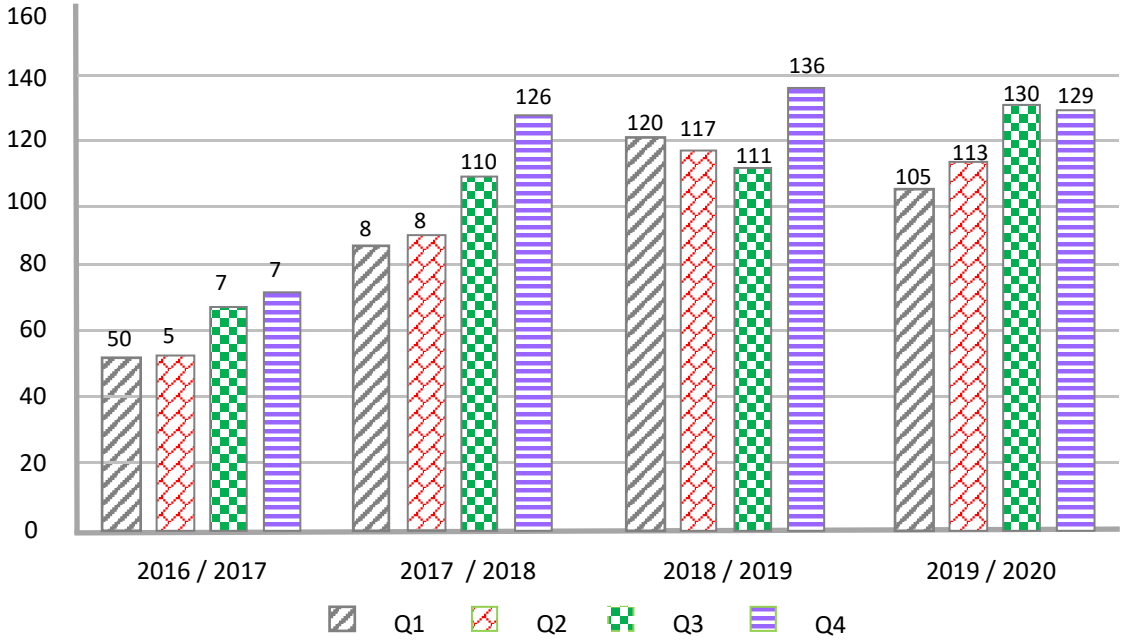
485

Safeguarding Concerns
Previous year
April 2018 - March 2020

447

Trust involvement with Safeguarding Concerns
April 2019 - March 2020

The drop is consistent with the decreased activity seen across all local authorities. The concerns are raised through the safeguarding process, investigated in line with TSAB procedures and recorded within the Trust database.



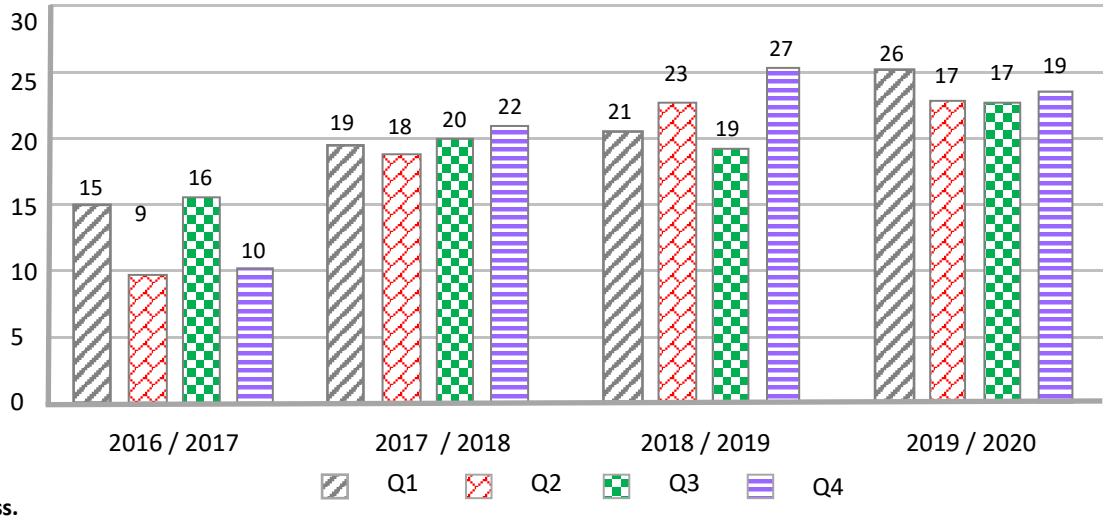
3.2 *Decrease in concerns against the Trust* is consistent with the decrease in numbers across Stockton and Hartlepool local authorities. The table below demonstrates the comparator data from 2017.

90

Concerns raised against the trust previous year

79

Concerns raised against the Trust this year investigated through safeguarding process.



Adult Safeguarding Training

4 The level one and level two adult safeguarding workbook has been incorporated into the Trust Corporate Induction Programme. The Trust has worked closely with Teeswide Adult Safeguarding Board training and education sub group to review the current training in place and alternative methodologies. The e-learning at level 1 and 2 training is available. Face to face is carried out within directorates.

4.1 In ***August 2018 the new Intercollegiate document for Adult Safeguarding was introduced***, this document outlined the recommendations required for training.

89% 18/19

95% 19/20

89% 19/20

86% 19/20

Requirements that 50% Training is Face to Face

4.2

Level 1

- Workbook provided at time of INDUCTION into the Trust
- E-Learning available through ESR.
- Face to Face included with MANDATORY training for each directorate.

Level 2

- Introduction of a new face to face level 2 training.
- 2 hour update on adult safe-guarding practices as aligned to new intercollegiate document.
- E-Learning through ESR.

Level 3

- Full day training provision for Band 6 nurses but not exclusively, open invitation to any nurse that requires more detailed knowledge of adult safeguarding is promoted as identified through
- personal development plans
- appraisal processes

The Trust has mapped the current training that we were providing and has been able to align the level 2 training that we were providing to equate to the new level 3. Level 1 training will remain the same and we have introduced a new level 2 training. As from April 2019 training needs analysis for all staff were updated to reflect the new levels.

4.3 **Face to Face Training delivered to**

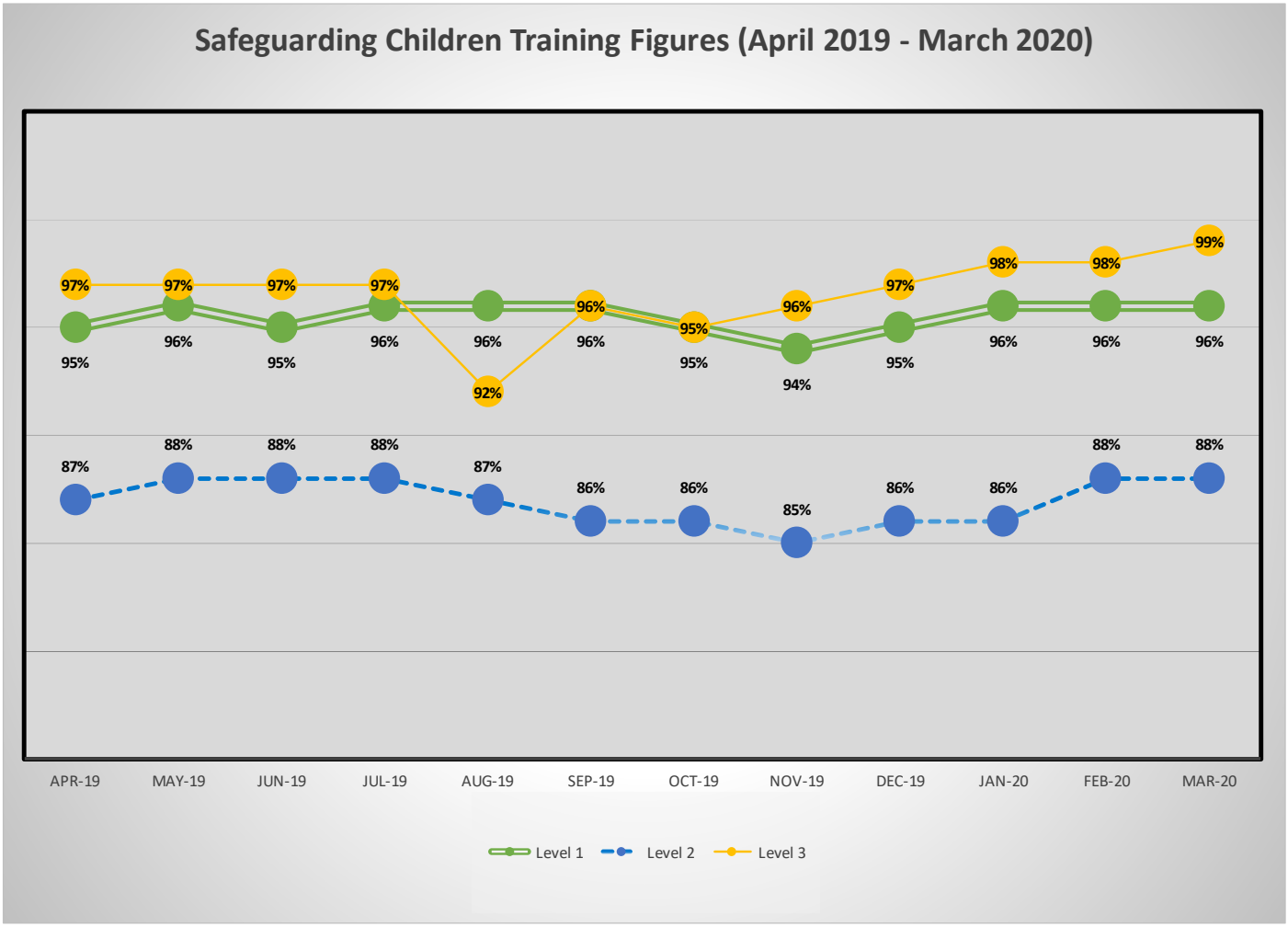
- Accident and Emergency
- Emergency Admission Unit
- Ambulatory Care
- Overseas Nurses
- Newly quality Staff
- Mandatory Training Programme in a number of Care Groups

