North Tees and Hartlepool NHS
NHS Foundation Trust

Board of Directors Meeting

Thursday, 5 October 2023
at 9.00am

Boardroom
University Hospital of Hartlepool

North Tees and Hartlepool
NHS Foundation Trust

University Hospital of North Tees
Hardwick
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29 September 2023

Dear Colleague

A meeting of the **Board of Directors** will be held in public, on **Thursday, 5 October 2023 at 9.00am** in the **Boardroom, University Hospital of Hartlepool.**

Yours sincerely

Professor Derek Bell, OBE
Joint Chair

Agenda

			Led by
1.	(9.00am)	Apologies for Absence	Vice Chair
2.	(9.00am)	Declaration of Interest	Vice Chair
3.	(9.00am)	Patient Story	L Robertson
4.	(9.15am)	Minutes of the meeting held on, 27 July 2023 **(enclosed)**	Vice Chair
5.	(9.20am)	Matters Arising and Action Log **(enclosed)**	Vice Chair
Items for Information			
6.	(9.25am)	Report of the Joint Chair **(enclosed)**	Vice Chair
7.	(9.35am)	Joint Partnership Board Update **(enclosed)**	Vice Chair
8.	(9.45am)	Report of the Managing Director **(enclosed)**	N Atkinson
Performance Management			
9.	(9.55am)	Integrated Performance Report **(enclosed)** (Reporting to 31 August 2023)	L Wallace, L Robertson, K Hudson-Halliday, S Cook
Governance			
10.	(10.05am)	Learning from Deaths Report **(enclosed)**	L Robertson/N Suresh
11.	(10.15am)	Guardian of Safe Working Hours Annual Report August 2022 to July 2023 **(enclosed)**	N Suresh

Quality

12. (10.25am)	Maternity Board Report **(enclosed)** - PQSM and Training Syllabus **(enclosed)**	L Robertson

Items to Receive

13. (10.35am)	Annual Quality Account **(enclosed)**	L Robertson
14. (10.40am)	Safeguarding Annual Report 2022-23 **(enclosed)**	Vice Chair/ L Robertson
15. (10.45am)	Assurance Report of Quality Committee **(enclosed)** (Reporting to 31 August 2023)	F Scullion/Vice Chair
16. (10.50am)	Assurance Report of People Committee **(enclosed)** (Reporting to 31 August 2023)	Vice Chair
17. (10.55am)	Assurance Report of Resources Committee **(enclosed)** (Reporting to 31 August 2023)	C Macklin/F Scullion
18. (11.00am)	Assurance Risk Management Group Report **(enclosed)** (Reporting to 31 August 2023)	N Atkinson
19. (11.05am)	Any Other Business	

Date of next meeting
(**Thursday, 2 November 2023, Boardroom, University Hospital of North Tees**)

Glossary of Terms

Strategic Aims and Objectives

Putting Our Population First

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

Valuing Our People

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

Transforming Our Services

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

Health and Wellbeing

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

North Tees and Hartlepool NHS Foundation Trust

DRAFT Minutes of a meeting of the Board of Directors held on Thursday, 27 July 2023 at 10.00am at the University Hospital of North Tees / Via Video Link

Present:

Professor Derek Bell, Joint Chair*	Joint Chair
Ann Baxter, Vice Chair / Non-Executive Director	AB
Chris Macklin, Non-Executive Director*	CM
Fay Scullion, Non-Executive Director *	FS
Alison Fellows, Non-Executive Director*	AF
Neil Atkinson, Managing Director*	MD
Deepak Dwarakanath, Chief Medical Officer/Deputy Chief Executive*	CMO/DCE
Kate Hudson-Halliday, Acting Director of Finance*	ADoF
Lindsey Robertson, Chief Nurse/Director of Patient Safety and Quality*	CN/DoPS&Q
Linda Hunter, Director of Performance and Planning	DoP&P
Rowena Dean, Acting Chief Operating Officer	ACOO
Stuart Irvine, Director of Strategy, Assurance & Compliance (Item 9 only)	DoSA&C
Elaine Jeffers, Deputy Director of Governance and Corporate Affairs	DDoG&CA

In Attendance:

Heidi Holliday, Secretary to the Trust Board [note taker]
Gary Wright, Deputy Chief People Officer
Dr Narayanan Suresh, Deputy Medical Director
Christopher Akers-Belcher (Item 3 only)
Dr Elaine Gouk, Deputy Medical Director (Item 12 only)
Stephanie Worn, Associate Director of Midwifery (Item 12 only)
Tony Horrocks, Elected Governor for Stockton
Lynda White, Elected Governor for Stockton

Via video link

Ruth Dalton, Associate Director of Communications Engagement & Marketing
Angela Warnes, Out of Area Elected Governor / Lead Governor
Alan Smith, Elected Governor for Hartlepool

BoD/5116 Apologies for Absence / Welcome

The Joint Chair welcomed members and members of the public to the meeting.

Apologies for absence were noted from Susy Cook, Chief People Officer, Professor Liz Barnes, Non-Executive Director, James Bromiley, Non-Executive Director.

BoD/5117 Declaration of Interests

Declarations of interest were noted from the ADoF for her role as a member of the LLP Management Board and the DoSA&C for his role as Chair of Hartlepool College of Further Education.

BoD/5118 Patient Story

The CN/DoPS&Q welcomed Christopher Akers-Belcher to the meeting who attended to share his story as a patient and how the services provided from community rehabilitation enabled him to move forward with his life.

Christopher Akers-Belcher explained that on 29 January 2023 he had started to experience severe

* voting member

chest pains and was advised that an ambulance could take one to two hours to arrive however, one arrived within 20 minutes and he was brought to the Trust for treatment. Christopher highlighted that whilst he was a patient in the Trust all the staff were lovely and caring and that the paramedics that brought him in returned the next day to check on him. Nevertheless, he found it very difficult to be in hospital, especially with regards to the waiting and was in a complete emotional state. Christopher needed to be transferred to James Cook University Hospital (JCUH) for an angiogram however, there were a number of delays in transferring him there. Once he arrived at JCUH he had an angiogram, was seen and discharged within six hours.

Christopher shared that he felt lost and that previously he had a very active lifestyle and routine. He then received a phone call from a Cardio Nurse in the Community who arranged for a home visit where she convinced him to work with her and the team and assured him that they would help get him back to where he was before. At first he felt very apprehensive as in 2001 he had developed Reiter's syndrome and arthritis and the trauma from this event had caused it all to return, which he had to receive treatment for. He spoke of the Rheumatology Helpline, which was a great service. Once he had an injection his symptoms relieved and he began cardio rehabilitation. Within the first couple of sessions he moved from Level 1 to Level 3 and within the third week he had a new trainer who did cross fit with him. The trainer went above and beyond to explain everything to him and to explore his previous routines. The peer support from those who had experienced similar health issues was great and he felt supported throughout his rehabilitation.

Following his really positive experience he went to the Communications and Engagement Team and spoke to them to do an article, a copy of which had been shared with members. He felt that the public perception was that the Trust looked after acute care only and didn't understand that 90% of services provided were community based.

Christopher had suggested an area of improvement which was for the development of a toolkit, which included National Institute of Clinical Excellence (NICE) guidelines around cardio recovery as not all options were the best for each individual. One other recommendation made was around emotional support for people going through health issues, as the closest class available for Christopher was in Redcar.

The Board of Directors thanked Christopher for sharing his story and were very pleased to hear that he was back to his fitness level prior to his health issues.

It was reported that the psychological support issues were already being looked in to and the value of information from someone with lived experience was fundamentally important to making improvements.

Resolved: that, the patient story be noted.

BoD/5119 Minutes of the meeting held on, Thursday, 25 May 2023

Resolved: that, the minutes of the meeting held on, Thursday, 25 May 2023 be confirmed as an accurate record.

BoD/5120 Matters Arising and Action Log

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

a. BoD/5047 Report of the Managing Director

Following a detailed interview process, focus groups and presentations a successful appointment had been made to the Chief Information and Technology Officer post and final aspects of the recruitment stage were ongoing. The successful candidate was required to serve a three month notice period at their current post however, discussions were taking place to confirm if this could be reduced. It was agreed that Neil Dobinson, Deputy Chief Information and Technology Officer would deputise until the candidate was in post.

b. BoD/5093 Utilisation of the University of Hartlepool Elective Hub

Following the recent visit to the University of Hartlepool Elective Hub, a report had been received and a decision had been made to defer accreditation however, the team were very impressed with the Elective Hub. A further visit was to be scheduled for some time in November 2023. Further work was to be undertaken around the utilisation of the Elective Hub. Posts were being recruited to across the Boards to increase the work that was ongoing. It was hoped that accreditation would be received following the visit in November. The MD was working very closely with Integrated Care Board (ICB) colleagues with regards to the next visit. Further work also needed to be undertaken regarding funding flows and shared consultancy costs.

Resolved: that, the verbal update be noted.

BoD/5121 Report of the Joint Chair

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

- The Joint Chair thanked staff for their continued support during the ongoing industrial action. It was noted that further action was planned during August 2023.
- A successful Volunteer Event was held on Wednesday, 7 June 2023 to celebrate the significant amount of work that the volunteers undertook on behalf of the Trust. This was the first event that had been held since the pandemic. The Board of Directors placed on record their thanks to all volunteers for their hard work and dedication. Following feedback obtained during the event improvements were being made, one of which was regarding wheelchair access.
- The Trust also held its first Trust Member Event since the pandemic, which was well received by those members in attendance. The Trust hoped to gain greater attendance at future meetings and to gain greater support in building up the membership of the Trust as a whole. This was being discussed further at Membership Committee meetings and the Communications and Marketing Team had developed a comprehensive marketing and engagement plan in order to reach new audiences to increase member numbers and potential Governors.
- The Joint Chair reported on a number of meetings and events he had attended which included an engagement event with the National Horizon Centre (NHC) of Teesside University held on Friday, 9 June, an NHS Confederation Expo Conference held on Thursday, 15 June and an North East and North Cumbria (NENC) Integrated Care Board (ICB) Chair's Forum held on Tuesday, 20 June 2023. Discussions focussed around collaboration, how to work at system and Place, how these could be brought together and how to improve working in the ICB.
- The Joint Chair reported that following interview, focus groups and stakeholder involvement James Bromiley had been appointed to the Associate Director of Group Development post, which was a joint appointment with South Tees Hospitals NHS Foundation Trust (STHFT). It was felt that James had the knowledge and experience to move the partnership agreement forward and was due to commence in post on 1 August 2023. The Joint Chair thanked James for his contributions in his role of Non-Executive Director to date.
- The Joint Chair reported on the Care Quality Commission (CQC) National Emergency Patient Survey 2022 reports, one regarding A&E Departments and the other regarding Urgent Treatment Centres. Members were encouraged to read the reports which were available using the following links:
  https://nhssurveys.org/wp-content/surveys/03-urgent-emergency-care/05-benchmarks-reports/2022/RVW_North%20Tees%20and%20Hartlepool%20NHS%20Foundation%20Trust_Type%201.pdf
  https://nhssurveys.org/wp-content/surveys/03-urgent-emergency-care/05-benchmarks-reports/2022/RVW_North%20Tees%20and%20Hartlepool%20NHS%20Foundation%20Trust_Type%203.pdf
- The Joint Chair and Vice Chair continued to have regular meetings with the Chief Executives from the Local Authorities regarding ongoing engagement.
- The Joint Chair congratulated Mark White, Elected Governor for Stockton following his CBE Award in the recent King's first birthday honours list.

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

BoD/5122 Joint Partnership Board Update

The Vice Chair presented the Joint Partnership Board (JPB) Update Report and highlighted the key issues.

- Since the last Board meeting there had been two meetings of the JPB where discussions took place regarding progress made to date to shape the future direction of travel. Key areas for discussion were around the Clinical Strategy, Partnership Agreement, Operating Model and the Engagement and Communication Plan.
- A further Clinical Strategy engagement session with clinical colleagues was planned for early October to continue to drive this forward.
- An Engagement and Communication Plan had been developed and shared with JPB and the detailed plan set out the requirements for both organisations, how the Group intended to operate and detailed the key stakeholders and external partners with whom the Trusts needed to engage with. Some of the engagement activities were underway, ensuring that opportunities to speak to staff across all sites were maximised and provided an opportunity for questions to be raised.
- Further meetings of the JPB were scheduled for August and September, with September being a key meeting to bring all aspects together and to finalise the partnership agreement.

Following a query raised, confirmation was provided that information would be shared with members of the public when appropriate and was part of the overall Engagement and Communication Plan.

Feedback received from the clinicians meetings was that there had been very positive levels of engagement, there had been open discussions and that the organisations were speaking as one. The engagement and communication plan was planned throughout the summer holidays which may cause some difficulties however, big steps forward were being made for both organisations.

The Joint Chair reported that the transfer of patients between the Trusts was being reviewed.

The Vice Chair reported that Hunters had been commissioned to lead the process of the appointment of a single Chief Executive on behalf of the Trust and STHFT. A brief overview of the recruitment process was given.

The DCPO provided assurance that work was ongoing on the people agenda and collaborative working to smooth the transition to joint working.

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

BoD/5123 Report of the Managing Director

The MD presented the Report of the Managing Director and highlighted key points.

- Within the Trust, operational pressures remained similar to previous reports.
- Trust bed occupancy continued to be below 92% at an average of 89.66% for June 2023. The Trust continued to work collaboratively with partners in Local Authorities to ensure discharges were effective and timely and Healthwatch had shared a helpful report regarding discharges.
- Following the reintroduction of the four hour emergency department standard, which required all Trusts to see 76% of patients within four hours by March 2024, the Trust was achieving 82.87% in June 2023. This has resulted in a change of focus for the Trust from clinical review standards of patients to the national four hour standard. A specific focus was being given to stage one patients and an improvement plan had been put in place. Work was ongoing with ICB colleagues with positive conversations taking place around key areas of focus and key highlights.
- There were 53 patients in June 2023 who had been waiting in excess of 12 hours. It was noted

that this was a very much reducing trend and was far lower than previous months.

- Ambulance hand over delays remained in a positive position, having achieved 98.86% of patients being handed over in less than 59 minutes in June 2023.
- The Trust continued to focus on reducing RTT trajectories and the 52-week wait position. The continued impact of industrial action had affected levels of activity, with significant levels of planned activity stood down to support maintaining safe services for patients.
- There continued to be no patients waiting longer than 104 or 78 weeks and the Trust continued to report the lowest number of both 52 and 40-week waiters across the North East and Yorkshire region.
- The MD also thanked staff for their continued support during the ongoing industrial action.
- The Leadership Strategic Plan was now in place and the Foundation Programme *'It all starts with me'* had seen an increase in the numbers attending the training with over 350 staff successfully completing the course.
- Research and Development continued to go from strength to strength and the clinical research trails remained high with 1218 patients recruited into research studies, compared to the 573 recruited at the same point in 2022.
- Confirmation had now been received from Synexus that their Board were in agreement with the surrender value of 12 months' rent and as a result, the Trust were content to progress with their release from the lease agreement.
- Chief Executives from across the North East and North Cumbria continued to meet with the ICB Executive Team to support the ongoing development of the system governance and an increased focus on operational resilience, discharge planning, system working, performance, industrial action and financial planning.
- Representatives from the ICB joined the Provider Collaborative meeting on Friday, 7 July 2023 to provide an outline of the ICB Joint Forward Plan (JFP) and highlighted the links to the wider Integrated Care Strategy. The JFP was built up from place and workstream plans over a five-year period. Members of the collaborative were requested to take the JFP back into their Foundation Trusts, as appropriate, and provide feedback such that it could be finalised in September 2023.
- Work continued regarding estates developments. The Trust had been unsuccessful with the application for the Government's New Hospital programme, however had been given approval to progress to an Outline Business Case (OBC). The OBC was being developed with support from the Trusts Advisor Project Team and would be targeted at specific funding requirements to ensure it was more manageable. The Trust was investing in primary care infrastructure at the University Hospital of Hartlepool and nine months of the year would be carbon neutral. Some of the savings were to be reinvested into patient care.
- Work continued at great pace with the development of the Community Diagnostic Centre (CDC), which would focus around early diagnosis and improvement outcomes. A robust procurement process had been undertaken and a contractor had been identified. Engagement with clinical teams was taking place to agree the right model moving forward. A planning application was submitted in collaboration with STHFT and an outcome was expected mid-late August. A key area of focus was also around the operating model.
- Work was underway in preparation for the 2023 staff survey. Long service awards had commenced, which was linked to Reward and Recognition, with those members of staff with over 40 years' service being recognised. Feedback to date had been positive. The appraisal process and documentation had been reviewed and updated in collaboration with staff feedback. The updated version now included Scope for Growth, which would allow development conversations to take place with staff, ensuring the retention of talent and provision of support for people's development aspirations.
- Plans continued to develop a Health and Social Care Academy in partnership with Hartlepool College of Further Education and Hartlepool Borough Council. Significant improvements and progress had been made and in addition to the funding already allocated, a submission had been made to the Local Skills Improvement Fund (LSIF) to support with costs associated with additional equipment.
- The CQC had lifted the restrictions against the Butterwick Hospice, therefore two beds were to be opened for known patients on the end of life pathway. The Trust was working closely with the hospice with a potential date for re-opening scheduled for Monday, 14 August 2023. Further

meetings had been planned with the hospice and the ICB on what the provision would look like moving forward.
- NHS England had published the NHS Winter Plan 2023/24 that day and two Trusts that had been cited as good performers were Chelsea and Westminster NHS Foundation Trust and North Tees and Hartlepool NHS Foundation Trust.

Following a member's query regarding the OBC it was noted that work was ongoing with STHFT to develop this and that the first draft would be developed by the turn of the calendar year, along with a working plan.

The CMO/DCE reported on the major stress the organisation and staff were facing relating to the industrial action, which was also having a huge impact on patients. It was felt that this may impact upon staffing in the future. The ACOO reported that cancellations were carried out on a clinical priority basis, with cancer patients being prioritised. It was highlighted that the cancellation of routine elective work would cause an impact on elective performance.

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

BoD/5124 Board Assurance Framework Report Quarter 1: 2023/24

The DoSA&C presented the Board Assurance Framework (BAF) Report for Quarter 1, 2023/24 and highlighted the key issues.

The BAF and broader governance processes were under an independent governance review, following the findings of the Care Quality Commission (CQC) report in September 2022. An internal audit of the Trust's BAF was undertaken as part of the internal audit plan for 2022/23 and this provided the Trust with Good Assurance, which meant governance, risk management and control arrangements provided a good level of assurance that the risks identified were managed effectively. A high level of compliance with the control framework was found to be taking place and minor remedial action was required.

The Trust's Business Team continued to meet on a weekly basis to review all newly proposed risks, providing scrutiny and oversight, supporting challenge and the development of risks, the controls and assurances, prior to approving the risk.

AuditOne attended a meeting of the Risk Management Group and feedback was awaited.

The BAF had 12 risk domains associated with delivery of the four strategic objectives. There were currently two principal risks identified with a current high risk rating.

Risk 6188 – Delivery of Savings:
Controls were in place to mitigate this risk including CIP workshops and support to Care Groups from the PMIO team to identify the delivery of schemes and to deliver the cost improvement plan.

Risk 6581 – Trust Aging Estate:
The Trust was unsuccessful following the application to the Government's New Hospital programme and an Outline Business Case (OBC) was being developed in 2023/24.

Following recent bad weather there had been a water leak which identified that there was reinforced autoclaved aerated concrete (RAAC) in two of the residences at the North Tees site and correction work was being undertaken as part of the backlog maintenance.

Assurance was provided that the Finance Committee had reviewed the BAF at its recent meeting and provided necessary challenge. External pressures related to non-recurrent savings and work was ongoing to address that balance and a review of schemes within the Trust and with other organisations, which would not be done in isolation. The Trust's Cost Improvement Plan (CIP) was very challenging and the Board were assured that quality impact assessments were in place and savings were being made where possible.

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

BoD/5125 Integrated Performance Report

The DoP&P presented the Integrated Performance Report (IPR) for 2023/24 and highlighted the key points.

Safe:

- Zero never events.
- Zero falls resulting in severe harm.
- Four cases of Clostridium Difficile and one case of MRSA had been reported in June.
- Monthly recruitment drives continued to fill nurse vacancies and levels were reducing. The recruitment team were also working closely with students that were due to leave their training.

Effective:

- The Trust continued to perform well against SHMI, reporting below the national mean of 100.
- The Trust Length of Stay for both elective and emergency pathways were meeting the standard, which helped support the Trust in meeting its bed occupancy target.

Caring:

- All six Friends and Family Test (FFT) metrics were exceeding the 75% standard, reporting at 92%.

Responsive:

- The Trust continued to meet the national four hour emergency department standard of 76%, reporting at 82.87% for June 2023. A significant focus for the Emergency Department was the improvement of Type 1 pathways and an improvement plan had been developed to help support the increased compliance for Type 1.
- Ambulance handovers remained in a positive position with 98.86% of handovers occurring in under 59 minutes.
- Cancer continued to be an area of focus and concern. The impact on capacity due to the extra Bank Holiday in May and patient choice was being managed.
- Work was ongoing to improve the Cancer 62 day target, ensuring that patients were seen in a timely manner. Significant improvements had been made in terms of turnaround times.
- The number of patients waiting longer than 52 weeks at the end of June was 51, of which one was waiting of 65 weeks.

Well Led (People & Finance):

- The Trust's overall sickness had decreased in April, with short term sickness increasing slightly and long term sickness reducing.
- Staff Turnover had seen a slight decrease from the previous month and remained below the Trust 10% threshold.
- At Month 3, the Trust was reporting an in-month surplus of £0.714m against a planned surplus of £0.955m, which was £0.241m behind plan.

Maternity:

- Smoking at booking was reporting at 16.93%, which was above the North East and North Cumbria (NENC) average of 11%, and was an area of focus.

The Vice Chair provided assurance that the People Committee reviewed in great detail sickness absence, which was making progress and mandatory training and work was being undertaken to embed this further into appraisals. It was noted that the Quality Committee also reviewed this report in detail and focused on the quality aspects.

Following a member's query regarding Clostridium Difficile statistics it was confirmed that the Trust was above its trajectory in month and was a positive outlier from a regional perspective.

CM provided assurance regarding the red risk associated with agency spend, which was due the fact that this had increased from previous years however, the Trust had started at a very low point and the Trust had a clear justification for the increase. Notwithstanding, a fortnightly meeting was taking place to look to minimising that.

It was agreed that it was very positive that the maternity section was now embedded within the IPR report.

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

BoD/5126 Nursing and Midwifery Bi-Annual Workforce Review

The CN/DoPS&Q presented the Nursing and Midwifery Bi-Annual Workforce Review report and highlighted the key issues.

Both the monthly and the bi-annual workforce reviews focussed on the clinical, quality, safety and financial importance of developing a workforce fit for purpose. It was vital to understand the nature of workforce pressures and actions taken to address this, both in the long and short term.

Section 12 presented the conclusion to the report with key points to note highlighted within the report. All of the efforts being undertaken provided assurance that there were workforce safeguards in place, that the right staff, with the right skills were in the right place at the right time, whilst being financially sustainable.

Maternity workforce was reviewed staffing as per Ockenden recommendation and undertook a workforce review by BirthRate+. The Trust agreed to the funded establishment which is compliant with the BirthRate+ assessment and agreed a 23% headroom which is an uplift of 2% based on additional training requirements in maternity following receipt of the BirthRate + assessment report.

The Professional Workforce Strategy was developed to address the strategic objectives posed by gaps across the professional workforce and the strategy underpinned the Trust's approach to Quality and Service Improvement with an aligned plan to all Trust wide workforce initiatives.

The Board of Directors noted the recommendations and assurances that were in place and that the Trust had complied with national standards. The Board also noted the substantial investment required to ensure the Trust was fit for purpose from a workforce perspective. Further international recruitment had been planned and work was on track for the intake of 38 wte's from universities in September 2023.

Following a members query it was confirmed that the Trust was confident that there was a robust audit trail.

The DCPO reported on the significant amount of work that was underway within the People Directorate to increased workforce planning, not just filling vacancies but future planning and significant strides had been taken forward.

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

BoD/5127 Maternity Board Report Quarter 1, 2023/24

Elaine Gouk, Deputy Medical Director and Stephanie Worn, Associate Director of Midwifery presented the Maternity Board Report Quarter 1, 2023/24 and highlighted the key issues.

The report provided an update with regards to the Quarter 1 position within maternity services including the following:

- Perinatal Mortality Review Tool (PMRT)
- Serious incidents and Healthcare Safety Investigation Branch (HSIB)
- Maternity Dashboard Quarterly Reports

- Workforce
- Training
- Service user insights
- Maternity Incentive Scheme Year 5

The PMRT is an embedded process meeting the required time frameworks and standards. A rapid response to learning is undertaken to identify any potential immediate actions for learning until the PMRT review process is complete. Learning points are shared via mandatory training, staff meetings and communication briefs. This process is reflective of HSIB requirements.

The maternity service provides transitional care with approved pathways. There is on-going work to enhance this service to minimise separation of mothers and babies. Regular reviews between midwifery and neonatal staff occur monthly to identify modifiable factors with an action plan, shared with both obstetric and neonatal staff.

Clinical workforce planning continues which includes obstetric, anaesthetics and neonatal staffing. Midwifery workforce planning is underpinned by the agreed BirthRate + assessment report which the funded establishment with a 23% headroom was agreed by the Board. The registered midwifery vacancy rate poses a significant challenge though the mitigations to address the shortfall were discussed. Maintaining labour ward coordinator supernumerary and the provision of 1-1 care in labour is a key focus. It was acknowledged red flags had been raised and the maternity team will undertake data validation and triangulation for further discussion and clarity with the senior leads and the maternity improvement advisor. Midwifery recruitment is an on-going campaign and the team midwifery team have demonstrated successful recruitment, it was noted there have been registered midwives returning to NTHFT which is to be recognised. The midwifery preceptorship programme has been revised to align to the national preceptorship framework and will be reviewed regularly.

In May 2023 the core competency framework v2 was published and a revised document was published in July 2023. The ultimate objective is to ensure maternity services provide safe care with a consistent approach. Training is planned monthly with the exception of August. Obstetric emergency MDT training is a part of mandated though the maternity incentive scheme guidance is not explicit in terms of minimal attendance per staff group for the MDT. The maternity team are collaborating with all MDT staff groups to plan training sessions to optimise an MDT approach.

The Maternity and Neonatal Voice partnership are an essential element to drive improvements for local services. A focus is to ensure communications are enhanced across the service. There is local work to drive an inclusive partnership which aligns to the LMNS plans for equality and equity.

During the last year, the main themes reported to the Professional Midwifery Advocate (PMA) were:

- Staff culture and morale
- Equitable Professional development

In November 2022, Aqua were invited as an external agency by the Trust to carry out a discovery and diagnostic piece of work which focussed on the culture within maternity services and positive steps forward were being made. The report provided a thematic review which acknowledged 5 themes and subsequently five working groups were established led by staff, regular meetings will monitor progress.

Elaine Gouk and Stephanie Worn requested feedback on the narrative report provided this time and what would be helpful for the Board to understand maternity services.

The Board of Directors felt that it was a very good precis of information, which was more streamlined and easy to understand and ensured they were sufficiently aware of the key areas or issues. It was noted that work was ongoing to triangulate information through maternity walkabouts to various parts of the service, with a recent visit taking place on the post-delivery suite. It was also noted, that as part of the recruitment and retention work, the Trust was now seeing staff leavers returning to the Trust. Feedback from those members of staff had been very positive and that it felt like a very different service now, which was accredited to the leadership team. AB agreed to forward future maternity visit

dates with AF. Discussions were also taking place with STHFT regarding walkabouts across the trusts. Colleagues from STHFT were due to attend the Trust on Friday, 11 August 2023 to undertake a peer review on both sites.

It was felt that the discussions held would help towards the Board Seminar scheduled for that afternoon.

Resolved: (i) that, the content of the report be noted; and
(ii) that, AB forward future maternity walkabout dates with AF.

BoD/5128 Director of Infection, Prevention and Control Annual Report 2022/23

The CN/DoPS&Q presented the Director of Infection, Prevention and Control Annual Report 2022/23 and highlighted the key issues.

The report outlined work that had been undertaken over previous year and following the pandemic. Elements of the report had been discussed in other agenda items above.

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

BoD/5129 Equality, Diversity & Inclusion Annual Report 2022/23

The DCPO presented the Equality, Diversity and Inclusion (EDI) Annual Report 2022/23 and highlighted the key issues.

The Trust was committed to ensuring equality, diversity and inclusion was embedded across the organisation. Over the past twelve months the Trust continued to strengthen the EDI agenda and the report highlighted the work that had been undertaken over the last twelve months. The Trust's EDI Report was to be published on the Trust website. In addition to this, the annual report would also play a part in the Trust meeting the specific duties included within the Public Sector Equality Duty. It was noted that some staff may face some social challenges and the Trust was looking to support them.

The Board of Directors thanked staff for the developments made to date.

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

BoD/5130 Report of Quality Assurance Committee

FS presented the Report of the Quality Assurance Committee and highlighted the key issues.

There was now a designated representative from the population that we serve as a core member of the Committee, who would provide necessary check and challenge. No new risks had been identified at the last meeting, with the risk rating remaining as minimal.

There were six key issues to note, with issues four to six already being discussed at length. This demonstrated that everything that was discussed was integrated across the organisation. An update was provided with regards to issues one to three.

With regards to new standards a Project Group was being established to work through the objectives.

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

BoD/5131 Report of People Committee

AB presented the Report of the People Committee and highlighted the key issues.

The report provided a summary and links to risk that were discussed in each meeting and how they link in with the overall BAF. There were no new risks identified at the last meeting. The last meeting focussed on mental health and recognised the pressures many staff face and further help that could

be offered would be and would be linked to the development of health and wellbeing. The Trust was also looking to expand apprenticeship programmes to help deal with workforce gaps.

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

BoD/5132 Report of Performance, Planning and Compliance Committee

AB presented the Report of the Performance, Planning and Compliance Committee and highlighted the key issues.

Standing items were discussed in depth which included, discussions regarding workforce, sickness and how the Trust could ensure staff remained healthy and happy at work.

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

BoD/5133 Report of Audit Committee

CM presented the Report of the Audit Committee and highlighted the key issues.

The Committee review governance arrangements to ensure they are what is required and that they work effectively. The documents that were recommended from Internal Audit and External Audit were reviewed to identify any particular improvements that could be made, ensuring they were implemented in a timely manner.

On behalf of the Board of Directors, the Audit Committee at its meeting held on Wednesday, 10 May 2023 approved the Draft Internal Audit Plan 2023/24 and the Internal Audit Charter 2023/24 and approved the Draft Counter Fraud Plan 2023/24. The Committee also signed off the Draft Annual Report and Accounts 2022/23, which would be taken to a future Council of Governors and AGM meeting once they had been laid before parliament, which was expected early September 2023.

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

BoD/5134 Report of Finance Committee

CM presented the Report of the Finance Committee and highlighted the key issues.

The meeting held on Monday, 24 April 2023 focussed on ensuring the Trust achieved a satisfactory year end position, which was closely being monitored. The meeting held on Tuesday, 23 May 2023 focussed on the new financial year, recommended approval of the budgets for the coming year and thereafter. It was noted that Non-Executive Directors were kept abreast of the financial position across the ICB.

The Board of Directors acknowledged the significant amount of work that had been undertaken by the financial team in achieving the year end position.

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

BoD/5135 Risk Management Group Report

The MD presented the Risk Management Group Report and highlighted the key issues.

The Risk Management Group was a Group and not a Committee as it was Executive Director led. The last meeting was observed by Stuart Fallowfield, Director of Assurance Services/Deputy Managing Director, AuditOne where a wide range of issues were discussed which included the Risk Management Policy and Risk Management Strategy and feedback was awaited. The Group also looked at operational risks and if they were significant enough to cause a risk to the strategic direction of the organisation. There were no matters that required escalation.

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

BoD/5136 Any Other Business

There was no other business to discuss.

BoD/5137 Date and Time of Next Meeting

Resolved: that, the next meeting be held on, Thursday, 28 September 2023 in the Boardroom at the University Hospital of North Tees.

The meeting closed at 12.45pm.

Signed:  Date: 5 October 2023

BoD Public

Date	Ref.	Item Description	Owner	Deadline	Completed	Notes
23 March 2023	BoD/5009	***BAF Quarter 4 Report: 2023/24*** Board Seminar meeting to focus on the Ageing Estate Risk	NA	28 September 2023		Following the Board Seminar on 16 March, a detailed update would be provided in 6 months. An update was provided in relation to the Trust's estates risk at the Public Board at 27 July 2023.
27 April 2023	BoD/5047	***Report of the Managing Director*** Update to be provided at the next meeting on the replacement of the Interim Chief Information and Technology Officer. Board Development Session to be held at a later date regarding the Health and Care Academy and the wider picture.	NA SC/EJ		Completed	Following a detailed interview process, focus groups and presentations a successful appointment had been made. Final aspects of the recruitment stage were ongoing. The successful candidate was required to serve a 3 month notice period at their current post however discussions were ongoing to confirm if this could be reduced. It was agreed that Neil Dobinson would deputise until the candidate was in post. A review of board meetings, development sessions and board seminars was being undertaken to agree an annual plan.
27 April 2023	BoD/5048	***Board Assurance Framework Report Quarter 4: 2022/23*** An update on the new hospital programme and alternative solutions be provided as and when necessary.	NA	26 October 2023		This would form part of the detailed update at a Board Seminar in six months time.
27 April 2023	BoD/5053	***Data Protection and Cyber Assurance Interim Position Report 2022/23*** Full report to be brought to a future meeting.	GC	23 November 2023		
27 April 2023	BoD/5056	***Learning from Deaths Report, Quarter 4 2022/23*** Further information to be provided in the next report regarding compulsory case reviews and training.	DD	27 July 2023		Work was ongoing with regards to review meetings with Mortality Leads to agree a plan. Further update to be provided in the next report.
25 May 2023	BoD/5088	***Report of the Managing Director*** An update on the NE&NC Provider Collaborative Clinical Summit be included in the next report. Further updates and plans regarding the CDC to be brought to a future meeting.	NA NA	27 July 2023		
25 May 2023	BoD/5089	***Board Assurance Framework Report Month 1: 2023/24*** A full update of the BAF review to be provided at the next meeting.	SI	27 July 2023	Completed	A Board Seminar took place after the Board meeting on 27 July setting out the review of risk management
25 May 2023	BoD/5090	***Integarated Performance Report*** Timescales around cancer performance be included in the next report. Updated information regarding staff turnover be included in future reports.	L Hunter L Hunter	27 July 2023 27 July 2023		
25 May 2023	BoD/5092	***NHS Workforce Disability Equality Standard (WDES) 2023*** Work be undertaken to identify barriers staff may experience when updating their disability status and what support could be put in place.	S Cook			Work continued to review the ESR system and the issues raised regarding barriers staff were experiencing.
25 May 2023	BoD/5093	***Utilisation of the University of Hartlepool Elective Hub*** The ACOO to identify areas of support that could be provided for the planned visit on Friday, 23 June 2023.	R Dean	23 June 2023		Following the recent visit the report had been received and a decision had been made to defer accreditation and that another visit would take place in November 2023. However, the team were very impressed with the Elective Hub. Further work was to be undertaken around the utilisation of the Elective Hub. Posts were being recruited to across the Boards to increase the work that was ongoing. It was hoped that accreditation would be received following the visit in November. The MD was working very closely with Integrated Care Board (ICB) colleagues with regards to the further visit. Further work also needed to be undertaken regarding funding flows and shared consultancy costs.
25 May 2023	BoD/5096	***Freedom to Speak Up Annual Report*** A copy of the report to be shared with the Governors.	L Robertson			The Annual Report was still yet to been shared.

Board of Directors

Title of report:	Joint Chair's Report										
Date:	5 October 2023										
Prepared by:	Sarah Hutt, Assistant Company Secretary										
Sponsor:	Professor Derek Bell, Joint Chair										
Purpose of the report	The purpose of the report is to update the Board of Directors on key local, regional and national issues.										
Action required:	Approve			Assurance			Discuss			Information	x
Strategic Objectives supported by this paper:	Putting our Population First	x		Valuing People	x		Transforming our Services	x		Health and Wellbeing	x
Which CQC Standards apply to this report	Safe	x		Caring	x		Effective	x		Responsive	x		Well Led	x

Executive Summary and the key issues for consideration/ decision:
The report provides an overview of the health and wider contextual related news and issues that feature at a national, regional and local level: : • Group and Joint Working • Collaborative Working with Teesside University • NHS Confederation Chairs Event • Quality and Safety Event • Industrial Action
Board Assurance Framework/Corporate Risk Register risks this paper relates to:
There are no risk implications associated with this report.
Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*

Equality, diversity and or inclusion		Reputational	x
Workforce		Environmental	
Financial/value for money		Estates and Facilities	
Commercial		Compliance/Regulatory	
Quality, safety, experience and effectiveness		Service user, care and stakeholder involvement	x

Board Subcommittee meetings where this item has been considered (specify date)	Management Group meetings where this item has been considered (specify date)
N/A	N/A

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

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

5 October 2023

Report of the Joint Chair

1. Introduction

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

2. Key Issues and Planned Actions

2.1 Group and Joint Working

We had a really positive meeting with both Council of Governors on 19 September and updated them on key topics and progress with joint working.

The Joint Partnership Board met on 20 September and development of the Group model continues to gather momentum. The draft Partnership Agreement was shared at the meeting led by James Bromiley, Associate Director of Group Development and was agreed in principle. It will now be shared with stakeholders prior to the document being finalised. The development of the clinical strategy is progressing with a workshop for clinical colleagues taking place on 9 October 2023.

The appointment process for the Group Single Chief Executive is well underway, with a number of candidates shortlisted. The formal interviews will take place on 13 October 2023 and a wider stakeholder event will be held on 12 October.

2.2 Collaborative Working with Teesside University

Along with the Managing Director and Chief People Officer from North Tees and the Managing Director, Chief Medical Officer and Chief Nurse from South Tees, I have met with Teesside University to explore working together more closely and development of the future workforce. A number of visits to the University have also been undertaken and we are excited about the work and progress to date.

2.3 NHS Confederation Chairs Meeting

I attended an NHS Confederation briefing event for Chairs in August regarding the Major Conditions Strategy, which was a national framework focusing on six major groups of conditions: cancers; cardiovascular disease including stroke and diabetes; chronic respiratory diseases, dementia, mental ill health and MSK disorders. The aim of the strategy is to ensure whole care pathway from prevention to treatment including the role of innovation to improve outcomes and take forward Levelling Up, the health mission to narrow the gap in health life expectancy by 2030.

2.4 Quality and Safety

A national event was held on 6 September with wide attendance from board members of provider organisations in order to discuss current monitoring arrangements such as Freedom to Speak Up, Fit and Proper Person and highlight any gaps to be addressed, in light of the recent Lucy Letby case ensuring quality and safety remain a top priority.

2.5 Industrial Action

There have been further periods of industrial action with both Consultants and Doctors in Training taking part. Once I again I would like to thank all staff who provide support.

3. Recommendation

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

Professor Derek Bell
Joint Chair

Board of Directors

Title of report:	Joint Partnership Board Update										
Date:	5 October 2023										
Prepared by:	Sarah Hutt, Assistant Company Secretary										
Sponsor:	Ann Baxter, Vice Chair										
Purpose of the report	The purpose of the report is to update the Board of Directors in respect of the work of the Joint Partnership Board.										
Action required:	Approve			Assurance			Discuss			Information	x
Strategic Objectives supported by this paper:	Putting our Population First	x		Valuing People	x		Transforming our Services	x		Health and Wellbeing	x
Which CQC Standards apply to this report	Safe	x		Caring	x		Effective	x		Responsive	x		Well Led	x

Executive Summary and the key issues for consideration/ decision:
The report provides an update regarding the work of the Joint Partnership Board. Key issues for Information: • Staff Story • Partnership Agreement • Communication and engagement of the group model • Finance Strategy • Performance reporting in the group
Board Assurance Framework/Corporate Risk Register risks this paper relates to:
There are no risk implications associated with this report.
Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*

Equality, diversity and or inclusion		Reputational	x
Workforce		Environmental	
Financial/value for money		Estates and Facilities	
Commercial		Compliance/Regulatory	
Quality, safety, experience and effectiveness		Service user, care and stakeholder involvement	x

Board Subcommittee meetings where this item has been considered (specify date)	Management Group meetings where this item has been considered (specify date)
N/A	N/A

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

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

5 October 2023

Joint Partnership Board Update

1. Introduction

This report provides information to the Board of Directors on the work of the Joint Partnership Board.

2. Key Issues and Planned Actions

2.1 Staff Story

The Board had an excellent and powerful staff story from Janice Atkinson, Neonatal Ward Manager about the changes to neonatal services involving the move of a clinical unit from North Tees to South Tees, which was a difficult and unsettling time for staff involved. Lessons were learnt about the benefit of effective communication and engagement and through excellent leadership, such service changes are possible for improved patient outcomes.

2.2 Partnership Agreement

It was agreed that subject to changes suggested in the meeting the draft Partnership Agreement could be circulated and discussed with internal and external stakeholders. The final draft would be presented at the Joint Partnership Board in November for approval as well as both unitary boards.