4.4 Focused work is being undertaken to improve compliance with mandatory training and an improvement trajectory is in place. The slight drop in the training figures is due to increasing training from once only to three yearly and also increasing the number of staff that require level 2 training and the new level 3 was not being recorded in the previous year.

Children's Safeguarding Training

4.5 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 (2018) and the Trust's Safeguarding Children Training Policy. The content of safeguarding Children's Training has been reviewed and updated to include scenarios from local incidents and also the requirement to complete a safer referral. This is in response to local learning and audits.

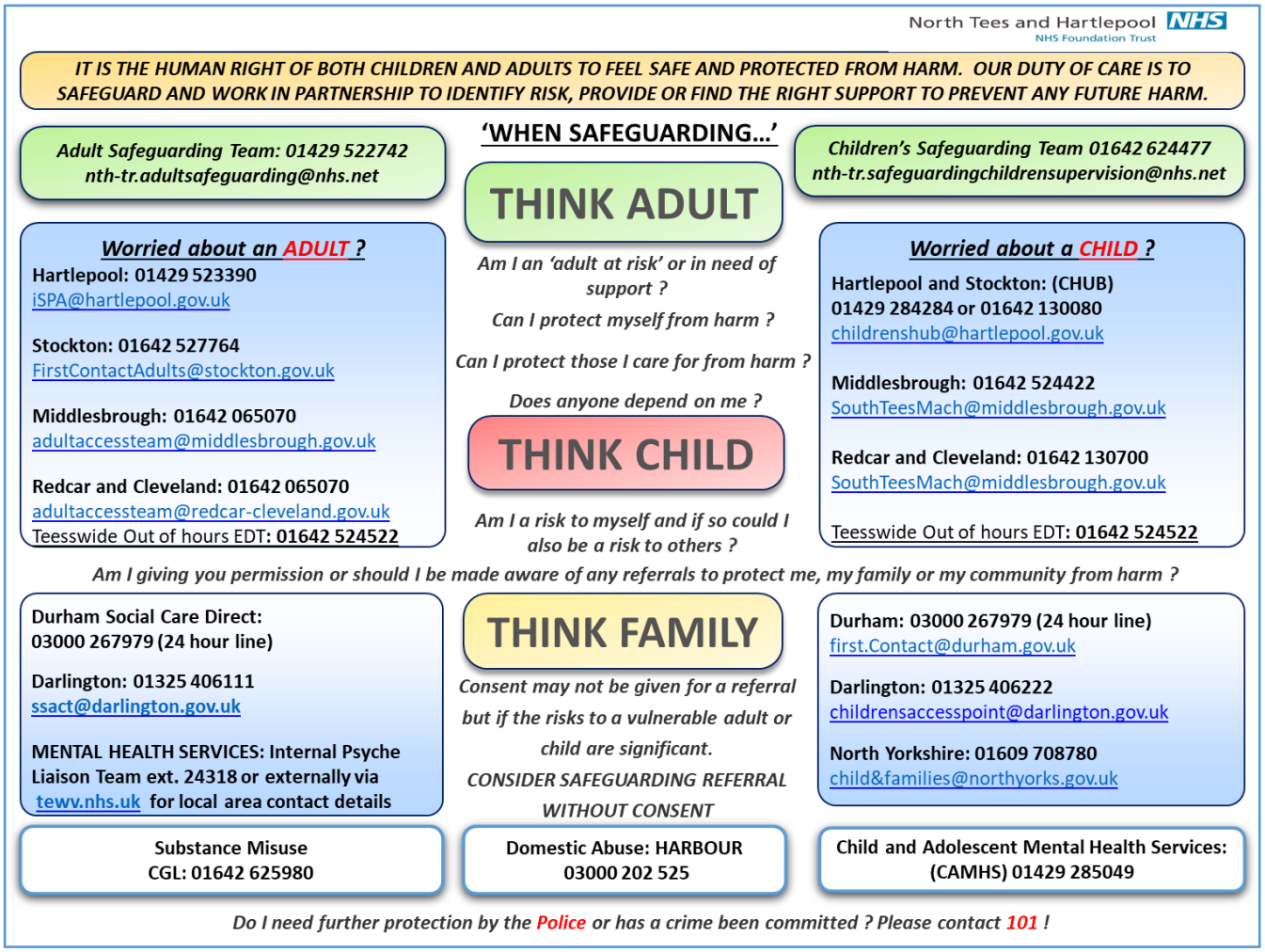
4.6 The table below demonstrates the training compliance monitored by the Safeguarding Steering Group and an action plan has been developed to address area of reduced compliance.



5 Domestic Abuse

5.1 In March 2013 the Government extended the definition of domestic violence and abuse to include young people aged 16 and 17 and has included wording to capture coercive control. There is representation from the Vulnerability Unit at the local Multi Agency Risk Assessment Conferences (MARAC) and regularly attend the three weekly conferences. The aim of MARAC is to ensure that high risk victims of domestic abuse are identified and their safety ensured as much as possible.

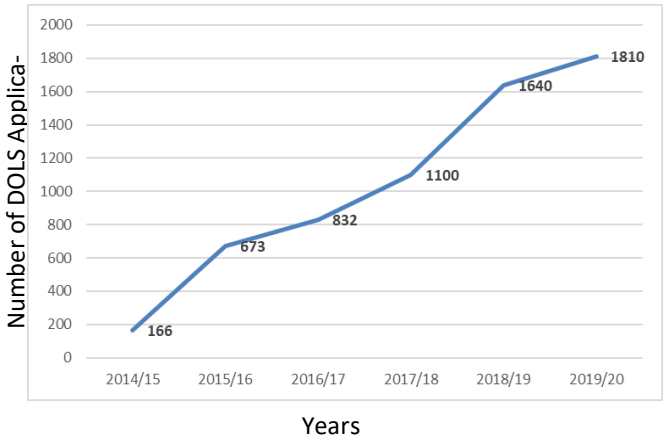
5.2 The adult safeguarding data base has been redesigned to include domestic abuse as a category. The Trust has contributed to one Domestic Homicide Review for the period of this report, which is on-going. The Trust is working with members of Teeswide Safeguarding Adults board to produce an action plan on the findings.



6 Deprivation of Liberty Safeguards (DoLS)

6.1 In March 2014 the Supreme Court handed down its judgment in the case of "P v Cheshire West and Chester Council and another" and "P and Q v Surrey County Council". The judgment is significant in deciding whether arrangements made for the care and/or treatment of an individual who might lack capacity to consent to those arrangements amount to a deprivation of liberty. The Supreme Court ruling now gives a new definition of what would constitute a deprivation of liberty, which is that if a person who lacks capacity is being kept in any setting under continuous supervision and control and they are not free to leave whenever they want, then they are being deprived of their liberty.

6.2 Over recent years the Trust has seen a significant increase in the number of DoLS applications. The new ruling has had a significant impact on the number of applications now being made as displayed in the graph below; the graph demonstrates the continued increase in DoLS applications and the significant increase in relation to the same period four years ago:



6.3 The DoLS database is now well established and applications of the DoLS are placed on Trakcare with expiry dates. Notifications of DoLS applications are sent to CQC, although due to the significant increase in activity, this is a challenge to achieve within the statutory 28 days. Extra administrative support has been aligned from within resource to support this function.

6.4 The DoLS policy has been updated to reflect Cheshire West and the changes in the DoLS process making it more user friendly. Prompt cards have been developed to help assist security staff when responding to incidents where patients are under a DoLS. The law commission reviewed the legislation underpinning DoLS and published its final report and draft bill on the 13 March 2017. It plans to replace the current process with Liberty Protection Safeguards (LPS), the code of practice has not been agreed due to government pressures, once this in place the Trust will look at moving towards LSP.

7 Safe Recruitment

7.1 Disclosure & Barring Scheme (DBS) checks are one aspect of safe recruitment and safeguarding and the check itself is only a snapshot of a point in time. To demonstrate this, in the past year there have been occasions where the Trust has been contacted by either the police or the Local Authority Designated Officer (LADO) in relation to a significant safeguarding issue, despite the individuals concerned having a clear DBS check. Therefore other arrangements for safeguarding are equally as important including:

- Safe recruitment – identity checks, reference checks, interviews.
- Safe working practices – vigilant and on-going day-to-day management.
- Training and awareness – ensuring employees are appropriately trained and aware of safeguarding issues.
- Confidential reporting procedures – to ensure staff are able to express any concerns they may have.

7.2 It is also important to note that staff have a contractual and professional duty to disclose any instances which are likely to be the subject of a police inquiry during the course of their employment.

8 Mental Health including Learning Disabilities

Carly Ogden
SAFEGUARDING ADVISOR AND LEARNING DISABILITIES SPECIALIST

8.1 The Adult Safeguarding team includes a Specialist Nurse for people with learning disabilities.

8.2 A database, to monitor inpatients with learning disabilities, has been maintained enabling the Learning Disability Nurse to proactively identify appropriate patients within the acute setting via a virtual ward and provide specialist advice helping with reasonable adjustments and planning discharges. The virtual ward system is linked to Trakcare therefore when a person is admitted into our hospitals information regarding the admission can be viewed on Trakcare. This enables early identification and interventions for patients with learning disabilities who require reasonable adjustments towards effective individualised care.

8.3 During the last financial year, the Trust has worked with Stockton and Hartlepool Borough Council, who has provided relevant information to enable the Trust to flag people, accessing services, who have a learning disability. This has enabled the Trust to flag an additional 124 patients this year. This has had an impact on the amount of referrals via the virtual ward system. To date there are 1761 patients with a learning disability flag.

8.4 Learning Disabilities Mortality Review Programme (LeDeR) is a national initiative to ensure lessons are learned from deaths where people with learning disabilities have received care and is undertaken as part of a multi-agency approach, which the Trust are actively involved in. There have been 16 reviews which have identified during 19/20 that in most cases the care has been co-ordinated with other care services or persons involved and has identified evidence of reasonable adjustments when planning and delivering care. The Trusts process of co-orienting the LeDeR reviews has received national recognition.

8.5 **A Service Level Agreement** is in place with Tees Esk and Wear Valley NHS Foundation Trust who provide;

- Mental Health Act advice
- Training

for lead professionals on behalf of the Trust. Work is continuing to flag patients with a diagnosis of dementia; during 19/20, 550 new patients were identified, the overall cohort is now 1316.

NHS Tees, Esk and Wear Valleys NHS Foundation Trust

9 Prevent Strategy and Channel

9.1 Three national objectives have been identified for the PREVENT strategy:

- **Objective 1**: respond to the ideological challenge of terrorism and the threat we face from those who promote it.
- **Objective 2**: prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support
- **Objective 3**: work with sectors and institutions where there are risks of radicalisation which we need to address.

9.2 During 19/20, staff have been trained as Health WRAP 3 trainers (Workshop for raising awareness on Prevent), through monthly planned WRAP sessions. The Trust has developed an e-learning package on Prevent for staff.

9.3 Awareness of **Prevent** is included in all adult safeguarding training in addition to Trust wide adult safeguarding dedicated literature available in all clinical and public settings and dedicated boards for campaign materials.

9.4 The named nurse for adult safeguarding is an active member of the regional safeguarding networks and provides updates to the Trust Resilience Forum.

9.5 **Channel** referrals are raised where there is a concern around behaviour of an individual which may suggest radicalisation or extremist behaviour.

Number of Channel referrals from Trust 2019—2020

9.6 The Trust is required to submit Prevent data via Unify quarterly. This data measures compliance with regards to training for WRAP and Prevent awareness and compliance with policies and procedures.

The current trajectory is **85%** compliance Preventing Radicalisation – Levels 3, 4 & 5 (PREVENT Awareness); the Trust is currently at **83%**.

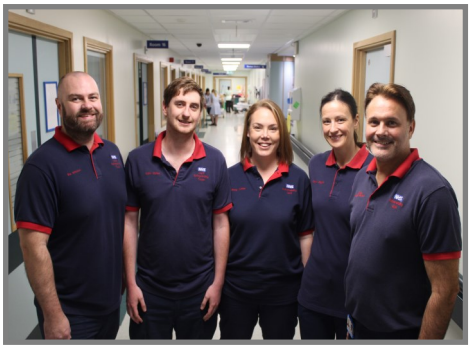
The current target for Preventing Radicalisation – Levels 1 & 2 (Basic PREVENT Awareness) is **85%;** the Trust is currently at **85%.**

10 Adult Safeguarding - Key Achievements 2019 / 2020

- Adult Safeguarding Policy has been updated.
- New training standards have been implemented.
- Enhanced Care Team integrated within the Vulnerability Unit.
- Quality Assessment Framework has been submitted to Teeswide Safeguarding Adults Board.
- Electronic referral system in place for Dementia and Learning Disabilities Specialists via Sharepoint.
- Developed Standard Operating Procedure for the care of patients with Learning Disabilities and Dementia.

10.1 Adult Safeguarding - Key Priorities 2020 / 2021

- Continue to improve the quality of DoLS completion and embed Best Interest discussions.
- Embed the Liberty Protection Safeguards within the Trust once the code of practice has been released.
- Provide education and support for staff with Liberty Protection Safeguards.
- Continue to embed and share learning from LeDeR (Learning Disability Mortality Review)
- Continue to disseminate lessons learned from Safeguarding Incidents.
- Provide clinical supervision for staff with regards to Safeguarding.
- Continue to audit and monitor performance and improve the quality of referrals.
- Continue to increase awareness and training on Prevent and WRAP 3.
- Identify opportunities for joint working between children and adult teams.
- Contribute to the Treat as One work to achieve parity between physical and mental health needs.
- Continue to support enhanced care team in education and to develop alternative therapies for those patients who require 1:1 care.



Teeswide Safeguarding Adults Board

11 Children's Safeguarding Work Programme

11.1 The Children's Safeguarding Work Programme monitors action plans from Children's Safeguarding Practice Reviews (CSPR); learning lesson reviews, Domestic Homicide Reviews and internal incidents. It also monitors the Trusts safeguarding children professionals' development work, the safeguarding children annual audit and assurance programme and reviews any key national drivers which may impact on the work of safeguarding children professionals in the Trust.

11.2 *Children's Safeguarding Practice Reviews (CSPR)*

Since going live in April 2019, HSSCP have undertaken four Rapid Reviews of Serious Safeguarding Incidents. The Trust completed chronologies and attended Rapid Reviews to determine whether the serious incidents met the criteria for a Child Safeguarding Practice Review (CSPR). Two of these cases progressed to CSPR's

11.3 One CSPR was in respect of a fatal road traffic incident involving a child whose family had a history of involvement with services due to neglect.

11.4 The Second CSPR was in respect of a baby with non-accidental injury. A reviewer with experience with the SILP methodology was commissioned.

11.5 The Trust has chaired 2 facilitated discussions. The learning from these and the CSPR's will be incorporated into the Trust's safeguarding work program.

11.6 *Learning Lesson's Reviews*

A Learning Lessons Review has been undertaken in respect of a Stockton child who had a persistent head lice infestation and a septic infection. A reviewer was appointed from the list of HSSCP 'Critical Friends'. Learning and recommendations have fed into a combined action plan to be progressed in 2020-21.

11.7 Publication of a Stockton-on-Tees Serious Case Review involving Fabricated Induction of Illness, which commenced prior to the new safeguarding arrangements going live, is delayed due to criminal proceedings. The learning and recommendations will be progressed by HSSCP during 2020 - Early learning from the case is already being actioned within the work program.

11.8 There have been no new Safeguarding Practice Reviews in Durham in the last financial year.

12 Development Work

12.1 Child not brought for appointments policy

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

12.2 Safeguarding Children's Policy

The Safeguarding Children Policy has been reviewed and updated ensuring that Trust staff understand and are supported in their responsibility under current legislation to safeguard and promote the welfare of children and to enable the Trust to meet its statutory duties in this regard.