2.3 Communication and Engagement

The Communications and Engagement Strategy to support the Partnership Agreement was shared.

2.4 Finance Strategy

The joint financial statement regarding the Group was ratified having been agreed virtually by members of the Joint Partnership Board. It sets out the Groups commitment to use the joint resources to improve the financial situation working in partnership and across the system. A small financial group would be formed to build upon this.

2.5 Performance Reporting

It was agreed that the Associate Director of Group Development would produce a proposal for Group performance reporting and present it to the next meeting in October

3. Recommendation

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

Ann Baxter
Vice Chair

Excellence as our standard

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Report of the Managing Director										
Date:	5th October 2023										
Prepared by:	Neil Atkinson, Managing Director										
Executive sponsor:	Neil Atkinson, Managing Director										
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	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 report provides an overview of the health and wider related news as well as, issues that feature at a national, regional and local level.

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

Key issues for this month include:

- Operational Challenges (incl. elective recovery and industrial action);
- Culture and Leadership Development;
- Research and Development;
- Integrated Care System and Integrated Care Board;
- North East and North Cumbria Provider Collaborative;
- Tees Valley Provider Collaborative;
- North Tees and Hartlepool NHS Foundation Trust Estates Strategy (incl. RAAC);
- Community Diagnostic Centre;
- Faculty of Learning, Leadership and Improvement;
- Workforce Development, and;
- Consideration of the wider national and regional contribution.
-

Board Assurance Framework/Corporate Risk Register risks this paper relates to:

This report takes account of all Strategic Risks identified within the Board Assurance Framework

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity, inclusion		Reputational	
Workforce		Environmental	
Financial/value for money		Estates and Facilities	x
Commercial		Compliance/Regulatory	x
Quality, safety, experience and effectiveness	x	Service user, care and stakeholder involvement	x
Board Subcommittee meetings where this item has been considered (specify date)		Management Group meetings where this item has been considered (specify date)	
N/A		N/A	
Recommendation	The Board of Directors is asked to note the content of this report including, the pursuance of strategic objectives, work to improve system working and operational resilience.		

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

5th October 2023

Report of the Managing Director

1. Introduction

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

2. Strategic Objective: Putting our Population First

2.1 Operational Challenges

2.1.1 Bed Occupancy

Trust bed occupancy saw a slight increase in August 2023 with an average occupancy of 92.28% against a threshold of 92%.

Wards 41 and 42 have undergone planned estate maintenance and as a consequence, patients were decanted to Ward 37. The planned estate maintenance is now complete with all previously closed beds now re-opened.

There has also been Covid-19 outbreaks which has resulted in a number of beds being unavailable in accordance with infection control standards.

The number of super stranded patients (21+ days) has increased slightly this month. The Trust continues to work collaboratively with partners in Local Authorities to ensure discharges are undertaken promptly, where clinically appropriate.

The national discharge team visited the Trust in August to meet staff and gain insight into the Trusts successful use of OPTICA, the multi-agency Integrated Single Point of Access and 2-hour community response, which has resulted in the Trust achieving one of the lowest number of stranded patients in the country.

Finally, the Trust continues to actively manage patients across the pathways with the proactive management of patient flow and timely discharge, with patients supported by the Home First team.

2.1.2 Four Hour Emergency Department Standard

The NHSE Planning Guidance for 2023-24 required Trusts to ensure 76% of patients are seen within four hours by March 2024.

The Trust began reporting against the four-hour standard from May 2023 following the completion of the national field testing exercise and continues to exceed the overall national standard, achieving 85.20% in August.

As part of the Trusts focussed work following the re-launch of the 4-hour standard a '*More Before 4*' group with included representatives from all specialities have identified themes and actions to support continuous improvement with a view to reducing the overall time spent in the department.

From September, the Trust piloted an additional senior decision maker role overnight to initially focus on earlier review and the discharge process. This is to be monitored through our '*Four Hour Standard Steering Group'* led by senior clinicians. The Trust has set an internal target of 90% for combined four-hour compliance by the end of March 2024.

Ambulance hand over delays remain in a positive position, achieving 99.57% of patient handovers in less than 59 minutes for the month of August. The statistical process chart demonstrates seven consecutive months above the mean. In August, the mean handover time was 26 minutes. Regionally, the Trust has one of the lowest rates of patients waiting 60 – 120 minutes.

During the month of August, there were 89 patients waiting beyond 12-hours. Almost 80% of the long waits were due to patients waiting to be admitted for on-going management to our emergency assessment unit, surgical decision unit or a transfer to a mental health facility. This a reflection of a combination of a busy emergency department and a high bed occupancy within the Trust leading to increased numbers of patients waiting for a bed.

2.1.3 Elective Recovery

At the beginning of the financial year, Trusts were requested by NHS England to provide assurance that plans are in place to eliminate 65 week waits, reduce the 62-day backlog and meet the Faster Diagnosis Standard, by March 2024.

More recently further correspondence has been received requesting assurance that Trusts are able to deliver operational resilience with the possibility of ring-fencing elective and cancer capacity throughout the winter period.

The continued impact of industrial action has impacted on the levels of RTT activity, with significant levels of planned activity being stood down to support safe services for patients. The Trust has maintained its position of no patients waiting longer than 104 or 78 weeks. It was however, noted there were two patients waiting over 65 weeks at the end of August. Despite this, the Trust has maintained positive performance regionally against the trajectory.

Work is underway to address diagnostic waiting times with a number of improvements commenced to support the current position.

2.1.4 Protecting and Expanding Elective Capacity

In August, further correspondence from NHS England, highlighted the need for focused attention on outpatients to drive recovery at pace. This required Board level assurance and following review the report recommended the Trust submit a return that was fully compliant.

2.1.5 Industrial Action

The Trust continues to plan and respond to ongoing doctor in training and consultant industrial action to ensure the Trust keeps patient safe and minimise the impact on daily activity during this period.

All staff groups (nursing teams, consultants, community services, pharmacy, allied health professionals and administration staff) have worked flexibly to provide cover. However, the cumulative impact on strike action since December 2022 has started to impact on the Trusts planned programmes of care including a growth in both admitted and non-admitted waiting lists and number of patients waiting over 52 weeks.

The teams are reviewing plans and replacing lost capacity where possible. Waiting lists continue to be validated in line with the NHSE guidance on protecting elective capacity.

3. Strategic Objective: Health and Wellbeing

3.1 Culture and Leadership Development

Our Culture programme '*Our Trust, Our Future*' and our recent Pulse Survey has seen a number of actions taken forward following staff feedback. A communication plan has been developed which provides staff with an overview of all changes implemented and planned. The aim is to drive engagement further with the launch of the 2023 National Staff Survey.

The three levels of leadership identified within the Leadership Strategic Plan are being progressed and the Foundation Programme, *'It all starts with me'* has seen an increase in the numbers accessing the training with over 350 staff successfully completing the course. The second level '*Leading with Care'* has commenced with four cohorts launched and cohort five launching this month.

The *'Leading with Unity'* sees the first cohort commence this month, with twenty-one staff enrolled on the six-month programme.

Work is underway to develop a *'Culture Dashboard'* within the Yellowfin platform. This will incorporate a number of metrics used to benchmark 'culture'. The People team are working with Business Intelligence to finalise the content for the dashboard.

3.2 Research and Development

3.2.1 Recruitment

Patient recruitment into clinical research trials remains high with 1741 patients recruited into the National Institute for Health and Care Research portfolio studies this year (by context 1170 patients were recruited at this point in 2022).

The Research and Development Team now have eleven Non-Medical Principal Investigators in post compared to seven investigators in 2022. Sharon Gowans, Trust Research Midwife is the Principal Investigator for the North East and North Cumbria and has the highest recruitment rate into open studies.

4. Strategic Objective: Transforming our Services

4.1 Integrated Care System (ICS)

Chief Executives from across the North East and North Cumbria continue to meet with the ICB Executive Team to support the ongoing development of the system. At the Chief Executive meeting in August the terms of reference for the Chief Executive strategic group were reviewed and updated. The system financial performance was discussed along with learnings from delivering urgent and emergency care as a North East and North Cumbria system.

4.1.1 North East and North Cumbria Financial Position

The Integrated Care System (ICS) submitted a deficit plan for the year. Within that plan three providers have a planned deficit, one a planned surplus and the remaining providers have break-even plans, including North Tees and Hartlepool NHS Foundation Trust.

At month five, the ICS is reporting a year to date deficit of £72.58m against a forecast year-end position of £49.9m deficit.

In terms of contribution to the ICS position, the Trust plan is to deliver surpluses over the first six months of the year and deficit in the last six months, to achieve an overall breakeven position over the year.

At month five, the Trust had a planned year to date surplus of £2.992m and has delivered a £1.074m surplus, which is £1.9m behind plan. This is attributable to the cost of the national pay award and industrial action.

The forecast position for the Trust remains breakeven with the Trust expecting to deliver to plan.

4.2 North East and North Cumbria Provider Collaborative (PvCv)

Every month, Chief Executives across our eleven Provider Collaborative Foundation Trusts meet in the Provider Leadership Board (PLB). At their meeting in August discussion focussed on elective recovery and choice with Simon Mawhinney, Quality Manager and Service Specialist at NHS England updating members on the progress with regard to the elective recovery plan, waiting list management, mutual aid and pathway re-design. Sean Fenwick, Chief Operating Officer at City Hospitals, Sunderland shared an overview of work being undertaken by the Urgent and Emergency Care Network (UEC) highlighting the current focus on delivery, placed based governance, mutual aid and winter planning.

The Provider Collaborative also approved the repatriation policy, this was developed following a request by the UEC Network. This will empower staff to make the right decisions for patients once the required pathway specific protocols are developed.

4.3 Tees Valley Provider Collaborative

Work continues to develop the Group model between North Tees and Hartlepool and South Tees Hospitals NHS Foundation Trusts. Development meetings are regularly taking place, chaired by the Managing Directors of both Trusts to sustain momentum for the Group arrangements, which report to the Joint Partnership Board.

4.4 Independent Inquiry – Countess of Chester Hospital NHS Foundation Trust

Following the outcome of the trial of Lucy Letby, the NHS has welcomed an independent inquiry announced by the Department of Health and Social Care led by Lady Justice Thirlwell into the events at the Countess of Chester Hospital.

The inquiry will have legal powers to compel witnesses including both former and current staff at the Countess of Chester Hospital and will also examine the wider circumstances, including the Trusts response to clinicians, the conduct of the wider NHS and its regulators.

4.5 NHS England's Fit and Proper Person Test Framework (FPPT)

NHS England have published a revised FPPT Framework in response to the recommendations made by Tom Kark KC in his 2019 Review of the FPPT as it applies under Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The review highlighted areas that required improvements to strengthen current arrangements.

The framework came into effect from 30th September 2023 and NHS organisations are expected to adopt it for all new board level appointments or promotions and for annual assessments. It should be read alongside the NHS Constitution, NHS People Plan, People Promise and forthcoming NHS Leadership Competency Framework.

It is proposed that the framework will strengthen individual accountability and transparency for board members, and enhance the quality of leadership within the NHS. It is a core element of a broader programme of board development, effective appraisals and value-based (as well as competency-based) appointments.

The framework will help board members build a portfolio to support and provide assurance that they are fit and proper, while demonstrably unfit board members will be prevented from moving between NHS organisations.

The framework applies to executive and nonexecutive directors (incl. interims) of Integrated Care Boards (ICBs), NHS Trusts and Foundation Trusts, NHS England and the CQC.

4.6 Service and Estate Developments

4.6.1 New Hospital Outline Business Case (OBC)

The Strategic Outline Case (SOC) was completed in February 2023 at which point the Trust Board gave approval to progress to an Outline Business Case (OBC). This is being developed with support from a dedicated project team.

The OBC will be progressed so the Trust are *"ready to bid"* following any future funding announcements that may arise prior or following the next general election. NHSE has confirmed the potential for bids to be sought for projects to address specific issues such as elective recovery, inpatient wards, intensive care, emergency care and maternity. It is unknown as to when the details of the timescales / process will be announced however, the Trust continue to pursue opportunities in accordance with Phase 1 of the OBC.

The Trust expects to complete the OBC by its target date of 28 February 2024.

4.6.2 Reinforced Autoclaved Aeriated Concrete (RAAC)

Guidance was published in August by the Department for Education regarding the approach to the presence of RAAC in the school estate. This has generated heightened public interest in the presence of RAAC in the NHS estate. Dr Mike Prentice, National Director for Emergency Planning and Incident Response chaired a meeting with impacted Trusts on 4th September to discuss the current position.

The Board of Directors are aware of the risks associated with RAAC as part of the extensive programme of work undertaken over recent years. NHS England have written to all NHS organisations and have outlined actions that individual NHS Trusts should be taking to assure themselves that RAAC is identified and appropriately mitigated, to keep patients, staff and visitors safe.

4.6.3 Community Diagnostic Centre (CDC)

A strategic plan for the health system in the Tees Valley to develop diagnostic capacity, including a new build Community Diagnostic Centre (CDC) has been agreed by the Tees system. This is a collaborative approach between North Tees and Hartlepool NHS Foundation Trust and South Tees NHS Foundation Trust.

Following the appointment of the Kier Group as principal contractor, construction of the new build community diagnostic centre commenced on 3rd September 2023. The "*first spade*" ceremony was held on 15th September led by a patient who had previously utilised diagnostic services. The event was attended by colleagues and partners from both Trusts, NTH Solutions LLP, Stockton Borough Council and local MPs.

The joint clinical leads supported by service managers, staff, workforce, digital and finance teams concluded the work on the operating model on Friday 8th September. This important piece of work defines how the diagnostic centre will operate, the pathways, workforce and digital to provide a seamless service. This is a major step forward for the Tees Valley, focusing on early diagnosis and treatment, improved care outcomes and wider economic regeneration in the drive to improve population health and tackle health inequalities.

The scheme is expected to be completed by the summer of 2024, six months ahead of the original plan.

5. Strategic Objective: Valuing our People

5.1 Staff Survey

The Staff Survey launched on the 19th September. The launch pack for teams also incorporated the feedback from the '*Our Trust, Our Future*' and People Pulse actions.

The Trust appraisal process and documentation has been reviewed and updated factoring in staff feedback. The updated version also includes Scope for Growth allowing development conversations to take place with staff, ensuring we retain talent and support development aspirations. The Appraisal 100 day challenge has seen benchmarking data comparisons and work to improve compliance and data capture via ESR.

In addition, a Talent Management strategic plan has been developed to ensure the Trust supports talent and succession planning across the organisation.

5.2 Faculty for Learning, Leadership and Improvement

Quality Service Improvement Redesign (QSIR) Foundation programmes have continued with a positive uptake across the Trust. In order, for the Trust to continue to develop capacity, capability and a sustainable approach to delivering QSIR, more associates will be developed in conjunction with AQUA.

The fifth cohort of QSIR Practitioner course is in the planning stage and will take place in due course. The Quality Improvement team are collaborating with Quality Improvement Leads on pieces of work and supporting the actions to operationalise the strategic plan.

Cohort 3 of the NTH100 programme launched on the 26th September 2023. The focus was on operational challenges, which were identified through triangulation of data across the Trust, aligned to strategic objectives. The approach will also incorporate the QSIR Foundation training ensuring we continue to build capability and capacity across the Organisation.

The five areas of focus are: flexible / agile working; patient communication; improving patient lifestyles; engaging service users in quality improvement and weight management (staff).

Each of the five 'packs' will have a Mentor and an assigned 'subject matter expert' to support the projects. A formal launch event for the faculty will take place at the end of October.

5.3 Workforce Development

Positive progress has been made with regards to developing the Health and Social Care Academy. The grant funding agreement is now in place between the Trust and Hartlepool Borough Council which will enable the project to progress at pace. The facility will be located within the University Hospital of Hartlepool that will support growing our own talent and ensuring we have a robust, sustainable workforce plan across the wider health and social care economy. A competitive tender process is underway to assist in the appointment of a main contractor. The academy supports

the Trusts commitment to provide our workforce with the skills needed to support high quality patient care.

In addition to the capital funding (circa £1.2m), a submission has been made to the Local Skills Improvement Fund (LSIF) to support with costs associated with additional equipment. The bid for funding is specifically focused around technology and will support the academy having the latest immersive technology available for staff / students.

5.4 Wider National and Regional Contribution

5.4.1 New staff cervical screening service shares progress over first six months

Staff health is important for any Trust and six months after launching a new staff-focused cervical cancer screening programme, has carried out 72 cervical screening tests, with six women being advised they would need a repeat test in 12 months and two women had results confirming the presence of pre-cancerous cells. The service was first created by lead specialist nurse colposcopist Nicola Anderson who said: "*The team is delighted with how the service has been received by staff so far*".

5.4.2 High-tech patient safety software shortlisted for prestigious award

The Trust was thrilled to be shortlisted for a Health Service Journal patient safety award for our CareScan+ project. CareScan+ is an innovative point of care scanning solution designed to track and trace products used by clinicians using a barcode scanning system to provide clinicians with accurate real-time decision support information such as expiry dates and product suitability.

Tony Naylor, associate director of ICT and CareScan+ lead said: *"We are delighted to be shortlisted for this prestigious award and I'm really proud of what the team has achieved. Working alongside our clinical colleagues to develop and implement a digital solution to increase patient safety is what motivates us all*."

6. Recommendation

The Board of Directors is asked to note the content of this report including, the pursuance of strategic objectives, work to improve system working and operational resilience.

Neil Atkinson
Managing Director

Excellence as our standard

NHS North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Integrated Performance Report										
Date:	September 2023										
Prepared by:	Linda Hunter, Director of Planning & Performance										
Executive sponsor:	Rowena Dean - Acting Chief Operating Officer Lindsey Robertson - Chief Nurse/ Director of Patient Safety and Quality Susy Cook - Chief People Officer & Director of Corporate Affairs Kate Hudson-Halliday - Director of Finance										
Purpose of the report	To provide an overview of performance and associated pressures for compliance, quality, finance and workforce.										
Action required:	Approve			Assurance	X	Discuss	X	Information	X		
Strategic Objectives supported by this paper:	Putting our Population First	X		Valuing 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 following is a summary of the performance for August 2023:

Safe

- There was one serious incident reported in August.
- One C. Diff infection reported in August, which is significantly lower than the average YTD. Regional and local focus on reduction is a priority in line with national drive and ICB C. Diff reduction strategy
- CAUTI cases reported in August was 23. Training programme focusing on catheter insertion and maintenance has taken place in July and September in an effort to reduce the number of infections occurring

Effective

- The Trust continues to perform well against SHMI, reporting below national mean of 100
- There is a continued decrease in did not attend with continued work on the roll out of the health inequalities pilot across all specialities
- An increase in PIFU rates reported, with Paediatrics being the latest service to set up pathways.

Caring

- For all six FFT metrics, the Trust is exceeding the 75% Very Good/Good standard.

Responsive

- The number of super stranded patients (21+ days) which has seen an increase this month. (Standard 43, Actual 48) The Trust continues to work collaborative with partners in Local Authorities to ensure discharge where clinically appropriate. The national discharge team visited

the Trust in August to meet the team and gain insight into the Trusts successful use of OPTICA, the multi-agency Integrated Single Point of Access and 2-hour community response.

- Whilst the Trust continues to exceed the overall 4-hour national standard, achieving 85.20% in August, it is cognisant that compliance with this standard has changed and a concentrated focus on the type 1 four-hour standard is in place.
- Ambulance hand over delays remain in a positive position, achieving 99.57% of patients being handed over in less than 59 minutes for the month of August. There were 6 over 59-minute handover delays in August and we continue to focus on the whole pathway, monitoring 30-minute target internally, for august the mean handover time was 26 minutes.
- The Trust continues to focus on reducing RTT trajectories (75.42%) and the 52-week wait position (107). The continued impact of industrial action this year has affected activity, with 2 significant levels of planned activity stood down to support maintaining safe services for patients.
- The cancer two week rule standard has shown a static position compared to the previous months, patient choice remains a factor
- Diagnostic performance for August seen an improvement on the previous month.

Well Led (People & Finance)

- The Trust overall sickness has increased in July from 4.94% to 5.39%. Long term sickness accounted for 3.32% of overall sickness.
- Staff Turnover has seen a slight decrease from the previous month, 0.12% lower.
- At month 5, the Trust is reporting an in-month deficit of £0.472m against a planned deficit of £0.195m, which is £0.277m behind plan.

Maternity

- VTE compliance improved in July from previous month, however still remains at 79% against Trust standard of 95%. Maternity Team undertaking a review into the reasons for under-performance.
- Smoking at Booking is at 16% which is higher than the 11% NENC average. Four QI projects linked to improving the performance. A recently launched QI project has observed a notable increase in referrals to Tobacco Dependent Treatment service, which aims to offer support to those who wish to stop smoking.
- Linked to the above, a 12-week programme on smoking in pregnancy has seen positive results with a 500% increase in cessation rates.

Board Assurance Framework/Corporate Risk Register risks this paper relates to:
BAF 1A, BAF 1B,BAF 1C, BAF 2A, BAF 2B, BAF 3C

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or inclusion		Reputational	X
Workforce	X	Environmental	
Financial/value for money	X	Estates and Facilities	
Commercial		Compliance/Regulatory	X
Quality, safety, experience and effectiveness	X	Service user, care and stakeholder involvement	X

Committees/groups where this item has been discussed	Resource Committee Quality Committee People Committee
Recommendation	The Board is asked to note:

	• The performance against the key operational, quality and workforce standards. • Acknowledge the on-going operational pressures and system risks to regulatory key performance indicators and the associated mitigation

NHS
North Tees and Hartlepool
NHS Foundation Trust

Integrated Performance Report (IPR)

September 2023 Report

(August 2023 data)

Executive Summary

Domain	Summary
Safe Page 6 to Page 11	The Trust continues to reported two high risks, both financial with a further high risk in regard to Paediatric workforce being approved in August. All of this risks continue to be monitored through the appropriate governance structures. Significant focused work is being undertaken in regard to reduction in infections The role of the skin integrity nurse has supported a programme of education that has supported an increase in category 1 and 2 pressure ulcers with a reduction seen in both type 3 and 4. The commencement of the Trust partnership working with NHS England in shaping the national would care strategy will commence at the end of September.
Effective Page 12 to Page 17	The Outpatient Transformation work continues with an increase in Patient Initiated Follow up (PIFU) and reduction in reviews. Focus work continues to reduce did not attend rates with a number of key initiatives underway to support including the introduction of the patient Engagement Portal (PEP) in Gastroenterology and work to contact patients to support attendance at appointments.
Caring Page 18 to Page 21	The number of Friends and Family Test (FFT) returns remains consistent to previous months, with a Very Good /Good rate at 92.73%, a slight improvement on the previous month. All six FFT standards have consistently achieved greater than 75%. The Complaints improvement project continues with the work on both stage 2 and 3 now completed. The next phase of this work is to review the stage 1 process working collaboratively with our group partners at South Tees.

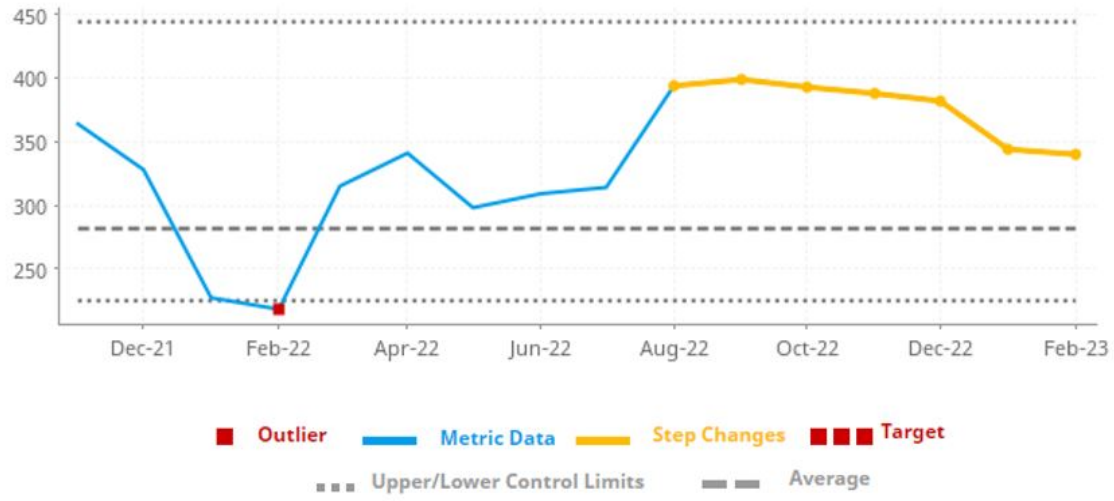
Executive Summary

Domain	Summary
Responsive Page 22 to Page 29	Trust ambulance handover performance continues to be one of the best in region. The Trust continues report above the national 4-hour standard with specific improvement work focussed for those patients attending the ED department, including fractured neck of femur pathways and additional senior decision makers overnight. The continued delivery of the 2 hour urgent response standard supports the management of patient flow into the organisation supporting the Home first ethos. The Trust remains on plan to meet the 2023/2024 planning submission for Trust occupancy. The Trust is achieving four out of nine Cancer standards, the a change to the metrics to be reported from October following a national consultation, reducing from the current 9 standards down to 3. Whilst cancer pathways remain protected during the industrial action period, overall capacity has been affected with appointments and procedures rearranged, particularly for non-urgent waiting list management (RTT).
Well-Led **People** Page 30 to Page 33 **&** **Finance** Page 34	People Clinics continue to be undertaken at Care Group and Corporate level to ensure robust management of absence and appropriate support to staff experiencing significant health and well-being challenges. Revised appraisal documentation has been implemented to address the barriers identified in appraisal processes, improve individual experience and achieve compliance levels. The 'core 10' mandatory training topics and reporting arrangements have been approved with implementation to commence from end of October 2023. Educational work continues to raise awareness and improve The Trust has a breakeven financial plan for 2023/24 with reported risks relating to inflationary pressures and efficiency requirements.At month 5, the Trust is reporting an in-month deficit of £0.472m against a planned deficit of £0.195m, which is £0.277m behind plan.The Trust is reporting a year to date surplus of £1.074m against a plan of £2.992m, which is £1.918m behind plan.

Executive Summary

Domain	Summary
Maternity Page 35 to Page 46	The new maternity section can be found from page 35 onwards, with a pathway approach to separating the standards into Pre-natal, Birth, Postnatal, Neonatal and feedback (complaints & compliments). The Trust local population reside in one of the most deprived areas in the country, with the rates of smoking one of the highest in the North East and is reflected in the maternity population. The Trust continues to support patients in reducing smoking to help optimise the health of the newborn and mother. The Trust has noted a decline in the VTE compliance within maternity services and has agreed to undertake a review in July, with an action plan to be developed to outline actions and key improvement timescales. The Trust continues to reduce Postpartum Hemorrhage (PPH) rates, which can be attributed to the recent introduction Quality Improvement (QI) project. Breast feeding rates within the Trust fall below the North East & North Cumbria average and one of the lowest in the region. To improve the take up rate throughout 2023, the Trust has employed an infant feeding specialist midwife.

Statistical Process Control (SPC) Charts



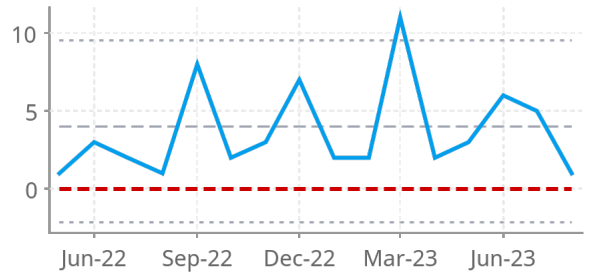
A Step Change occurs when there are 7 or more consecutive points above or below the *average*.
Outliers occur when a single point is outside of the Upper or Lower Control Limits. The adjust automatically so they are always 2 Standard Deviations from the .

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

Safe

North Tees and Hartlepool NHS Foundation Trust

Serious Incidents

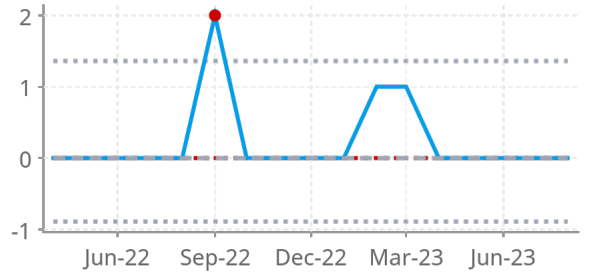


Month	Aug-23
Actual	1
Standard	0

Summary of Current Issues/ Recovery Plans

During August, the Trust reported one serious incidents in line with the Serious Incident framework; this case is under review using the appropriate safety processes and relates to a delay in diagnosis following discrepancy in radiology reporting for a scan.

Never Events

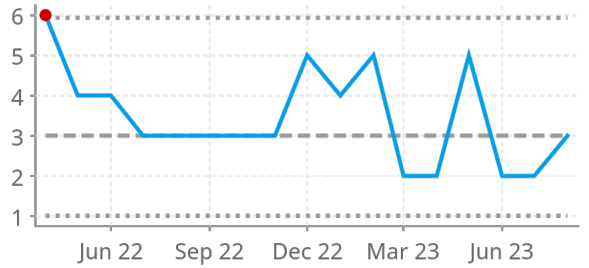


Month	Aug-23
Actual	0
Standard	0

Summary of Current Issues/ Recovery Plans

During August 2023, there were zero Never Events reported.

High Risks



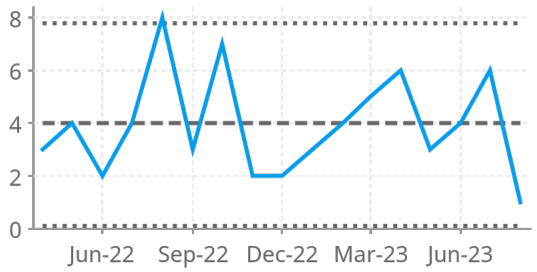
Month	Aug 23
Actual	3
Standard	N/A

Summary of Current Issues/ Recovery Plans

All risks are approved through the agreed governance structure and are reviewed in line with Trust Policy. There were three high risks at the end of August 2023 two financial risks relating to Trusts Aging Estate, the Delivery of Savings and one risk relating to neonatal and Children and Young people's acute service delivery (and associated pathways) due to potential Consultant vacancies, business continuity plans are being updated to manage the impact of mitigations and controls proposed should the risk manifest.

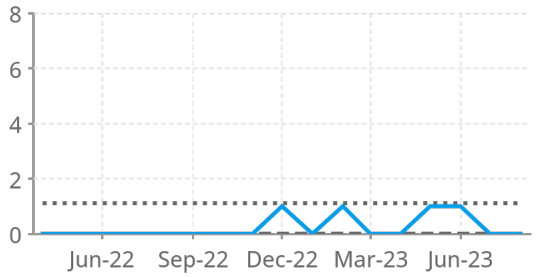
Safe

Clostridium difficile (C. diff)



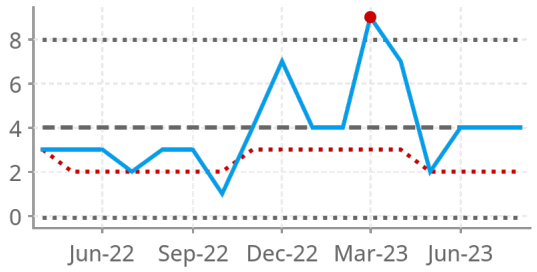
Month	Aug-23
Actual	1
Standard	3

MRSA



Month	Aug-23
Actual	0
Standard	0

MSSA



Month	Aug-23
Actual	4
Standard	2

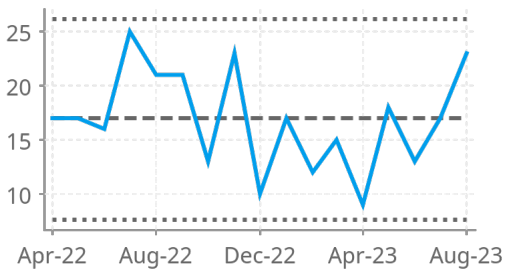
Summary of Current Issues/ Recovery Plans

C.diff reduction remains a focus as a regional and national priority. The trust continue to engage and take part with the Intergrated Care Board C.Diff reduction strategy and currently report 20 cases against our threshold of 46 cases for 2023. Roll out of our 'STOP!' Signs and cleaning regimes has been on going with the Infection Prevention & Control team, domestics and clinical areas.

There were no healthcare associated MRSA bacteraemia cases in August, although the trust report two cases, against a zero tolerance threshold. This is a similar position to regional partners who have seen an increase in MRSA bacteraemias. Increased training has been delivered to junior medics and non-medical prescribers in relation to reviewing screening results and prescription of decolonisation treatment. Orthopaedic ward areas have also focused on improving screening and MRSA eradication pathways.

MSSA bacteraemias do not have a threshold associated but the trust currently reports 22 cases against an internal threshold of 29. Skin preparation prior to procedures, cannulations and blood culturing is being addressed as part of a wider education package led by the blood culture focus group.

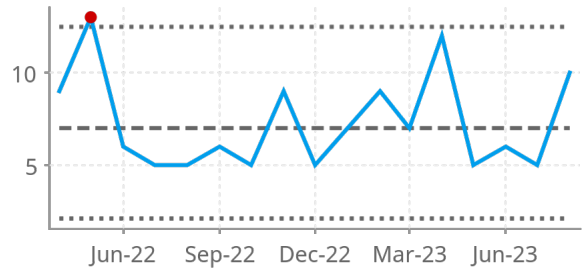
CAUTI



Month	Aug-23
Actual	23
Standard	17

Safe

Escherichia coli (E. coli)

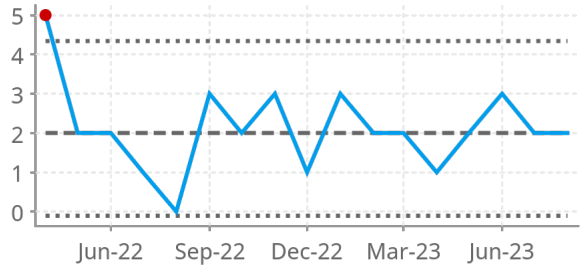


Month	Aug-23
Actual	10
Standard	6

Summary of Current Issues/ Recovery Plans

An ICB reduction strategy for Gram Negative Bloodstream Infections (GNBSI) is also underway. An increase across the region is noted in E-coli bacteraemias and nearly all local partners are performing above their expected trajectory. Currently the trust reports 38 cases against a threshold of 69 cases for E-coli.

Klebsiella

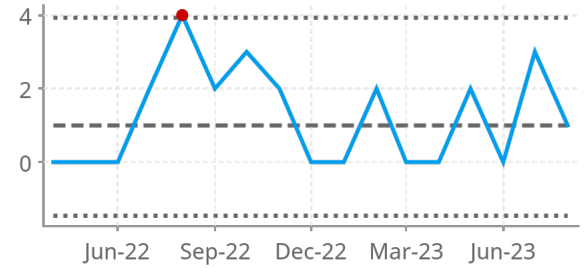


Month	Aug-23
Actual	2
Standard	2

Summary of Current Issues/ Recovery Plans

Klebsiella bacteraemias across the region remain in line with trajectories and the trust currently report 10 cases against a threshold of 20.

Pseudomonas aeruginosa



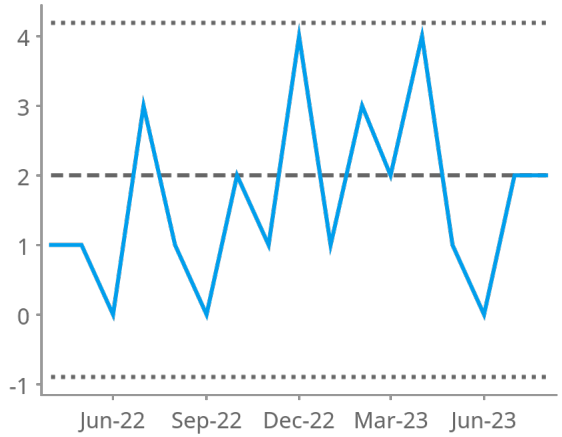
Month	Aug-23
Actual	1
Standard	1

Summary of Current Issues/ Recovery Plans

Pseudomonas infections also remain challenging regionally, with the trust reporting a total of six cases against a threshold of 11. Lower urinary tract remains the highest reported source for the GNBSI's and in line with a rise in Catheter Associated Urinary Tract Infection (CAUTI) increased training on insertion and management of catheters has been delivered at the end of July and beginning of September.

Safe

Falls with Moderate Harm

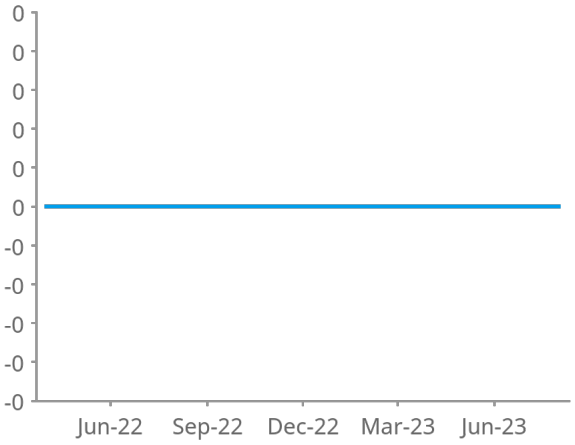


Month	Aug-23
Actual	2
Standard	2

Summary of Current Issues/ Recovery Plans

There have been two in-patient falls reported in August resulting in moderate harm, both have been reviewed and closed; with assurance that all appropriate actions had been taken to reduce any risks of falling. Duty of candour has been completed for both cases.

Falls with Severe Harm

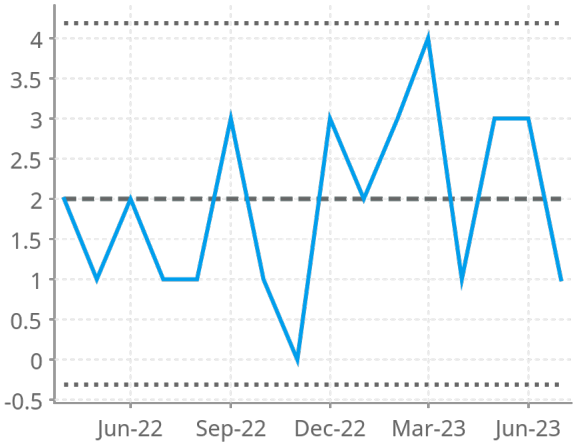


Month	Aug-23
Actual	0
Standard	0

There have been no reported falls resulting in severe harm.

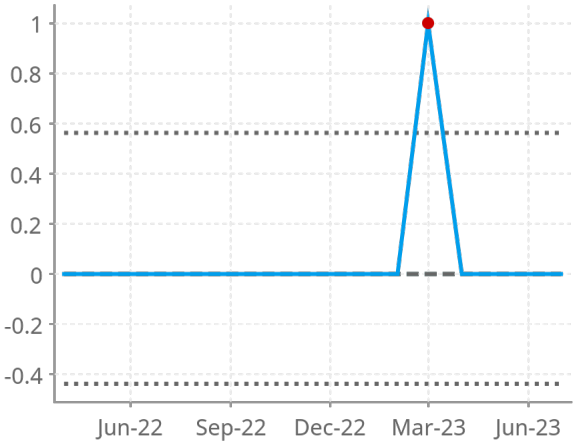
Safe

Pressure Ulcers Category 3



Month	Jul-23
Actual	1
Standard	2

Pressure Ulcers Category 4



Month	Jul-23
Actual	0
Standard	0

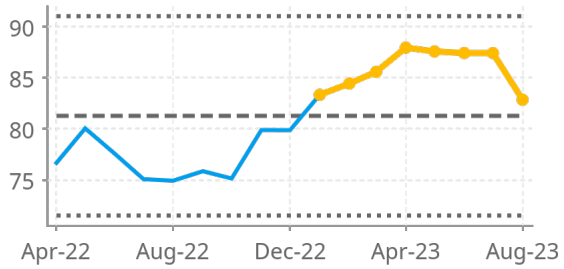
Summary of Current Issues/ Recovery Plans

A continued and sustained increase in Category 1 pressure ulcer reporting is noted for July 2023, which demonstrates early identification of damage. Reporting of Category 2 pressure ulcers also remains elevated and improvements continue to bring reported data in line with validated numbers. The role of the skin integrity nurse has been vital in delivering education to support this. There has been a reduction in Category 3 pressure ulcers in July 2023 and no category 4 pressure ulcers reported.

At the end of September, the Trust will begin their journey with NHS England to shape the national wound care strategy in tackling pressure ulcer prevention, specifically in their diagnostic phase of the project.