13 Safeguarding Children's Supervision

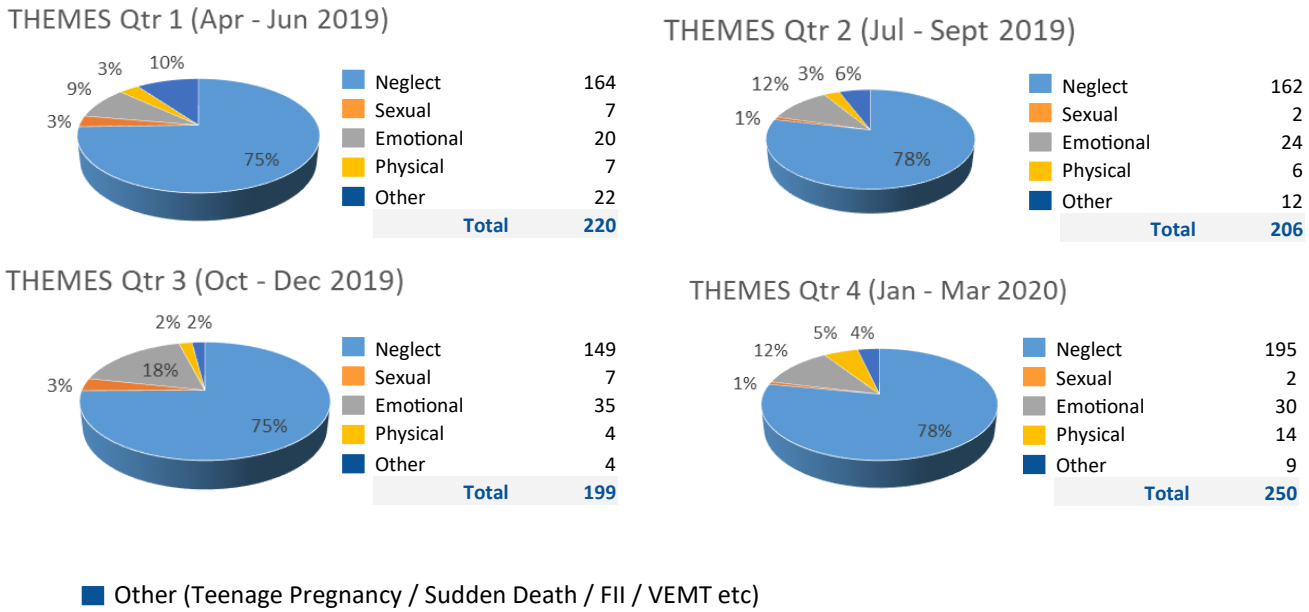
13.1 The local quality and performance indicators include supervision of Trust staff in relation to safeguarding children. Safeguarding supervision is recognised as being fundamental for safe practice therefore the team supports this in the delivery of mandatory supervision for every staff member who has contact with children and young people within their caseload (predominantly Midwives, Community Paediatric Nurses and Speech and Language Therapists.

13.2 1:1 or group supervision is undertaken with a senior nurse on a three monthly basis. Compliance is reported via the quarterly dashboard and demonstrated in the table below. Supervisee sickness is *not included* in compliance figures.

Q1 2019	Q2 2019	Q3 2019	Q4 2020
100%	100%	95%	96%

SAFER REFERRALS

The Charts represent referrals based on categories of abuse as per quarter.



The table below identifies referrals completed by each department as per quarter.

	Qtr 1 (Apr - Jun 2019)	Qtr 2 (Jul - Sept 2019)	Qtr 3 (Oct - Dec 2019)	Qtr 4 (Jan - Mar 2020)
A&E / Urgent Care / One Life / Critical Care	145	163	132	202
Children's Day Unit / Children's Ward / Consultant Paeds / Physio Paeds / PDU Nurses	13	3	6	6
Maternity (Midwifery / Delivery Suite / Neo- Nates)	52	34	55	35
Wards (i.e. Ward 4 / Ward 24 / Ward 33 / Ward 36 / Ward 41 etc…)	3	0	0	1
Community (SALT / MSK / Dietician / Dental / Orthoptist)	3	3	2	2
ENT	1	2	2	
Ortho			2	
Clinical Psychology / Education Psychotherapist	2			1
Endoscopy	1			
Radiology				1
Others (Safeguarding Adults & Children / Nursing Education / NHS Direct etc...)		1		2
Total figures as per quarter	220	206	199	250

15 Domestic Violence and Abuse

15.1 The Trust is represented at Multi Agency Risk Assessment Conferences (MARAC) in Hartlepool and Stockton by a safeguarding children's senior nurse, 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).

15.2 A Domestic Abuse Policy is in place across the Trust.

16 Bruising in Immobile Babies Policy

16.1 Bruising in non-mobile children is rare and therefore there is a significant risk that bruising may indicate abusive or neglectful care. Unfortunately, nationally and locally bruising is not always responded to appropriately by health practitioners. As a result, a significant number of abusive events have been missed nationally resulting in children being placed at risk, serious incidents and serious case reviews.

16.2 In response to this the Tees Procedures Group reviewed the existing procedure and significant changes were made and ratified in the Tees Procedures group. The immobile baby pathway is now embedded across the Trust. This pathway requires all professionals to refer bruising in immobile children for assessment by a Consultant Paediatrician and Children's Social Care. In Feb the safeguarding team facilitated a multi agency learning event with support from the Stockton and Hartlepool Safeguarding Partnership (HSSCP).

17 Child Sexual Exploitation (CSE)

17.1 CSE and criminal exploitation continues to be a growing concern. Representation from the safeguarding team continues at the Stockton and Hartlepool VEMT (Vulnerable, Exploited, Missing Trafficked) practitioners group. This 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.

17.2 A CSE risk assessment is completed on all LAC children over the age of 11 years and on all children who attend unscheduled care within the Trust if they fit within an agreed criteria of risk. This risk assessment has also been rolled out to Paediatric wards.

18 Local Authority Designated Officer (LADO)

18.1 Regular meetings have been established between the Named Nurse and staff within the Human Resources (HR) department to improve communication and referrals to the LADO. Additional safeguarding training has been delivered to Trust senior managers to increase their awareness of adult risky behaviors that may require safeguarding intervention when supporting staff are on sickness/ absence or there are capability issues.

19 Joint working with Adult Safeguarding

19.1 A Senior Nurse in the Vulnerability Unit continues to provide both adult and children's safeguarding training across the Trust including Female Genital Mutilation (FGM), Prevent, Forced Marriage and Modern Slavery. The Name Nurses for Adult and Children's safeguarding both equally contribute to the Safeguarding Children's Steering Group and The Adult Vulnerability Committee

20 Voice of the Child

20.1 Following recommendations from the CQC report 'Not Seen, Not Heard' the Trust took forward a number of actions to further improve how we listen to children and gain their wishes and feeling around the care they receive.

20.2 The LAC team have devised new health assessment forms that enable the practitioner to capture the wishes and feelings of children in care receiving health assessments. 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.

21 Child Protection Information System (CP IS) and Unscheduled Care Settings

21.1 The Trust has worked closely with NHS England to ensure that the CP-IS project is implemented across all unscheduled care settings within the Trust.

22 New Partnership Arrangements

22.1 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).

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

- Tees procedures policy group
- Tees Engine room
- County Durham MASH Board
- County Durham Neglect Sub Group
- County Durham Safeguarding Health Leads

23 Audit

23.1 The safeguarding work program has a strong focus on quality and improving outcomes for children and young people. Examples include:

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

24 Children's Safeguarding Key Achievements 2019 / 2020

24.1

- Provision of bespoke training in response to lessons from serious untoward incident investigations
- The introduction of scenario based safeguarding children's training with a requirement to complete a Safer Referral
- Sustained high compliance for safeguarding supervision
- Increased Visibility of Safeguarding Nurses in high demand areas such as A&E and UCC
- Implementation of the Child Protection Information System (CP-IS)
- A very recent change to safeguarding practice to enable safeguarding supervision and training to be delivered remotely if required.

25 Children's Safeguarding Key Priorities 2019 / 2020

25.1

1. Align key priorities of the Trust to the priorities of HSSCP and DSCP
2. Achieve 100% compliance for all local safeguarding children quality requirements
3. Continue to enhance the Trust safeguarding children training program
4. To continue to raise awareness of the VEMT agenda in the Trust utilizing agreed risk assessment tools to improve outcomes for children and young people who may be vulnerable, exploited, missing or trafficked;
5. To continue to develop and monitor any action plans following recommendations from the Joint Targeted Area Inspections and local Safeguarding Children Practice Reviews.

26 Looked After Children (LAC)

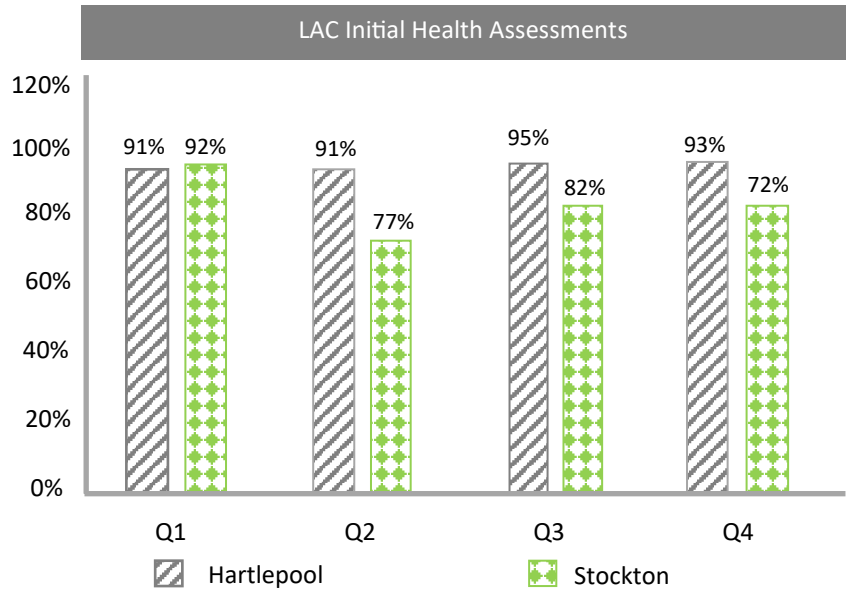
26.1 The services and responsibilities for LAC are underpinned by legislation, statutory Guidance and good practice guidance which include: "Statutory Guidance on Promoting the Health and Well-being of Looked After Children" (DH, 2015) and "Promoting the Quality of Life of Looked After Children and Young People" (NICE, 2010). The importance of the health of children and young people in care cannot be overstated; many children in care are likely to have had their health needs neglected prior to coming into care. The health of looked after children is everyone's responsibility, so partnership working is essential to ensure optimum health for each individual child and young person.

- LAC health provision is an integral part of the Trust Safeguarding and LAC Steering Group work programme which reports to the Trusts Children's Safeguarding Steering Group and Patient Safety Committee.
- The Trust continues to be represented and is an active member of the Children In Care Council (CICO) in Stockton and more recently Corporate Parenting Group in Hartlepool.

27 Looked After Arrangements and Provision

27.1 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.

The table demonstrates compliance when children are notified to the service that they are in care:



27.2 Any reduction in compliance is now being addressed by regular LAC Performance Management Team Meetings which identify any predicted increases in service demand so that resilience plans can be implemented to ensure sufficient capacity to respond. Points to note in relation to reduced compliance include:

- Not receiving timely and appropriate consent for IHA's.
- Appointments being rearranged or cancelled by carers/parents.
- Children and Young people refusing assessments.

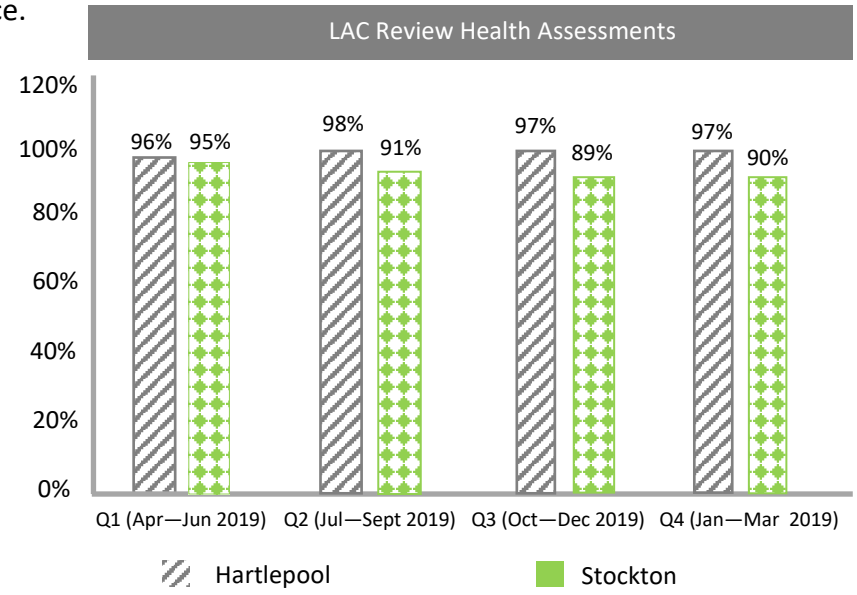
28 Review Health Assessments

28.1 Review Health Assessments must be undertaken at 6 monthly intervals for children under five years; annually for those over five up until they turn 18 years old.

28.2 Reviews are designed to identify and monitor health needs of LAC and are a statutory obligation. In Stockton the service model includes Health Visitors and School Nurses who undertake the RHA for those LAC accessing Universal services. Health Visiting and School Nursing are a Public Health commissioned service.

28.3 In 2018 the Trust was commissioned to provide the RHA's for all LAC children in Hartlepool. These assessments were previously completed by the 0-19 service provided by Hartlepool Borough Council Public Health. The LAC team are committed to improving LAC services and are able to evidence a sustained improvement in compliance with dedicated resource to undertake the assessments.

The table demonstrates compliance of review health assessments:



28.4 The data identifies issues where compliance has not been maintained and include:

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

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

29 Looked After Children - Key Achievements

- Ongoing updates and improvements to the Electronic Health Care Record to improve the identification of health trends in the LAC population.

- The sustained significant improvement in the completion of IHAs and RHAs within statutory timescales.

- All new LAC are now flagged within the child's health care record, including SystmOne and Trakcare enabling early identification of vulnerability.

- CSE screening tool used on all LAC children over the age of 11.

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

30

Looked After Children Key Priorities 2020—2021

- Achieve 100% of IHAs completed within the statutory 20 day timescale.
- Achieve 100% of RHA completed within the statutory time scale.
- To continue robust oversight of the health assessment of all looked after children and ensures a health care plan is available within 20 working days.
- To ensure that families and carers are engaged and involved as appropriate to promote optimum health and development of all looked after children.
- To ensure that the young person's views, as appropriate are included in the health care plan.
- To work in conjunction with local authority and other partners to promote the health and well-being of looked after children.
- To take appropriate action to protect vulnerable children and adults at risk.
- Ongoing updates and improvements to the Electronic Health Care Record to improve the identification of health trends in the LAC population.
- To identify and address barriers to accessing health services and make them accessible to Looked After Children and Young People.
- To provide training for foster carers and residential workers in agreement, or jointly, with social work and health colleagues.
- To provide expert health advice and training for partner agencies and carers in the needs of this specific client group.

Vulnerability Team Summary

It is the human right of both children and adults to feel safe and protected from harm. Our duty of care is to safeguard and work in partnership to identify risk, provide or find the right support to prevent any future harm.

The Vulnerability Team is committed to providing leadership support, advice and guidance to staff across North Tees and Hartlepool Foundation Trust, ensuring that the Trust provides the highest level of care to all its patients and their families.

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Director of Infection Prevention and Control Annual Report 2019/20										
Date:	28 May 2020										
Prepared by:	Lesley Wharton, Assistant Director of Nursing & IPC										
Executive Sponsor:	Julie Lane, Chief Nurse/Director of Patient Safety and Quality										
Purpose of the report	This report provides a summary of the performance and activity in relation to healthcare associated infection during 2019-20.										
Action required:	Approve	✓	Assurance		Discuss		Information				
Strategic Objectives supported by this paper:	Putting our Population First	✓	Valuing People		Transforming our Services		Health and Wellbeing	✓			
Which CQC Standards apply to this report	Safe	✓	Caring		Effective	✓	Responsive		Well Led	✓	

Executive Summary and the key issues for consideration/ decision:

The risk of healthcare associated infection has remained a priority for the Trust in 2019/20. During the year significant progress was made in the reduction of healthcare associated infection within the Trust. However, the year ended with the early stages of a global pandemic, which brought significant challenges to the NHS and the organisation which cannot be underestimated.

Of note, success was achieved in reducing cases of MRSA, Klebsiella and Pseudomonas bacteraemia cases and C difficile infections. A reduction was also seen in the number of outbreaks due to diarrhoea and vomiting, which can have a detrimental impact both on patients and the business of the Trust.

The report describes the activities that have been undertaken to improve and sustain patient, visitor and staff safety across all of our healthcare settings, much of which has been achieved in conjunction with partner organisations.

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

The current risks relating to failure to achieve reduction objectives and impact on patients due to suffering a healthcare associated infection remain on the Board Assurance Framework and risk register but have been managed as moderate risks.

One area of concern is the increase in Pseudomonas bacteraemia cases in 2018-19 but as the numbers are still very small and the increase may not be sustained this has not been highlighted as an individual risk.

Committees/groups where this item has been discussed	Healthcare Associated Infection Operational Group Infection Control Committee
Recommendation	The Board is requested to approve this report which will be published in the public domain via the Trust website.

North Tees and Hartlepool
NHS Foundation Trust

Director of Infection Prevention and Control Report 2019-2020

Contents

Part 1: Executive Summary

1.1 2019/20 saw a number of achievements in the reduction of healthcare associated infection within the Trust, however the year ending with the early stages of a global pandemic brought significant challenges to the NHS and the organisation which cannot be underestimated.

1.2 Our successes were in MRSA, Klebsiella and Pseudomonas bacteraemia cases and C difficile infections. We also saw a reduction in the number of outbreaks due to diarrhoea and vomiting which can have a detrimental impact both on patients and the business of the Trust

1.3 This report describes the activities we have undertaken to improve and sustain patient, visitor and staff safety across all of our healthcare settings, much of which has been achieved in conjunction with partner organisations.

Julie Lane

Chief Nurse/Director of Infection Prevention and Control

Date: May 2020

Part 2: Infection prevention and control arrangements

2.1 The prevention and control of infection is a top priority for the public and our patients. Avoidable infections can be devastating for patients and their families and therefore North Tees and Hartlepool NHS Foundation Trust continues to place this patient safety issue as a priority for action and improvement.