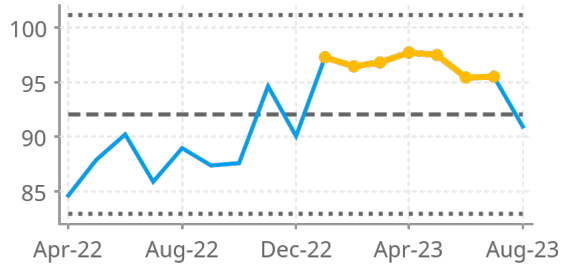
Safe

UNIFY Day RCN



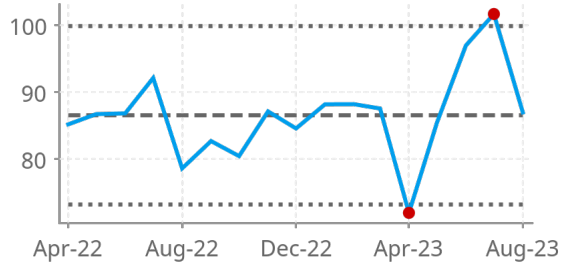
Month	Aug-23
Actual	82.84%
Standard	>=80% and <=109.99%

UNIFY Night RCN



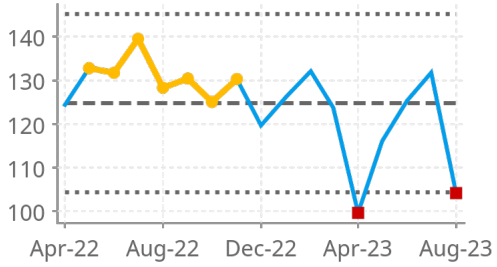
Month	Aug-23
Actual	90.93%
Standard	>=80% and <=109.99%

UNIFY Day HCA



Month	Aug-23
Actual	86.95%
Standard	>=80% and <=109.99%

UNIFY Night HCA



Month	Aug-23
Actual	104.14%
Standard	>=110% and <=125.99%

Summary of Current Issues/ Recovery Plans

Nursing fill rates have been sustained and sit within the recommended standard of >80%. The demand rates to NHSP continue to reduce each month. Nurse vacancy levels continue to reduce in line with the planned trajectory.

Monthly recruitment remains on-going for both registered and unregistered nurses and midwives. On-boarding work with third year nursing students who register in September 2023 and approx. 35wte nurses are currently locked into vacancies with planned start dates arranges.

International recruitment (IR) of nurses continues with 60wte nurses now deployed to the UK. There has been success in offering 2wte Registered Midwives positions and an additional 26wte Registered Nurses who are due to arrive in September 2023 and Midwives due to arrive in October 2023. This planned recruitment will further increase the shift fill rate across establishments and will reduce the overarching nursing and midwifery vacancy level from November 2023 (following OSCE pass).

Effective

Summary Hospital-level Mortality Indicator

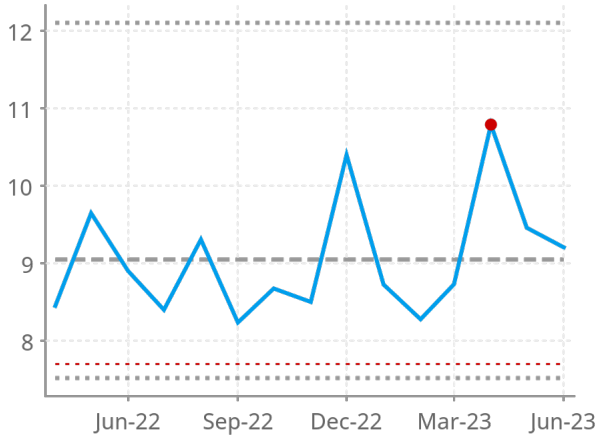
Month	Apr 22 - Mar 23
Actual	95.66
Standard	100

Summary of Current Issues/ Recovery Plans

The latest SHMI value is now 95.66 (April 2022 to March 2023) which has decreased from the previous rebased value of 96.38 (March 2022 to February 2023)

The value of 95.66 is 5th lowest in the region, which ranges from 87.00 to 112.14, with the national range falling between, 71.91 to 120.74.

Re-admission Rate



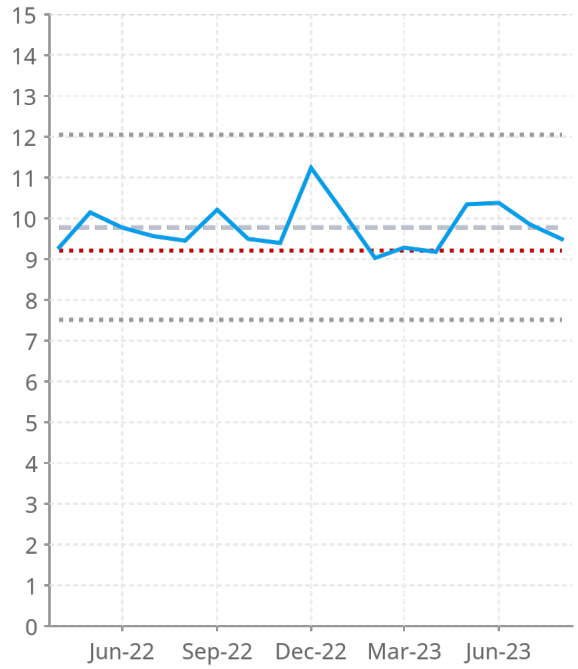
Month	Jun-23
Actual	9.21%
Standard	7.70%

Summary of Current Issues/ Recovery Plans

The Care Groups continue to audit readmission rates across each of the speciality areas undertaking deep dives in areas above the target with focussed work being undertaken in Urology and within General Medicine in regard to emergency health care plans to support the on-going management of appropriate patients.

Effective

Outpatient Did Not Attend - Combined



Month	Aug-23
Actual	9.48%
Standard	9.20%

Summary of Current Issues/ Recovery Plans

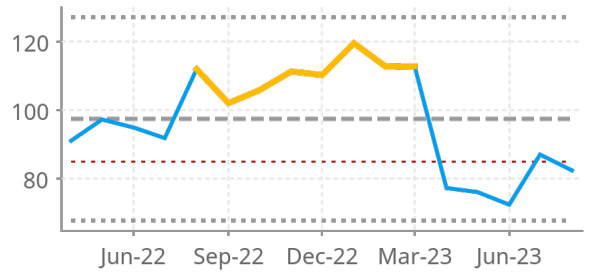
A slight reduction in the Outpatient DNA rate over the last two months, with ongoing work to achieve the standard of 9.20%, with some reduction seen in Pain management.

The Health Inequalities project continues where patients or carers from low deprivation areas are contacted prior to their appointment. If the patient is unable to attend, they are re-booked for one that they can. This falls within our aligned approach with the CORE 20 PLUS 5 NHS initiative.

The trial of the Patient Engagement Portal (PEP) in Gastroenterology, where patients can see and change their appointments is underway

Effective

Reducing Reviews

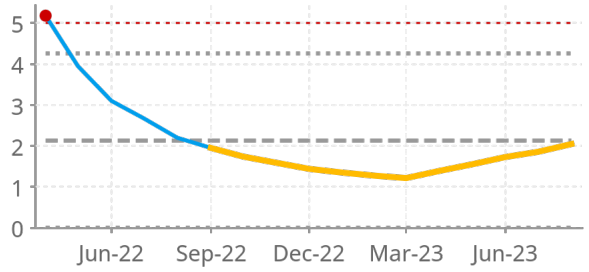


Month	Aug-23
Actual	82.47%
Standard	85.00%

Summary of Current Issues/ Recovery Plans

There is continued focus on reducing review outpatient appointments to free up capacity for long waits. Whilst some of this reduction is likely to be attributed to reduced activity resulting from industrial action, the Trust is on track to meet the agreed 15% reduction agreed against the annual planning submission and continues to strive towards national best practice in line with GIRFT guidance. Waiting list validation is a project underway to identify patients who no longer require an appointment and "Online forms" is another NHSE funded project underway with Dr doctor, to stratify follow-up activity in cancer pathways and offer alternative communication (such as online forms) to reduce the need for reviews. This project will run for 18 months and will likely go live at the end of Q2

Patient Initiated Follow-Up (PIFU)



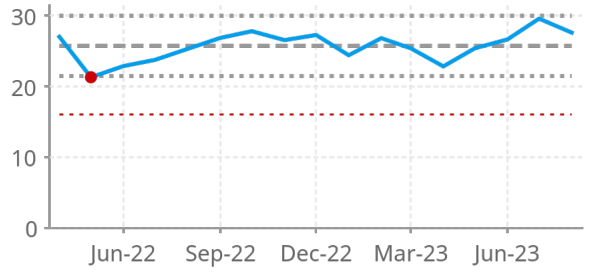
Month	Aug-23
Actual	2.04%
Standard	5.00%

Summary of Current Issues/ Recovery Plans

An increase in PIFU rates can be seen since March 23, with Paediatrics being the latest service to set up a pathway.
PIFU also has increased within Orthopaedics, Urology and Pain services.

There is a continued focus within Orthopaedics with a lead who also advocates PIFU within the service who continue to work to reduce reviews where clinically appropriate.

Advice and Guidance



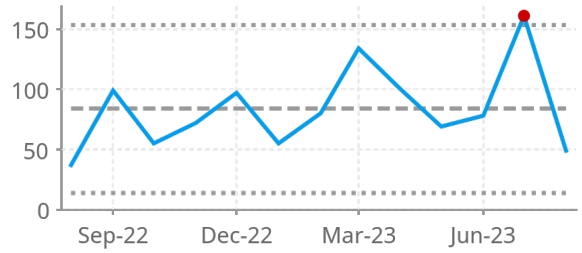
Month	Aug-23
Actual	27.57%
Standard	16.00%

Summary of Current Issues/ Recovery Plans

Collaborative Care is seeing a continual increase in advice and guidance, particularly within both Orthopaedics ad Urology services.

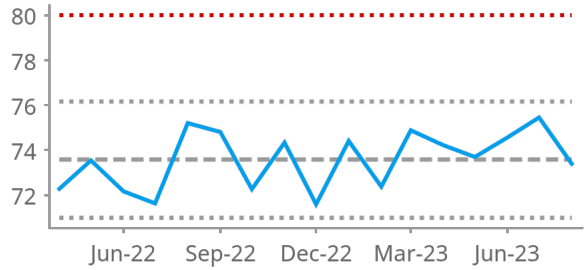
Effective

Theatre - Reportable Cancellations



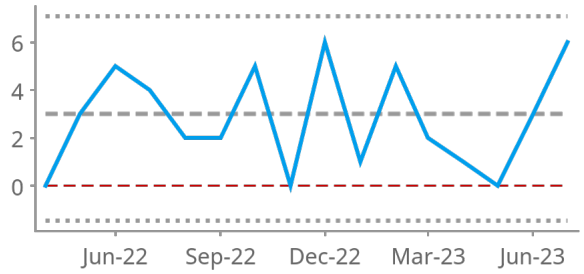
Month	Aug-23
Actual	49
Standard	N/A

Theatre Utilisation (%)



Month	Aug-23
Actual	73.39%
Standard	80.00%

Not Re-appointed within 28 days



Month	Jul-23
Actual	6
Standard	0

Summary of Current Issues/ Recovery Plans

Reportable cancellations in August were attributed to the ongoing Industrial Action, necessity to accommodate additional Emergency Trauma patients and surgeon unavailability.

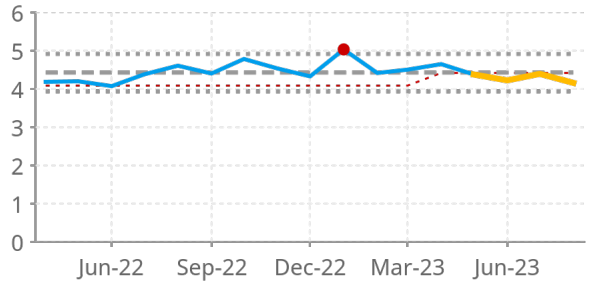
During August, theatres delivered 274 theatre lists which equated to 1009 patient procedures. A refresh of the 6:4:2 meetings has been undertaken which has supported an average increase in theatre utilisation at UHH by 6.9%. The utilisation of the CSS software has provided increased visibility of theatre scheduling and although the initial focus has been on the elective hub, the plan is to expand to all lists at North Tees by November.

July data shows that the Trust have been unable to reappoint 6 patients within the 28 day standard. This is due to the impact of industrial action.

Effective

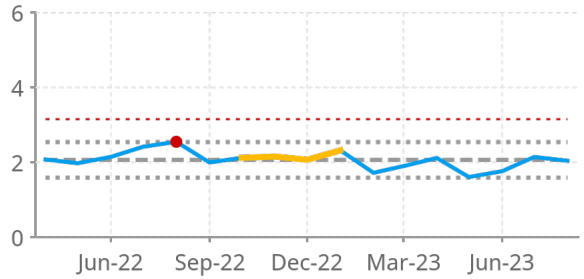
North Tees and Hartlepool NHS Foundation Trust

Length of Stay (Combined)



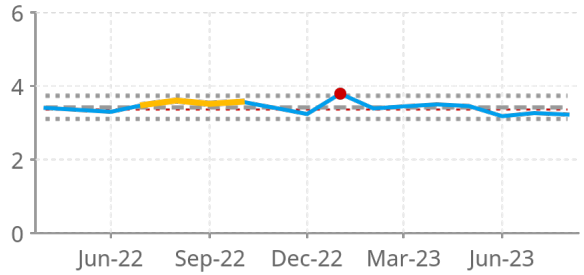
Month	Aug-23
Actual	4.15
Standard	4.41

Length of Stay (Elective)



Month	Aug-23
Actual	2.03
Standard	3.14

Length of Stay (Emergency)



Month	Aug-23
Actual	3.21
Standard	3.35

Summary of Current Issues/ Recovery Plans

The Trust continues to achieve targets for Length of Stay, whether the patient be on a elective or emergency pathway.

This works is supported by both effective In-hospital care teams and Community / Local Authority teams to support timely discharge.

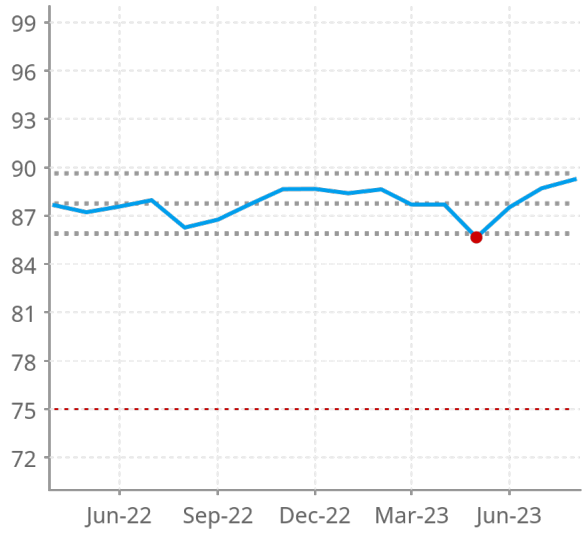
Elective General Surgery and Elective Orthopaedic patients have a reduced length of stay compared to the national average at 1.6 days for general surgery and 2.5 days for elective orthopaedic.

Breast surgery and Urology are both in line with peers and national average with 1.2 days and 1.8 days respectively.

Effective

North Tees and Hartlepool NHS Foundation Trust

Day Case Rates



Month	Aug-23
Actual	89.25%
Standard	75.00%

Summary of Current Issues/ Recovery Plans

The Trust continues to achieve this standard aided by the High Volume

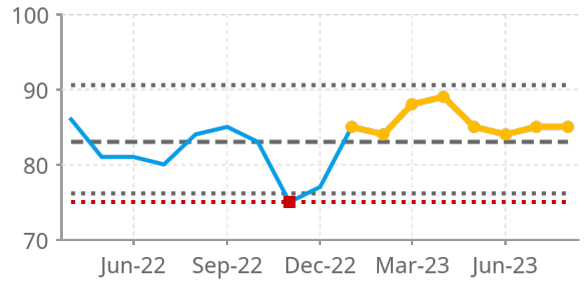
Low Complexity (HVLC) type procedures and the Trust continues to review other procedures as part of the elective hub.

The implementation of British Association of Daycase Surgery (BADS) discharge criteria has supported and increase in the Trust day case rates. The Trust has a day case working group which is clinically lead with stakeholder engagement from all specialities with focused work streams for urology and orthopaedics (hips and knees) which is demonstrating an upward trajectory.

Caring

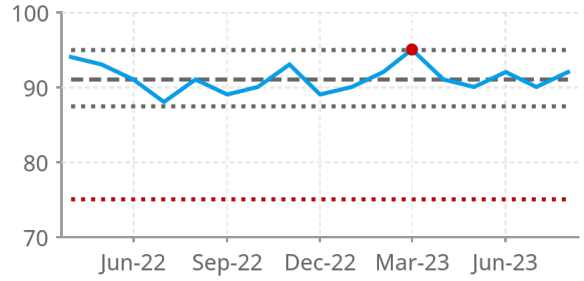
North Tees and Hartlepool NHS Foundation Trust

Friends & Family Test - A & E



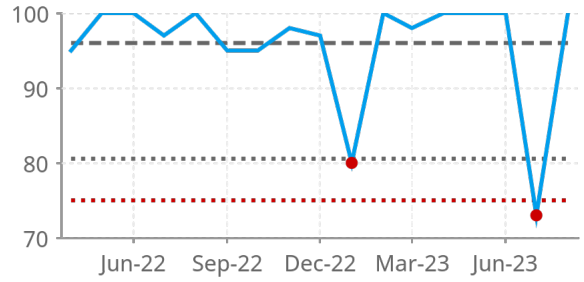
Month	Aug-23
Actual	85.00%
Standard	75.00%

Friends & Family Test - Inpatient



Month	Aug-23
Actual	92.00%
Standard	75.00%

Friends & Family Test - Maternity



Month	Aug-23
Actual	100.00%
Standard	75.00%

Summary of Current Issues/ Recovery Plans

The Trust received 2,147 Friends & Family Test returns this month, this is a increase on the previous months updated return of 1,966 and remains between the control limits.

Between the time period of April 2023 to August 2023 the Trust received 11,093 FFT responses, this is an increase of 37.09% compared to the same period last year (8,092 responses).

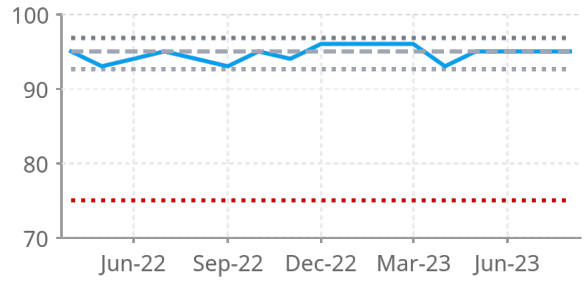
The Very Good or Good responses returned for August 2023 is 92.73%.

All Friends & Family Test metrics fall within their relevant control limits and above the minimum standard of 75%.

Caring

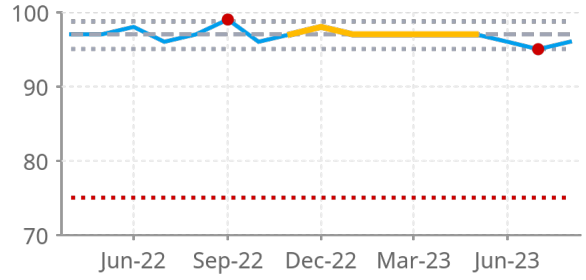
North Tees and Hartlepool NHS Foundation Trust

Friends & Family Test - Outpatient



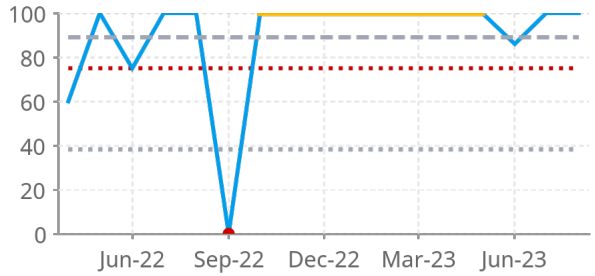
Month	Aug-23
Actual	95.00%
Standard	75.00%

Friends & Family Test - Community



Month	Aug-23
Actual	96.00%
Standard	75.00%

Friends & Family Test - Long Covid



Month	Aug-23
Actual	100.00%
Standard	75.00%

Summary of Current Issues/ Recovery Plans

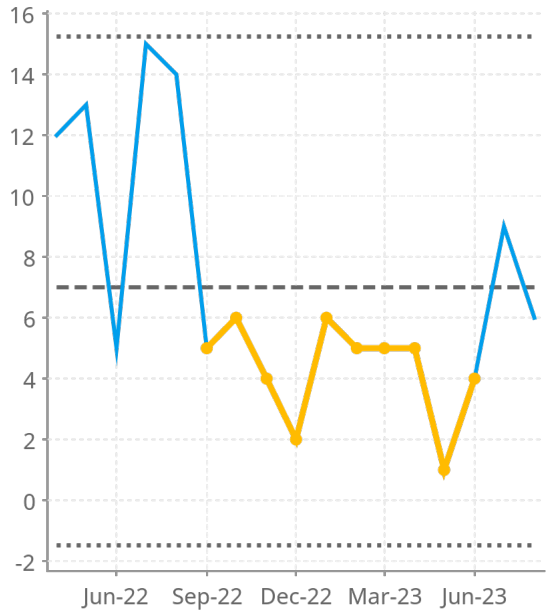
All three metrics falling within their relevant control limits with the recent trends displaying natural cause variation.

Work continues to promote the Friends & Family Test, particularly from the in-patient areas to improve the amount of feedback.

Caring

North Tees and Hartlepool NHS Foundation Trust

Complaints - Stage 3



Month	Aug-23
Actual	6
Standard	5

Summary of Current Issues/ Recovery Plans

Complaint themes continue to be monitored on a daily basis, with the Trust continuing to drive for local and face to face resolution of concerns. Of the 125 complaints received in August, 89% were to be resolved locally, 5% are to be resolved with a face to face meeting, and 6% have opted for a written response.

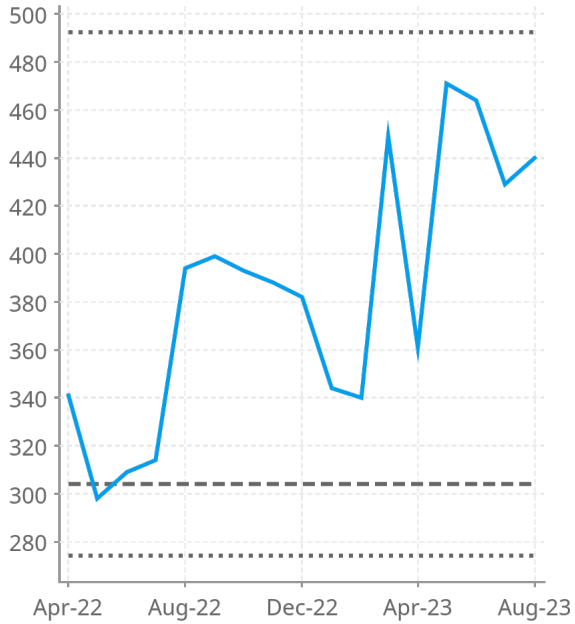
Complaints data and analysis is presented and discussed during the weekly Safety Panel meetings, and a Patient Experience Report presented on a quarterly basis.

Complaint analysis is also raised during weekly Senior Clinical Professional (SCP) Huddles. This robust process continues to support timely identification of the themes, which enables faster resolutions.

The Complaint Improvement Project is continuing, with an evaluation of the revised Stage 2 and Stage 3 process now complete. Overall feedback has been positive and the teams have opted to continue with this revised process. The Project Group are currently reviewing the Stage 1 and working collaboratively with South Tees to align process where possible.

Caring

Compliments



Month	Aug-23
Actual	440
Standard	304

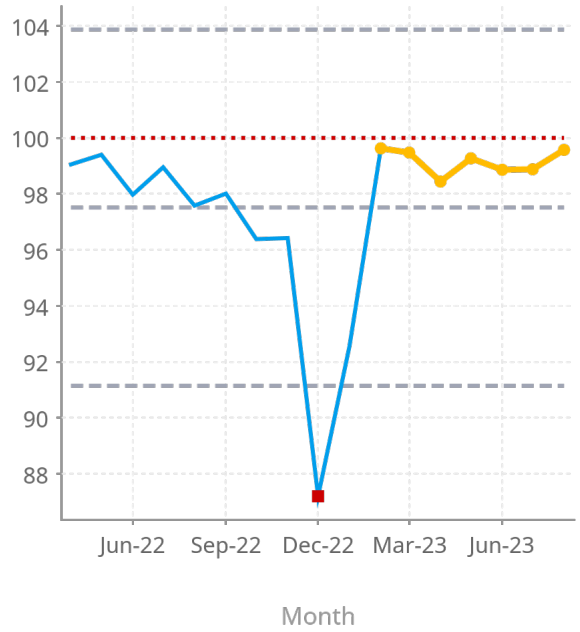
Summary of Current Issues/ Recovery Plans

The number of compliments received in August 2023 slightly decreased from July 2023. However, the total amount of compliments received in Q1 2023/24 is 1,417 which is significantly higher than the number received in Q4 2022/23 when 1,022 were received.

As with complaints, identification of themes arising from compliments is also shared at the weekly SCP huddles for shared success across all teams. Additionally, the number of the compliments received for the previous week is presented at the weekly Safety Panel meeting, together with a number of compliments in detail. The promotion of Greatix continues to ensure all positive feedback received by clinical teams is recorded to support the overarching trust position and the positive balance of complaints and compliments.

Responsive

Ambulance Handovers <59minutes



Month	Aug-23
Actual	99.57%
Standard	100.00%

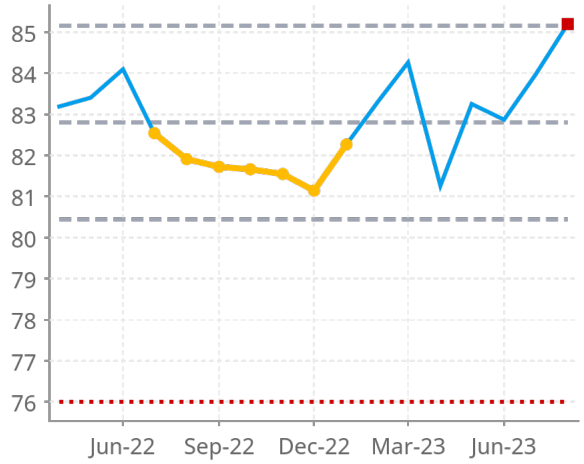
Summary of Current Issues/ Recovery Plans

Ambulance handovers continue to remain in a positive position with the SPC showing 7 consecutive months above the mean. There were 6 over 59 minute handovers in August, leading to a compliance of 99.57%. As a Trust we continue to focus on the whole pathway, including monitoring 30 minute target internally. In August we had a mean Ambulance handover time of 26 minutes.
The Trust reported 0.3% second in the region, with a regional average of 1.3% - Performance ranging from 0% - 6.1%

Improving waiting times is a key focus within our Accident and Emergency Improvement Plan

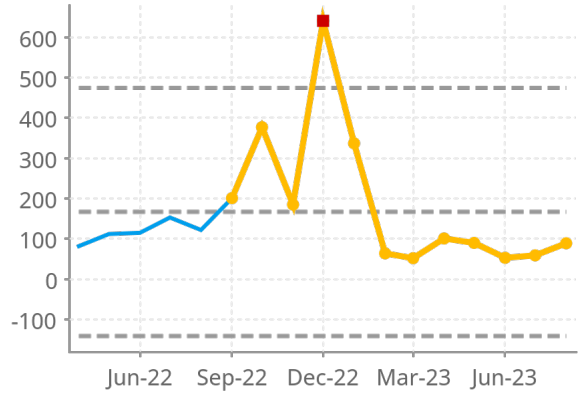
Responsive

4 hr Accident & Emergency Waiting Times



Month	Aug-23
Actual	85.20%
Standard	76.00%

12 Hour Waits in Accident & Emergency



Month	Aug-23
Actual	89
Standard	0

Summary of Current Issues/ Recovery Plans

Whilst the Trust continues to meet the National standard of 76% of the overall 4-hour standard, there is an acknowledge that pressures remain within Type 1 pathways. A steering group has reviewed our process with improvements already being seen in this position, with the achievement of the in-month improvement trajectory aligned to the target outlined in the annual planning round to achieve 90% by March 2024.
As part of our focussed work following the relaunch of the 4 hour standard within the organisation in May 2023 there is an established 'More Before 4' group with representatives from all specialities reviewing themes from long waits in ED. Working together to identify themes and any actions required to support continuous improvement remains key to reducing the overall time spent in the department. From September we are piloting an additional senior decision maker overnight with the intention to initially focus on earlier review and planning for those patients likely to go home. This is to be monitored through our '4 Hour Standard Steering Group'.

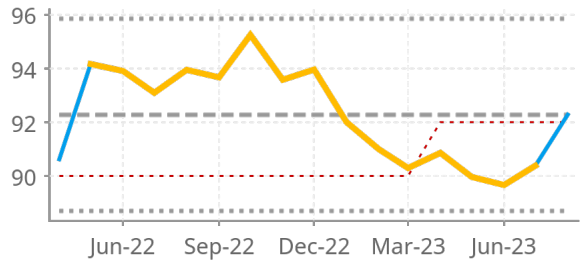
We continue to work collaboratively with Mental Health services to improve patient safety and outcomes, establishing a three month pilot to base the overnight Psychiatry Liaison Team at Roseberry Park.

In August almost 80% of the long waits within ED were due to patients waiting to be admitted for on-going management to our emergency assessment unit, surgical decision unit or a transfer to a mental health facility. There were days where the organisation was under significant pressure with a combination of a busy ED department and a high bed occupancy which led to increased numbers of patients waiting. All patients waiting over 12 hours on these particular days arrived into the department in the evening and overnight emphasising the on-going pressure building over the day. Of those not admitted to hospital patients were either awaiting an alternate option for on-going care closer to home rather than a

hospital admission or waited for a review and management plan at times when the department was busy and clinical time was prioritised to those most unstable patients.

Responsive

Trust Occupancy

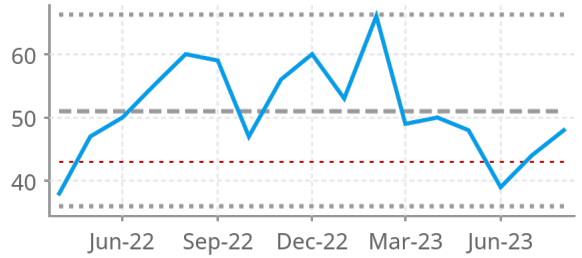


Month	Aug-23
Actual	92.28%
Standard	92.00%

Summary of Current Issues/ Recovery Plans

The Trust has seen an increase in Bed Occupancy in August. Ward 41 and 42 has undergone maintenance of their estate, resulting in a decant of patients to ward 37. This ward has seven fewer beds, resulting in a decrease in available beds. We have also seen COVID-19 outbreaks that have reduced this bed capacity further.

Super Stranded Patients (21+days)

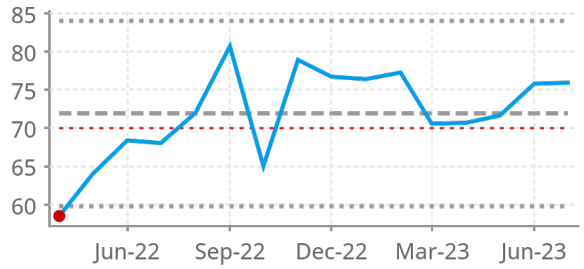


Month	Aug-23
Actual	48
Standard	43

Summary of Current Issues/ Recovery Plans

Despite continued work ongoing in the community and with partners in the Local Authorities, the trust had 48 patients who remained in hospital over 21 days. This is in association with increased hospital occupancy. The Trust is fully committed to proactive management of patient flow and timely discharge, with a number of patients supported by the Home First team.

2 hour Community Response



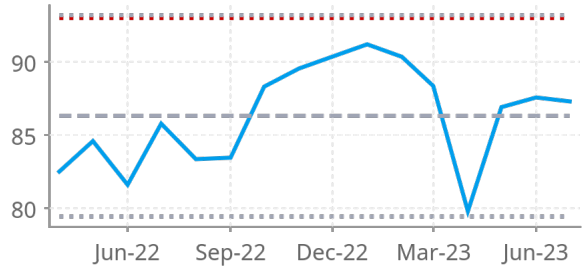
Month	Jul-23
Actual	75.94%
Standard	70.00%

Summary of Current Issues/ Recovery Plans

The Trust continues to exceed the national target of 70% of Urgent Community Response referrals being seen within two hours. We received 877 referrals in July with 821 of these directed to District Nursing teams. Our UCR pathways remain a important part of our Home First ethos.

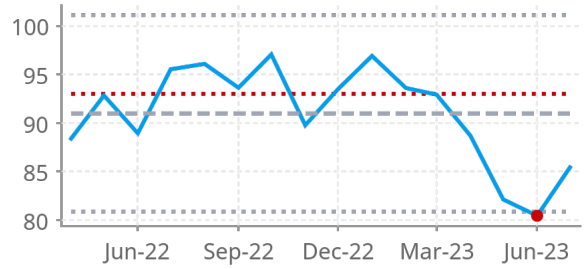
Responsive

New Cancer Two Week Rule



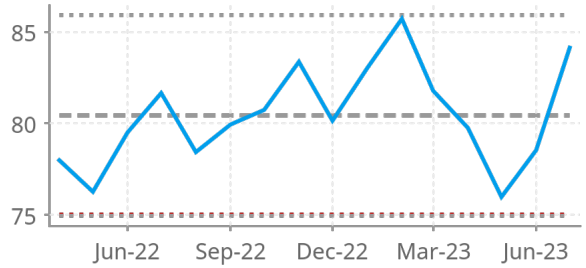
Month	Jul-23
Actual	87.30%
Standard	93.00%

Breast Symptomatic Two Week Rule



Month	Jul-23
Actual	85.43%
Standard	93.00%

Cancer 28 day Faster Diagnosis



Month	Jul-23
Actual	84.13%
Standard	75.00%

Summary of Current Issues/ Recovery Plans

A fairly static performance compared to the previous month for the two week rule cancer standard. With patient choice remaining a factor, Cancer Navigators are now contacting patients prior to appointments to ensure attendance.

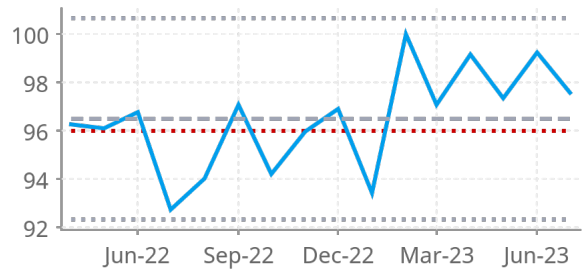
No regional Trust achieved the standard in July.

An improved performance compared to the previous month, despite a 13% increase in referrals and consultant staffing challenges. A Consultant breast Radiologist has now been appointed with a plan to commence employment in October.

An improved performance compared to the previous month is noted, along with the achievement against the 2023/24 annual plan submission trajectory set at 79% for July.

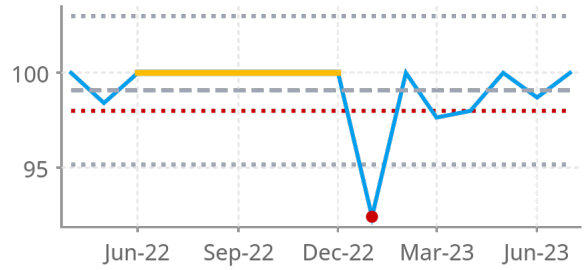
Responsive

New Cancer 31 Days



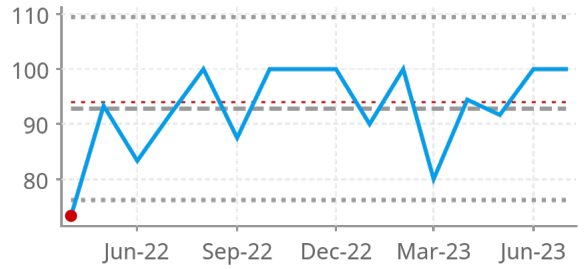
Month	Jul-23
Actual	97.58%
Standard	96.00%

New Cancer 31 Days Subsequent Treatment (Drug)



Month	Jul-23
Actual	100.00%
Standard	98.00%

New Cancer 31 Days Subsequent Treatment (Surgery)



Month	Jul-23
Actual	100.00%
Standard	94.00%

Summary of Current Issues/ Recovery Plans

Cancer currently has nine separate performance standards, following an NHS England consultation the proposal is to simplify and modernise the existing reporting. This consolidation reduces the measurement down to three standards:

- Removing the Two Week Wait standard which requires all cancer referrals to be 'seen' within two weeks and replacing it with the Faster Diagnosis Standard (with an initial performance target of 75%)
- Combining together three 62 day targets applying to GP referral, screening and consultant upgrade into a single standard (retaining the headline 85% performance target)
- Combining together four 31 day targets applying to first treatment and each of three possible subsequent treatments into a single standard (retaining the headline 96% performance target)

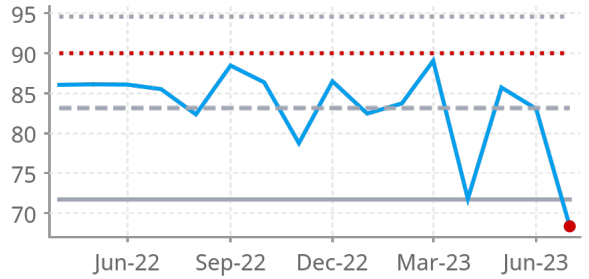
All changes will be implemented from 1 October 2023

Responsive

New Cancer 62 Days

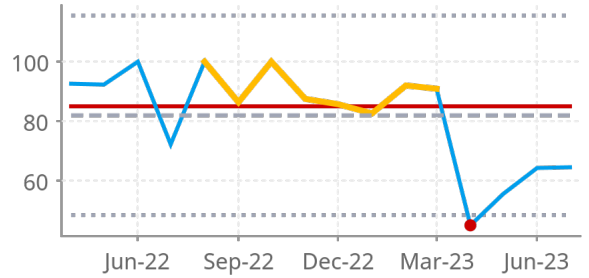
Month	Jul-23
Actual	56.59%
Standard	85.00%

New Cancer 62 Days (Screening)



Month	Jul-23
Actual	68.35%
Standard	90.00%

New Cancer 62 Days (Consultant Upgrade)



Month	Jul-23
Actual	64.52%
Standard	85.00%

Summary of Current Issues/ Recovery Plans

Pressures were evident across the majority of tumour specific pathways in July, in particular Urology, Upper GI and Colorectal. Pathway delays include long waits for diagnostics including TRUS and biopsy, colonoscopy, elective capacity, oncology waits and complex pathways across specialties, these are key areas of focus within the Trust's Cancer Improvement Plan, which is currently being refined, aligning to the Best Practice Timed Pathways and the Annual Plan trajectories.

The Trust has successfully recruited to a substantive Consultant Urologist who is due to commence employment in October, which will provide additional capacity within the service.

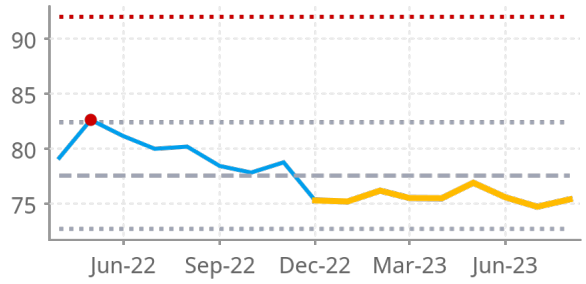
The weekly Cancer Patient Tracking List (PTL) Meetings continue with appointments/ treatments being expedited where possible to ensure pathways progress in a timely manner.

A drop in performance can be seen against the 62-day screening standard, with breaches in the main as a result of patients requiring multiple diagnostic investigations.

An improved performance against the 62-day Consultant upgrade standard can be seen for June, albeit reporting under target. No regional Trust achieved the standard.

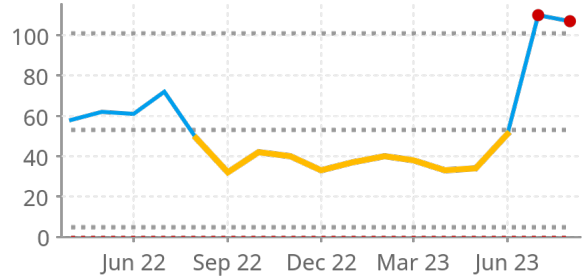
Responsive

Referral to Treatment Incomplete Pathways Wait (92%)



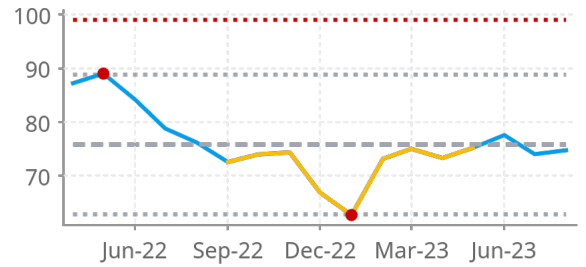
Month	Aug-23
Actual	75.42%
Standard	92.00%

Incomplete Pathways Wait (>52 Week Wait)



Month	Aug 23
Actual	107
Standard	0

Diagnosis <6 Weeks (DM01 %)



Month	Aug-23
Actual	74.77%
Standard	99.00%

Summary of Current Issues/ Recovery Plans

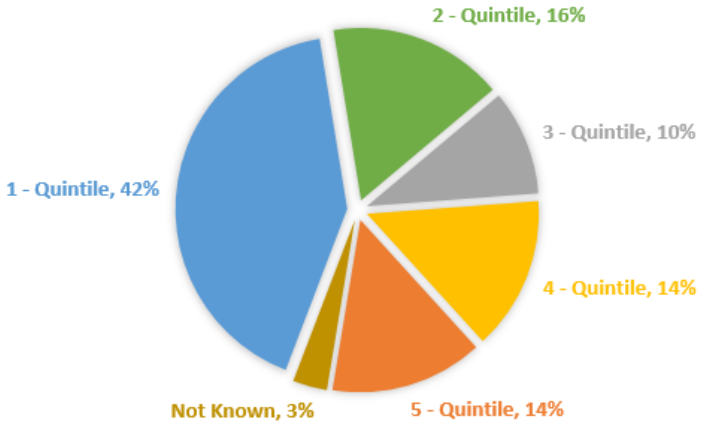
52-week waits have seen an increase this month, with the ongoing industrial action impacting on lost capacity. Latest benchmarking position being July, is reflective of a regional average at 68.7% and the national position reporting at 58.6%. The Trust is ranked 3rd regionally in relation to performance and 2nd with regards to the lowest number of 52 week waits.