2.2 The Infection Prevention and Control Team (IPCT) provide a service to trust staff across all settings and also support care homes, local hospices, GP practices and an independent hospital through service level agreements and local agreements. We have an experienced team of Infection Prevention and Control (IPC) nurses supported by clerical and surveillance team members, working in close collaboration with Consultant Microbiologists, biomedical scientists the antimicrobial pharmacist and clinical teams across the Trust.

2.3 The Assistant Director of Nursing and Infection Prevention & Control is responsible for leading the IPCT and for providing support to the Director of Infection Prevention and Control (DIPC) who is the Chief Nurse and Director of Quality & Patient Safety.

2.4 In addition to the Assistant Director the following nurses are employed within the IPCT to cover the service needs of the settings described above.

Infection Prevention Matrons	1.8 WTE
Infection Prevention and Control Nurses	3.4 WTE

2.5 The service is supported by 1.5 WTE clerical and surveillance staff who also provide support to the tissue viability and chaplaincy team.

2.6 The Consultant Medical Microbiologists play an active role in infection prevention and control with one of them taking on the role of Infection Control Doctor and another being the Trust Antibiotic Lead. Out of hours IPC advice is provided by the on call microbiologist, which is a shared arrangement between two local NHS trusts.

2.7 The DIPC provides a report to each Board of Directors via an Integrated Quality report. A performance report is provided to the monthly Patient Safety and Quality Standards Committee, which is a sub Committee of the Board and is chaired by a Non-Executive director.

2.8 The reporting and governance structure for infection prevention and control is shown in Fig 1.

Fig 1. Reporting and accountability for Infection Prevention and Control

2.9 The *Health and Social Care Act 2008, Code of Practice on prevention and control of infection and related guidance* (2015) guides the activities carried out by the Infection Prevention and Control Team (IPCT) and is the basis of our annual programme. A self-assessment to measure adherence to the requirements of the Code of Practice is carried out annually and reported to the Infection Control Committee.

Part 3: Healthcare Associated Infection Surveillance and Performance

3.1 Mandatory Surveillance

3.1.1 The Trust continues to report on the infections required by the mandatory surveillance programme facilitated by Public Health England:

- Clostridioides difficile infection (CDI)
- Methicillin-resistant Staphylococcus aureus (MRSA) blood stream infections (bacteraemia)
- Methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemia
- Escherichia coli (E.coli)
- Klebsiella species (Kleb sp) bacteraemia
- Pseudomonas aeruginosa (Ps a) bacteraemia

3.1.2 National criteria are applied to establish whether cases of these infections are attributable to the Trust (hospital onset or healthcare associated).

3.1.3 For bacteraemia cases when the sample is taken on the day of admission or the following day it is considered to be community onset but samples taken after that time are considered to be hospital onset.

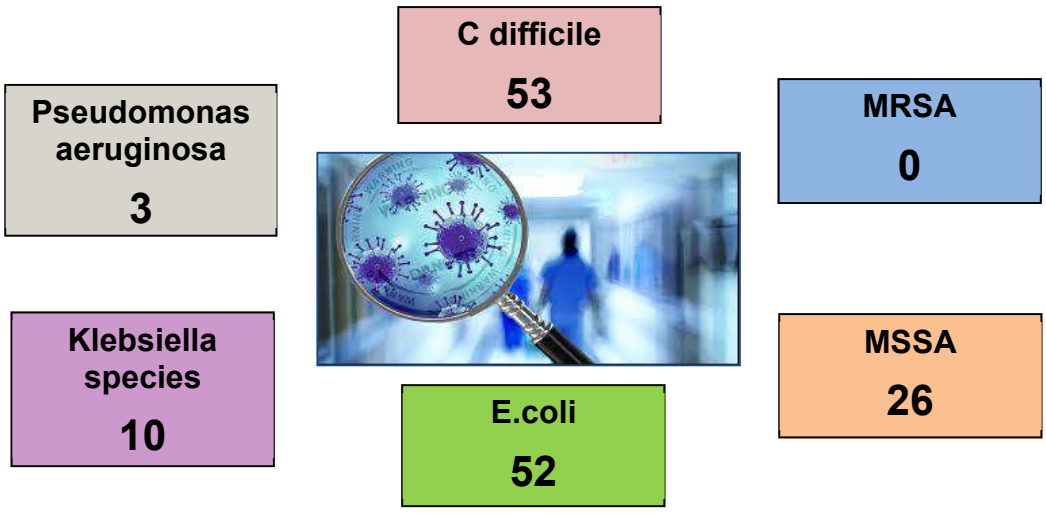
3.1.4 For CDI the thresholds for attribution changed form 1 April 2019 meaning there are now four categories of infection:-

- Hospital onset healthcare associated: cases that are detected in hospital three or more days after admission
- Community onset healthcare associated: cases that occur in the community (or within 2 days of admission) when the individual has been an in-patient in the trust reporting the case in the previous 4 weeks.
- Community onset indeterminate association: cases that occur in the community (or within 2 days of admission) when the individual has been an in-patient in the trust reporting the case in the previous 12 weeks but not in the most recent 4 weeks.
- Community onset community associated: cases that occur in the community (or within 2 days of admission) when the individual has not been an in-patient in the trust reporting the case in the previous 12 weeks.

The first two categories count as attributed to the trust reporting the case (healthcare associated).

3.1.5 National reduction objectives are set for all trusts. In 2019-20 the Trust had a CDI reduction objective of no more than 56 healthcare associated cases, and a zero tolerance of avoidable infections approach is adopted for MRSA bacteraemia. The Trust sets internal targets based on the performance of the previous year for the other organisms which in 2019-20 was a 10% reduction for each infection.

Fig 2 Total number of hospital onset infections during 2019-2020.



3.2 Clostridioides difficile infection (CDI)

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

3.2.2 During 2019-20 the Trust achieved the CDI target having reported **53** Trust healthcare associated cases against a trajectory of 56 cases. In addition to achieving the required objective we also achieved a 13% reduction when comparing the new criteria to the previous year when 61 cases would have been reported

3.2.3 We continue to focus our efforts on actions to control and reduce opportunity for infections to spread, whether we treat people in our hospitals, community premises or in their own homes. We have maintained a consistent approach to cleanliness across all areas of our environment. The commitment to environmental cleanliness is achieved in partnership with North Tees and Hartlepool Solutions LLP who provide our decontamination services. The focus on antimicrobial stewardship has continued and the importance of carrying out the fundamental aspects of good infection prevention practice is the basis of all of our work.

3.2.4 Actions to reduce the risk of CDI form part of the overall healthcare associated infection (HCAI) improvement plan which has been developed in conjunction with clinical staff and reviewed monthly. Progress against the plan is reported to the HCAI Operational Group and Infection Control Committee and the document has been regularly shared with commissioners.

Fig 3 Clostridium difficile cases 2018-20

Trust Clostridium difficile cases 2018-20

	Hospital onset	Community onset
2018-19	61	54
2019-20	**53**	**39**

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

3.3 Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia

3.3.1 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

3.3.2 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 and nasal cream that helps to get rid of MRSA. This measure reduces the risk of an infection developing.

3.3.3 In 2019-20 our organisation reported **zero** hospital onset MRSA bloodstream infection, which means we have not had a hospital onset for 25 months at the end of March 2020. This is a significant achievement. Three community onset cases were reported in 2019-20 which is an

increase on the previous year.

Fig 4 MRSA bacteraemia cases 2013-20

	Hospital onset	Community onset
2013-14	0	4
2014-15	1	2
2015-16	2	3
2016-17	1	2
2017-18	4	2
2018-19	0	0
2019-20	**0**	**3**

Data from Healthcare Associated Infections (HCAI) data capture system

3.4 Methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemia

3.4.1 MSSA is a strain of 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.

3.4.2 In 2019-20 we reported **26** cases of Trust attributed MSSA bacteraemia. Unfortunately this is an increase of 5 cases on the previous year. Each case is subject to a root cause analysis and the analysis of these investigations has shown that there are no apparent trends in terms of linked cases or frequently seen sources of infection. In many cases the source has been a chest or skin infection which would have been difficult to prevent and a number of these cases classed as hospital onset are as a result of infection already present when the patient was admitted.

3.4.3 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 community onset cases was seen this year

Fig 5 MSSA bacteraemia cases 2013-120

	Hospital onset	Community onset
2013-14	13	30
2014-15	18	41
2015-16	24	64
2016-17	21	57
2017-18	25	71
2018-19	**21**	**93**
2019-20	**26**	**75**

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

3.5 E coli bacteraemia

3.5.1 Escherichia coli is a very common bacterium found in the human gut which can cause serious infections such as blood poisoning.

3.5.2 The numbers of E coli bacteraemia reported by the Trust for the year are shown in the table below. As the majority of these cases are those that are identified within the first 48 hours of hospital admission work is required across all healthcare settings to achieve improvements. In 2019-20 we saw an increase of 13 instances of hospital onset cases which is disappointing given previous improvements made.

3.5.3 Root cause analysis is completed for all cases deemed to have been hospital onset and action plans are developed where issues are identified. In many cases these bloodstream infections are related to urine infections and are thought to be not preventable, with only a small number of cases being in patients with a urinary catheter where there may be potential for improved practices. However we continue to work with staff to reduce the unnecessary use of catheters and encourage prompt removal to reduce risk of catheter associated infections. Some of these bacteraemia relate to infections present on admission to hospital.