The Trust maintained the position of no patients waiting longer than 104 or 78 weeks. There was two patients reported waiting over 65 weeks as at the end of August. All long waiters are regularly reviewed to ensure pathways are progressed by expediting appointments, however patient choice remains a factor.

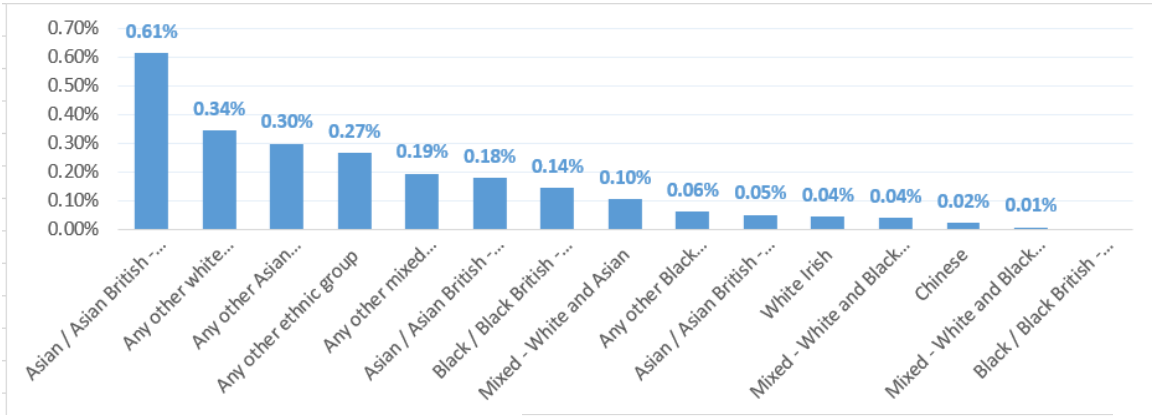
Although we continue to see challenges with Diagnostic waiting times, a number of key improvements are in place to support an increase in compliance. Greater MRI capacity has been created with the addition of a mobile unit at Hartlepool. Community Diagnostic activity is now taking place in Lawson Street Health Centre, supporting an increase in Capacity. Additional Endoscopy lists are being explored to aid a reduction in waiting times.

Responsive - Health Inequalities - RTT Waiting List

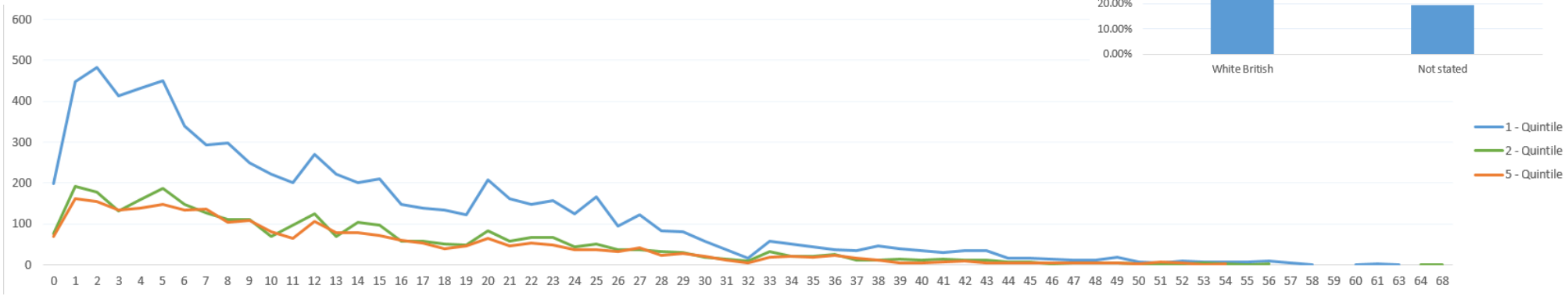
By Deprivation Quintile (1 Most - 5 Least Deprived)

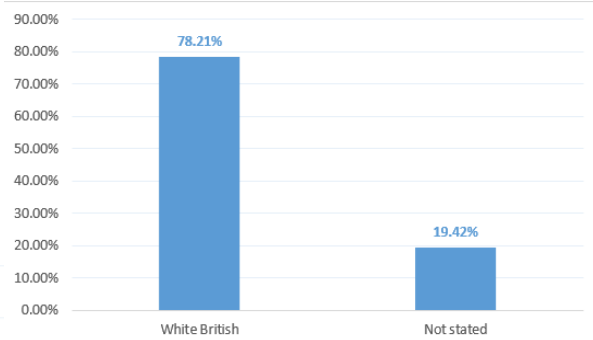


By Ethnicity



Waiting List by Weeks Waiting and Deprivation Quintile 1, 2 & 5

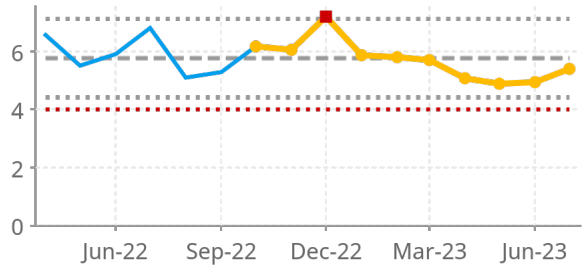




Well-Led People

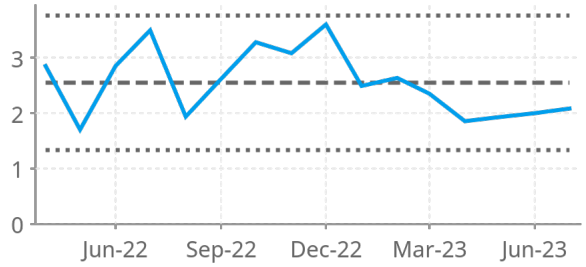
North Tees and Hartlepool NHS Foundation Trust

Sickness % - Trust



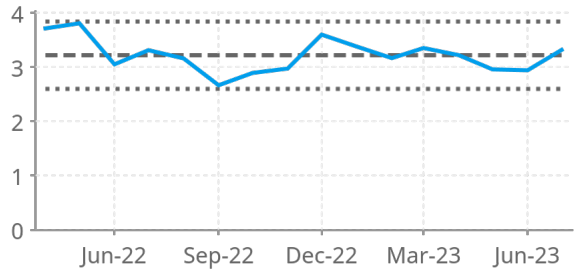
Month	Jul-23
Actual	5.39%
Standard	4.00%

Sickness % - Short Term



Month	Jul-23
Actual	2.08%

Sickness % - Long Term



Month	Jul-23
Actual	3.32%

Summary of Current Issues/ Recovery Plans

The sickness absence rate increased from 4.94% in June 2023 to 5.39% in July 2023.

Long-term sickness accounted for 3.32% of overall sickness with short term being 2.08%.

Stress/Anxiety/Depression, Back problems and other Musculoskeletal issues are the three highest classified reasons for absence, collectively accounting for 66.66% of the overall absence.

Covid absences saw a decrease to 0.03% in July 2023.

People Clinics continue to be undertaken at Care Group level to ensure robust management of absence and appropriate support to staff experiencing significant health and well-being concerns. This standardised approach for the management of absence of medical staff is being implemented.

The Absence task and finish group continues to progress with the development and improvements to policy, procedure, application and prevention of absence where possible.

Well-Led People

North Tees and Hartlepool NHS Foundation Trust

Appraisal %

Month	Aug-23
Actual	87.24%
Standard	95.00%

Summary of Current Issues/ Recovery Plans

The position for appraisal compliance for August 2023 from the Trust RAG report stands at 87.24% which is an increase of 0.68% on the previous month.

In order to support manager awareness and planning for appraisals, the education team provide monthly summary reports by department, directorate and Care Group level to aide in increasing compliance.

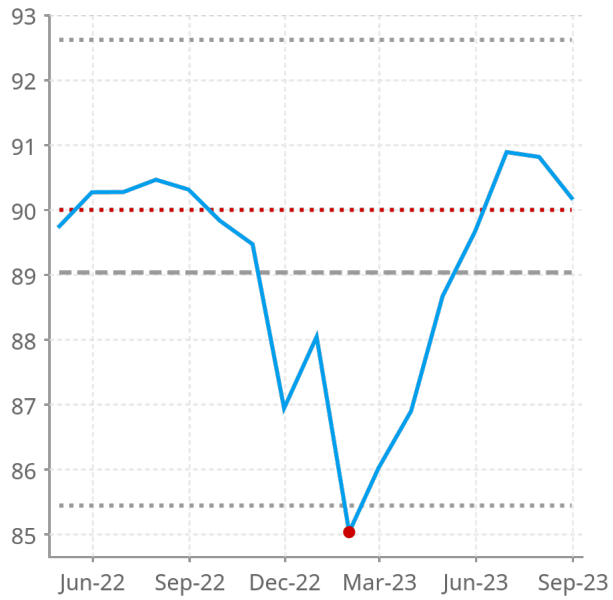
Engagement continues with the Care Groups and Corporate areas in supporting appraisals to take place and an improvement workshop was recently held to identify and address the barriers to achievement.

Following on from the improvement workshop, revised appraisal documentation has been trialled and is now being rolled out across the Trust.

The revised process and documentation incorporates talent management using 'Scope for Growth' methodology.

Well-Led People

Mandatory Training %



Month	Aug-23
Actual	90.18%
Standard	90.00%

Summary of Current Issues/ Recovery Plans

Mandatory training compliance for August 2023 is 90.18%, which represents a decrease on the previous month of 0.64%. Resuscitation topics remain a compliance challenge, specifically Intermediate Life Support (ILS). Following a review of Training Needs Analysis, work is underway to update competency requirements for specific roles to ensure staff undertake the most appropriate level of training depending on their role.

Care Groups and Corporate services are cited on departmental and individual level mandatory training requirements and are being supported via the relevant Clinical Educators in order to ensure address and improvements in compliance.

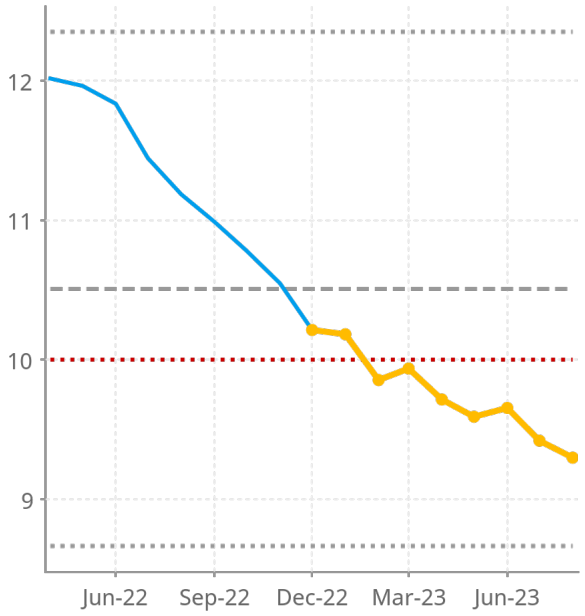
Mandatory training for medical staff remains an area of low compliance. The appointment of a new Medical Staffing Manager role will support both the Care Groups and Educators in identifying and addressing areas of concern and improvements required to achieve compliance.

Following a comprehensive review of mandatory training, agreement has been reached to move to a ‘core 10’ topics and

single reporting system via ESR. This is due to commence from the end of October 2023.

Well-Led People

Staff Turnover %



Month	Aug-23
Actual	9.30%
Threshold	10.00%

Summary of Current Issues/ Recovery Plans

Turnover for August 2023 is 9.30% which is 0.12% lower than July 2023.

The Trust recognises and acknowledges a healthy turnover, 10% , ispositive for the organisation as staff develop within their careers, specialism and others who decide to retire after years of service to patients.

Turnover rates in clinical staff groups are below the 10% threshold.

There is a noted increase in the number of staff internally transferring roles for development rather than exiting the organisation, reflecting the benefits of internal development of talent management opportunities.

Partnership working with colleagues at South Tees is progressing to undertake joint job evaluation processes across the two organisations. This will improve the standardisation of evaluation and banding of roles across organisations in order to address the migration of staff across Trusts due to banding differentials and improve retention.

Well-Led Finance

North Tees and Hartlepool NHS Foundation Trust

Overview - Month 5

Income/Expenditure	Plan (£000)	Actual (£000)
In Month	(195)	(472)
Year to Date	2,992	1,074

Capital	Plan (£000)	Actual (£000)
In Month	732	2,621
Year to Date	1,782	6,234

Balance Sheet	£m
Cash Actual	72.1
Cash Plan	69.8

*Broadly on plan.

NHS Oversight Framework	Issued 27 June 2022

Financial Efficiency

Financial Stability

Mental Health Investment

Agency Spending

The Trust has a breakeven financial plan for 2023/24 with reported risks relating to inflationary pressures and efficiency requirements.

At month 5, the Trust is reporting an in-month deficit of £0.472m against a planned deficit of £0.195m, which is £0.277m behind plan.

The Trust is reporting a year to date surplus of £1.074m against a plan of £2.992m, which is £1.918m behind plan.

Total Trust income in month 5 is £34.501m (including donated asset income and finance income), with pay expenditure totalling £24.647m and non-pay expenditure totalling £8.959m.

The month 5 year to date net contribution from Optimus is £0.110m against a plan of £0.071m (£0.039m ahead of plan) and the year to date net contribution from the LLP is £1.210m against a plan of £0.919m (£0.292m ahead of plan).

The Trust's cash position is £72.1m, against a plan of £69.8m, which is slightly ahead of plan.

The key risks at month 5 relate to the reduction of run rates and identification and delivery of CIP within the Care Groups. Industrial action continues to have a financial impact on the Trust's financial position and the delivery of elective recovery.

Maternity

Maternity Overview

	Current Month	Met	Actual	*National Standard or Average*	*NENC Average*
Antenatal					
Smoking at Booking	Jul-23	X	15.32%	*n/a*	*11.00%*
VTE Compliance	Jul-23	X	77.24%	*95.00%*	*n/a*
Right Place of Birth	Jul-23	X	100.00%	*100%*	*n/a*
Birth					
1:1 Care in active Labour	Jul-23	X	95.34%	*100.00%*	*n/a*
Labour ward Co-ordinator supernumary	Jul-23			*100.00%*	*n/a*
Number of babies born	Jul-23	*n/a*	222	*n/a*	*n/a*
Induction of Labour	Jul-23	✓	47.75%	*46.90%*	*46.90%*
PPH >1500mls (%)	Jul-23	X	6.31%	*3.30%*	*3.30%*
3rd & 4th Degree tears	Jul-23	✓	1.35%	*n/a*	*2.70%*
Assisted Birth	Jul-23	✓	7.21%	*n/a*	*12.90%*
Still Births	Jul-23	✓	0.00%	*0.40%*	*0.45%*
Postnatal					
Smoking at Delivery	Jul-23	X	17.12%	*n/a*	*11.00%*
Breast Feeding Initiated within 48 hours	Jul-23	X	49.10%	*n/a*	*74.40%*
Neonatal					
ATAIN Neonatal Admissions >=37 weeks	Jul-23	✓	5.15%	6.00%	*n/a*
Feedback					
Complaints	Jul-23	*n/a*	4	*n/a*	*n/a*
Compliments	Jul-23	*n/a*	59	*n/a*	*n/a*

The overview is split into the following sections:

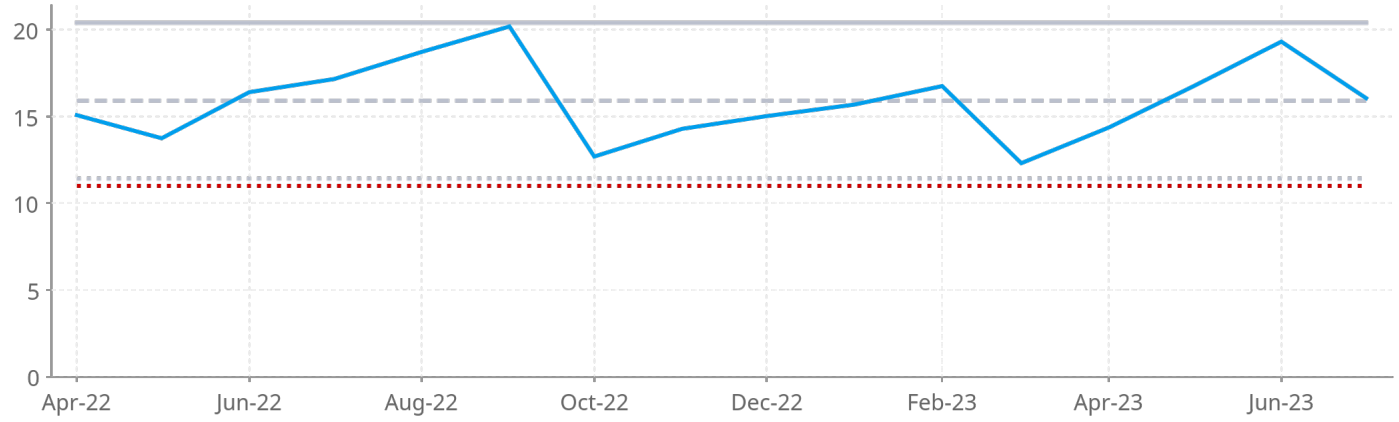
- **Pre-natal**
- **Birth**
- **Postnatal**
- **Neonatal**
- **Feedback**

The following maternity sections details measures, with the narrative to support if the Trust is achieving or not against the relevant standard and what the next steps and actions will be.

Maternity - Safe

NHS
North Tees and Hartlepool
NHS Foundation Trust

Smoking at Booking (%)



Month	Jul-23
Actual	16.06%
NENC Average	11.00%

Measure Summary

Smoking is a Public Health priority as it is a determinant of health, including being a potential contributing factors of stillbirths.

The Trusts local population rates of smoking are one of the highest in the North East of England and is reflected in the maternity population. To optimise health of the newborn and mother, there is a National recommendation to support a reduction in smoking or a cessation.

Actions

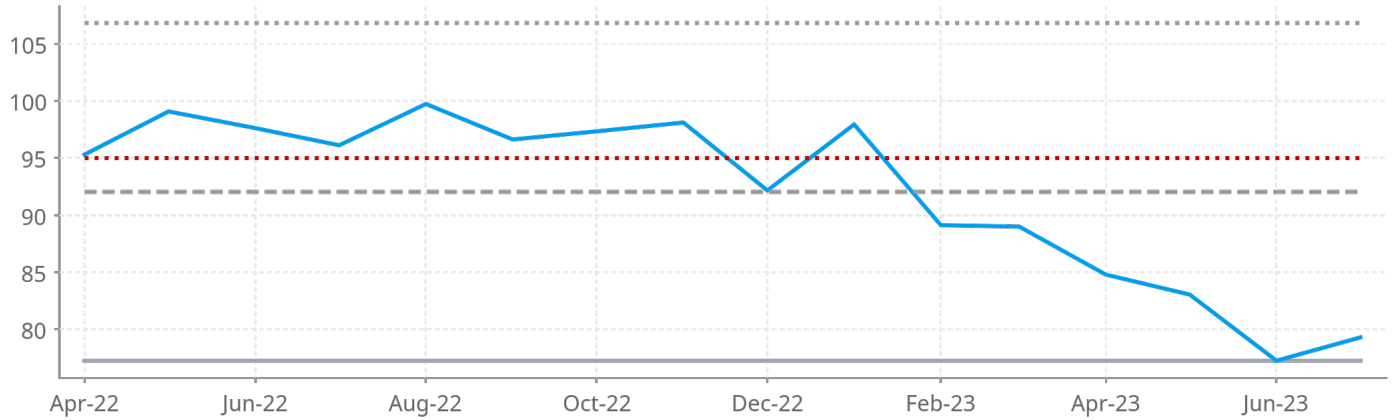
The Quality Improvement lead has initiated 4 projects:

1. Community led 12 week quit programme - positive initial results with a 500% increase in cessation rates.
2. Increasing the rate of measuring Co2 levels on admission
3. Increasing Referrals on admission to Tobacco dependency
4. Issuing Nicotine Replacement Therapy within maternity services

Maternity - Safe

NHS
North Tees and Hartlepool
NHS Foundation Trust

VTE compliance (%)



Month	Jul-23
Actual	79.29%
Trust Standard	95.00%

Meassure Summary

A decline in performance against the Trust standard has been seen over the last few months, with the latest value just above the lower confidence limit (LCL).

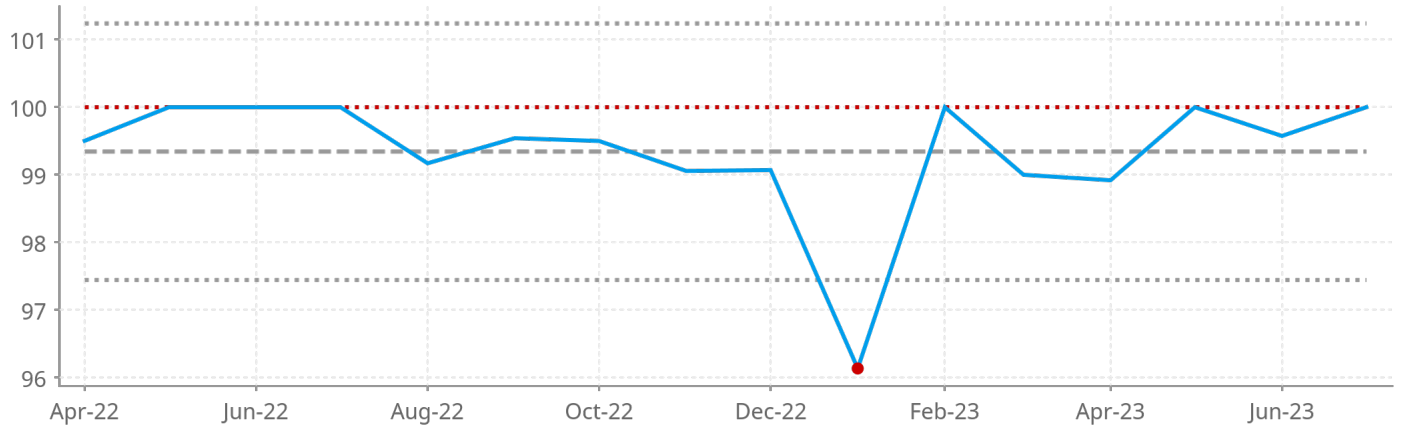
The maternity team has undertaken a review in July to explore and understand the reasons for this decline in compliance. Identified administration teams have supported clinical teams to upload completed VTE assessments onto Trakcare. Administration support has been limited due to workforce pressures over a period of a couple of months. This has informed an action plan to increase compliance.

Actions

1. A review of VTE Compliance started in July 2023.
2. Action plan has been developed and implemented in August.

Maternity - Safe

Right place of birth (%)



Month	Jul-23
Actual	100.00%
National Standard	100.00%

Measure Summary

The above chart represents the percentage of babies born in the right maternity service based on clinical indications for gestation.

In order to optimise outcomes for babies born with less than 30 weeks gestation, care should be delivered at a maternity service with a Neonatal Intensive Care Unit (NICU).

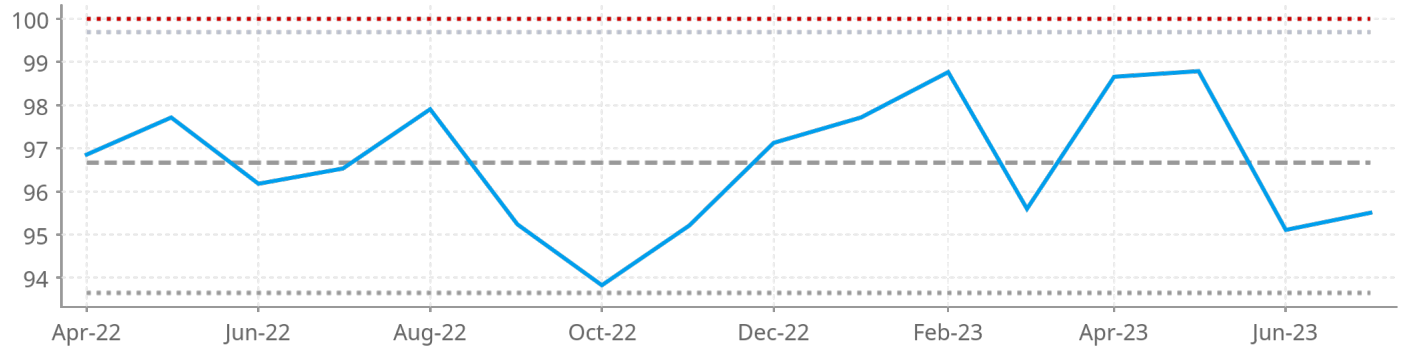
Actions

1. Metric to be developed further once the new Badgernet Electronic Patient Record (EPR) system is implemented (Phase 1 September 2023), this will enable reporting of the achievement of preferred place of birth.
2. Undertake a Multi Disciplinary Team case review for babies born at North Tees who had less than 30 weeks gestation period to identify themes and learning points.

Maternity - Safe

NHS
North Tees and Hartlepool
NHS Foundation Trust

1:1 care in active labour (%)



Month	Jul-23
Actual	95.51%
National Standard	100.00%

Measure Summary

1:1 care in active labour is monitored and reported weekly, with the data acquired from the Birth Rate plus (BR+) acuity app. Daily huddles are held by the Senior Clinical Matrons (SCMs) where a review and planned forecasting of staffing and activity occurs with information at that point in time. A key element of this review is to provide mitigation around red flags associated with staffing.

Actions

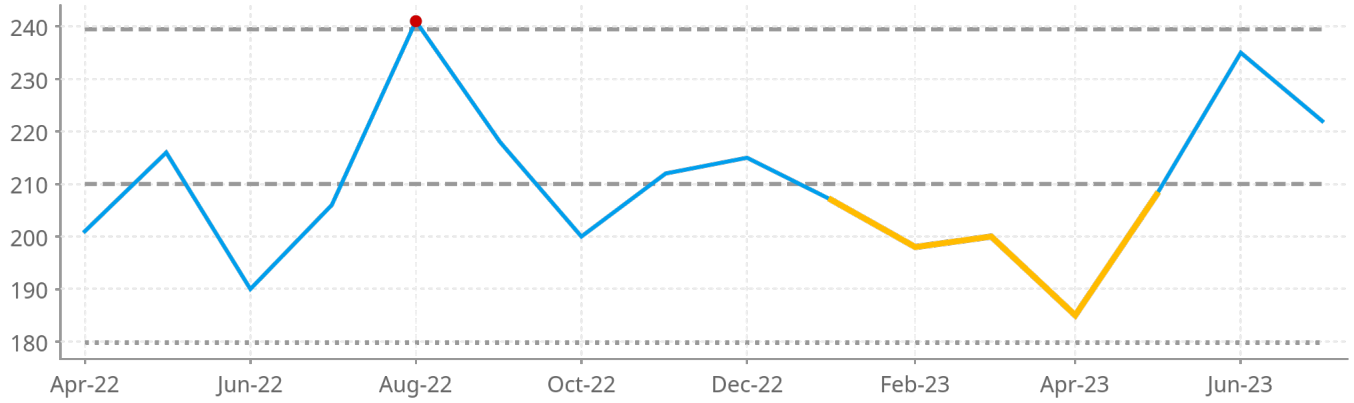
1. On-going work with the Labour ward Coordinators to ensure appropriate use of the acuity app and clinical decision making.
2. Typical escalation and mitigation include:
   - Redeploying staff
   - Utilisation of on-call staff
   - Reviewing and temporarily pausing elective activity

   At time of escalation mainly around out of hours, a midwife can oversee care of a postnatal women awaiting transfer whilst supporting a woman in active labour.
3. A full data validation process has commenced after a full data validation process has commenced and initial findings have shown there are 2 data sources; BR+ acuity tool and Trakcare. The questions on Trakcare will be removed in time for Badgernet EPR implementation. Data will sourced from the BR+ acuity tool will be the only data source.

Maternity - Safe

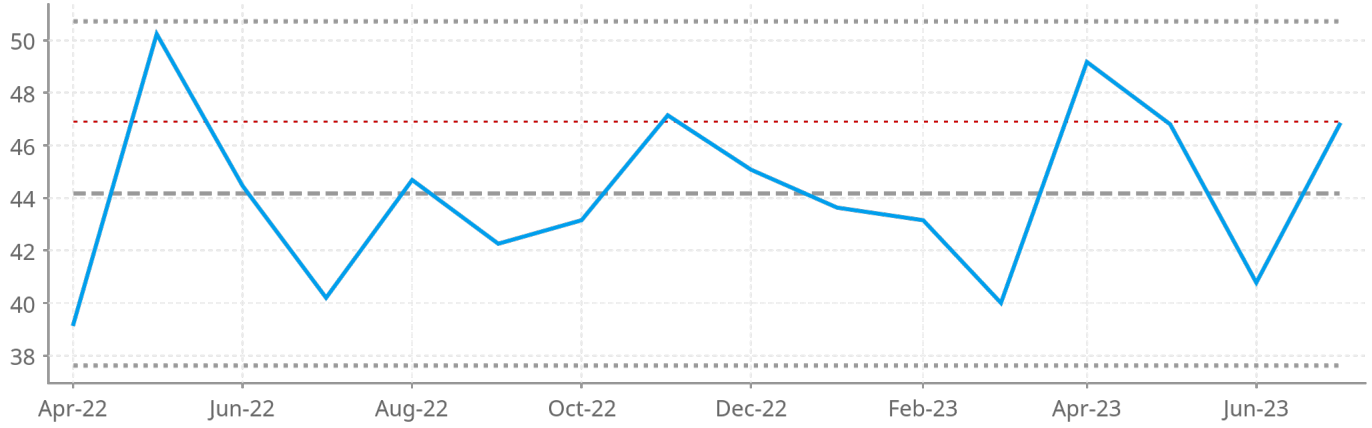
NHS
North Tees and Hartlepool
NHS Foundation Trust

Total Births



Month	Jul-23
Actual	46.79%
NENC Average	46.90%

Induction of Labour (%)



Measure Summary

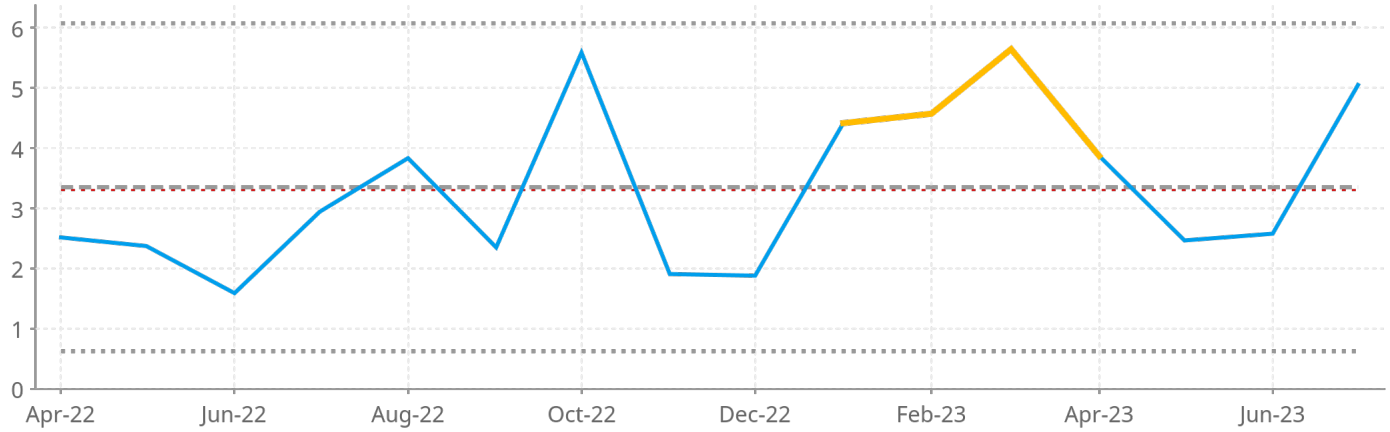
The Induction of Labour (IOL) rate at North Tees and Hartlepool is representative of the national increase in rates.

There is no local or National standard associated with this metric.

Maternity - Safe

NHS
North Tees and Hartlepool
NHS Foundation Trust

Postpartum hemorrhage > 1500mls (%)



Month	Jul-23
Actual	5.05%
NENC Average	3.30%

Measure Summary

The increase in Postpartum Hemorrhage (PPH) rates is attributed to the recently introduced Quality Improvement (QI) project which accurately measures blood loss rather than estimating.

Actions

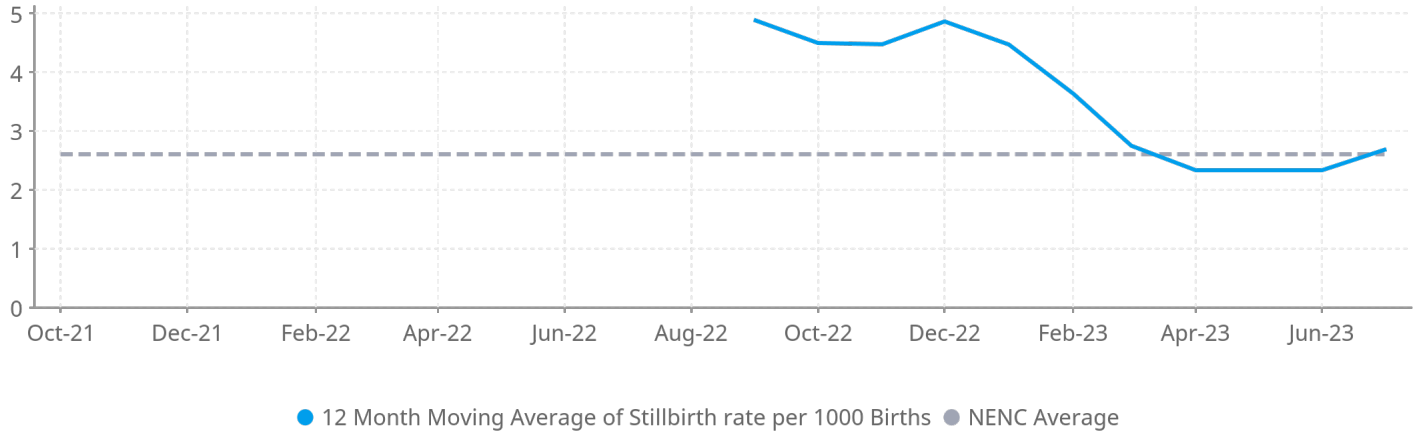
Next steps of the project include:

1. Introducing an enhanced risk assessment tool to promote earlier intervention and assess impact of this on major haemorrhage rates.
2. A thematic case review did not identify any themes. The rise in PPH rates corresponds to the QI project to measure blood loss.

Maternity - Safe

North Tees and Hartlepool NHS Foundation Trust

Still births (%)



Month	Jul-23
Actual	0.90%
NENC Average	0.45%

Measure Summary

A thematic review was undertaken and the commonality was smoking in pregnancy. The Smoking in Pregnancy QI work will be evaluated to include any change in outcomes for those women who experience a stillbirth.

From April 2023, a bereavement midwife commenced with the Trust.

This measure was changed to a 12 month rolling average per 1000 births, in line with national reporting standards.

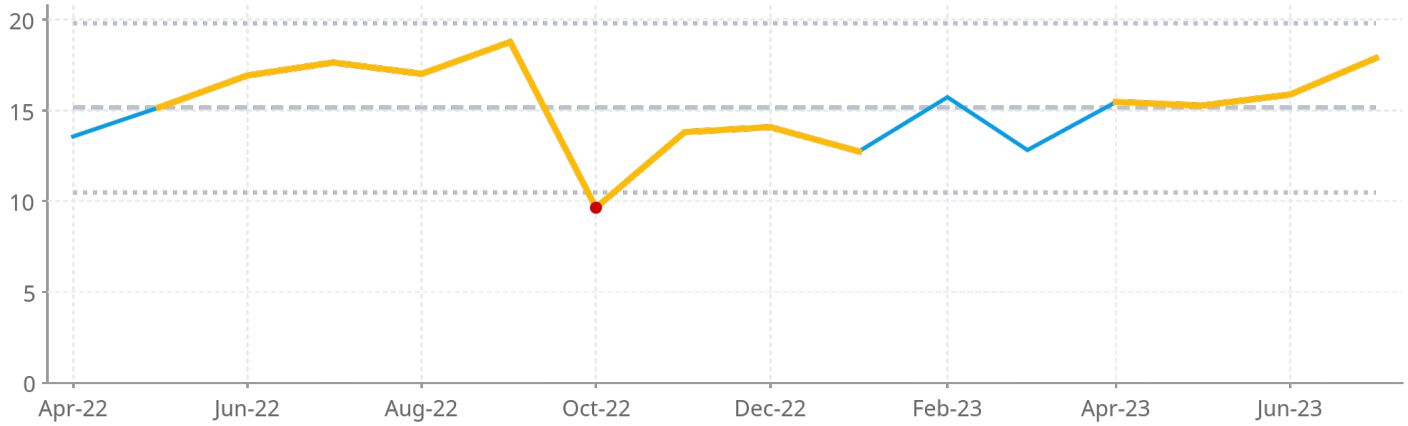
Actions

1. Key focuses include support offered to women and their families and benchmarking services against the National Bereavement Care pathways.
2. Continue with Smoking in Pregnancy Quality Improvement Project.

Maternity - Safe

NHS
North Tees and Hartlepool
NHS Foundation Trust

Smoking at Delivery (%)



Month	Jul-23
Actual	17.89%
NENC Average	11.00%

Measure Summary

To optimise health of the newborn and mother, it is a recommendation to support a reduction in smoking or a cessation.

Local population rates of smoking are one of the highest in the North East of England and is reflected in the maternity population.

Actions

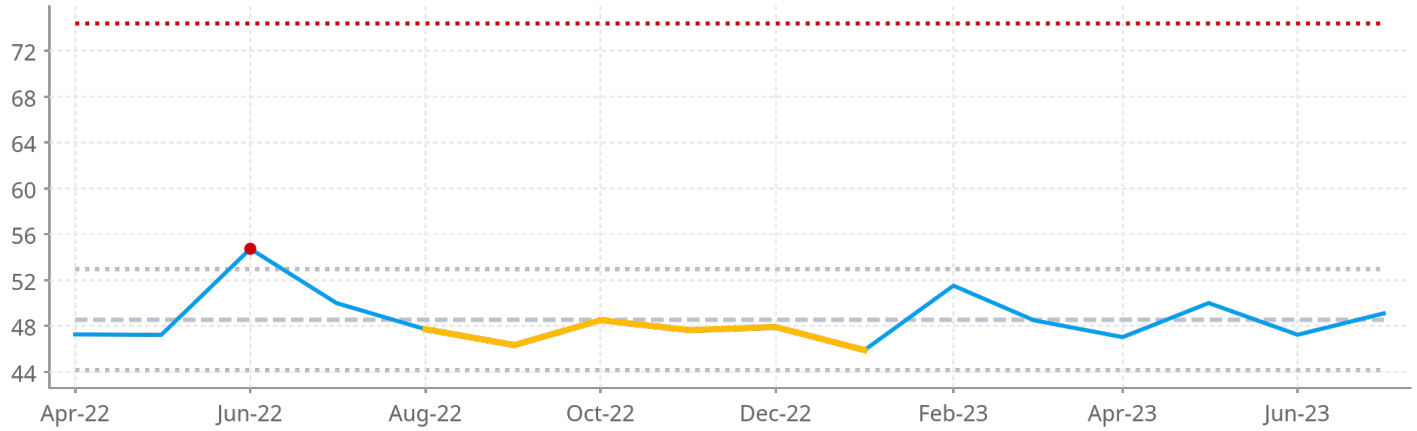
The Quality Improvement lead has initiated 4 projects:

1. Community led 12 week quit programme
2. Increasing the rate of measuring Co levels on admission
3. Increasing Referrals on admission to Tobacco dependency
4. Issuing NRT within maternity services

Maternity - Effective

NHS
North Tees and Hartlepool
NHS Foundation Trust

Breast feeding initiated within 48 hours



Month	Jul-23
Actual	49.10%
NENC Average	74.40%

Measure Summary

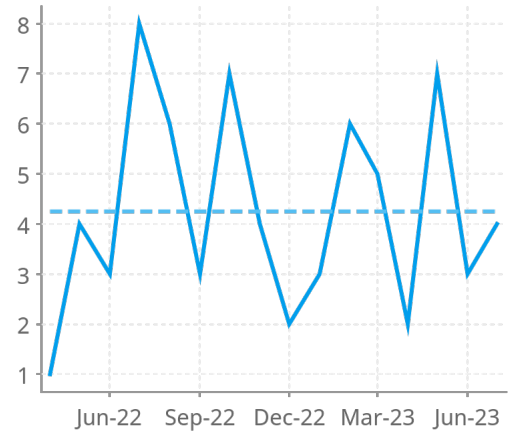
The Trust has some of the lowest rates of breast feeding in the North East.

To provide assurance and to increase rates through knowledge and support, the Trust employed an infant feeding specialist midwife who commenced this role at the start of 2023, with the key focus to gain Breast Feeding Initiative (BFI) accreditation. It is expected the service will achieve year 1 by the end of the financial year.

Maternity - Responsive

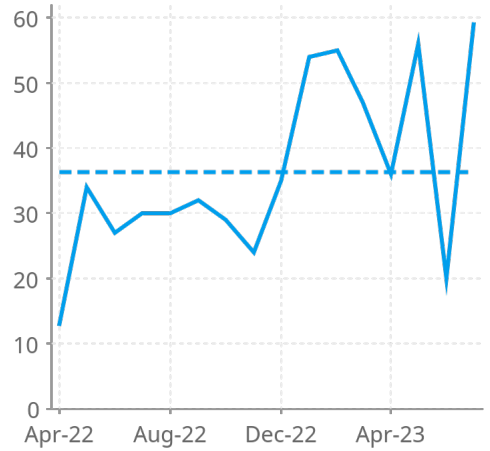
North Tees and Hartlepool NHS Foundation Trust

Complaints



Month	Jul 23
Actual	4

Compliments



Month	Jul-23
Actual	59

Measure Summary

There were 4 complaints in July around maternity services with themes of:

1. **Communication**

Staff attitude and communication was identified as a theme in 3 complaints. Information not shared through departments. This will be actioned via mandatory training, staff briefings, staff handovers and meetings. Lack of flexibility for an antenatal booking was received.

Actions

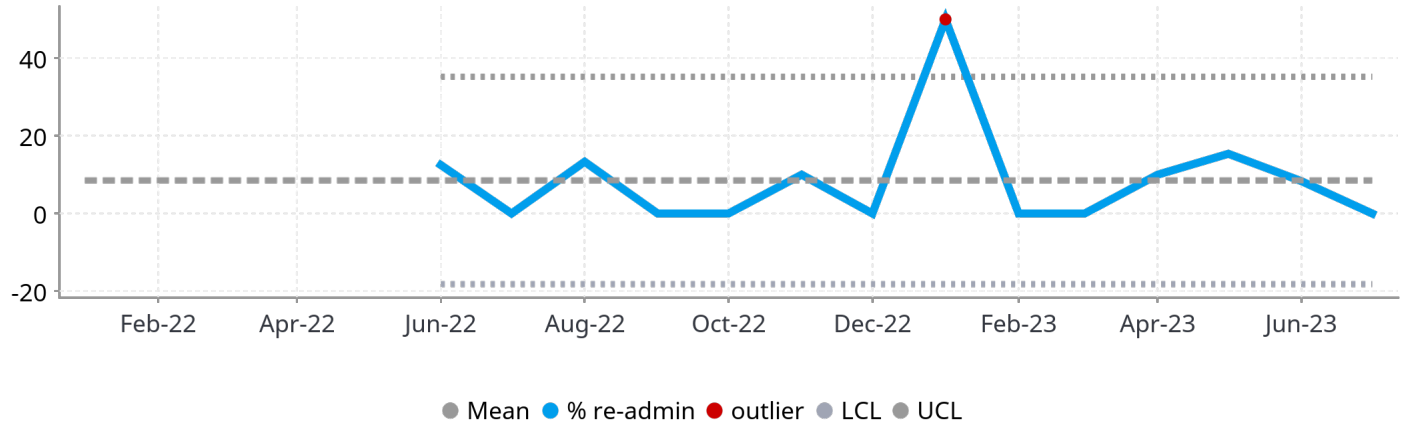
Maternity services recieved 59 compliments in July, the themes of compliments were:

1. **Reassurance**
2. **High level of care**
3. **Friendliness**
4. **Kind and caring department**

Maternity

NHS
North Tees and Hartlepool
NHS Foundation Trust

Re-admissions of babies



Month	Jul-23
Actual	0.00%
Standard	

Measure Summary

As a quality metric the perinatal team are being proactive in monitoring and reviewing readmission of babies to identifying any themes and learning points.
The maternity services have appointed an Infant Feeding Specialist Midwife and undertaking the Breast Feeding Iniative (BFI) accreditation programme. Infant feeding training and education is a possible contributory factor for readmissions for weight loss.

Actions

1. Continue with ongoing thematic reviews
2. A seperate review for weight loss and juandice to be conducted by the Infant Feeding Specialist Midwife

Excellence as our standard

NHS North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Learning from Deaths Report										
Date:	5 October 2023										
Prepared by:	Dr Julie Christie, Dr Katie Elmer										
Executive sponsor:	Elaine Gouk, Acting Chief Medical Officer										
Purpose of the report	To provide Mortality Data and update on the development of the Learning from Deaths Process.										
Action required:	Approve	x	Assurance	x	Discuss	x	Information	x			
Strategic Objectives supported by this paper:	Putting our Population First	x	Valuing 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:

- The latest SHMI value is now 97.5 (Feb 2022 to Jan 2023) from the previous rebased value of 96.8 (Jan 2022 to Dec 2022). The value continues to remain inside the 'as expected' range.
- The Hospital Standardised Mortality Ratio (HSMR). HSMR is no longer in use by the trust as of the end of March 2023.
- The Report outlines our projection for completion of the backlog of Structured Judgement Reviews over the next year.
- The Trust Mortality Leads continue to develop a comprehensive Learning from Deaths Strategy. Plans are in place to ensure completion of Structured Judgement Reviews. Other plans include a Learning from Deaths Steering Group to oversee implementation of the strategy, recruitment of a Co-ordinator into the team, collaboration with specialty groups and input into the PSIRF roll out.

Board Assurance Framework/Corporate Risk Register risks this paper relates to:

The Learning From Deaths programme is covered in BAF 1A, relating to the strategic risk in relation to effectiveness.

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*

Equality, diversity and or inclusion		Reputational	
Workforce		Environmental	
Financial/value for money		Estates and Facilities	
Commercial		Compliance/Regulatory	X
Quality, safety, experience and effectiveness	X	Service user, care and stakeholder involvement	X

Board Subcommittee meetings where this item has been considered (specify date)	Management Group meetings where this item has been considered (specify date)
Quality Committee, 7 August 2023	Quality Assurance Council, 12 July 2023

Recommendation	• The Board of Directors is asked to note the content of this report and the information provided in relation to how we learn from deaths within the Trust. • The Board are asked to note the on-going work programme to promote learning and quality improvements resulting from reviews of deaths, adhering to NHSE best practice guidance. Best Practice Guidance • The Trust Board are asked to support the current business case to facilitate a robust Learning from Deaths process including timely Structured Judgement Reviews, structured and systematic sharing of finding and linking to quality improvement.

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

5th October 2023

Learning from Deaths Report, Q1 2023-24

Report of the Medical Director

1. Introduction

1.1 In March 2017, the National Quality Board (NQB) published **"Learning from Deaths: A Framework for NHS Trust and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care", i**ncluding stipulations for the Quality Account. The report sets out the requirements necessary for a focused approach to learning from deaths of patients under our care.

1.2 Through identifying and understanding issues related to the provision of safe, effective and quality care, learning can be shared and improvements made.

1.3 This report presents both quantitative and qualitative data about the number of deaths and the care received by those patients, as well as our ongoing work to ensure we conduct an appropriate number of mortality reviews (Structured Judgement Reviews) to support this process.

2. Mortality Data

2.1. There have been 329 inpatient deaths from April-June inclusive

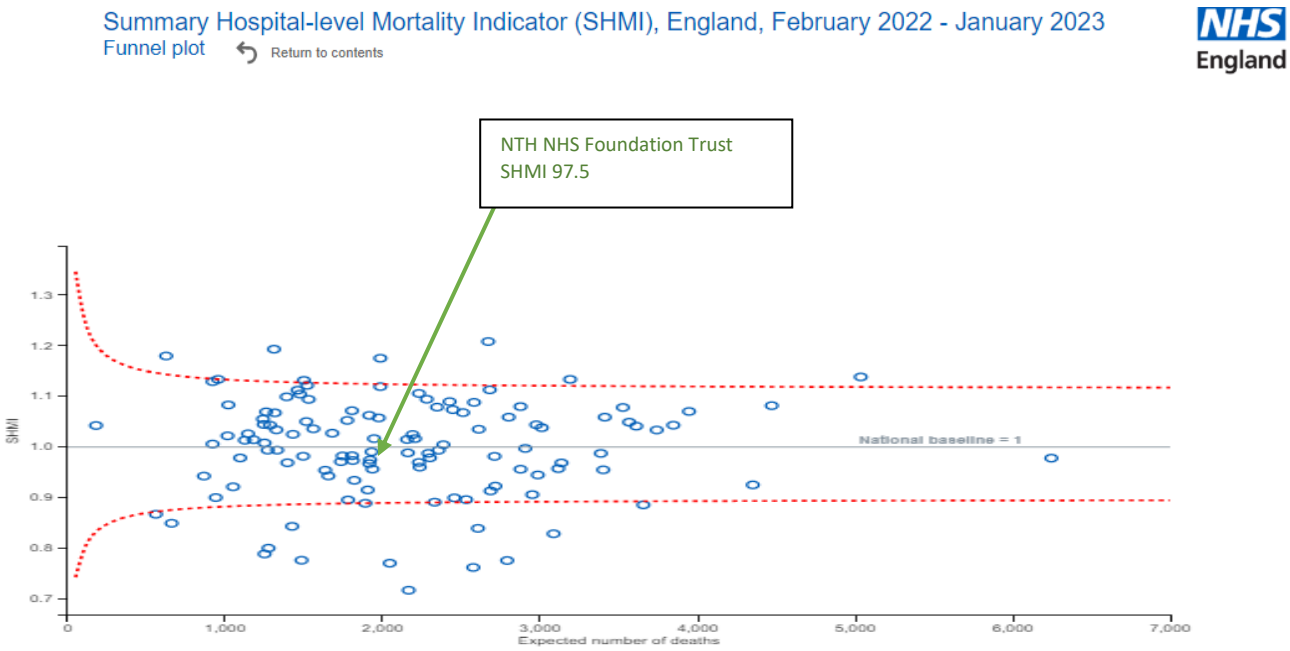
2.2. The Trust supplies data to the national system where all Hospital Episode Statistics (HES Data) is collated. There are two measures derived from these figures. Previous reports have included **The Hospital Standardised Mortality Ratio (HSMR).** HSMR is no longer in use by the trust as of the end of March 2023.

2.3. **The Summary Hospital-level Mortality Indicator (SHMI),** along with other measures such as Structured Judgement Reviews (SJR's) will form our overall mortality picture:

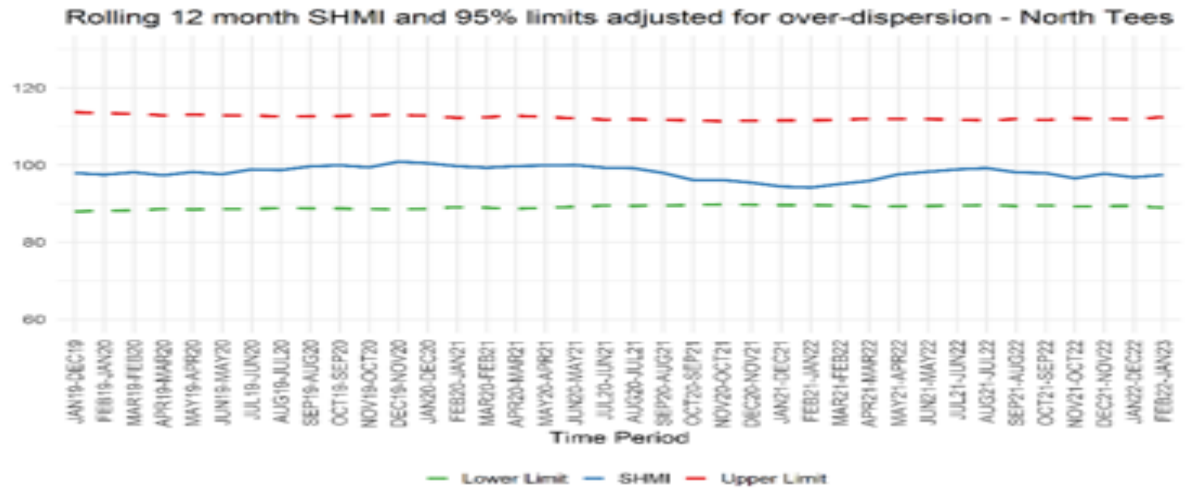
2.4. The **SHMI** is a ratio between the number of actual (observed) deaths to the "expected" number of deaths for an individual Trust, including deaths in hospital and up to 30 days following discharge. The ratio is calculated with consideration of gender, age, admission method, admissions in the last year and diagnosis being treated for the last admission.

2.4.1. The latest SHMI value is now **97.5** (Feb 2022 to Jan 2023) from the previous rebased value of **96.8** (Jan 2022 to Dec 2022). The value continues to remain inside the 'as expected' range.

2.4.2. This chart demonstrates our position amongst hospital trusts in England:



2.4.3. The graph below shows our rolling SHMI over a 12 month period.



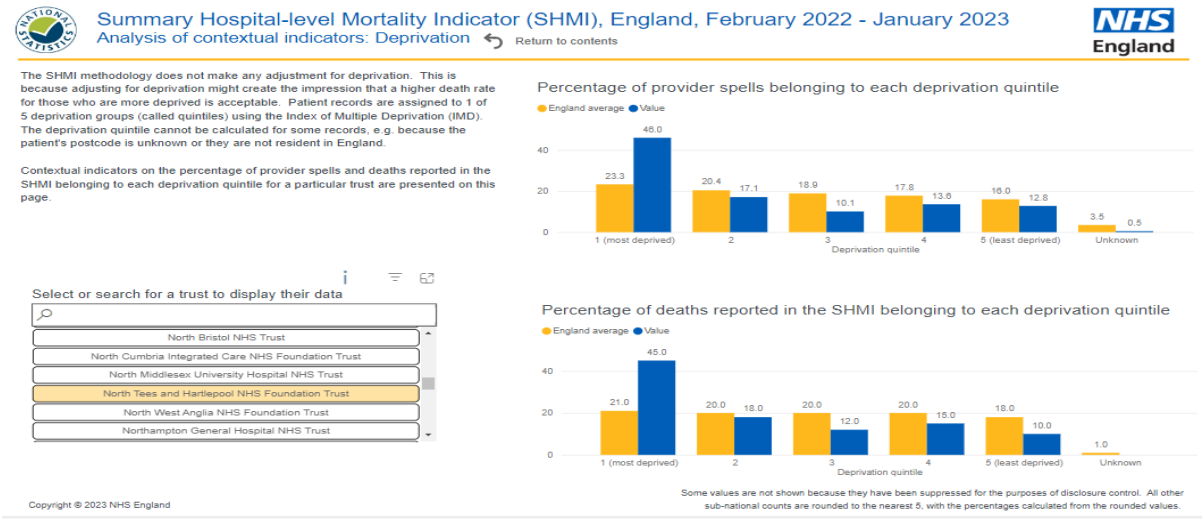
2.5. For all of the NENC trusts the SHMIs are 'as expected' except for Gateshead where the observed deaths had fallen since the period ending January 2022 and the SHMI is 'Lower as expected'.

2.6. In the latest period, there was an increase in observed deaths for most of the NENC trusts including North Tees and Newcastle.

2.7. The SHMI can be broken down further to look at specific groups of patients:

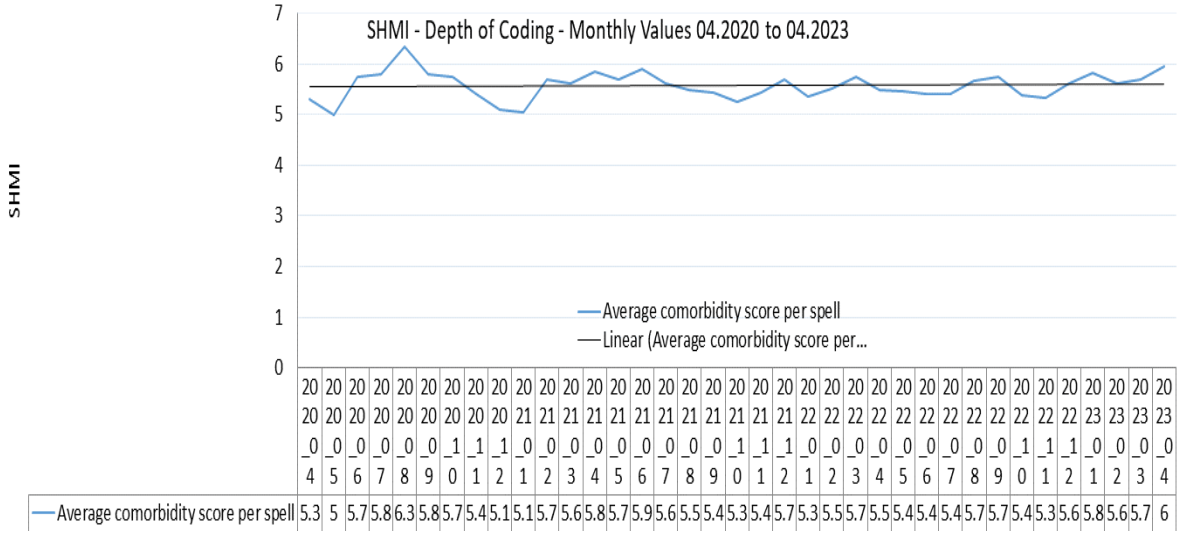
2.7.1. The table below shows that NTHFT SHMI for common diagnoses is within the expected range.

2.7.2. The graph below demonstrates that many of the people who die in our Trust are amongst the most deprived in our society. This has implications around access to diagnosis and treatment, multi-morbidity and complex social situations.



2.7.3 The Trust have approached NEQOS to ascertain if it is possible to separate a SHMI ratio for extended perinatal / neonatal deaths. If this is feasible, an update will be provided in future reports.

2.8 The depth of coding within the Trust remains consistent, as seen below.



	2020_04	2020_05	2020_06	2020_07	2020_08	2020_09	2020_10	2020_11	2020_12	2021_01	2021_02	2021_03	2021_04	2021_05	2021_06	2021_07	2021_08	2021_09	2021_10	2021_11	2021_12	2022_01	2022_02	2022_03	2022_04	2022_05	2022_06	2022_07	2022_08	2022_09	2022_10	2022_11	2022_12	2023_01	2023_02	2023_03	2023_04
Average comorbidity score per spell	5.3	5	5.7	5.8	6.3	5.8	5.7	5.4	5.1	5.1	5.7	5.6	5.8	5.7	5.9	5.6	5.5	5.4	5.3	5.4	5.7	5.3	5.5	5.7	5.5	5.4	5.4	5.4	5.7	5.7	5.4	5.3	5.6	5.8	5.6	5.7	6

3. Medical Examiner In-patient service:

The Medical Examiner Service has scrutinized 100% of the inpatient deaths.

2023 Quarter 1	April	May	June	Total
ME scrutiny recommending SJR	4	10	1	15
Coroner referrals (CR's)	49	40	23	112
Number of CR's taken for investigation	16	18	16	50

3.1. All in-patient deaths for the quarter underwent scrutiny and 15 were recommended for SJR's.

3.2. 112 deaths were notified to the coroner's office of which 62 had death certificates issued without further concern or investigation. The coroner, for post mortem or inquest, took on 50 deaths for further investigation. The majority are for an unknown cause of death or harm pre-admission.

3.3. The service continues to expand out into the community, collaborating with local GP practices.

3.4. Thematic analysis – the Q1 Thematic Analysis is awaited.

4. Structured Judgement Reviews:

4.1. The sessions for completion of Structured Judgment Review's (SJR'S) commenced in June. There are monthly sessions of 3-4 hours timetabled going forward. We have 12 trained reviewers from a range of specialties with more identified awaiting training. Sessions to train reviewers are planned. Reviewers have been asked to commit to attending 4 or more sessions each year.

4.2. SJR's will be considered in the following instances aiming for reviews in 10-15% of all cases

- Deaths where the bereaved or staff raise significant concerns about the care.
- Deaths in a specialty, diagnosis or treatment group where an 'alarm' has been raised (for example, an elevated mortality rate, concerns from audit, CQC concerns).
- Deaths where learning will inform the providers' quality improvement work.
- SJR recommended following Medical Examiner (ME) scrutiny
- Random selection

4.3. There is a backlog of 79 cases from last year and a further 15 from this quarter recommended for the SJR process by the Medical Examiner team.

4.4. On review a proportion of these are not suitable for the SJR process, as they have been reviewed by a different route e.g. safety event review, or the concern triggering SJR request related to pre-admission or out of hospital care. These will be removed from the list.

4.5. We will work through this list by completing roughly the same amount of new and historic cases.

4.6. A number of the cases are related to patients with mental health diagnoses – we will schedule an extra session for these and hope to encourage colleagues from the local mental health trust Tees, Esk and Wear Valley NHS FT, to train and contribute to this session

4.7. Going forward our aim is to look at community and pre hospital care as this is relevant and important. We are working on the best way to do this.

4.8. We estimate a timescale of 10-12 months to work through these SJRs

5. Avoidable Deaths

We have not identified any preventable deaths, or deaths related to problems in care.

6. Mortality in specific groups:

6.1. LeDer

No deaths of patients with Learning Disability for this report

Going forward we are liaising with the Trust Lead for learning disability to ensure our work compliments the reports we receive from the LeDer inquiries.

7. Maternity

No maternal deaths for this report.

8. Coroner Regulation 28 reports

The Trust has not received any Regulation 28 reports.

The Trusts Claim and Coroners team review the overarching summary reports published by the Chief Coroner to support learning and improvement in the trust.

9. Alerts/reports

9.1. A recent NCEPOD report, Re-measuring the Units, looked at the care of people admitted to hospital with Alcohol Related Liver Disease. The report looks at multiple areas including admission to critical care, involvement of palliative care and mortality reviews of patients who die. There have been a number of developments within the Trust including a joint Liver MDT between Gastroenterology and Palliative Care.

https://www.ncepod.org.uk/pdf/current/Remeasuring%20the%20Units_full%20report.pdf

9.2. NCEPOD End of Life Care Study.

Currently collecting data, looking at heart failure, dementia, lung cancer and liver disease deaths in hospital and in the community. Looking at recognition of dying, communication across sectors, advance care planning.

10. Audit

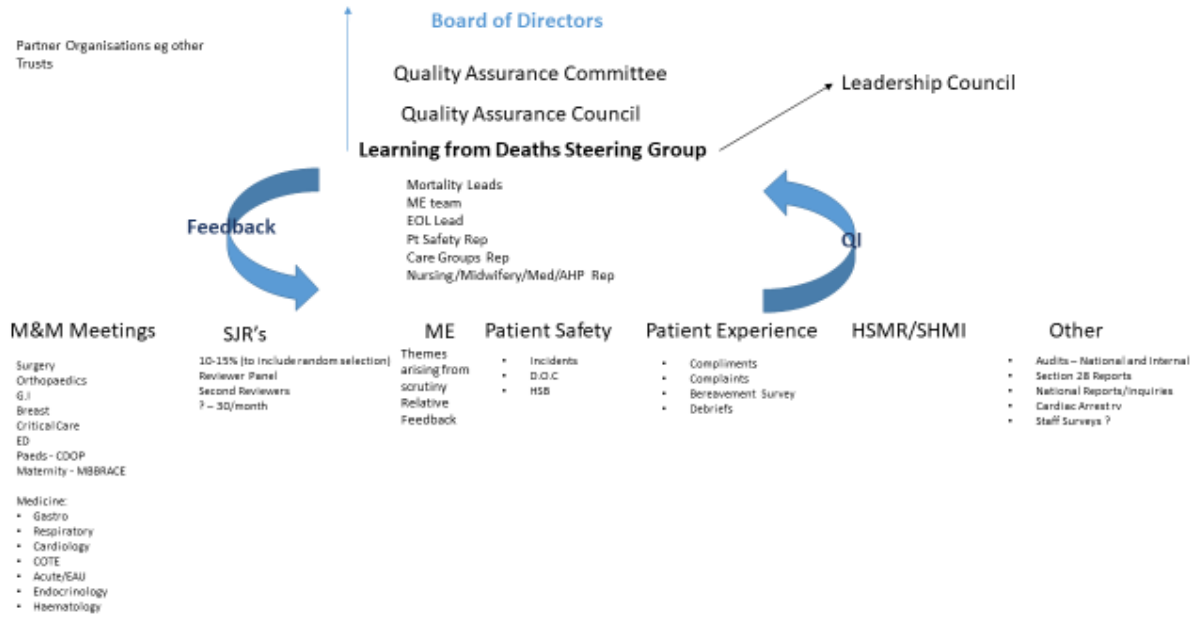
The trust participated in the annual 'National Audit of Care at the End of Life (NACEL)' which looked at the below measures:

1. Recognising the possibility of imminent death
2. Communication with the dying person
3. Communication with families and others
4. Involvement in decision making
5. Individualised plan of care
6. Needs of families and others
7. Families' and others' experience of care
8. Workforce/specialist palliative care
9. Staff confidence
10. Staff support
11. Care and culture

The results showed that we have maintained high standards of end of life care. In a few areas (eg use of individualized plan of care) there is ongoing work to improve care, for example through the End of Life Facilitator Role

11. Plans for the Learning from Deaths Service

We continue to work towards a comprehensive approach to Learning From Deaths:



Current developments:

11.1. We are using the SJR Plus App to facilitate our reviews. Ultimately, this will produce an interactive dashboard.

11.2. Job description for Learning from Deaths Co-coordinator role submitted to the Workforce Department, with a plan to begin recruitment soon.

11.3. SJR reviewer recruitment and training going well.

11.4. Terms of reference for the Learning from Deaths Steering Group have been drafted, members to be invited and meeting dates set soon.

11.5. There is ongoing work with the Trusts PSIRF Implementation group as stakeholders.

11.6. Meetings planned with Paediatrics and Maternity colleagues to establish best ways of working together.

11.7. We continue to attend the Regional Mortality Surveillance Group and have joined a national Learning from Deaths Community of Practice.

Next stages:

11.8. Review of Morbidity and Mortality Meetings across the Trust with a view to standardization where appropriate. This will also enable relevant information to feed into Learning from Deaths Steering Group and learning to be disseminated.

11.9. Explore opportunities to collaborate across settings (e.g. hospital and community) and between organisations.

11.10. Update Trust Learning from Deaths Policy.

12. Conclusion/Summary

12.1. The latest SHMI value is now **97.5** (Feb 2022 to Jan 2023) from the previous rebased value of **96.8** (Jan 2022 to Dec 2022). The value continues to remain inside the 'as expected' range.

12.2. The Report outlines our projection for completion of the backlog of Structured Judgement Reviews over the next year.

12.3. The Trust Leads for Mortality and Learning from Deaths continue to establish a comprehensive process, overseen by the Learning From Deaths Steering Group.

13. Recommendations

13.1. The Board of Directors is asked to note the content of this report and the information provided in relation to how we learn from deaths within the Trust.

13.2. The Board are asked to note the on-going work programme to promote learning and quality improvements resulting from reviews of deaths, adhering to NHSE best practice guidance. Best Practice Guidance

13.3. The Trust Board are asked to support the current business case to facilitate a robust Learning from Deaths process including timely Structured Judgement Reviews, structured and systematic sharing of finding and linking to quality improvement.

Dr D Dwarakanath
Medical Director / Deputy Chief Executive

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NHS North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Guardian of Safe Working Hours Annual Report August 2022 to July 2023										
Date:	September 2023										
Prepared by:	Mr Rajesh Nanda, Guardian of Safe Working Caroline Metcalf, Senior Rota Lead										
Executive sponsor:	Elaine Gouk, Acting Chief Medical Officer										
Purpose of the report	The New Junior Doctor Contract (2016) requests that the Guardian of Safe Working Hours (GOSW) prepares a quarterly report and annual report to the Board of Directors. These reports contain information relating to the safe working practices of Junior Doctors within the Trust.										
Action required:	Approve		Assurance	x	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:

To safeguard junior doctors and patients the 2016 contract set working hour's limits and rest requirements, with the aim of preventing fatigue and burnout, and to protect training.

Providing assurance through a system of exception reporting, Guardians of Safe Working Hours (GOSW) ensure that the requirements of the contract are met and educational opportunities are not being missed. Where the Trust fails to meet these obligations, the Guardian has the power to levy financial penalties.

The purpose of this report is to provide data and identify trends captured through the exception reporting system and from the Junior Doctors Forum, highlighting key issues raised and areas of good practice.

Key points:

- The current Guardian of Safe Working was appointed to the role in September 2022.
- Engagement with the exception reporting process continues to improve, with a total of 214 exceptions submitted by 42 doctors in training.
- However, no reports have been submitted by Trust Doctors who often work the same rotas. Suggesting a lack of engagement within this group. Therefore, further work is underway to address this.
- Exception reports mostly reflect additional hours worked in medicine specialties, due to staffing shortages and workload pressures.
- Six fines have been levied by the Guardian (total of £385.95), due to doctors working beyond the maximum 13 hours' shift length and/or not achieving 11 hours rest between shifts.
- There has been a significant reduction in the number of overdue exceptions and those awaiting agreement.

- The increasingly busy nature of the hospital means that our doctors are regularly working beyond their contracted hours. Safeguards within rota design minimise the likelihood of penalties being levied.
- The leadership team within Medicine have taken on board previous concerns highlighted through feedback and exception reporting. Progress is being made in addressing handover and continuity issues with the input of their doctors. New rotas went live from August 2023.
- Shortfalls of junior doctors within medicine specialties is still a concern and the service should be supported in recruiting the required workforce.
- The 'out of hours' hot food provision (8-week pilot) was welcomed, however the Trusts decision to cease the service because of poor uptake has caused some upset amongst doctors in training. The Trust is now looking at vending machines as an alternative.
- Action has been taken to improve the communication and feedback with junior doctors through the introduction of a Guardian of Safe Working newsletter and intranet site.
- Regular Junior Doctor Forums are being held to engage doctors and discuss their issues and concerns, as well as provide feedback.
- Introduction of a QR code to allow quick and easy access to the exception reporting system.

Board Assurance Framework/Corporate Risk Register risks this paper relates to:

- Continued pressures could result in excessive working hours and could affect wellbeing.
- Resulting in possible breaches to safe working hours and rest requirements, and fines being levied.
- Doing nothing could result in loss of training posts creating further shortfalls, and impacting Trust reputation
- Shifts which are 13 hours long should be avoided where possible, in order to limit the risk of breaches.
- Shortfalls of junior doctors within medicine, workload, funding and recruitment greatest risk.
- Administrative support for the Guardians Team is needed due to Team changes and workload.

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*

Equality, diversity and or inclusion		Reputational	x
Workforce	x	Environmental	
Financial/value for money		Estates and Facilities	
Commercial		Compliance/Regulatory	x
Quality, safety, experience and effectiveness	x	Service user, care and stakeholder involvement	

Board Subcommittee meetings where this item has been considered (specify date)	Management Group meetings where this item has been considered (specify date)
People Committee 28th September 2023	

Recommendation	The Board of Directors is asked to note the content and accept this report.

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

September 2023

Guardian of Safe Working Annual Report August 2022 to July 2023

Report of the Guardian of Safe Working

1. Report

1.1 This report highlights data and trends captured through the exception reporting system. It presents key issues raised by Junior Doctors and forms part of the reporting requirements of the 2016 national terms and conditions of service.

1.2 The Guardian was appointed into the role in September 2022. Prior to this, there was a period where no Guardian or members of the Guardian's team were in post.

1.3 Whilst this has been addressed, it did result in a period of irregular Junior Doctors forums, overdue exceptions, and some doctors not knowing how to access the electronic exception reporting system, or where to go to for support. Since being in post the Guardian's Team has worked with doctors to make significant improvements.

1.4 Over the last twelve months (1 August 2022 to 31st July 2023) a total of 214 exceptions were submitted by 42 doctors **(appendix 1)**. Demonstrating continued engagement with the process when compared to previous years. There has been a significant reduction in overdue exceptions and those waiting for agreement.

1.5 The majority of exceptions are from foundation year one doctors (41%) and ST/CT1-2 training grades (41%). Five exceptions were marked as an immediate safety concern (ISC).

1.6 Six fines have been levied due to a breaches in the maximum 13-hours shift length and/or 11 hours rest between shifts. Equating to a total of 385.95 in fines, increasing the Guardian's reserves to £493.03. New guidance has been published by NHS Employers on when a fine should be applied **(appendix 2).**

1.7 Medicine specialties continue to receive the most exceptions (83%); however, they also have a higher proportion of trainees in comparison to other specialties. The majority of reports continue to relate to working hours (94%), highlighting a reliance on doctors working beyond their contracted hours and/or missing their breaks to deliver services. With staffing shortages, workload, work intensity, and handover perceived as the main causes.

1.8 Payment for additional hours worked is now the main outcome (71%) in response to the reports, as opposed to 'time in lieu' which is normally recommended to prevent burnout and breaches in working hours and rest requirements. This is in recognition that time in lieu may exacerbate current staffing and workload issues.

1.9 This increases the likelihood of breaches relating to working hours limits and rest requirements. However, Medicine rotas have avoided breaches as they comply with Trust recommended safeguards of a maximum average of 46 hours and 30 minutes, and a maximum of 70 hours per week when designing rotas.

1.10 It is not always possible for the Guardian to immediately identify whether a breach has occurred which attracts a financial penalty. This is due to some of the breaches having to be assessed over a period of time or a review of actual shifts worked. This requires a manual analysis. As the number of exceptions increases so does the work of the Guardian's Team. Therefore, further administrative support is required for the Guardians Team, by recruiting to hours previously lost.

1.11 Medicine rotas remain the main challenge, with Doctors in training continuing to report concerns relating to workload and staffing shortages. The clinical rota leads continue to review the working pattern with the aim of improving continuity on the wards.

1.12 New medicine rotas from August 2023 group front of house shifts and back of house shifts. Handover arrangements have also been reviewed. Whilst this doesn't increase workforce numbers it does aim to assist in reducing workload pressures through continuity and improved handover.

1.13 Part of this work included reducing shifts which were 13-hours in length to the recommended 12 hours and 30 minutes. The proposed amendments to the rota were discussed with existing trainees via teaching sessions and the Junior Doctors Forum. The amended rotas went live in August 2023.

1.14 Getting the staffing right within Medicine remains a priority and is a work in progress. Where staffing shortfalls are identified, it is recommended that Medicine are supported in recruiting the required workforce.

1.15 Despite the exception reporting process being open to Trust Doctors no exceptions have been received from this Group. Therefore, a key aim going forward is to raise awareness with the hope of improving engagement. Plans include adding a section to the Guardian's intranet site dedicated to locally employed Trust Doctors.

1.16 Concerns have previously been raised around out-of-hours catering facilities, not just for doctors but for all those who work in the evening and throughout the night. Following repeated requests from staff, the Tees restaurant piloted overnight opening hours. This was welcomed by the doctors' forum who would like to thank their catering colleagues.

1.17 Following the 8-week pilot, the trust took the decision to cease the service at the end of June 2023 due to poor uptake. The decision to stop the service caused angst amongst Junior Doctors. They feel that the venture should be more about supporting staff and raising morale rather than the economics of it. Having an out of hours' hot food provision is a recommendation in the BMA charter which the Trust signed up to. Vending Machines which provide hot meals are currently being looked at as an alternative.

1.18 By listening to our doctors we learnt that they can't always remember how to access the exception reporting system or find the link (URL) when it comes to reporting. In response to this, a 'quick response' (QR) code has been introduced to allow quick and easy access to the system.

1.19 The code has been well received and is being displayed on posters where doctors work or congregate **(appendix 3)**. All they need to do now is simply scan the code and log in. A Guardians intranet site has also been published, providing a central hub which doctors can access for support and information. Including guidance on exception reporting, flexible training, supported return to training. Feedback from doctors has been very positive.

1.20 During the Foundation School visit, feedback highlighted that communication needed to be improved so that doctors are reassured that action is being taken to address their concerns. To address this, a Guardian quarterly newsletter is being published. The first one has already been produced and displayed in the doctors' lounge, focusing on a 'you said, we did' theme. The poster includes the QR code created for quick access to the exception reporting system **(appendix 4)**

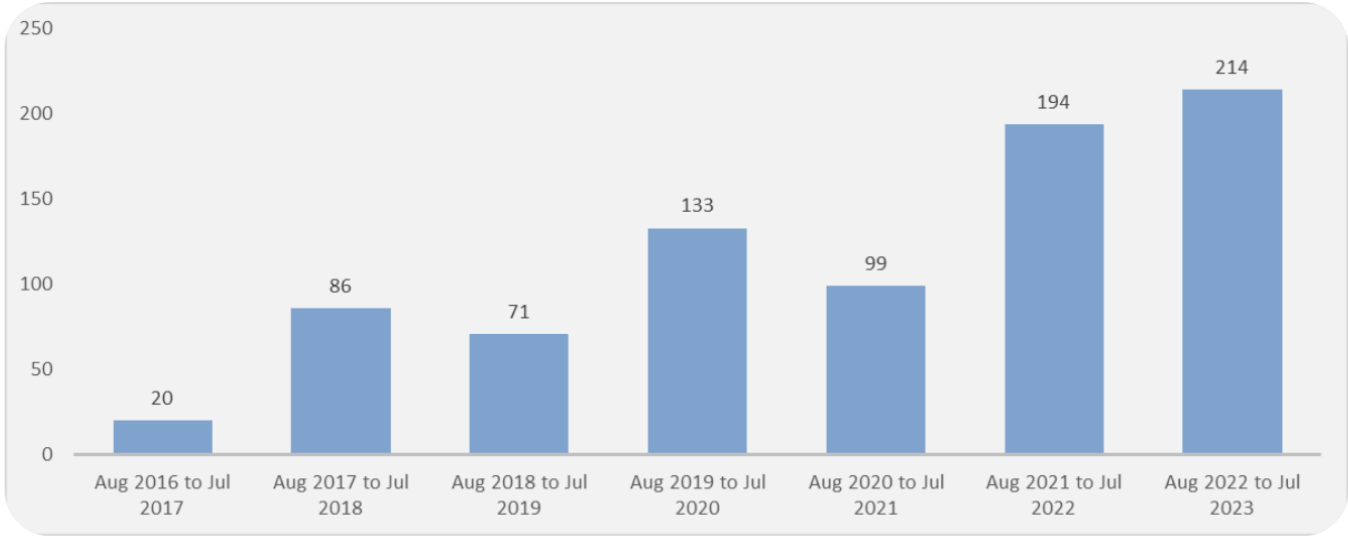
1.21 Regular Junior Doctor Forums are being held to engage doctors and discuss their issues and concerns as well as feedback to them.

2 Recommendation

2.1 The board are asked to note this report for information and assurance Receive the paper for information only

Mr Rajesh Nanda
Guardian of Safe Working

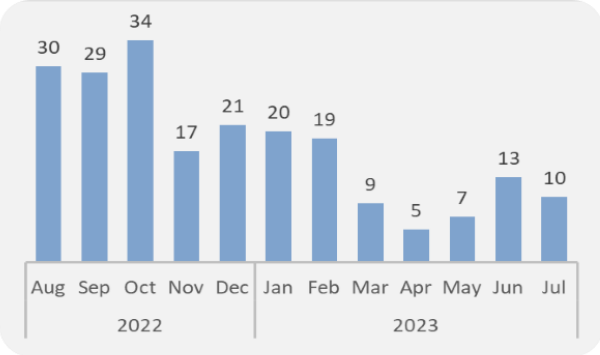
Highlights



- 214 exceptions submitted between 1st August 2022 to 31st July 2023, by 42 doctors
- 5 marked as an immediate safety concern (ISC). All FY1 doctors (4 in Medicine and 1 in Surgery)
- All exceptions submitted during this time are closed
- 6 **FINES** levied totalling £385.95, due to doctors working beyond the maximum 13 hours limit and/or less than 11 hours rest between shifts
- £144.88 of this was paid to the doctors and £241.07 went into the Guardians reserves. Putting the Guardian reserves at £493.03 at the end of July 2023.