Fig 6 E coli bacteraemia cases 2013-20

	Hospital onset	Community onset
2013-14	22	169
2014-15	28	176
2015-16	44	224
2016-17	50	267
2017-18	43	304
2018-19	39	317
2019-20	**52**	**279**

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

3.6 Klebsiella species bacteraemia

3.6.1 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

3.6.2 In 2019-20 the Trust reported **10** Klebsiella species bloodstream infections. This is a 50% improvement on the cases reported in the previous year. There is no reduction target associated with this infection currently but the Trust aims for a 10% reduction each year. Enhanced data collection is being carried out on each case to understand if there are any common themes to the

infections. This will allow us to target our efforts effectively to reduce the number of cases further in future.

Fig 7 Klebsiella bacteraemia cases 2016-20

	Hospital onset	Community onset
2016-17	22	49
2017-18	29	42
2018-19	20	40
2019-20	**10**	**49**

3.7 Pseudomonas bacteraemia

3.7.1 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. Pseudomonas aeruginosa is resistant to many commonly used antibiotics

3.7.2 In 2019-20 the Trust reported **3** trust attributed cases of Pseudomonas aeruginosa bloodstream infections. This represents a 66% improvement in this infection. As with Klebsiella there is no national reduction target assigned and enhanced data collection is underway to better understand the sources of these infections but it is difficult to identify any trends with such small numbers.

Fig 8 Pseudomonas bacteraemia cases 2016-20

	Hospital onset	Community onset
2016-17	9	9
2017-18	5	19
2018-19	**9**	**20**
2019-20	**3**	**17**

3.8 Glycopeptide resistant Enterococcus (GRE)

3.8.1 Enterococci are normally found in the gut and are part of the normal human gut flora. Although a common cause of urinary tract infections they can also cause serious infections such as endocarditis and can be a particular risk to immunocompromised patients.

3.8.2 The number of bacteraemia caused by GRE is low and cases are sporadic however the Trust has seen an increase in the number of other, non-blood culture specimens, being positive for this organism due to an increase in screening for other infections and the introduction of a sensitive test medium. In 2019-20 we reported **1** GRE bacteraemia cases which is an improvement on 2 cases reported in the previous year. This one case was not hospital onset.

3.9 Surgical Site Infection (SSI)

3.9.1 It is a mandatory requirement to conduct surveillance of orthopaedic surgical site infections for a minimum of one quarter in each reporting year, using the Public Health England Surgical Site Surveillance Service. The data collected is forwarded to the service for analysis and reporting.

3.9.2 We participate in continuous surveillance and collect data on several procedure groups. In 2019-20 **two** surgical site infections were identified as part of this surveillance. Both cases have been followed up and reviewed within the orthopaedic team so that any learning can be identified

3.9.3 In 2019 we also participated in a surgical site data collection for the Getting It Right First Time (GIRFT) programme. Data was collected over 6 months across a number of specialities. Over 8,000 applicable procedures were checked and 753 potential cases for review identified. Each of these cases was reviewed and the numbers of surgical site infections were identified as below

Fig 9 Surgical Site Infections (GIRFT) 2019

Type of surgery	No of cases included	No of SSI identified	Trust SSI rate	National SSI rate
Breast	85	1	1.6%	4.8%
General Surgery/Urology	226	8	3.7%	4%
Urology		0	0.0%	1.8%
Orthopaedics	442	2	0.5%	0.7%
Spinal		0	0.0%	1.1%

3.9.4 Further information on specific procedures was also provided in the report from GIRFT and the Trust achieved lower than the national SSI rate for 12 procedures out of 15 for which data was submitted. This information will be presented to the Infection Control Committee and will be used as the basis for discussion to identify pathways to further reduce SSIs

3.10 Influenza

3.10.1 In 2019-20 the Trust experienced a lower number of seasonal influenza cases than were expected. A small number of patients were treated in the critical care unit. On site and point of care testing was carried out to identify positive patients in order to facilitate prompt isolation and control measures.

3.10.2 All staff are encouraged to receive the seasonal influenza vaccination as a means of protecting themselves, their families and our patients. In 2019-20 we saw the percentage of front line staff who received the vaccine increase to **80%** thanks to a campaign led by the occupational health department and the use of peer immunisers to support the programme.

3.11 Voluntary Surveillance

3.11.1 In addition to the mandatory surveillance, the infection prevention and control team conducts voluntary surveillance to monitor infections in the Trust. This includes:

- Newly identified MRSA colonisation or infection (samples other than blood cultures)
- 'Alert' organism surveillance – results with a potential infection control significance
- Targeted surveillance – infections seen in specific specialities
- Voluntary reporting of norovirus outbreaks
- Central line related bloodstream infections (Matching Michigan)

3.12 Hand Hygiene

3.12.1 Monthly hand hygiene audits are carried out across the Trust. These are a combination of independent unannounced observations, self-assessment and patient/carer feedback. The results are provided to clinical areas in a monthly RAG report and form part of a safety and quality dashboard where compliance by staff group and ward can be displayed. The overall trust results for the year are displayed below. The Trust target for achievement is 95% and this has been achieved or exceeded every month with particularly good results in the last 4 months of the year. There may have been an impact on hand hygiene compliance from the COVID-19 pandemic.

Fig 8 Trust wide hand hygiene compliance 2019-20

Month	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
%	96	97	98	98	98	98	97	98	99	99	99	100

3.12.2 The audit results are discussed bimonthly at the HCAI Operational Group Meeting where areas with the lowest scores are invited to present their improvement plans, and quarterly at the Infection Control Committee, where they form part of directorate reports.

3.12.3 We have a network of hand hygiene champions across the Trust with volunteers from all types of staff. These champions play a role in promoting good hand hygiene practice and challenging poor practice if they observe it. Each month they are given a challenge, which could be as simple as talking about hand hygiene at ward meetings or as practical as offering gel to those who are not carrying it.

3.12.4 Each year the Trust participates in events to raise awareness of the importance of hand hygiene for staff and patients, including World Hand Hygiene day which is on 5th May. In 2019 the campaign was 'Clean Care for all – it's in your hands' and focused on correct glove use and hand hygiene before and after glove use.

3.13 Outbreaks

3.13.1 Each year there are a number of outbreaks which affect patients and staff both in hospital and the community. In 2019-20 we had **zero** confirmed outbreaks of diarrhoea/vomiting and **8**alert situations where a full outbreak is not declared but a number of patients may be monitored for symptoms. This reduction was reflected in a lower number of outbreaks reported in local care homes.

3.13.2 An outbreak can have a wider effect than the ward where the affected patients are situated. When a ward is closed it reduces the number of beds available to admit new patients into and can also delay discharges of patients waiting to go into care homes

3.13.3 Increased cleaning is implemented during an outbreak or an alert situation and the ward is 'deep' cleaned before re-opening once the outbreak has been declared closed. This is a very important part of outbreak management and is instrumental in ensuring that there is no recurrence of the outbreak in the same setting.

Part 4: Policies and Audit

4.1 Policies

4.1.1 The Trust has a programme for review and revision of core infection prevention and control policies as required by the Health and Social Care Act 2008 Code of Practice (2015). All policies are available to staff on the Trust intranet site and many are also available to the public on the main internet web page.

4.1.2 A schedule for review and revision of policies forms part of the annual IPC programme. The status of policies can be seen below:

Policy Code	Policy Title	Status
IC1	Outbreak Policy	For review January 2023
IC2	Hand Hygiene Policy	For review June 2022
IC3	Infection Control Policy	For review May 2022
IC5	CJD Policy	For review October 2022
IC6	MRSA Policy	For review May 2022
IC7	Management of Viral Haemorrhagic Fevers incl Ebola Policy	For review Sept 2021
IC11	Tuberculosis Policy	For review May 2021
IC12	Local Decontamination of Medical Equipment Policy	For review June 2022
IC14	Clinical Specimen Policy	For review October 2020
IC15	Patient Isolation Policy	For review June 2022
IC17	Standard Precautions Policy	For review February 2021
IC18	Peripheral Cannulation Policy	For review June 2020
IC19	Clostridium difficile Policy	For review April 2021
IC 20	MRSA screening Policy	For review March 2021
IC21	Theatre Policy	For review September 2019
IC22	Management of Patients with Ectoparasitic Infestation Policy	For review July 2022
IC23	Infection Prevention and Control Surveillance Policy	Under review
IC24	Management and Control of CPE Policy	For review August 2020
IC25	Animals in Clinical Areas	New policy
C56	Antibiotic Strategy	For review April 2021

4.2 Audit programme

4.2.1 An annual programme of audit is agreed as part of the annual IPC programme. The audit programme is a combination of policy audits and general IPC audits carried out as part of an unannounced visit schedule. Audit results are collated and fed back to the clinical area and action plans are requested as appropriate. The audits are presented to the Infection Control Committee and an annual report is produced, summarising all of the audit activity and high level findings.