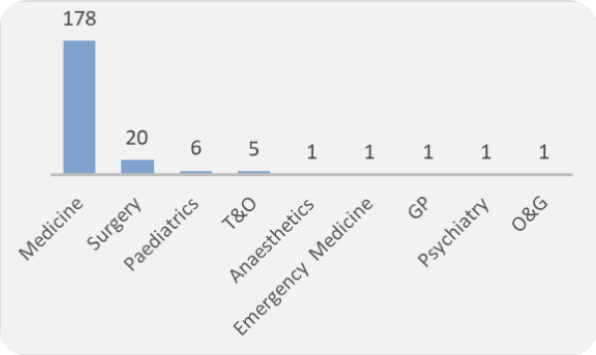
Exception reporting

1st August 2022 to 31 July 2023

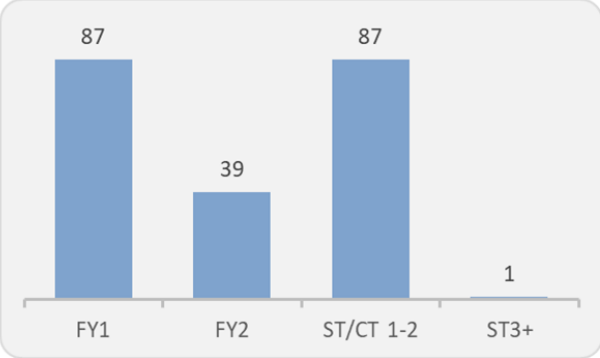


214 exceptions submitted

71% (151) were given an outcome of payment

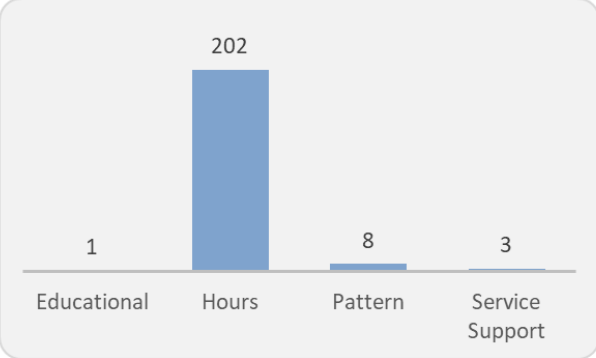


83% by doctors in Medicine specialties



Majority from Foundation and ST/CT1-2 doctors

None submitted by Trust Doctors



Majority (94%) relate to hours:

- 152 staying late
- 50 rest/missed breaks

Appendix 2: When a Guardian's fine should be applied

A guardian fine should be applied where any of the following breaches occur:

1. A doctor works in excess of the 48-hour average working week (across the reference period agreed for that placement in the work schedule).

2. More than 72 hours are worked across any consecutive 168 hour period.

3. A shift exceeds more than 13 hours in length.

4. A doctor does not achieve 11 hours of continuous rest in a 24 hour period (excluding on call periods).

5. A doctor does not achieve five hours of continuous rest between 22:00 and 07:00 during a non-resident on-call period.

6. A doctor does not achieve at least eight hours of total rest during a 24-hour non-resident on-call period.

7. A doctor has been unable to take their scheduled breaks on at least 25 per cent of occasions across a four-week reference period.

Appendix 3: Exception Reporting Poster

Includes tips:

- Adding the url to the home screen for an app like experience
- what to do if you can't remember your log in details
- Who to contact for help

Appendix 4: Guardian's Newsletter

YOU SAID. WE DID.

"We don't know how to access the exception reporting system"
We created a QR code which can be scanned for instant access to the system. It will be displayed in doctors' areas across the organisation.

"Out of hours catering facilities need improving"
The catering team will be piloting an out of hours catering service in April 2023.

"Where can we get information and support when we need it"
We've developed a Guardian of Safe Working intranet page to act as a central hub of information and support.

SCAN ME

"We want better feedback on the issues raised"
We will be publishing a Guardian newsletter to be displayed in the doctors lounge and on the intranet for those unable to attend the Junior Doctors Forum.

"Ward 42 doesn't have enough computers to do our job"
Additional PC's will be provided.

Rajesh Nanda
Guardian of Safe Working

Board of Directors

Title of report:	Maternity Board Report – PQSM and Training Syllabus										
Date:	05.10.2023										
Prepared by:	Stephanie Worn - Associate Director of Midwifery										
Executive sponsor:	Lindsey Robertson - Chief Nurse										
Purpose of the report	The purpose is to update the Trust Board on Maternity Services, in line with the national recommendations										
Action required:	Approve	x	Assurance	x	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				
Which CQC Standards apply to this report	Safe	x	Caring	x	Effective	x	Responsive	x	Well Led	x	

Executive Summary and the key issues for consideration/ decision:

The purpose of the report is to inform and provide assurance to North Tees and Hartlepool Foundation Trust (NTHFT) Trust Board that there is an effective system of clinical governance monitoring of the safety of our maternity services. The report is based on the perinatal quality surveillance model.

Quality and Safety
In July there were 2 cases for a perinatal mortality review tool (PMRT) review, a rapid review did not identify any learning points. There were no reportable cases that met the Healthcare Safety Investigation Branch criteria. The maternity services continue to work with the Simon Mehigan who is the maternity improvement advisor for the Maternity Safety Support Programme.

Culture and Leadership
The NTHFT quadrumvirate have joined the national Perinatal Culture and Leadership Programme and have been supported in this work by the Board Maternity Champion and Non-Executive Director Maternity Champion who have joined the related Futures platform workspace. There is organisational planning underway for the SCORE (Safety Culture, Operational risk, Reliability/burnout and Engagement) staff survey scheduled for later this year. There are plans in place to enable the Board Maternity Champion and Non-Executive Director Maternity Champion to have regular meetings with the quadrumvirate.

Key Performance Indicators
The report identifies the maternity dashboard metrics for July. It is recognised a decrease compliance of reporting VTE assessment onto TrakCare. A review has taken place by the Senior Clinical Matrons and an action plan has been implemented across in-patient areas. Continued Quality Improvement project for Obstetric Haemorrhage >1.5l. A risk assessment tool has been produced to interface with the new electronic patient record system and a thematic review of PPHs is underway. This month an improvement in Avoiding term admissions in neonates (ATAIN) was seen, with ongoing monthly MDT reviews and development of an action plan.

Workforce
The report identifies the funded establishment is compliant with BirthRate+. Staffing levels have continued to be challenging and this report details the steps that have been taken to mitigate staffing levels. In July 1-1 care in labour was 100% and 2 red flags were submitted for loss of labour ward coordinator (LWC) supernumerary status though on review this at a short internal of time as internal escalation was activated and the LWC did not provide 1-1 care. Recruitment continues at pace and the forecasted trajectory demonstrates an improvement for November. The service has seen several Band 6 midwives returning to NTHFT. Obstetric delivery suite cover was achieved. Work is underway within the medical workforce schedule to achieve full compliance with compensatory rest.

Maternity Training position
The obstetric emergency training with an overall compliance trajectory for all staff groups is demonstrated. Training is held monthly with the exception of August. Staff groups involved with maternity training include the following groups; midwives, maternity support workers, maternity assistants, obstetric consultants, doctors in training and anaesthetists. The Maternity Incentive Scheme requires all of the above staff groups to be trained, each group should have a minimum of 90% compliance with an all staff compliance of 90% during the monitoring period of the 1st December 2022 – 1st December 2023. There is a potential risk of non-compliance as training is to be multi-professional though within the MIS technical guidance it is not specific training must be quorate. A formal meeting is scheduled on the 14th September for SMT discussion at the Maternity Quality Assurance Council.

The maternity training core compete framework v2 (CCFv2) launched on the 30th May.The NENC Training Faculty has membership from all 8 Trusts and has co-designed a programme to fulfil the training requirements to achieve compliance and consistency with training to drive safer maternity care. The NENC Maternity Mandatory Training Needs Analysis, Syllabus and Assessment Framework constitutes an LMNS/ICB approved plan and aims to reduce repetition of training and support interoperable training across the ICB. The Trust Board is asked to approve the Maternity Training Syllabus.

Maternity Incentive Scheme (MIS) year 5
The starting point for year 5 is that we will be non-compliant with all 10. This is due to the date requirements for submission and potential amendments and additions to the requirements. The Maternity team are continuously monitoring progress towards compliance and report through the governance structures. There is a potential risk of non-compliance with the following:

Safety Action 4 - Medical staff compensatory rest
Safety Action 5 - Labour ward coordinator supernumerary status
Safety Action 8 – MDT Obstetric emergency training

Work is ongoing to review technical evidence and collate evidence for review at September's Maternity Quality Assurance Council meeting

Board Assurance Framework/Corporate Risk Register risks this paper relates to:
Risk 6643, Risk 6644

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or inclusion		Reputational	
Workforce	x	Environmental	
Financial/value for money		Estates and Facilities	

Commercial		Compliance/Regulatory	x
Quality, safety, experience and effectiveness	x	Service user, care and stakeholder involvement	x
Board Subcommittee meetings where this item has been considered (specify date)		Management Group meetings where this item has been considered (specify date)	
Quality Committee – 25 September 2023		Maternity Quality Assurance Council – 14 September 2023	
Recommendation	The Board of Directors are asked to note the content of this report and to derive assurance that there is continued focus on improvement and learning. The Board of Directors are asked to note the quadrumvirate Perinatal Culture and Leadership Programme work, SCORE survey plans and AQUA culture work that is supported by the Board Maternity Champion and Non-Executive Director Maternity Champion. The Board of Directors are asked to approve the Maternity Training Syllabus.		

North Tees and Hartlepool
NHS Foundation Trust

Maternity Perinatal Quality Surveillance Report for July 2023

Trust Board
October 2023

Maternity Perinatal Quality Surveillance Report July 2023

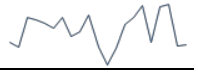
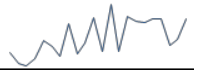
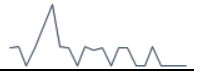
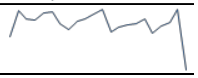
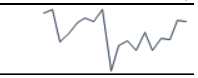
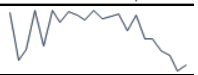
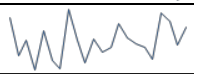
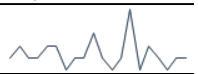
North Tees and Hartlepool NHS Foundation Trust

CQC Maternity Ratings 2022	Safe	Effective	Caring	Responsive	Well-Led	Overall
	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

Standard	Latest Value	Narrative
Findings from review of all perinatal deaths.	2 cases reported for PMRT	**PMRT - Learning & action from recent case reviews** Rapid review for learning undertaken, no immediate identified learning points. **HSIB** 1 case under investigation and 1 case completed and final report received in July. No Safety recommendations were identified from the final report. **Coroners Inquests and Regulation 28, Prevention of Future Deaths Reports** – Maternity Services have not had any cases which have been reviewed at a coroners inquest this month. **MIS** The reporting period is from the 30th May 2023 to 7th December 2023. Following discussions with the Maternity SMT, Care Group 1 SMT, Chief Nurse and the National Maternity Improvement Advisor, it was agreed compliance cannot be declared until the time of submission. The Maternity team are continuously monitoring progress towards compliance and report through the governance structures. Our current position demonstrates a potential risk of non-compliance with Safety Action 4,5,6 and 8. There are workforce pressures within the obstetric workforce. Reorganisation of activity to enable full compliance with compensatory rest for the obstetric workforce is being completed. Work is ongoing to review technical evidence and collate evidence for each Safety Action which is for review at September's Maternity Quality Assurance Council.
Findings of review of all cases eligible for referral to HSIB	0 reportable cases.	
HSIB/NHSR/CQC or other organisation with a concern or request for action Maternity Safety Support Programme	Ockenden: continued monitoring of Immediate & Essential Actions CQC must do's - ongoing monitoring MSSP - continued work with Simon Mehigan National Maternity Improvement Advisor	
The number of incidents logged graded as moderate or above	84 Incidents were logged this month : Zero moderate harms 80 x no harms / 4 x low harm	
The number of incidents related to out of hours supervision	0 incidents reported	
Progress with Maternity Incentive Scheme	Year 5 published 30th May 2023 . Current position all 10 Safety actions are deemed non complaint until time of submission .	

Maternity Perinatal Quality Surveillance Report July 2023

North Tees and Hartlepool NHS Foundation Trust

KPI	Latest value against target	
Number of Births	222	
1:1 Care in labour	95.34%	
3rd / 4th Degree Tear Rate	1.38%	
Obstetric Haemorrhage >1.5L	5.05%	
Still Birth Rate	0.90% / 0.45%	
Breastfeeding at first feed	49.10% / 74.40%	
Smoking at Booking	16.06% / 11.00%	
Smoking at Delivery	17.89% / 11.00%	
Right place of Birth	100% / 100%	
VTE assessment	77.24% / 95.00%	
Induction of Labour	46.79% / 46.90%	
Preterm Births (<30 weeks)	1	
ATAIN	4.2% / 6%	

Narrative

1-1 Care in active labour
National standard is 100%. Midwifery staffing compliance is reviewed on a weekly. a decrease in compliance occurs when the unit is in high acuity and in escalation. Mitigations to manage high acuity are followed. Further work ongoing with data quality and validation

Obstetric Haemorrhage
The results of a Post Partum haemorrhage >1.5L review has has been undertaken in conjunction with the clinical effectiveness team, with the data collection stage now completed. Q4 data demonstrated an increase in PPH rates which placed the Trust as an outlier within the NENC system however, it is to be noted not all Trusts have changed from estimated blood loss to measured blood loss therefore limiting comparison. The QI project continues

VTE assessment compliance
The Maternity VTE assessment is paper based. Compliance is recorded from TrakCare. A review has been undertaken which has informed an action plan. One theme identified from the review noted historically administration staff have supported the teams to complete the data input on TrakCare however, over the last few months administration support has been limited across all areas of maternity which is reflected in the months of reduced compliance. The action plan has been commenced and will be monitored. Additionally the administration support services have led a successful recruitment.

4 x Smoking in pregnancy projects
Weekly checks are now underway in all ward areas to asses if CO readings are taking place on admission and all smokers are being referred to tobacco dependency treatment service . An update is provided to each clinical area weekly on their progress.
Nicotine replacement therapy will be issued within maternity services
A community based 12 week stop programme is in progress and initial results have seen an increase in stop rates by

ATAIN – Avoiding Term Admissions Into Neonatal Units
Monthly review undertaken by neonatal and midwifery representatives

Maternity Perinatal Quality Surveillance Report July 2023

North Tees and Hartlepool NHS Foundation Trust

Standard	Latest Value
Service User Feedback	100% Positive Feedback
Feedback from frontline staff on champions walkabouts	July Walk About undertaken on Ward 22
Complaints	Stage 1: x3 Stage 2: x1
Compliments	59 received : 15 Generic 26 Rowan team & community 5 Delivery Suite 1 Maternity day assessment unit 12 Antenatal/ Postnatal ward
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment (reported annually)	54% 2022 Combined obstetric & gynaecology staff
Proportion of speciality trainees in obstetrics and gynaecology responding with excellent or good on how they would rate the quality of clinical supervision out of hours (reported annually)	82% 2023 report

Narrative

The Maternity and Neonatal Voices Partnership(MNVP)
The MNVP are supporting work with patient information leaflets.

The Board Maternity Safety Champions
July 'Walk About' highlighted areas associated with improvements in patient flow via IT and pharmacy. The culture was reported as more positive and staff expressed they felt an improvement in team working.

Complaints
Staff attitude and communication was identified as a theme in 3 complaints. Information not shared through departments. This will be actioned via mandatory training, staff briefings, staff handovers and meetings. Lack of flexibility for an antenatal booking was received. Community midwifery services are undergoing a service review to explore different ways of

Compliments
Compliments reflect satisfaction with care provided across the service. This includes face book feedback and an anniversary of a patients birth acknowledged.

Leadership and culture
The Perinatal quadrumvirate commenced the national Perinatal Culture and Leadership Development Programme. The work is supported by the Board and NED Maternity Champions, who have joined the workspace on the Futures platform and have a schedule for regular meetings with the quadrumvirate team associated with the champions' meetings. There is a focus in communication and forming a true collaborative leadership team. Currently in planning stage for the SCORE (Safety Culture, Operational risk, Reliability /burnout & Engagement) survey. AQUA culture work continues and renewed engagement is the priority.

Maternity Perinatal Quality Surveillance Report July2023

North Tees and Hartlepool NHS Foundation Trust

Workforce

RM vacancy position

	Budget	Establishment	Variance
Band 5/6 (RN's/RMs)	108.03	93.05	-14.98
Band 7 Clinical and SPMW	25.52	26.81	1.29

1-1 care in labour = 100%
Labour Ward Coordinator supernumerary - <100%
Obstetric Delivery Suite Cover = 100%
RM fill rate – 81.3%

The funded establishment is compliant with BirthRate+. The RM vacancy position is reflective of the inclusion of registered nurses in accordance

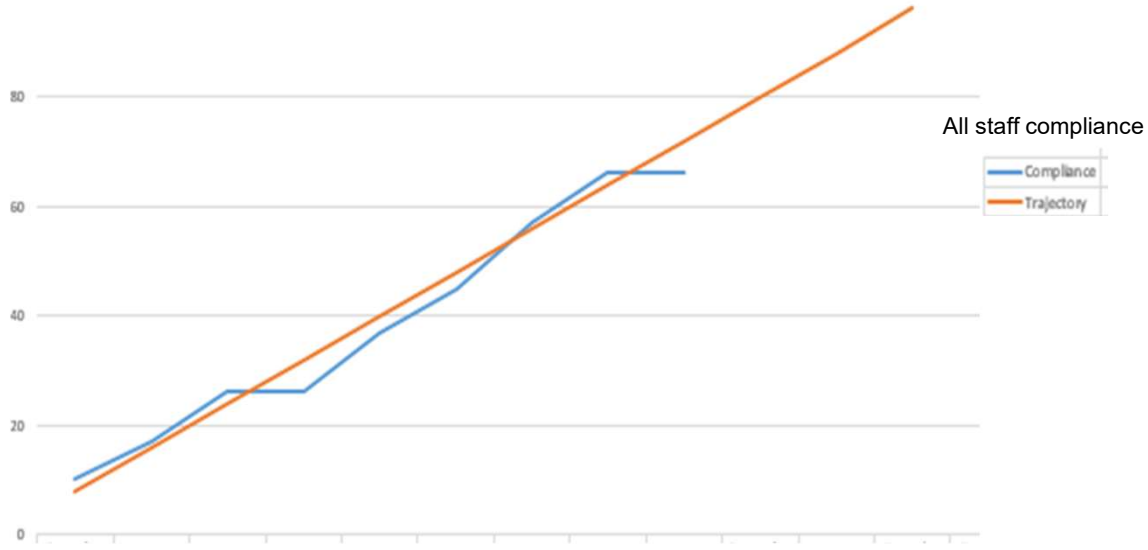
Staffing shortfalls have continued during this reporting period. A risk assessment of midwifery staffing is complete and on the risk register for the division with actions and controls in place to mitigate risks as listed below.

- Request midwifery staff undertaking specialist roles to work clinically
- Elective workload prioritised to maximise available staffing
- Managers at Band 7 level and above work clinically
- Relocate staffing to ensure one to one care in active labour and dedicated supernumerary labour ward co-ordinator (LWC) roles are optimised
- Activate the on call midwives from the community to support labour ward
- Supporting LW in the appropriate use of BR+ acuity tool and escalation decision making

Recruitment: the team have ran successful recruitment cafes, developed a preceptorship programme, agreed International recruitment of midwives and retention work.

Training position for MDT obstetric emergencies

	RMs	Cons	DiT	HCA/MSW/RN	Anae'ts
Number	13	2	2	6	0
Overall	62%	64%	90%	68%	50%



Maternity Perinatal Quality Surveillance Report July2023

North Tees and Hartlepool NHS Foundation Trust

Maternity Training - we ask for the trust Board approval

The maternity transformation programme aims to to address known variation in training and competency assessment across England. In December 2020 the Core Competency Framework was published followed by a revised version published in May 2023 – CCFv2

- The principle is to address significant areas of harm through training which includes minimum core requirements and standardisation for every maternity and neonatal service.
- Compliance with the CCFv2 is a condition of the Maternity Incentive Scheme Year 5, Safety Action 8, updated in July 2023. Safety Action 8: Can you evidence the following 3 elements of local training pans and 'in-house', one day multi professional training?
- The NENC Training Faculty has membership from all 8 Trusts and has co-designed a Programme to fulfil the training requirements of the CCFv2 to support Trusts to achieve compliance, and consistency, with training to drive safer maternity care. The NENC Maternity Mandatory Training Needs Analysis, Syllabus and Assessment Framework constitutes an LMNS/ICB approved plan and aims to reduce repetition of training and support interoperable training across the ICB

What does this mean for our Trust ?

- ✓ 3 day programme – No change in requirements as we provide a 3 day programme
- ✓ Training Content – No impact as we deliver the core requirements but the format we will become standardised with other Trusts
- ✓ Local mandatory training – No impact, staff will continue to undertake local mandatory training

NENC Maternity Training Needs Analysis

CCFV2

Maternity
Clinical Network
North East and North Cumbria

NHS
North East and North Cumbria
Clinical Networks

NHS
North East and
North Cumbria

Strategic Context

- Core competency framework version two, published 31st May 2023, sets out clear expectations for all trusts, aiming to address known variation in training and competency assessment across England. It ensures that training to address significant areas of harm are included as minimum core requirements and standardised for every maternity and neonatal service.
- Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

Required standard and minimum evidential requirement

1. *A local training plan is in place for implementation of Version 2 of the Core Competency Framework.*
2. *The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB.*
3. *The plan is developed based on the "How to" Guide developed by NHS England.*

Trusts should update their existing training plans in alignment with Version 2 of the Core Competency Framework.

<u>What training should be included for the Core Competency Framework Version 2?</u>

All 6 core modules in V2 of the Core Competency Framework (CCFv2) must be covered as detailed in the minimum standards.

Module 1: Saving babies' lives care bundle

- Requirements for this module have been aligned to the third version of the Saving Babies Lives Care Bundle (SBLCB).

- Minimum standard
- 90% attendance – annually for each element with eLfH module every three years.
- Training must include learning from incidents, service user feedback and local learning.
- Training must include local guidelines and care pathways.
- e-Learning can be appropriate for some elements.
- Learning must be responsive to local clinical incidents and service user feedback.

Module 2: Fetal monitoring and surveillance (in the antenatal and intrapartum period)

- Minimum standard, 90% attendance, annual update.
- All staff will have to pass an annual competency assessment that has been agreed by the local commissioner (ICB) based on the advice of the clinical network. Trusts should agree a procedure with their ICB for how to manage staff who fail this assessment. (Pass mark of 85%)
- **One full day's training in addition to the local emergencies training day.**
- Fetal monitoring lead trainers must attend annual specialist training updates outside of their unit.
- Training must:
- be responsive to local clinical incidents, service user feedback and local learning, using local case histories.
- include use of risk assessment at start of and throughout labour complying with fetal monitoring guidelines.
- include antenatal fetal monitoring, intermittent auscultation, and electronic fetal monitoring.
- be tailored for specific staff groups, e.g., homebirth or birth centre teams.
- be multidisciplinary and scenario based.
- include information about using the equipment that is available.
- include the fetal surveillance of multiple pregnancies.
- include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns; the content of human factor training must be agreed with the LMNS.

Module 3: Maternity emergencies and multiprofessional training

Minimum standard - 90% of each relevant maternity unit staff group has attended an ‘in-house’ MDT training day which includes a minimum of four maternity emergencies with all scenarios covered over a three-year period and priorities based on locally identified training needs:

Antepartum and postpartum haemorrhage.

Shoulder dystocia.

Cord prolapse.

Maternal collapse, escalation, and resuscitation.

Pre-eclampsia/eclampsia severe hypertension.

Impacted fetal head.

Uterine rupture.

Vaginal breech birth.

Care of the critically ill patient.

Annual update.

Training should be face-to-face (unless in exceptional circumstances such as the covid pandemic).

Module 4: Equality, equity, and personalised care

Minimum standard

- 90% attendance (three yearly programme of all topics).
- Training should cover local pathways and key contacts when supporting women and families.
- Training must include:
- learning from incidents
- service user feedback
- local learning
- local guidance
- referral procedures
- ‘red flags’
- One topic from each of the following lists must be covered as a minimum, identified from unit priorities, audit report findings, and locally identified learning, involving aspects of care which require reinforcing and national guidance.

Module 5: Care during labour and immediate postnatal period

- Minimum standard
- 90% attendance (three-yearly programme of all topics).
- Training must:
- include learning from incidents, audit reviews and investigations, service user feedback and local learning
- learning from themes identified in national investigations, e.g., HSIB
- have a focus on deviation from the norm and escalating concerns
- include national training resources within local training, e.g., OASI Care Bundle (obstetric anal sphincter injuries), RoBUST Operative Simulation Birth Course, prevention and optimisation of premature birth.
- be tailored for specific staff groups depending on their work location and role, e.g., homebirth or birth centre teams/maternity support worker (MSW).

Module 6: Neonatal basic life support

- 90% attendance at a neonatal basic life support annual update, either as an in-house neonatal basic life support training or newborn life support (NLS).
- Only registered RC-trained instructors should deliver their local NLS courses and the in-house neonatal basic life support annual updates.
- Training must:
- be ‘hands-on’ and scenario based and tailored to learning from incidents, service user feedback and local learning priorities
- include knowledge and understanding of NLS algorithm
- include recognition of the deterioration of Black and Brown babies
- include recognition of deteriorating newborn, action to be taken and local escalation procedures, and the use of SBARD tool for handovers (or local equivalent)
- include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns
- include human factors
- be tailored for specific staff groups depending on their work location and role, e.g., homebirth or birth centre teams/MSW
- cover scenarios in different environments and must include training on use of the equipment available in those environments to ensure staff are familiar.

Basic standards and opportunities

- 1 full day Fetal Wellbeing Training
- 1 full emergency skills training incl. basic newborn life support
- Equity, equality and personalised care

Currently variance in training plans and protected time, most Trusts currently have 3 days (Sunderland have 5 days) and some less than 3 days.

Repetition in training as staff rotate around NENC, duplication of effort and time.

Opportunity to standardise training syllabus in accordance with CCFv2

Reduce duplication with central register

Proposal

- Establish NENC MDT Training Faculty
- Introduce co-produced 3 day training plan for NENC
- Standardise training
- Adopt LMNS/ICB approved plan
- Pragmatic interim step for 2023/24 working towards 5 days of training as per CCFv2
- Set baseline for 2024/25
- Support CNST compliance
- Utilise Futures platform
- Use NENC training resources

- Training compliance would include training provided up until the Go Live date, and after December deadline for CNST training compliance ‘mop up’ training for those who haven’t received full syllabus to ensure standardised baseline for 2024/25
- Proposed ‘Go Live’ 4th September

North East and North Cumbria
Local Maternity and Neonatal System

NENC Maternity Training Needs Analysis, Syllabus and Assessment Framework

Standard Operating Procedure

Midwifery Clinical Lead: J Wall Obstetric Clinical Lead: S Robson Author (s): J Wall North East North Cumbria Local Maternity and Neonatal System	Document Type: Standard Operating Procedure Version: 1.0 Review Date: 26.7.2023 Date Ratified by LMNS Board:18.7.2023

Relevant to:

County Durham and Darlington NHS Foundation Trust, Gateshead Health NHS Foundation Trust, Newcastle Hospitals NHS Foundation Trust, Northumbria Healthcare NHS Foundation Trust, North Tees and Hartlepool NHS Foundation Trust, North Cumbria Integrated Care NHS Foundation Trust, South Tyneside and Sunderland NHS Foundation Trust, South Tees Hospitals NHS Foundation Trust; For all maternity staff, Obstetric consultants, all other obstetric doctors, Midwives (including midwifery managers and matrons, community midwives; birth centre midwives and bank and agency midwives), Maternity theatre midwives who also work outside of theatres, Maternity support workers and health care assistants, Obstetric anaesthetic consultants and all other obstetric anaesthetic doctors who contribute to the obstetric rota, maternity theatre staff, Neonatal and Paediatric consultants covering neonatal units, Neonatal junior doctors who attend births, Neonatal nurses and ANNP. Nursing and Nursing Assistant staff working within the maternity and neonatal services.

Strategic Context

In collaboration with national maternity and neonatal partner organisations, the Maternity Transformation Programme published a Core Competency Framework (CCFv1) in December 2020. The Core Competency Framework version 2 (CCFv2), updates and replaces that first version and was published in May 2023.

CCFv2 sets out clear expectations for all trusts, aiming to address known variation in training and competency assessment across England. It ensures that training to address significant areas of harm are included as minimum core requirements and standardised for every maternity and neonatal service.

Compliance with the CCFv2 is a condition of the Maternity Incentive Scheme Year 5, Safety Action 8, updated in July 2023. Safety Action 8: Can you evidence the following 3 elements of local training pans and 'in-house', one day multi professional training?

Required standard and minimum evidential requirement.

1. A local training plan is in place for implementation of Version 2 of the Core Competency Framework.

2. The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB.
3. The plan is developed based on the “How to” Guide developed by NHS England.

12 consecutive months should be considered from 1st December 2022 until 1st December 2023 to ensure the implementation of the CCFv2 is reported on and, an appropriate timeframe for trust boards to review.

It is acknowledged that there will not be a full 90% compliance for new elements within the CCFv2 i.e Diabetes. 90% compliance is required for all elements that featured in CCFv1

A training plan should be in place to implement all six core modules of the Core Competency Framework over a 3-year period, starting from MIS year 4 in August 2021 and up to July 2024. Trusts should update their existing training plans in alignment with Version 2 of the Core Competency Framework.

Purpose

The NENC Training Faculty have co-designed a programme to fulfil the training requirements of the CCFv2 to support Trusts to achieve compliance, and consistency, with training to drive safer maternity care. The NENC Maternity Mandatory Training Needs Analysis, Syllabus and Assessment Framework constitutes an LMNS/ICB approved plan and aims to reduce repetition of training and support interoperable training across the ICB.

The 2023/24 Framework, to be delivered over 3 days, is a pragmatic interim step as all providers work towards securing 5 days of training in accordance with the indicative training time outlined in the CCFv2.

All 6 core modules in V2 of the Core Competency Framework (CCFv2) are covered as detailed in the minimum standards and have been developed using the four key principles:

1. Service user involvement in developing and delivering training.
2. Training is based on learning from local findings from incidents, audit, service user feedback, and investigation reports. This should include reinforcing learning from what went well.
3. Promote learning as a multidisciplinary team.
4. Promote shared learning across a Local Maternity and Neonatal System.

The training requirements set out in the Core Competency Framework require 90% attendance of relevant staff groups by the end of the 12-month period. This will set the baseline for the 2024/25 TNA. It is acknowledged that there will not be a full 90% compliance for new elements within the CCFv2 i.e Diabetes. 90% compliance is required for all elements that featured in CCFv1

Process

Day 1 Fetal Wellbeing Training

Each Trust should ensure that the following staff are scheduled to attend a training day which delivers the agreed learning outcomes and syllabus, and that the competency assessment is utilised.

- Obstetric consultants
- All other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)
- Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives).
- Maternity theatre midwives who also work outside of theatres.

Staff who do not need to attend include: Anaesthetic staff, Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit), MSWs and GP trainees

Attendance should be recorded locally, and on the NENC Education Faculty Futures site. Trusts are encouraged to ensure staff have not already attended training with another Trust prior to scheduling local training days. Only staff who pass the competency assessment should be recorded on the NENC education Faculty register.

Peer sign off, with LMNS/ICB approval, is required for all teaching resources. All teaching resources and presentations should be saved on the NENC Education Faculty Futures site.

Day 2 Obstetric Emergencies Multidisciplinary Training

Each Trust should ensure that the following staff are scheduled to attend a training day which delivers the agreed learning outcomes and syllabus.

- Obstetric consultants.
- All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota.
- Midwives (including midwifery managers and matrons), community midwives; birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives.
- Maternity support workers and health care assistants
- Obstetric anaesthetic consultants.
- All other obstetric anaesthetic doctors (SAS/Fellows/LEDs) who contribute to the obstetric rota.

- Neonatal staff (Nursing, ANNP and Medical) for the neonatal basic life support element.

Neonatal staff are a vital part of the multidisciplinary team and are encouraged to attend the Obstetric Emergencies Multidisciplinary training day, however, are only required to receive the neonatal basic life support element of the day.

All obstetric anaesthetic doctors (consultants, staff grades and anaesthetic trainees) contributing to the obstetric rota and Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit) are not required to attend neonatal basic life support training but are encouraged to attend the full Obstetric Emergencies Multidisciplinary training day which incorporates basic newborn life support.

Maternity theatre staff are a vital part of the multidisciplinary team and are encouraged to attend
the Obstetric Emergencies Multidisciplinary training day, however, they will not be required to attend to meet MIS year 5 compliance assessment.

Attendance should be recorded locally, and on the NENC Education Faculty Futures site. Trusts are encouraged to ensure staff have not already attended training with another Trust prior to scheduling local training days

Peer sign off, with LMNS/ICB approval, is required for all teaching resources. All teaching resources and presentations should be saved on the NENC Education Faculty Futures site.

Day 3 Maternity Multidisciplinary Training

Each Trust should ensure that the following staff are scheduled to attend a training day and are aware of the requirement to complete the additional e-learning modules as outlined in the syllabus.

Smoking in Pregnancy: Midwives, Obstetric Doctors including Obstetric Consultants, Maternity Support Workers and Health Care Assistants, Nursery Nurses.

Personalised Care (Cultural Competency, Maternal Mental Health, Shared learning): Midwives, Obstetric Doctors including Obstetric Consultants, Anaesthetists, Maternity Support Workers and Health Care Assistants, Theatre Staff, Nursery Nurses.

Diabetes: Midwives, Obstetric Doctors including Obstetric Consultants, Anaesthetists, Maternity Support Workers and Health Care Assistants.

Attendance should be recorded locally, and on the NENC Education Faculty Futures site. Trusts are encouraged to ensure staff have not already attended training with another Trust prior to scheduling local training days.

NENC training resources, available on the NENC Education Faculty Futures site, should be used to facilitate the training sessions.

Service User involvement

Service User Representation is included on the NENC Training Faculty. The current programme has been reviewed, and approved, by the LMNS Board which includes SUV representatives.

The training resources for the personalised care elements have been co-designed by the Learning Disabilities Clinical Network with service users. Video case studies are available on the NENC Education Faculty Futures site. The NENC Training Faculty will explore ways in which service users, and representatives, can support the delivery of training in 2024/25, by developing further resources.

Basic Newborn Life Support Training

Some Trusts may have difficulty in sourcing NLS instructors with GIC qualification to deliver training. Local HEI can support deliver of basic newborn life support training as both Northumbria and Teesside have NLS instructors. As a minimum, training should be delivered by someone who is up to date with their NLS training, in addition Neonatal Consultants and Advanced Neonatal Practitioners (ANNP) will be qualified to deliver the training. The Maternity Incentive Scheme requires all Trusts unable to facilitate training by NLS instructors provide evidence to their Trust Board providing evidence that they are seeking mitigation across their LMNS. Engagement with the NENC Training Faculty and compliance with this standard operating procedure should be used as evidence as all Trusts have engaged in the development of the syllabus and training plans, including sourcing NLS instructors to provide training.

Assuring compliance

All attendance at training should be recorded on the NENC Training Faculty Futures page. All staff are only required to receive the 3 days of training once within the training period. Staff can receive training in other Trusts in accordance with the NENC Maternity Training Needs Analysis, Syllabus and Assessment Framework.

Compliance with Safety 8 action requirement to update the CCFv2 is confirmed by commencing the training utilising NENC Maternity Training Needs Analysis, Syllabus and Assessment Framework from 4th September.

MIS Year 5 LMNS submission framewo

MIS Year 5 ICB submission framewor

It is acknowledged that there will not be a full 90% compliance for new elements within the CCFv2 i.e Diabetes. 90% compliance is required for all elements that featured in CCFv1.

Excellence as our standard

NHS North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Annual Quality Account										
Date:	5 October 2023										
Prepared by:	Lindsey Robertson, Chief Nurse/Director of Patient Safety and Quality										
Executive sponsor:	Lindsey Robertson, Chief Nurse Director of Patient Safety and Quality										
Purpose of the report	Quality Accounts are the Trust's annual reports to the public about the quality of healthcare services that we provide. They are both retrospective and forward looking as they look back on the previous year's data, explaining our outcomes and, crucially, look forward to define our priorities for the next year to indicate how we plan to achieve these and quantify their outcomes.										
Action required:	Approve		Assurance	x	Discuss		Information	x			
Strategic Objectives supported by this paper:	Putting our Population First	x	Valuing People	x	Transforming our Services	x	Health and Wellbeing	x			
Which CQC Standards apply to this report	Safe	x	Caring	x	Effective	x	Responsive	x	Well Led	x	

Executive Summary and the key issues for consideration/ decision:

Quality Account provides an opportunity for the Trust to report on progress against quality priorities agreed with external stakeholders in 2021-22. We are very pleased to report some significant achievements during the course of the year:

During 2022-23, the Trust met all standards required for successful and unconditional registration with the Care Quality Commission (CQC) for services across all of our community and hospital services. The focused CQC inspection in May 2022, reported in September 2022 identified 13 Must Do and 18 Should Do action across Maternity, Children and Young People services and Well Led. In addition to this Quality Account identified priorities for 22/23 focused work has been undertaken in relation to Duty of Candour, Maternity Leadership and Board to Ward Governance.

Quality Standards and Goals

The quality indicators that our external stakeholders said they would like to see reported in the 2022-23 Quality Accounts were:

Patient Safety	Effectiveness of Care	Patient Experience
Mortality	Learning from Deaths	Palliative care and care for the dying patient (CFDP)
Dementia	Discharge Provesses	Is our care good? (Patient experience surveys)
Mental Health	Accessibility	Frientds and Family Test
Safeguarding (Adult and Children's)	Violent Incidents	
Infections	Safety and Quality Dashboard	

Page 7-38 outlines the Trust priorities and achievements in relation to Safety in 22/23 including performing well in relation to the Summary Hospital-level Mortality Indicator (SHMI) mortality values, continuing to achieve reductions –consistently in the 'as expected' range and below the national average.

Recording a 12% increase in those patients admitted with a diagnosis of Dementia. We have produced a new dementia strategy to share our vision, improve how we communicate information on our electronic patients records system with the local mental health trust and run regular dementia champions courses.

Launching our first Mental Health Strategy this year setting out our ambitions for the next three years demonstrating how the Trust will work towards delivering an integrated approach to physical and mental health. A significant staff support programme delivered by the Workforce and Occupational Health teams in the Trust, which supports staff in all areas of health and wellbeing.

Our most vulnerable patients continue to be our priority and this year the team have developed level 2 training to give key staff intensive training and understanding of Adult Safeguarding resulting in a 12% increase in concerns raised by the Trust. As with Adults we promote the welfare of our Children, Young People and their families and this year with support from out Named Doctor we created a Child Protection Medical Suite in recognition of the stress for children, their families and professionals having to undergo and support Child Protection Medicals.

Ensuring the we are fully compliant with the Accessible Information Standards to improve healthcare for millions of people with sensory loss and other disabilities - accessibility champions have been introduced to support patients and visitors who require reasonable adjustments and to work within the Care Groups in the Trust on projects to improve patient experience. The Trust has invested in 100 places to train staff in British Sign Language during 2022-23.

Being a positive outlier for Clostridium Difficile reporting 48 cases against a target of 54 during 2022-23.

Page 39-53 outlines the Trust priorities and achievements in relation to Effectiveness of Care with new Learning from Deaths Process being introduced and two Mortality Leads appointed in Nov 2022. Working with the NHSE Better Tomorrow team we have signed up to use SJRplus Mortality Review system and dashboard and the Trust now has approximately 15 trained mortality reviewers from a range of professional groups (medical/nursing/AHP).

Continued focus on improving hospital discharge and patient flow with major developments including the opening of our integrated co-ordination centre in April 2022, which has brought together different specialist staff from across different organisations, all sharing a number of electronic systems. Other successes have included the use of the national OPTICA electronic system, which clearly shows what needs to be achieved to help a hospital patient be ready to go home.

Page 54-69 outlines the Trust priorities and achievements in relation to Patient Experience receiving almost 20,000 responses – 92.87% of these were either 'very good' or 'good' in relation to the national Friends and Family Test.

The introduction of new referral criteria and an evidence based triage tool, in specialist palliative care, has helped to ensure that patients and / or their next of kin are contacted and assessed in a timely and standardised way. The team has also established a daily co-ordinator role, which helps to streamline requests, urgent advice and referrals into the team. This ensures that all work is prioritised and allocated accordingly. Alongside this, the Family Voice has had a refresh as part of a funded research project and offered throughout the organisation. Working collaboratively with Alice House

Hospice in Hartlepool two dedicated end of life care beds available to offer patients, who are in hospital, a rapid transfer to a bed for end of life care.

We have taken part in several national and local surveys and the mandated CQC survey for all Trusts. Whilst we scored higher than the national average in several areas there were 4 areas where we scored worse than the national average. Those areas include length of time on a waiting list; involvement in decision about leaving hospital; notice about discharge and information about any medications given when being sent home.

As we move forward into 23/24 through the Quality Accounts stakeholder meetings and other engagement events, we provided an opportunity for stakeholders, staff and patients to suggest what they would like the Trust to prioritise in the 2023-24 Quality Accounts. We then chose indicators from each of the key themes of Patient Safety, Effectiveness of Care and Patient Experience. The Trust will continuously monitor and report progress on each of the above indicators throughout the year by reporting to the Board. The priorities remain the same as 22/23 with one addition of Maternity in the priority area of Safety.

Board Assurance Framework/Corporate Risk Register risks this paper relates to:
No impact upon the two high risks: Risk 6581 The Trusts Ageing Estate Risk 6188 Delivery of Savings

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or inclusion	x	Reputational	x
Workforce	x	Environmental	
Financial/value for money		Estates and Facilities	
Commercial		Compliance/Regulatory	x
Quality, safety, experience and effectiveness	x	Service user, care and stakeholder involvement	x

Board Subcommittee meetings where this item has been considered (specify date)	Management Group meetings where this item has been considered (specify date)
Quality Committee – 25 September 2023	Quality Council – 9 August 2023

Recommendation	To note the significant progress and improvements in relation to the Quality Priorities 22/23; Board to note the addition of Maternity to the priorities in Safety for 23/24

NHS
North Tees and Hartlepool
NHS Foundation Trust

Quality Accounts
2022-23

Contents

Part 1. Statement on quality from the Chief Executive

Our approach to Quality: An Introduction to this Annual Quality Account from the Chief Executive

I am pleased to bring you this year's Quality Accounts report for North Tees and Hartlepool NHS Foundation Trust, as we look back over the last 12 months.

This report highlights some of the many initiatives being carried out across the organisation to ensure high quality, safe care for our patients.

As it always should be and always has been, our ongoing focus has remained on providing the very highest level of care to our patients and understanding the health needs of our population.

There are a number of themes we have followed in this report, all created from feedback we have had from patients, staff, our stakeholders and our community. These are in areas including dementia, mental health, safeguarding, discharge, violent incidents, palliative care and measuring if our care is good.

The Trust continues to perform well. During 2022-23 in relation to the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) mortality values, we have continued to achieve reductions – so much so that we are now consistently in the 'as expected' range and below the national average. We have made a number of improvements over this time, including setting up a clinical link between doctors and the coding department which has allowed us to pick up more health issues and give a greater understand of a patient's level of sickness.

Our work around dementia has been significant over the last year. Sadly, our community has the highest predicted increase of dementia across the region – but our commitment and dedication to improve care for these patients could not be greater. We have been involved in a national audit which looked at the whole patient journey and we look forward to a formal report into this in the summer. Meanwhile, we have produced a new dementia strategy to share our vision, improved how we communicate information on our electronic patients records system with the local mental health trust, run regular dementia champions courses as well as much more.

Mental health is also increasingly a real key priority for us – integrating mental and physical health is vital. Over the next three years we want to achieve a culture change across the organisation. Mental health must be considered in all developments we make at this Trust. Several things have been achieved to help this – including special online training, which nearly all of our staff have completed, a higher level of university training for clinical staff and special regular staff discussions known as Schwartz Rounds.

Though the impact of the pandemic is certainly nothing like it was previously, Infection Prevention Control (IPC) has continued to be one of our key areas as it always should be. The Trust continually monitors infection rates and remains ambitious for improvement implementing new initiatives and innovations, which are outlined within this report.

The Trust reported 48 cases of Clostridium Difficile against a target of 54 during 2022-23. The forthcoming year will see further challenges in the work toward improving infection, prevention and control, and this remains a firm priority for us as an organisation.

The highest number of hospital patients the organisation was treating with COVID-19 over the course of the pandemic was 216. This figure has significantly reduced since then – but the Trust continues to see some admissions of patients with COVID-19. The challenge continues to be to

reduce the level of transmission and keep our patients safe as we continue our wider recovery plan.

Our work around improving hospital discharge and patient flow has continued. Major developments have included the opening of our integrated co-ordination centre in April 2022, which has brought together different specialist staff from across different organisations, all sharing a number of electronic systems. Other successes have included the use of the national OPTICA electronic system, which clearly shows what needs to be achieved to help a hospital patient be ready to go home. I am proud to say we are leading the way with initiatives like this, which have had a real positive impact on reducing any delays in patients being discharged. This is something recognised at a national level and we regularly share our good practice with other organisations and individuals – including with the Prime Minister and Health Secretary on a visit to the Trust earlier this year.

The national Friends and Family Test is one of our ways of getting feedback from our patients – coming in the form of a questionnaire as patients prepare to leave hospital to go home. The answers are monitored on a weekly basis to ensure any concerns are acted on at pace. In 2022/23 we received almost 20,000 responses – 92.87% of these were either 'very good' or 'good'. We are pleased with the progress made and will remain focussed on this as we move forward.

We also have other ways of gathering feedback including through the Patient and Staff Experience Survey. This information is analysed and reported to the care groups, our clinical teams and to the Patient and Carer Committee. You will see below some of the positive and negative responses received through this – they provide a real insight into patient experience and help us improve the care we give.

There are many other initiatives contained within this report – too many for me to reference here. As we look back over the last year, the organisation has achieved a significant amount and carried out a huge amount of work to improve patient care.

To the best of my knowledge, the information contained in this document is an accurate reflection of our outcomes and achievements, which I am pleased to present to you.

Julie Gillon
Chief Executive

What is a Quality Report/Accounts?

Quality Accounts are the Trust's annual reports to the public about the quality of healthcare services that we provide. They are both retrospective and forward looking as they look back on the previous year's data, explaining our outcomes and, crucially, look forward to define our priorities for the next year to indicate how we plan to achieve these and quantify their outcomes.

Our Quality Pledge

Our Board of Directors receive and discuss quality, performance and finance at every Board meeting. We use our Patient Safety and Quality Standards (Ps & Qs) Committee to provide assurance in relation to patient safety, effectiveness of service, quality of patient experience and to ensure compliance with legal duties and requirements, the Audit Committee to to review our systems of internal control. The PS & QS and Audit Committees are each chaired by Non-Executive directors with recent and relevant experience, these in turn report directly to the Board of Directors.

The Board of Directors seek assurance on the Trust's performance at all times and recognise that there is no better way to do this than by talking to patients and staff at every opportunity. This is supported by a departmental visiting programme.

Quality Standards and Goals

The Trust values the contributions made by all members of the organisation to ensure challenging standards and goals are achieved which are set to deliver high quality patient care. The Trust also works closely with commissioners of the services provided to set challenging quality targets. Achievement of these standards, goals and targets form part of the Trust's four strategic quality aims.

Unconditional CQC Registration

During 2022-23 the Trust met all standards required for successful and unconditional registration with the Care Quality Commission (CQC) for services across all of our community and hospital services.

Listening to Patients and Meeting their Needs

We recognise the importance of understanding patients' needs and reflecting these in the Trust values and goals. Patients using the services deserve excellent clinical care delivered with dignity, compassion, and professionalism and these remain our key quality goals.

Over the last year we have spoken with over **20,000** patients in a variety of settings including their own homes, community clinics, and our inpatient and outpatient hospital wards as well as departments. We always ask patients how we are doing and what we could do better.

CQC Rating

The most recent CQC visit took place between the 3 to 26 May 2022. The Trust has been rated as **'Requires Improvement'**, for all domains; additional detail regarding the recent visit is located in the CQC section on page 95.

Part 2a. 2022-23 Quality Improvement Priorities

Part 2 of the Quality Account provides an opportunity for the Trust to report on progress against quality priorities that were agreed with external stakeholders in 2021-22. We are very pleased to report some significant achievements during the course of the year.

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

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

Progress is described in this section for each of the 2022-23 priorities.

Stakeholder priorities 2022-23

The quality indicators that our external stakeholders said they would like to see reported in the 2022-23 Quality Accounts were:

Patient Safety	Effectiveness of Care	Patient Experience
Mortality	Learning from Deaths	Palliative care and care for the dying patient (CFDP)
Dementia	Discharge Provesses	Is our care good? (Patient experience surveys)
Mental Health	Accessibility	Frientds and Family Test
Safeguarding (Adult and Children's)	Violent Incidents	
Infections	Safety and Quality Dashboard	

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

Priority 1: Patient Safety

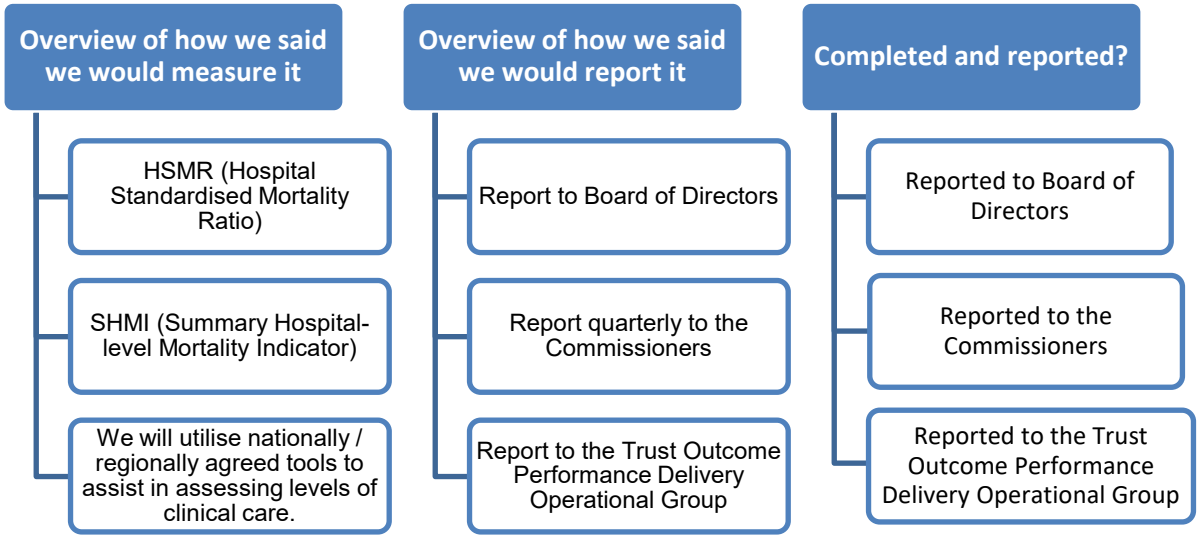
Mortality

Rationale: To reduce avoidable deaths within the Trust by reviewing all available mortality indicators.

Overview of how we said we would do it

The Trust used the Healthcare Evaluation Data (HED) benchmarking tool to monitor and interrogate the data to determine areas that require improvement. We will also review/improve existing processes involving palliative care, documentation and coding process.

The Trust continues to work with the North East Quality Observatory System (NEQOS) for third party assurance.



The Trust Board of Directors continues to understand the values of both Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI). The Trust has achieved reductions for both metrics, to such an extent they are now consistently in the **'as expected'** range.

The Trust, while using national mortality measures as a warning sign, is investigating more broadly and deeply the quality of care and treatment provided. The Trust established a clinical link between consultants and the Trusts Coding Department, this work throughout 2022-23 continues to reap great rewards in respect of depth of coding. This increase in the number of co-morbidities being captured and documented per patient to over seven, from the lows of just over three, has had a profound effect on the HSMR and SHMI values, as well as giving a more accurate reflection of the patient's true level of sickness.

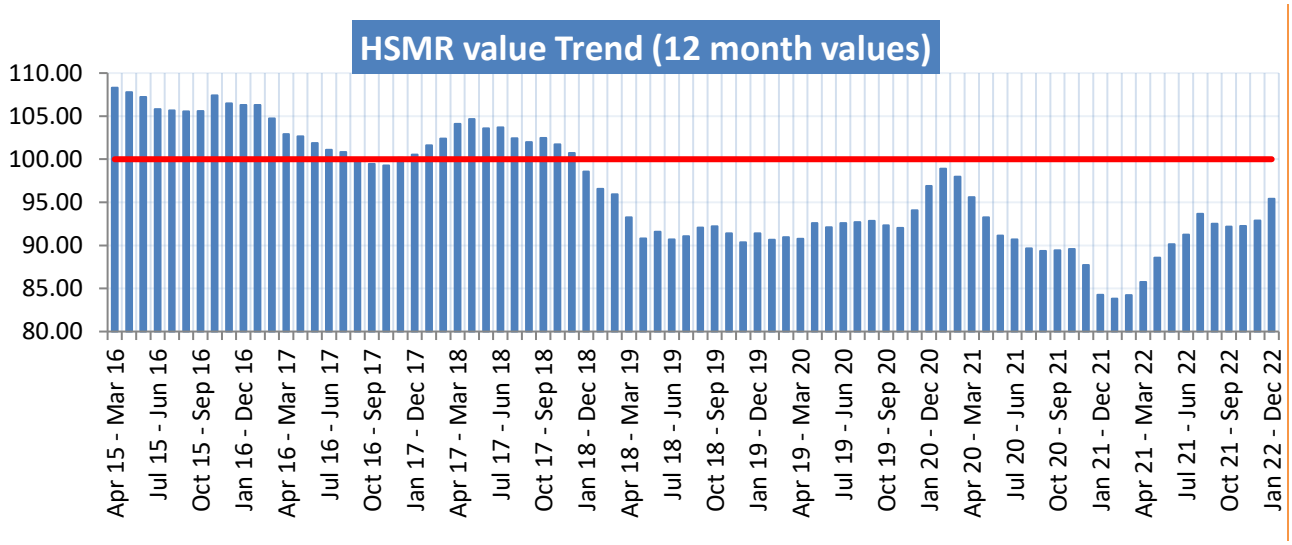
The following data is from the two nationally recognised mortality indicators of Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI).

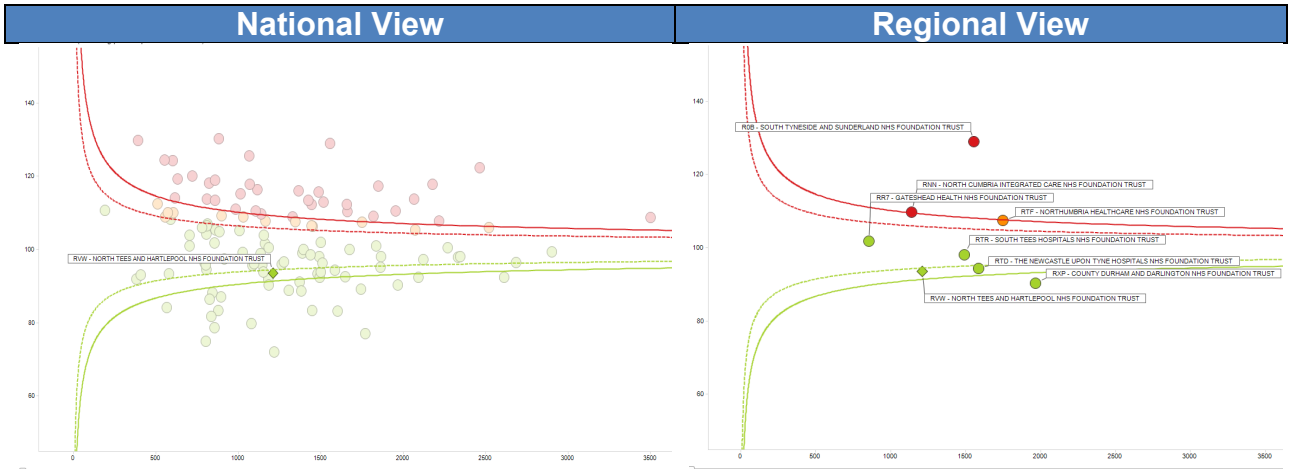
Hospital Standardised Mortality Ratio (HSMR)

The Trust **HSMR** value is **95.41** for the reporting period from **January 2022 to December 2022**; this value continues to place the Trust in the **'as expected'** range. The National Mean is 100, which denotes the same number of people dying as expected by the calculations, any value higher means more people dying than expected.

Reporting Period	*CMR	HSMR	National Mean
Jan 22 - Dec 22	**4.25%**	**95.41**	**100**
Dec 21 - Nov 22	3.38%	92.88	100
Nov 21 - Oct 22	2.79%	92.26	100
Oct 21 - Sep 22	2.74%	92.18	100

*Crude Mortality Rate (CMR)





*Latest 12 month position (January 2022 to December 2022) Data obtained from the Healthcare Evaluation Data (HED)

Summary Hospital-level Mortality Indicator (SHMI)

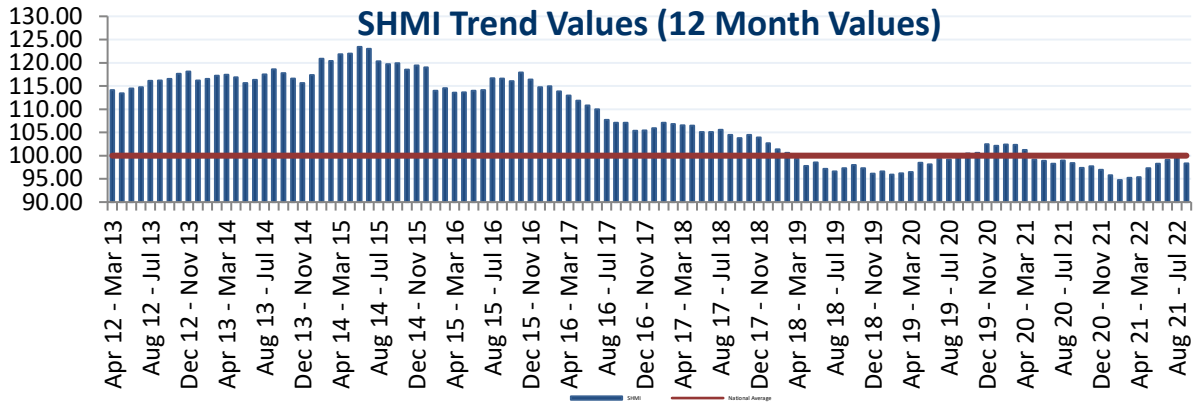
The **SHMI** indicator provides an indication on whether the mortality ratio of a provider is as expected, higher than expected or lower than expected when compared to the national baseline in England.

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

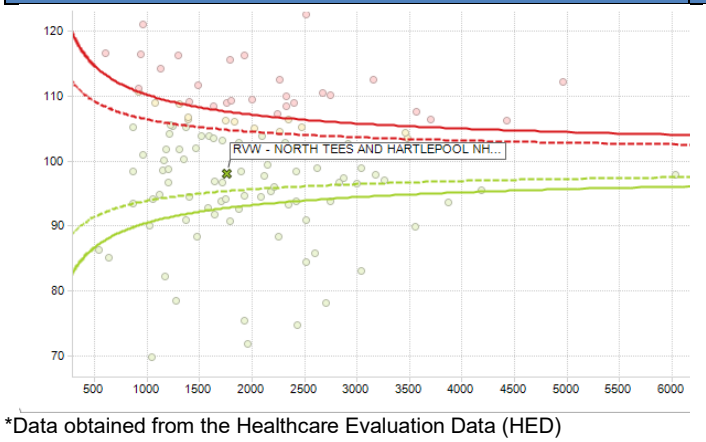
The latest SHMI value of **97.91** **(October 2021 to September 2022)** continues to reside in the **'as expected'** range.

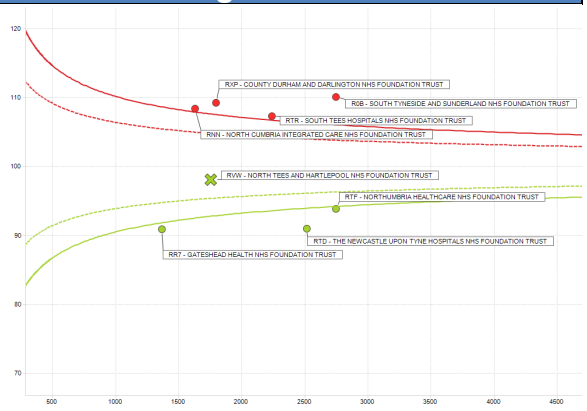
Reporting Period	*CMR	SHMI	National Mean
Oct 21 - Aug 21	**3.22%**	**97.91**	**100**
Sep 21 - Aug 22	**3.20%**	**98.33**	**100**
Aug 21 - Jul 22	3.26%	99.68	100
Jul 21 - Jun 22	3.27%	99.06	100
Jun 21 - May 22	3.27%	98.23	100

*Crude Mortality Rate (CMR)



National View	Regional View





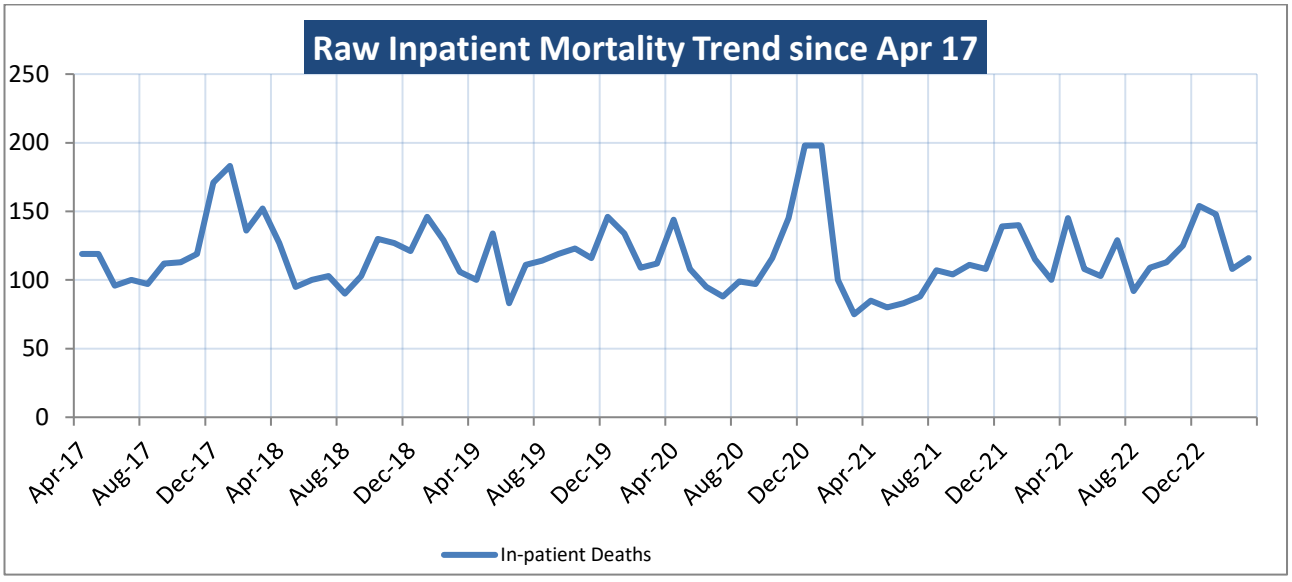
*Data obtained from the Healthcare Evaluation Data (HED)

Trust Raw Mortality

The following table and chart demonstrates the raw number of mortalites the Trust has experienced since 2015-16. For the latest financial year of 2022-23, the Trust experienced **1,543** mortalities (April to March), this is **186** more mortalities than experienced in 2021-22.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	119	124	103	92	99	119	95	124	134	134	135	142
2016/17	142	131	123	119	107	97	132	119	144	155	136	136
2017/18	126	128	103	104	105	120	121	129	182	194	138	163
2018/19	135	104	102	114	92	108	139	134	132	149	132	113
2019/20	106	142	90	118	117	124	126	125	157	146	116	118
2020/21	152	113	101	93	102	106	120	154	206	207	110	83
2021/22	95	87	84	100	113	112	120	113	152	151	120	110
2022/23	**153**	**117**	**111**	**134**	**95**	**115**	**113**	**135**	**171**	**158**	**116**	**125**

	Apr to March
2015/16	**1,420**
2016/17	**1,541**
2017/18	**1,613**
2018/19	**1,454**
2019/20	**1,485**
2020/21	**1,547**
2021/22	**1,357**
2022/23	**1,543**



Priority 1: Patient safety

Dementia

Rationale: NHS Hartlepool/Stockton on Tees has the highest projected increase of dementia across the North East by 2025. All stakeholders identified dementia as a key priority. The region has an 85.8% diagnostic rate. This is significantly higher than the 66.7% national benchmark; which shows the progress the region has made in relation to accurate and timely diagnosis.

The National audit of Dementia commenced in September 2022 and concluded March 2023. North tees and Hartlepool were once again involved.

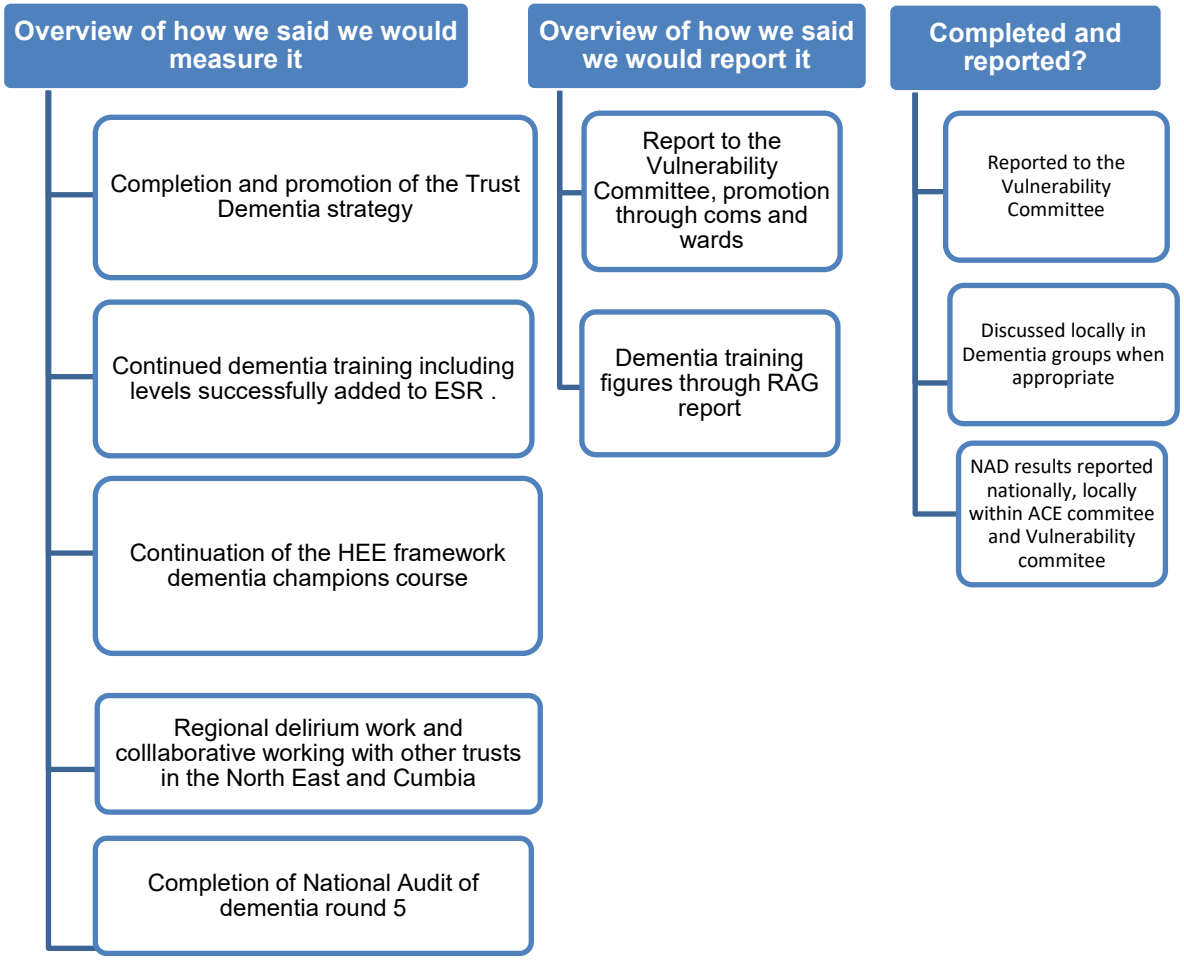
It consisted of 80 patients with a diagnosis of dementia. It was broken down into 3 parts: Part 1 admission, Part 2 inpatient stay and Part 3 discharge.
There was also a carers and patients questionnaire, and an organisational audit in relation to dementia care. All carer and patient comments that were fed back from the national team from carer/patient questionnaires in round 5 and are below.

Local and national reports are due summer 2023.

Round 6 of the National audit of Dementia is due to commence in Summer 2023, and is a repeat of round 5.

What we have achieved in the last year:

- Patients with Dementia are appropriately assessed, and referred on to specialist services if needed.
- Development of a new North Tees and Hartlepool Dementia Strategy has been shared to promote our vision for supporting people living with dementia that we serve. Improvements are monitored through the national audit of dementia reports and feedback from carers and patient living with dementia.
- Cross-reference people regarding a dementia diagnosis on North Tees and Hartlepool Trust Trakcare and other recording systems with Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) Paris system (electronic care record system) to confirm if a clinical diagnosis has been given by mental health services. If the diagnosis of dementia is confirmed, an alert is added to Trakcare system. This alert assists all staff including the dementia champion that is available on every ward. This is to continue, and has proved very useful in terms of identifying patients with a dementia diagnosis.
- The HEE Tier 2/3 dementia champions course has continued to support staff to be leaders in their area in dementia care.
- Ongoing involvement in the regional HEE delirium group, working with regional trusts to improve awareness around delirium on a background of dementia
- The completed activity room, named ‘the bluebell suite’ is now in use for patients under the remit of the enhanced care team.



Continuing to Improve Carers/family Support which includes:

- Informing carers what services they can access and how
- Increased information on how they can access individual carer's assessment
- Both Local authorities have detailed directory of services to support people living with dementia and their carers and families
- Support and advice for financial and social benefit
- Continued involvement in the dementia networks groups/dementia friendly Hartlepool group
- Community Dementia Liaison service run carers support sessions through The Bridge at Hartlepool, to support and educate carers of people living with a dementia.
- Continue to promote the John's Campaign (www.Johnscampaign.org.uk) This supports carers to outline which elements of care/support they would prefer to do for the patient whilst in hospital, and which elements they would prefer staff to complete. It also outlines allowances for carers and family i.e. if family/carers are spending significant amounts of time visiting, allowing flexible visiting, ability to order from the hospital menu for themselves and the Trust now has an agreement with Parking Eye regarding parking allowances for eligible families and carers.
- John's campaign shows as an alert on Trakcare for staff awareness.
- University Hospital of North Tees has become part of Dementia Friendly Stockton and University Hospital of Hartlepool has also been given this accolade. The aim is to continue to develop close and consistent links with relevant local agencies.

Qualitative comments from National Audit of Dementia Patient Survey:

Did the hospital staff caring for you listen to you and understand your needs:

"I think so"

"They are nice"

Did staff speak to you using the name you prefer to be called by?*:*

"It is on the board"

Did staff keep you informed about what care and treatment you were being given?

"I think so"

"Don't know"

"Go away now (swore at staff)"

"I sometimes forget what's being said so I just say 'sometimes'"

"Not sure"

When you needed help, did staff give you enough of their time?

"There isn't enough of them (staff)"

"They are very busy and sometimes I don't like to ask"

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

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

Financial Year	Patients admitted to the Trust with a diagnosis of Dementia/Delirium	Increase or Decrease from Previous Year
2016-17	3,298	+587
2017-18	3,614	+316
2018-19	4,218	+604
*2019-20	3,784	-434
*2020-21	3,253	-531
2021-22	3,624	+371
*2022-23	3,842	+218

*Data from Information Management Department April 2022 to March 2023
** 2019-20 and 2020-21 affected by Covid-19

Dementia Training Levels

Level 1 - Dementia Awareness Raising

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

This is mandatory to the entire workforce in health and care, involving the completion of 'Essential Dementia Workbooks' at the appropriate level according to job role. This is also available as e-learning.
There has been an identified training need for the Trust volunteers in relation to dementia. As a result, volunteer training in dementia and delirium is offered regularly and attendance is always good.

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

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

The team also provide a 1.5 hour face to face training session. This is constantly evaluated and updated. It is also delivered to all new recruits to the Trust- overseas nurses, newly qualified staff, students, return to practice nurses, trust induction and can be delivered on request for team days.

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

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

This is the level of 'Trust Dementia Champions'.

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

To support this level of training we have the Trust Dementia Champion programme which, following feedback, has been reviewed and now runs over two consecutive days on alternate months. The purpose of the Dementia Champions is to create an individual with a high level of knowledge of dementia. The 6 stages of 'Barbara's Story' is used and discussed. This training involves support from other multi-disciplinary teams as well as guest speakers. It is open to all staff, of any profession or grade, either inpatient or community. This new programme enables it to be carried out 5 times a year, excluding winter months when staffing pressure on the trust is expected to be higher.

We are also placing more emphasis on the role of the Dementia Champions and have compiled a list of expectations which outline their responsibilities following the course.

Training figures 2022-23

Training level	(%)
Dementia Level 1	95%
Dementia Level 2	92%
Dementia Level 3	96%

*Data obtained from the Trust dementia training for March 2023.

Priority 1: Patient safety

Mental Health

Rationale: *Post Stakeholder engagement, this was decided to be a key metric going forward for measurement.*

High quality mental healthcare offered to patients across the services we provide is our aim. Integrating mental and physical health and social care will improve patient experience and outcomes, as well as staff experience, and reduce system costs and inefficiencies. However, good integrated care for people with mental health conditions often appears to remain the exception rather than the rule, with physical healthcare and mental healthcare largely disconnected. There has been, and still are, many drivers to try and change the situation, to improve the care for this patient group.

By focusing on the whole person, healthcare professionals will be knowledgeable and confident in understanding and managing mental health conditions and knowing when and how to access mental health services for the patients they see. The integration of all healthcare professionals to provide care as needed for each patient is a crucial part of the solution to providing a higher quality of care to all patients.

We aimed to:

- embed integrated mind and body care as common practice, joining up and delivering excellent mental and physical health care, research and education so that we treat the whole person;
- improve patient care and staff experience through the sustainable provision of effective learning and development of our workforce;
- provide services where users routinely access care that addresses their physical and mental health needs simultaneously provided by services and staff who feel valued, supported and empowered to do so;

To achieve these aims the objectives were to:

- Foster positive attitudes towards integrated mental and physical health, combatting stigma
- Improve recognition and support for both the mental and physical health needs of patients
- Assist staff to access support and resources for working with mind and body
- Ensure that mind and body care is addressed at all levels of healthcare
- Engage local partners in improving mind and body training and subsequently care
- Through Treat as One, develop a 1 day, tier 2 course to ensure that appropriate staff has a more in-depth understanding of how mental health and physical health are linked.

Overview of how we measured and reported this

2023 Update

During 2023 a Mental Health Strategy was developed to set out our ambitions for the next three years and demonstrates how the Trust will work towards delivering an integrated approach to physical and mental health. This strategy is focussed on the mental health of our patients and how we best support this, we recognise that good staff mental health is a vital component to ensuring the wellbeing of our workforce. Therefore staff mental health and significant staff support programme is delivered by the Workforce and Occupational Health teams in the Trust, which supports staff in all areas of health and wellbeing.

Our vision

- Over the next three years, we want to achieve a culture change across our organisation.
- We will aim to further reduce stigma surrounding mental health and enable our staff to embrace conversations about mental health and wellbeing.
- Mental health will be considered in all initiatives and developments Trust wide.

We have three key objectives:

- Improve the quality of care that we deliver to our patients, carers and families who are living with serious mental illness.
- Support patients with long term physical health conditions to identify and manage their mental health needs.
- Ensure our workforce has the right skills, knowledge and attitudes to recognise and care for patients, carers and families with mental health

How we will measure this:

- Provide quarterly updates to the Quality Assurance Council. This will include exception reporting for assurance purposes to the Board of Directors.
- Develop metrics to monitor implementation of the strategy.
- Continued participation in local Health and Wellbeing Boards and Integrated Care Partnership forums including evolving Mental Health Partnership Board

Priority 1: Patient safety

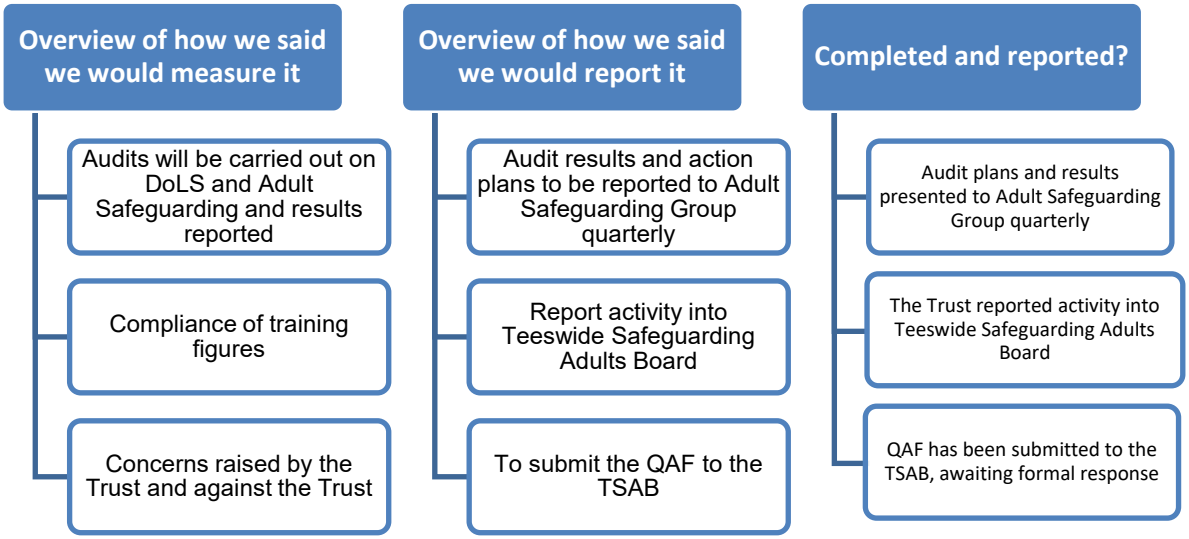
Safeguarding

Rationale: Adult Safeguarding is defined by the Care Act (2014) and is carried out where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)-

- has needs for care and support (whether or not the authority is meeting any of those needs),
- is experiencing, or is at risk of, abuse or neglect, and
  as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

Overview of how we said we would do it

- Ensure staff are well equipped to deal with Adult Safeguarding issues and have a good understanding of the categories of abuse
- Staff are aware of how to raise a safeguarding concern
- Continue to increase the visibility of the Adults Safeguarding Team
- Audit the policy to look at good practice and areas for improvement
- Local quality requirements (LQR) as defined by the commissioners will be monitored on a quarterly basis
- Quality assessment frameworks (QAF) on adult safeguarding has been produced, RAG rated is currently been audited by Tees-wide Safeguarding Board (TSAB)



Safeguarding Adults

The Trust continues to work to enhance and develop standards for safeguarding adults across hospital and community services. The Care Act (2014) has been embedded in practice and close working with the Teeswide Adults Safeguarding Board has helped to update policies and procedures in a coordinated approach.

The Adults Safeguarding team continue to raise the profile and visibility of Adult Safeguarding; this is in the form of walkabouts, increased teaching and attendance at staff meetings.

The safeguarding team have developed level 2 training to give key staff more intensive training and understanding of Adult Safeguarding. This is delivered both online and as face to face training to meet ward/department needs.

Training figures 2022-23

Training level	(%)
Level 1	92%
Level 2	88%
Level 3	79%

*Data obtained from the Trust workforce for March 2023.

Trust Reporting

For each quarter the Trust produces an Adult Safeguarding report. The purpose of this report is to provide the Trust Safeguarding Committee members with an overview of safeguarding activity, with the objective that information relevant to their areas of representation may be disseminated.

Additionally, the importance of two way communications are recognised as vital to ensure safeguarding adult activity is embedded within practice across adult health and social care. Therefore, this report highlights areas of good practice within all service areas requiring development as well as providing actions agreed from discussion within the group.

The data contained in the reports includes:

- Number of referrals
- Number of alerts raised by location
- Number of alerts raised by theme
- Incidents raised by type of abuse, Trust role and outcome

Number of Concerns / Enquiries raised within the Trust

The Trust use an incident reporting system to manage and record safeguarding concerns. This helps to collate, trend and theme the data. The data produced is governed through the quarterly Safeguarding Vulnerable Adults Steering Group and the Quality Assurance Council.

There have been **660** concerns the Trust has been involved with in 2022-23, the Trust raised **453** (12% increase) of these concerns. This trend demonstrates that there has been an increase in reported concerns in 2022-23.

2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
244	413	484	478	540	565	**660**

*Data as of March 2023

Types of Concerns

The following tables detail the allegation types raised across all three Local Authorities, it is important to note that there can be multiple allegation types per referral.

Type of Concern	Q1	Q2	Q3	Q4	Total
Discriminatory	0	0	1	0	**1**
Domestic Abuse	14	21	19	19	**73**
Financial or Material	12	15	19	15	**61**
Modern Day Slavery	2	0	0	1	**3**
Neglect and Acts of Omission	68	71	73	97	**309**
Organisational	3	5	5	7	**20**
Physical	17	15	28	22	**82**
Psychological	12	9	14	13	**48**
Self-Neglect	41	35	49	36	**161**
Sexual Abuse	2	5	4	6	**17**
Sexual Exploitation	0	0	2	0	**2**
Total	**171**	**176**	**214**	**216**	**777**

Neglect and acts of omissions remain as the main cause for safeguarding concerns, followed by self-neglect. Concerns around physical and domestic abuse have continued to rise. The rise may indicate greater understanding of when to raise a concern, as a result of training and awareness campaigns. The Trust now has the services of an Independent Domestic Violence Advisor, who may also be increasing awareness regarding domestic abuse.