4.2.2 In summary the audit findings for 2019-20 are as below

Audit	Overall Trust compliance 2019-20	Overall Trust compliance 2018-19
Hand Hygiene	95% ↑	91%
Standard Precautions	78% ↓	88%
Environmental	91% ↑	84%
Uniform	98% ↑	97%
Overall Compliance	90% →	90%

Isolation policy		Peripheral Cannulation Policy	
Overall Trust compliance 2019 20	Overall Trust compliance 2018 19	Overall Trust compliance 2019 20	Overall Trust compliance 2018 19
76% ↓	80%	81% ↓	91%

MRSA Policy		Clostridium difficile policy	
Overall Trust compliance 2019 20	Overall Trust compliance 2018 19	Overall Trust compliance 2019 20	Overall Trust compliance 2018 19
60% →	60%	87% ↓	91%

4.2.3 The actions identified from audits are added to an action tracker document with deadlines which are followed up and escalated if not met.

Part 5: Training

5.1 A blended approach to training has been applied in the Trust with a mixture of face to face and electronic learning or workbooks being available to staff. The IPC team attend a number of directorate training days to provide training and an opportunity for staff to ask questions.

5.2 We continue to utilize training within a streamlining programme, which means that training is portable between a number of organisations with a standard programme being agreed and delivered, has continued for all Trust staff. Level 1 training for non-clinical staff is required 3 yearly and is available in a number of formats. Level 2 training for clinical staff is required annually, and the existing workbook has been updated to reflect the national programme. This is also able to be used in facilitated sessions.

5.3 In addition to the mandatory training programme the IPC team also facilitate a number of different training sessions including:

- Decontamination of patient equipment
- Clostridium difficile infection
- Error room session where staff have to spot mistakes in a clinical room
- Infection specific sessions delivered in response to an incident or increase in infection such as CPE or COVID-19 for example

Part 6: Antimicrobial Stewardship

6.1 The antimicrobial audit programme continues with audit data uploaded to an online spreadsheet to aid with data collection and feedback reports to clinical areas.

6.2 We have a multidisciplinary approach to improving and expanding our outpatient antibiotic therapy (OPAT) services which allows us to treat more patients at home thus reducing bed pressures and facilitating patient flow, reducing the use of broad spectrum antibiotics, increasing cost efficiency and improving patient satisfaction and experience.

6.3 Our empirical antibiotic guidelines have been reviewed, with a view to reducing use of carbapenems and will be published once approved.

6.4 There is ongoing work with the Electronic patient record (EPR) team for Trakcare in order to improve stewardship by using software design of decision aids, incorporation of empirical guidelines and review reminders.

6.5 The Trust is represented at a regional Antimicrobial Stewardship work stream committee which aims to employ a regional approach to stewardship.

6.6 Antibiotic ward rounds take place daily in critical care and it is hoped that additional wards can be added with the recruitment of new consultant microbiologists. Weekly ward rounds also take place in Haematology and Orthopaedics as well as weekly Multidisciplinary Team review of CDI patients

6.7 The Trust again participated in European Antibiotic Awareness day in November 2019 where staff were encouraged to sign up as antibiotic guardians

Part 7: Decontamination of the environment and equipment

7.1 Decontamination is a process which removes or destroys infectious agents from furniture or medical equipment. Cleaning is always the first step in this process, which can then be followed by disinfection or sterilisation depending on the circumstances in which the equipment is used.

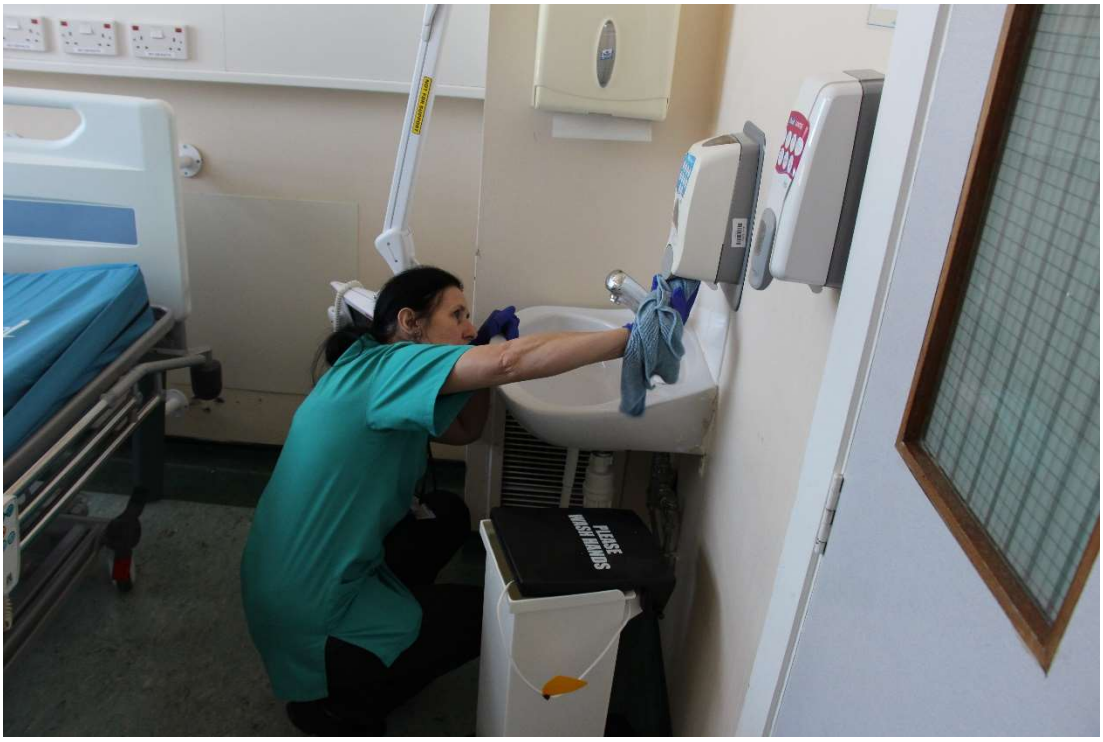
7.2 The sterile services department is responsible for reprocessing reusable medical devices. All processes are fully validated and compliant to national standards HTM 01-01 and ISO 13485:2016 an internally and externally audited process. Disposable items are used wherever this is possible and efficient.

7.3 Decontamination audits are carried out annually in departments where local decontamination takes place and the IPC team are part of the audit team. The results are presented to the Decontamination Group which reports into the Infection Control Committee.

7.4 The endoscope decontamination facilities on both sites are validated and compliant with national requirements HTM 01-06 and compliant to ISO 13485:2016. An Authorising Engineer (Decontamination) has validated the annual reports. All endoscopy reprocessing is provided by Decontamination services staff, trained and compliant in line with ISO 13485:2016.

7.5 The provision of cleaning services in hospital and external premises was provided in 2019-20 by a combination of LLP staff and external contractors who cover some community premises. Performance management systems are in place with monitoring staff carrying out checks of the environment and equipment in line with national standards of cleanliness and reporting via the HCAI Operational Group.

7.6 In addition to routine cleaning the Trust provides an enhanced cleaning service via the LLP with a response team and hygienist team responsible for additional cleaning of frequently touched items, deep cleaning, fogging with hydrogen peroxide and use of ultra violet light plus a mattress decontamination service



Part 8: Other significant issues

8.1 In January 2020 it was announced that a novel coronavirus was the cause of an outbreak in China which has since been designated a global pandemic. Coronaviruses are a large family of viruses with some causing less severe disease such as the common cold and others causing more severe disease such as Middle Eastern respiratory syndrome (MERS) and Severe Acute respiratory syndrome (SARS). This current virus is referred to as SARS CoV-2 and the associated disease is COVID-19.

8.2 The development of the pandemic led to a rapidly changing and evolving group of guidelines which were challenging to implement, and has impacted on the delivery of normal healthcare. Along with other organisations the trust has had pressures on obtaining supplies but has worked with local and national organisations and benefitted from the generosity of donors to ensure our staff are protected and can deliver safe care to our patients.

8.3 The infection prevention and control team have worked with community nursing teams, local authorities and care home providers to support care workers in difficult circumstances and the relationships built during this pandemic will continue in the future in the spirit of collaborative working.

Part 9: Conclusion

9.1 Eliminating avoidable healthcare associated infection has remained a top priority for our staff and patients. In response a robust annual programme has again been implemented.

However, a number of risks and challenges exist. In particular, these relate antimicrobial stewardship, the availability of sufficient single rooms to allow Trust policy to be fully implemented and the emergence of new infections such as COVID-19 which have placed such pressure on all NHS and care organisations. Our staff have risen to the challenge in a way that they should be proud of and have maintained high standards of care despite the difficult circumstances.

9.2 Where risks are identified these have been added to the Trust risk register and are monitored and managed accordingly and reported into the Infection Control Committee.

9.3 We continuously strive to improve practice and keep our patients as safe as possible and protected from avoidable infections. We will continue to work with partner organisations to take a whole systems approach to infection prevention across all patient pathways. We take great pride in having made reduction in four out of the six infections in the mandatory reporting programme and will continue to work towards further improvements in the coming year.

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