Alerting Care Group

Care Group	Q1	Q2	Q3	Q4	Total
Care Group 1 - Healthy Lives	59	50	51	55	**215**
Care Group 2 - Responsive Care	44	41	60	59	**204**
Care Group 3 - Collaborative Care	7	6	5	8	**26**
Corporate Group	1	2	3	8	**14**
North Tees & Hartlepool Solutions (Estates & Facilities)	0	0	0	0	**0**
Total	**111**	**99**	**119**	**130**	**459**

Number of concerns against the Trust

There have been **95** concerns against the Trust.

2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
50	79	79	79	80	93	**95**

Themes of Alerts against the Trust

Themes of Alerts	Q1	Q2	Q3	Q4	Total
Assault	0	0	0	0	**0**
Communication	0	10	10	8	**28**
Dehydration	0	0	0	0	**0**
Discharge Issue	3	13	14	16	**46**
Documentation	0	3	6	3	**12**
Lack or Reasonable Adjustments	0	0	0	1	**1**
Malnourishment	0	0	0	0	**0**
Medication Error	2	4	3	10	**19**
Moving & Handling	0	1	1	2	**4**
Pressure Damage/Ulcer	2	5	5	3	**15**
Psychological	0	0	1	0	**1**
Sexual	0	0	1	0	**1**
SPA Referral	0	3	3	2	**8**
Theft	0	0	0	0	**0**
Unexplained Injury	0	0	0	1	**1**
Unkempt	1	2	0	1	**4**
Unwitnessed Fall	0	0	0	0	**0**
Total	**8**	**41**	**44**	**47**	**140**

*To note: one concern can cover multiple themes

Work is on-going within the Trust on discharge with the discharge team, and pressure related incidents with Tissue Viability team. In relation to concerns around Medication Errors. Ward Pharmacists are continuing to working closely with Medical, Nursing and Midwifery Staff to provide support and Education.

Deprivation of Liberty Safeguards (DoLS)

Provision of specialist advice relating to implementation of The Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS) and the Human Rights Act provides added assurance that the Trust remains compliant with legislation. The Trust continues to provide education regarding the awareness of DoLS; improvements have been made to the paperwork to assist staff in its completion.

In April 2023, the Government made the decision to delay the implementation of the Liberty Protection Safeguards (LPS) beyond the life of the current Parliament. The Trust has removed the implementation risk from its Risk Register accordingly.

The Trust has seen **1,697** applications for the financial year 2022-23.

2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
832	1,100	1,638	1,810	1,545	1,760	**1,697**

*Data as of 31 March 2023

Trust Adult Safeguarding Governance Arrangements

The Chief Nurse, Director of Patient Safety and Quality, is the executive lead for safeguarding adults, supported by the Associate Director of Nursing for Patient Safety; with the Named Nurse Adult Safeguarding holding the overall operational responsibility.
Care Group management teams are responsible for practices within their own teams and individual clinicians are responsible for their own practice.

The Trust Adult Safeguarding Committee has been combined with Children's so that there is a joint strategic Safeguarding Council, this reports to Quality Assurance Committee, including representatives from key Trust clinical and non-clinical directorates and also partners from Local Authority and Harbour who are experts in domestic abuse.

The Trust is represented at the Tees-wide Adult Safeguarding Board, and its subgroups. This ensures co-ordinated multiagency working, which safeguards and protects adults at risk of harm or neglect.

The Trust Strategy groups for adult safeguarding, learning disability and dementia, have now been amalgamated into the Adult Safeguarding Operational Group to ensure reciprocal standard agenda items and membership. This supports sharing of information and lessons learnt so that they can be incorporated into relevant work streams relating to the most vulnerable groups.

Adult Safeguarding - Prevent

Throughout 2022-23 Adult Safeguarding has continued to make positive strides towards its objectives.

The aim of PREVENT is to stop people from becoming terrorists or supporting terrorism.

Global events have continued to ensure the principles of counter terrorism outlined below remain in the NHS workforce agenda. PREVENT continues to be addressed within the adult safeguarding portfolio. The Trust facilitates training according to staff Training Needs Analysis (TNA). Staff requiring Level 1 and 2 training complete Preventing Radicalisation-Basic Prevent Awareness via e-learning for health. Staff requiring Level 3 complete PREVENT Home Office approved online training.

The 'Named Nurse' for Adult Safeguarding represents the Trust at a multi-disciplinary meeting (Silver command) around PREVENT. During this year **0** Prevent concern have been raised.

Training figures 2022-23

Training type	(%) trained
PREVENT	92%
WRAP	90%

Children's Safeguarding

A child/young person is defined as anyone who has not yet reached their 18th birthday.

North Tees and Hartlepool NHS Foundation Trust has a duty in accordance with the Children Act 1989 and Section 11 of the Children Act 2004 to ensure that its functions are discharged with regard to the need to safeguard and promote the welfare of children and young people. The Trust recognises the importance of partnership working between children/young people, parents/carers and other agencies to prevent child abuse, as outlined in Working Together to Safeguard Children and their Families, 2018. In addition, arrangements to safeguard and promote the welfare of children must also achieve recommendations set out by the CQC Review of Safeguarding: A review of arrangements in the NHS for safeguarding children, 2009 and give assurance as outlined in the National Service Framework for Children, Young People and Maternity Services, 2004 (Standard 5). The Trust continues to demonstrate robust arrangements for safeguarding and promoting the welfare of children.

Children & Young People Governance Arrangements

The Trust has maintained a robust Board level focus on Children's Safeguarding led at executive level by the Chief Nurse/Director of Patient Safety and Quality. A quarterly Safeguarding Council , chaired by a Non-Executive Director maintains responsibility for the performance monitoring of the Children's Safeguarding work program. The Council also brings together commissioners and providers with representation from Tees Valley ICB (Designated Doctor and Designated Nurse for Safeguarding and Looked after Children) and Designated Nurse Safeguarding and Looked after Children from Durham, Darlington, Easington & Sedgefield.

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

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

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

- Tees Procedures and Policy group
- HSSCP (Hartlepool and Stockton Children's Partnership) Strategic - Engine room
- DSCP (Durham Safeguarding Children's Partnership) Strategic Board
- MACE Board
- CHUB Board
- MARAC (Multi Agency Risk Assessment Conference)
- MATAC (Multi Agency Tasking and Co-ordination)
- County Durham Safeguarding Health Leads

- County Durham Child Exploitation Group (CEG)
- Serious Organised Crime Group

Representatives from across all Care Groups take a lead role to act as champions for the safeguarding of children and through the safeguarding operational professional group meets on 6 weekly basis. Key professionals for example from Emergency Department and Women's and Children's services are brought together to ensure momentum of the Safeguarding and Children's Health in Care agenda and work program remains paramount. This governance framework provides safeguarding assurance to the Trust and its partners through the Safeguarding Council.

Children's Safeguarding Work Program

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

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

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

Between March 2022 - 2023 the Trust has been involved and contributed to four new Rapid Reviews that Hartlepool and Stockton Children's Safeguarding facilitated in response to notification of serious safeguarding incidents where children have suffered significant harm. 3 of these 4 children died as a result of indicators of harm.

None of these Rapid Reviews progressed to a Local Safeguarding Practice review as agreed by the National Panel. Contextual safeguarding was central to 1 of the reviews resulting in the death of a young adolescent due to exploitation, however there was no significant learning for the Trust. Sudden unknown deaths of 2 children identified indicators of neglect, historical domestic abuse, substance misuse and social care involvement. Unsafe sleeping practices identified however all appropriate health promotion is provided by the Trust around safe sleeping. There was no significant learning that was identified from these reviews that would indicate that any change in practices would have prevented these deaths. A facilitated learning review is waiting to be carried out in response to the death of a 10 year old where there were features of the child not being brought to appointments where the trust need to review their actions to.

Focus on learning for all agencies has been to raise awareness around the impact of Adverse Childhood Experiences on parenting capacity and the challenge to staff to adopt a Trauma informed approach to practice, that supports further risk assessment. Further training has been identified for staff from local and other national reviews that requires a greater understanding and empathy of the transition from adolescents to adulthood and approaching presenting 'challenging behaviours' as indicative of a child in distress rather than a troublesome child. This requires professionals to be curious about any triggers from trauma. Trauma informed practice and neglect continues to be the ongoing focus for children's safeguarding partnership training and aligns to the updates to the training for our trust staff. To support all agencies to work towards seeking to understand the child's lived experiences, starting with the creating safe spaces and safe relationships to support the child having a voice.

There have been no Rapid Reviews during this year where the Trust has been involved with our Durham Safeguarding Children's Partnership colleagues.

Part 2 - Development Work

Children Not Brought for Appointments by Parents/Carers' Policy

The policy and assurance process embedded across the Trust is in response to a local children's safeguarding case reviews and learning lessons review and has been in place for six years. The policy enables practitioners to understand that when a child has not been brought to appointments this may be an early indicator of neglect and requires a risk and impact assessment that supports an appropriate safeguarding response where required. The Trust now also considers this for children where appointments are frequently rescheduled and cancelled by parents/carers alongside those that do not attend and improvements are monitored through auditing as to how practitioners respond.

Safeguarding Children's Policy

The Safeguarding Children's Policy ensures that Trust staff understand their responsibility under current legislation to safeguard and promote the welfare of children and to enable the Trust to meet its statutory duties in this regard. This policy is presently under review and is due for review and agreement by members of the Children's Safeguarding Operational Group, Safeguarding Council and the Patient Safety Council.

Safeguarding Children Supervision

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

Safeguarding Children's Supervision Policy has been recently updated (Jan 2023) and provides guidance to practitioners regarding expectations around supervision and support available.

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

Supervision figures 2021-22

Quarter	(%)
Q1	100%
Q2	98%
Q3	96%
Q4	94%

North of Tees Children's Hub

The Trust is an integral part of the Hub and although the senior nurses in the safeguarding team are not co-located within the Hub they continue to provide support and advice remotely.

Child Sexual Exploitation (CSE) and Child Criminal Exploitation (CCE)

CSE and CCE continue to be a growing concern. Both the function and response from Stockton and Hartlepool Multiagency Children Exploitation Group (MACE) practitioners group and the Child Exploited group (CEG) in County Durham has improved significantly to provide a more timely response to children who are at risk from exploitation and although the trust does not directly attend continues to provide information to support identification and those children and young people most at risk. Information is flagged on records to support trust staff to consider further information sharing and safety planning where ongoing risk is identified. A CSE risk assessment screening tool is completed on all children who attend unscheduled care within the Trust if they fit within an agreed criteria of risk.

Domestic Violence & Abuse

The Trust is represented at Multi Agency Risk Assessment Conferences (MARAC) in Hartlepool and Stockton where high risk victims of domestic abuse are identified and safety plans put in place. The Trust also contributes to Multi Agency Tasking and Coordination (MATAC) where response to high risk perpetrators are managed.

A Domestic Abuse Policy is in place across the Trust to support staff in responding to indicators that are suggestive of Domestic Abuse. The Policy supports staff on how to use a 'think family' approach, considering not only risk to the vulnerable adult as a victim but considering other victims such as children or other dependent adults in their assessment of an appropriate response, including what to do if a colleague discloses Domestic Abuse. The policy has recently been updated to ensure it reflects guidance to staff on recent changes as a result of the Domestic Abuse Act 2022. This has further informed changes to the Safeguarding training updates.

Local Authority Designated Officer (LADO)

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

Voice of the Child

Actions in response to recommendations from the CQC report 'Not Seen, Not Heard' continue to be reinforced by the Trust and are embedded within the Safeguarding Children's Foundation, yearly update and e-learning training. We continue to promote the importance of listening to children and promote working in partnership with the child to understand their felt needs. The wishes and feelings of Children in our Care (LAC) continue to be captured through Initial Health Assessments carried out for children on initially coming into care to ensure all Health needs are being fully met.

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

Bruising in Immobile Babies Policy

Bruising in non-mobile children is rare and therefore there is a significant risk that bruising may be indicative of abusive or neglectful care. Unfortunately, bruising is not always responded to appropriately by health practitioners both nationally and locally. As a result, a significant number of abusive events have been missed nationally resulting in children being placed at risk, serious incidents continue to be identified through Safeguarding Children's Practice Reviews. The assessment of children who present to A&E with a bruise is presently under review and will inform an update to the immobile baby pathway in response to another learning review, this will not effect

the response and will align more with what practitioners are required to do when a child is identified in the community with a bruise, ensuring all of these children are reviewed by the Paediatrician and social care information / advice or support is sought.

Joint working with Adult Safeguarding

Children's Safeguarding trainers continue to support joint working across the Vulnerability Unit in providing training for both children and adult safeguarding across the Trust including Domestic Abuse, Female Genital Mutilation (FGM), Prevent, Forced Marriage and Modern Slavery and Trafficking. The Adult Vulnerability Committee and Children's Steering Group have been brought together into the Safeguarding Council to facilitate the 'Think Family' approach at a strategic level.

Audit

The audit forward plan has a strong focus on quality and improving outcomes for children and young people. Examples include:

- Adult risky behaviours A&E Audit
- Section 11 Audit
- NICE Guideline 89 Audit
- Midwifery Quality Assurance Record Audit
    - Paediatrics Child Protection Medical Quality Assurance Record Audit
    - Medical Audits
    - Child Protection Medical Assessment
    - Haematological investigations
    - Abusive head trauma
    - FII
- Safer referral audit
- Looked after children initial health assessment audit
- Immobile baby pathway audit
- Children not brough for appointments by parents/carers policy audit

Children's Safeguarding Key Achievements 2022/2023

- The Child Protection Medical Suite is now in operation within the Trust from October 2022, this was supported in recognition of the stress for children, their families and professionals having to undergo and support Child Protection Medicals. Providing an increased level of confidentiality for families and multiagency information sharing. Feedback from these changes has been very positive from our social care colleagues and police.
- The Domestic Abuse Policy, Safeguarding Learning and Development Policy, Children's Safeguarding Supervision Policy and Child Not Brought Policy have all been reviewed and updated at the beginning of 2023.
- Genital Injuries Training was delivered in September 2023 following the introduction of the Genital injuries pathway in response to local learning. This pathway is now fully embedded to support both CYPED / Paediatricians and Gynaecology staff to understand risks and appropriate response and assessment needs for children who attend with Genital injuries, aligning with the Forensic network guidelines.
- The Multiagency interface group continues to be well attended and supports partnership working by front of house services from all agencies. Members now include representative's from the Emergency Department, CYPED Urgent Care and with Social Care's Emergency Duty Team, Social Care Children's Hub, CAMHS and Police Specialist Safeguarding Nurses for the Trust. This group has proved to be successful through improving collaboration and understanding of each other challenges, embedding any learning and breaking down barriers to sharing of information in a timely way.
- Dental Neglect Pathway pilot commenced in January 2023 and 3 month pilot is now complete, evaluation and audit of this pathway is presently underway and initial feedback

from focus groups held by NHS England have been very positive indicating the ongoing need for commissioning for dental practice to support improved access for our vulnerable children (following child protection medical and our Children in Care)

- Paediatricians now offered mini pupillage and group supervision in addition to Peer Review.
- Daily audit of children admitted to adult wards and the Children's Safeguarding Specialists nurses visiting these wards to review any safeguarding needs, has increased the visibility of the team as captured in a recent audit, promoting 'Think family' approach.
- The team have maintained a high compliance for safeguarding supervision sustained for professionals who hold children on their caseload.
- As safeguarding is a continuum, through collaboration with the communications team, a children's safeguarding specialist nurse developed a communication aid in the form of a QR code displayed in CYPED / ED to support easy access to advice and help lines around all aspects of abuse. This supports the first safeguarding principle of empowerment and was recognised by the trust as part of Celebrating Excellence.
- The Trust is now compliant to all standards set out by Royal College in October 2020 for child protection medicals through the development of New Trust Guidelines, review and update of Child Protection Medical Proforma for Consultant Paediatricians and chaperoning with completion for staff of relevant training. Prospective Auditing of Child Protection Medical Standards is in progress and is part of the Safeguarding Committee work plan.
- Children's safeguarding group supervision has been extended to further allied services within the Trust who although do not caseload manage children do provide an intensive, continuous level of health care delivery. This is in response to increasingly complex safeguarding case discussions to support staff understanding of role and responsibilities in identifying and assessing safeguarding needs. Safeguarding supervision further enhances safeguarding training and allows for the safeguarding nurses to update practitioners around learning from reviews and internal incidents in a more timely way.
- The successful introduction to annual safeguarding Schwartz round.
- Multiagency conference on Fabricated Induced Illness was hosted by the Trust in October 2022 and attended by over 100 delegates both locally and nationally to support better understanding of the new RCPCH new FII guidance published end of 2020.
- Our Named Doctor for children's safeguarding has secured three safeguarding good practice initiatives developed by the trust, of which the abstracts are to be presented at the national RCPCH conference. Extraordinary funding has been secured for trainee doctors to enhance their understanding around safeguarding.
- An FII national specialist interest group to share learning from these complex cases has also been initiated by our Named Doctor and the completion of a FII multi-centre audit in June 2022 to review the implementation of new guidance.

Children's Safeguarding Key Priorities 2023/2024

- Development of a new Fracture review pathway in response to lessons learned through incidents
- Communications and Engagement strategy to ensure lessons are learned from internal incidents, local and national learning reviews are considered by all staff in how these impact their practice.
- To address the ongoing challenges to ensuring staff maintain the skills and knowledge to be able to identify, assess and respond appropriately to any safeguarding concerns a new safeguarding training proposal has been development and is due to be presented by the trusts safeguarding and operational groups.
- Continue to work with colleagues in Care Group one to support the improvement plans in response to CQC report produced in 2022.
- To review the out of hours multiagency professional challenge pathway.
- Continue to escalate and advocate for support from Designated Safeguarding professionals statutory posts, where there are present vacancies.

- The ongoing development of a rolling program of simulation training for staff around Safeguarding, SUDIC and Abduction.
- Consideration and collaborative working with our neighbouring South Tees colleagues to ensure that any safeguarding pathway reviews are aligned where possible to support staff working across both Trusts.
- CDOP workshops to support staff in understanding the process and any changes in light of new guidance.

Safeguarding Children Training Programme

Throughout 2022 the Trust's in-house Safeguarding Children Training Programme has continued to provide mandatory foundation and update single agency training for all staff employed within the organisation. The training is in-line with the requirements of Safeguarding Children and Young people: roles and competences for health care staff, Intercollegiate Document (2019) and the Trust's Safeguarding Children Training Policy. This includes:

- **Level 1** – All non-clinical staff working in health care settings. For example, receptionists, administrative, porters
- **Level 2** – All clinical staff who have any contact with children, young people and/or parents/carers. This includes health care students, clinical laboratory staff, pharmacists, adult physicians, surgeons, anaesthetists, radiologists, nurses working in adult acute/community services, allied health care practitioners and all other adult orientated secondary care health care professionals, including technicians
- **Level 3** – All clinical staff working with children, young people and/or their parents/carers who could potentially contribute to assessing, planning, intervening and evaluating. The needs of a child or young person and parenting capacity where there are safeguarding/child protection concern. This includes paediatric allied health professionals, all hospital paediatric nurses, hospital based midwives, accident and emergency/minor injuries unit staff, urgent care staff, obstetricians, paediatric radiologists, paediatric surgeons, children's/paediatric anaesthetists, and paediatric dentists.

Level 1 and 2 Safeguarding Children Training is also aligned to the regional Core Skills Framework.

Level 3 Safeguarding training content has been refreshed and now includes scenario based training with the elements of effective referrals and information sharing.

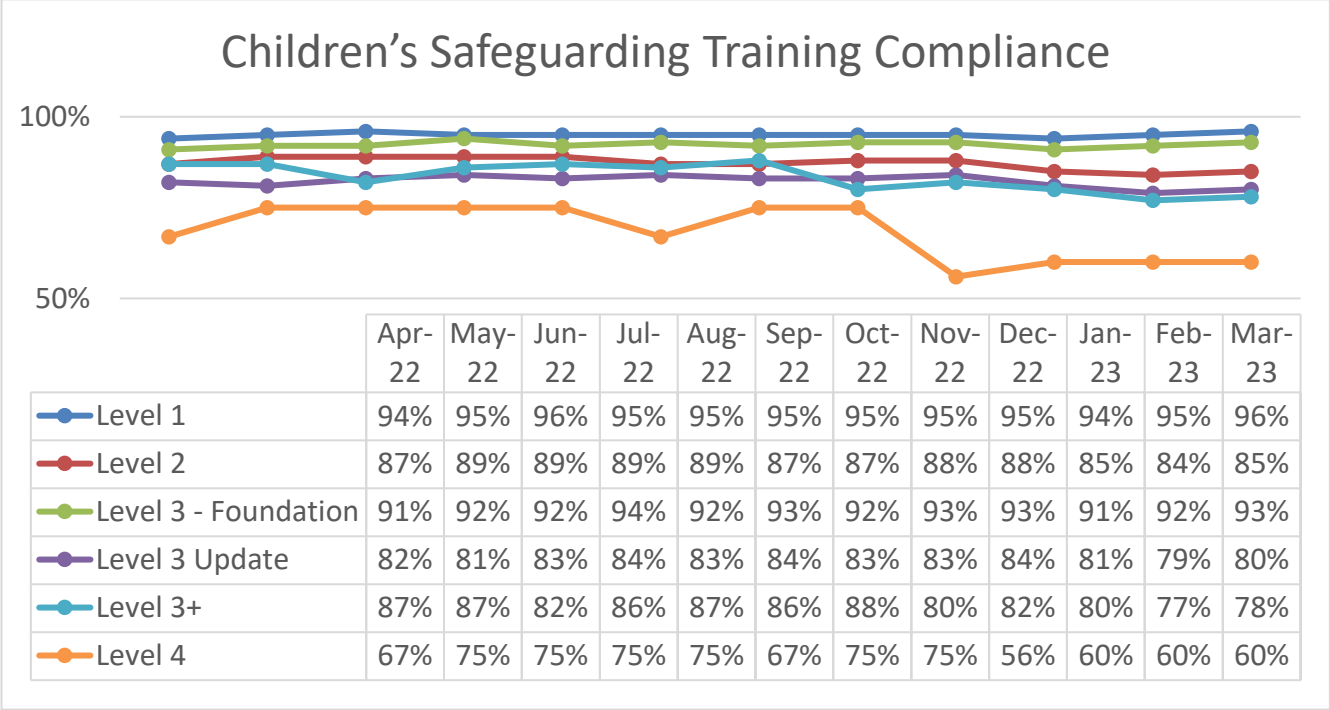
Where appropriate staff are required and supported to attend multi-agency training provided by the Safeguarding partnerships and other external providers and is strongly recommended for those staff groups identified as requiring Level 3 plus competencies.

Bespoke training is developed and provided as required and mandatory in-house training is continually updated and reviewed in response to learning identified in practice, during supervision, appraisals, incident themes, Learning Lessons Reviews, LSCPR's, and new and changing national guidance and legislation.

In response to the challenges and pressures on staffing during recovery from COVID a decision has been made to continue to provide updated e-learning packages for level 3 foundation and update training alongside face to face sessions

Overall Trust Compliance for Safeguarding Children Training

Training compliance is monitored by the Safeguarding Committee and Operational Group. Care Groups are required to present a quarterly improvement plan to address any compliance issues outside the agreed Local Quality Requirements between the Trust and Integrated Care Board. The Electronic Staff Record (ESR) competency reporting covers compliance for 12 months.



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Level 1	94%	95%	96%	95%	95%	95%	95%	95%	95%	94%	95%	96%
Level 2	87%	89%	89%	89%	89%	87%	87%	88%	88%	85%	84%	85%
Level 3 - Foundation	91%	92%	92%	94%	92%	93%	92%	93%	93%	91%	92%	93%
Level 3 Update	82%	81%	83%	84%	83%	84%	83%	83%	84%	81%	79%	80%
Level 3+	87%	87%	82%	86%	87%	86%	88%	80%	82%	80%	77%	78%
Level 4	67%	75%	75%	75%	75%	67%	75%	75%	56%	60%	60%	60%

Level 4 percentage is affected by the small number of staff that is eligible for this training, therefore 1 or 2 non-compliant staff members affects the percentage.

Sensory Loss

The Trust has legal duties to meet individual's information, communication and support needs.

The Trust continues along its journey to ensure the we are fully compliant with the Accessible Information Standards launched by NHS England in 2016 which builds upon the existing legal duties which public sector bodies and all service providers are already obligated to follow, the aim being to improve healthcare for millions of people with sensory loss and other disabilities.

A baseline audit was developed during Quarter 4 2022-23 for rollout and evaluation in Quarter 1 2023-24.

During 2022-23 the Trust have invested in the Trust website, to ensure it is fully accessible and easier to navigate. This is due to be launched in Quarter 1 2023-24.

The Trust's Accessibility Meeting monitors compliance with the Trust's legal obligation in meeting the Standards. The Meeting incorporates developments to ensure equal access and experience of service to patients and carers within the Trust's sphere of control, as well as sharing good practice.

Identifying Patients with Sensory loss

A Steering Group was established in Quarter 4 2022-23 to create and add a Reasonable Adjustment Flag to the Trust's patient administration system. This will enhance the processes already in place to consider where reasonable adjustments are required.

A Steering Group has been set to improve collaborative working with Patients, People and Public with Lived Experience (PPPLE). A stakeholder engagement event has taken place which included engaging with members of the community who support those with sensory loss to gain feedback on improving engagement within the Community. The objectives and goals of the PPPLE Steering Group are currently being finalised. Community engagement has commenced, attending meetings and discussions groups which include people who require reasonable adjustments. A central register of patients, people and the public with lived experience who wish to work with the Trust when developing our services has been initiated and work will continue during 2023-24 to develop this.

Patient Experience

The Trust is actively involved in Sensory loss planning and provision with external stakeholders. The Trust contributed to the Hartlepool Borough Council Joint Sensory Support Plan produced during 2022-23.

The Trust Accessibility monthly meeting includes core members from external stakeholder organisations.

Accessibility Champions have been introduced to support patients and visitors who require reasonable adjustments and to work within the Care Groups in the Trust on projects to improve patient experience, where patients require reasonable adjustments.

The Trust's language and interpreting support provider delivers training to all staff in relation to Working with an Interpreter – this includes support in relation to British Sign Language.

The Trust invested in 100 places on a British Sign Language training course during 2022-23, some staff have completed the course with other well on the way.

During Quarter 4 2022-23 plans were established to support National Deaf Awareness Week (1-7 May 2023) in the trust. The aim is to highlight the impact of hearing loss on everyday life and

increase visibility and inclusion of Deaf people. There will be a promotion event running for 2 days to offer support and guidance to staff. The event has been planned with the support of the Deaf community and will include representation from the Trust's contracted interpreting and translation service, and staff members who have taken up the offer of one of the 100 British Sign Language training places.

A Reasonable Adjustment Policy is under development for completion in Quarter 2 2023-24.

Specialist Equipment

The Trust have invested in a DDA Access Audit during 2022-23. The Audit was undertaken of the Trust sites, taking into account a patient's journey from the bus stop or car park through to each ward and department. There are multiple recommendations in the report which would improve the experience of patients and visitors with sensory loss, including a full review of hospital signage.

The report has been published and a work plan produced. Where guidance is required to support the work plan in relation to patients and visitors who require reasonable adjustments, this is brought to the Accessibility Meeting for input from stakeholders.

Priority 1: Patient safety

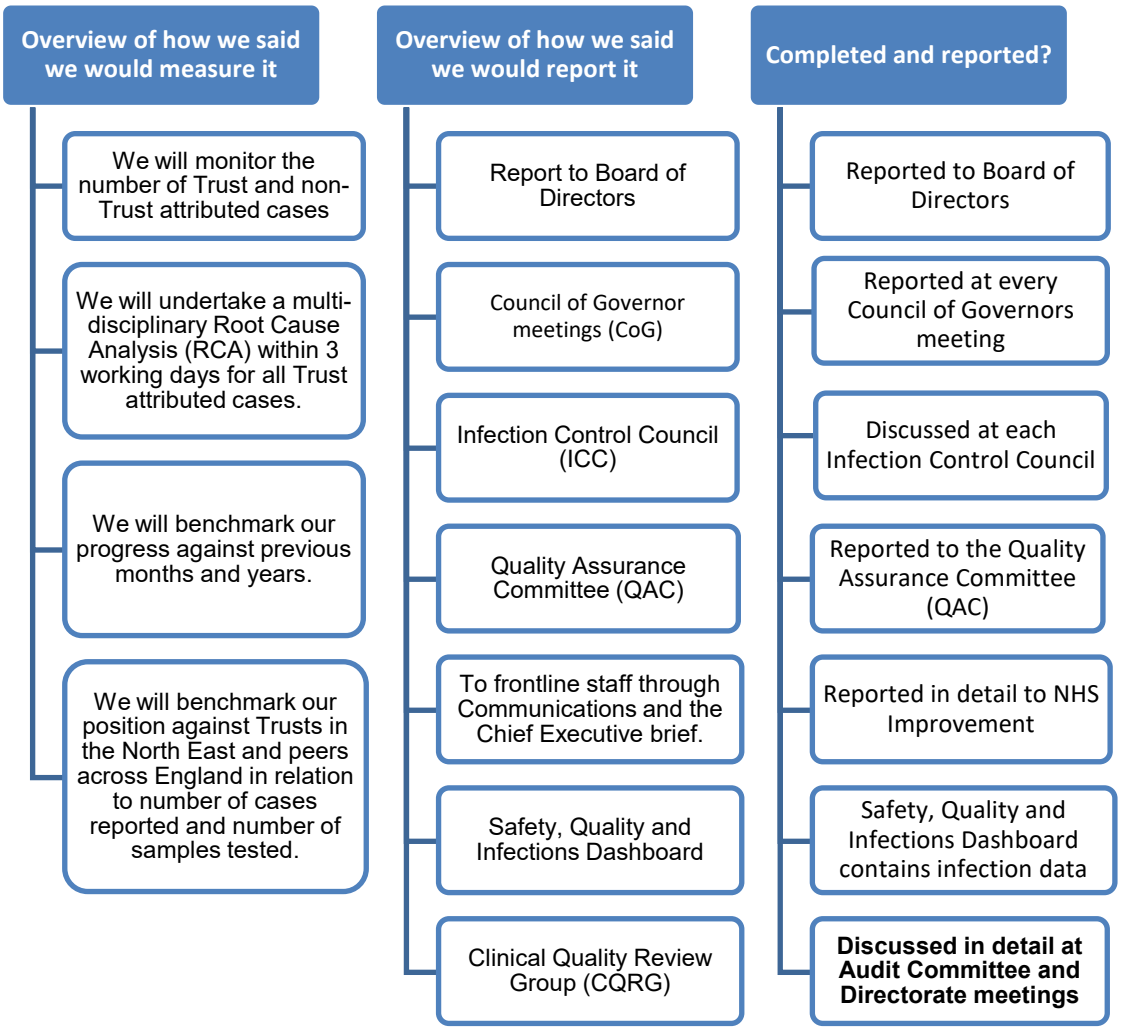
Infections

Rationale: The Trust continues to report on infections of:

- Clostridioides difficile (C.diff),
- Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia;
- Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia; and
- Escherichia coli (E.coli)
- Klebsiella species (Kleb sp) bacteraemia; and
- Pseudomonas aeruginosa (Ps a) bacteraemia.
- Catheter-associated urinary tract infection (CAUTI)
- COVID-19

Overview of how we said we would do it

- We will closely monitor testing regimes, antibiotic management and repeat cases and ensure we understand and manage the root cause wherever possible.



Due to COVID-19, there was not a trajectory set in 2020-21 for any of the reportable infections. In 2021-2022 trajectories were renewed for all trusts. However, the reporting criteria has changed and we currently report all **healthcare-associated** cases whether their onset was in hospital or in the community. This is in line with the criteria that is used for Clostridioides difficile, which means that data from 2022-23 is the first comparable data that we have.

Clostridioides difficile (C.difficile)

Clostridioides difficile is a bacterium that is found in the gut of around 3% of healthy adults. It seldom causes a problem as it is kept under control by the normal bacteria of the intestine. However certain antibiotics can disturb the bacteria of the gut and Clostridioides difficile can then multiply and produce toxins which cause symptoms such as diarrhoea.

The trajectory set for 2022-23 for Clostridioides difficile was reduced from 64 cases to 54. The trust is reporting **48** trust-attributable cases for the 2022-23 period.

Staff continue their efforts to control and reduce opportunities for infections to spread, whether we treat people in our clinical premises or in their own homes. The Trust has maintained a consistent approach to cleanliness across all areas of our environment including enhanced decontamination with triple actichlor plus cleaning and hydrogen peroxide vapour, and the provision of a hygienist team to support additional cleaning. The importance of adherence to high standards of hand hygiene has continued to be a core element of our strategy.

Actions to reduce C difficile are within an integrated HCAI improvement plan and Board Assurance Framework (BAF) covering all infections and practices and is reviewed quarterly. Progress against the plan is reported to the Healthcare Associated Infection Operational Group and Infection Control Committee and is regularly shared and discussed with commissioners.

The following table identifies the number of hospital and community onset cases of C.difficile reported by our laboratory.

Data reporting using the new requirements

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

***Trust Cdiff cases 2020-23**

	2020-21	2021-22	2022-23
Healthcare-associated	49	**50**	**48**
Community-associated	44	**55**	**45**

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

Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia

Staphylococcus Aureus is a bacterium commonly found on human skin which can cause infection if there is an opportunity for the bacteria to enter the body. In serious cases it can cause blood stream infection. MRSA is a strain of these bacteria that is resistant to many antibiotics, making it more difficult to treat.

Many patients carry MRSA on their skin and this is called colonisation. It is important that we screen some groups of high risk patients when they come into hospital so that we know if they are carrying MRSA. Screening involves a simple skin swab. If positive, we can provide special skin wash that helps to get rid of MRSA, this measure reduces the risk of an infection developing.

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

***Trust MRSA bacteraemia cases 2021-23**

	2021-22	2022-23
Hospital-onset Healthcare-associated	0	2
Community-onset Healthcare-associated	0	0
Community-onset Community-associated	1	2

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

Methicillin-Sensitive Staphylococcus Aureus (MSSA)

MSSA is a strain Staphylococcus Aureus that can be effectively treated with many antibiotics. It can cause infection if there is an opportunity for the bacteria to enter the body and in serious cases it can cause blood stream infection.

In 2022-23 we currently report **47** cases of healthcare-associated MSSA bacteraemia to date.

***Trust MSSA bacteraemia cases 2021-23**

	2021-22	2022-23
Hospital-onset Healthcare-associated	29	37
Community-onset Healthcare-associated	9	10
Community-onset Community-associated	59	65

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

This is an increase from 2022-23 where we reported 37 hospital-onset cases. Each appropriate case is subject to a root cause analysis and the analysis of these investigations has shown that although a high proportion of cases have been difficult to prevent, as they are linked to chest or hepatobiliary sources, there has been an increase in those linked to intravascular devices. Therefore the Trust has undertaken focused work on cannula insertion, maintenance and early removal of devices, which supports antibiotic stewardship, with IV to oral antibiotic switches and a move to non-ported intravascular devices aims to reduce opportunities for the development of infections supported with a robust education and training package for staff.

Escherichia coli (E.coli)

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

The threshold set for 2022-23 for E-coli was reduced from 117 cases to 73. The trust is reporting **87** healthcare–associated cases for the 2022-23 period.

***Trust E.coli bacteraemia cases 2021-23**

	2021-22	2022-23
Hospital-onset Healthcare-associated	35	41
Community-onset Healthcare-associated	42	46
Community-onset Community-associated	185	213

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

As the majority of these cases remain those that are identified within the first 48 hours of hospital admission, work is required across all healthcare settings to achieve improvements. A national objective to reduce gram-negative blood stream infections (GNBSI) (E coli, Klebsiella and Pseudomonas) by 50% by 2023 is in place and within this to reduce E coli bacteraemia by 10% each year. The recent publication of the Commissioning for Quality and Innovation (CQUIN) in January 2022 for 2022-23 also addresses the need for appropriate antibiotic prescribing for urinary tract infections, which remains the leading cause for gram –negative bloodstream infections. Work continues within the Trust and with our regional partners to tackle GNBSI as an Integrated Care Board.

Root cause analysis is completed for cases deemed to have been hospital-onset and healthcare-associated and action plans are developed where actions are identified. In many cases these infections are related to urine infections and are thought to be not preventable with only a very small percentage of cases being in patients with a urinary catheter where there may be potential for improved practices.

Klebsiella species (Kleb sp) bacteraemia

Klebsiella species are a type of bacteria that are found everywhere in the environment and also in the human gut, where they do not usually cause disease. These bacteria can cause pneumonia, bloodstream infections, wound and surgical site infections and can be associated with invasive procedures such as venous cannulation or urinary catheterisation.

The threshold set for 2022-23 for Klebsiella Species was reduced from 24 cases to 21. The trust is reporting **28** healthcare-associated cases for the 2022-23 period.

***Trust Klep sp bacteraemia cases 2021-23**

	2021-22	2022-23
Hospital-onset Healthcare-associated	9	17
Community-onset Healthcare-associated	6	11
Community-onset Community-associated	45	43

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

An increase in hospital onset healthcare associated cases was identified and investigated at the beginning of the 2022-23 period. Findings showed that infection sources were endogenous (Hepatobiliary and Upper UTI) and therefore unavoidable, but sampling dates meant that the apportionment criteria met hospital onset definition. A national change to the management of cholecysititis and gall bladder procedures, similar to pre-pandemic times, is likely responsible for a reduction in hospital-onset figures throughout the year.

Pseudomonas aeruginosa (Ps a) bacteraemia

Pseudomonas aeruginosa is a bacterium often found in soil and ground water. It rarely affects healthy individuals but can cause a wide range of infections particularly in those with a weakened immune system. P aeruginosa is resistant to many commonly used antibiotics.

The threshold set for 2022-23 for Pseudomonas Aeruginosa was increased from 11 cases to 12. The trust is reporting **15** healthcare associated cases for the 2022-23 period.

***Trust Ps a bacteraemia cases 2021-23**

	2021-22	2022-23
Hospital-onset Healthcare-associated	9	8
Community-onset Healthcare-associated	5	7
Community-onset Community-associated	13	15

Many of these cases are considered unpreventable infections. In the 2022-23 period there was a reduction in case numbers in the last 6 months of the year with 4 healthcare-associated cases from November to March.

Catheter-associated urinary tract infection (CAUTI)

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

	2020-21	**2021-22**	**2022-23**
Hospital Onset	**211**	**265**	**209**

In 2022-23 the Trust reported **209** cases of CAUTI, demonstrating a good reduction on the previous 2 years. The trust continues to report CAUTI cases at the safety huddles and to the trust board. Work is ongoing to reduce the prevalence of catheters by using alternate urine monitoring devices. A focus on promoting early removal of catheters and ensuring that diagnostic testing and antibiotic prescribing is in line with recommended national guidance. There are currently no set targets for trusts but it is recognised that a reduction in CAUTI will have a positive impact on the gram-negative bacteraemia cases.

Coronavirus disease (COVID-19)

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

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

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

Between 17 March 2020 and 31 March 2023, there have been **6,139** number of COVID-19 positive patients in the Trust with **790** deaths.

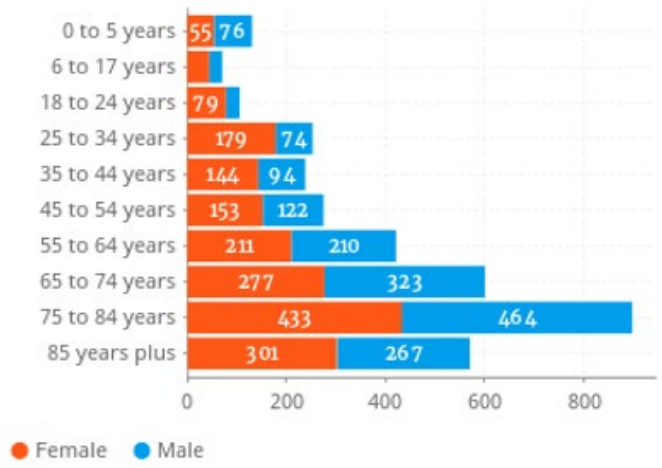
COVID-19 Positive Patients in the Trust

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

The Trust continues to see daily admissions of COVID-19, with 36 patients still within the Trust at het end of March 2023.

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

Cases by age group and gender



Priority 2: Effectiveness of Care

Learning from Deaths

Learning from deaths of people in their care can help providers improve the quality of the care they provide to patients and their families, and identify where they could do more.

In March 2017, the National Quality Board (NQB) introduced new guidance for NHS providers on how they should learn from the deaths of people in their care.

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

During April 2022 to March 2023, 1550 of North Tees and Hartlepool NHS Foundation Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

388 in the first quarter;

349 in the second quarter;

412 in the third quarter;

455 in the fourth quarter.

By 31st March 2023, 96 case record reviews have been carried out.

There are 9 cases classed as incidents and 5 investigations have been completed. 4 are ongoing.

4 deaths (2 in Q1 and 2 in Q2) have been identified as possibly avoidable. This represents 0.1% of all deaths.

A summary of the mortality and quality improvement work over the past year.

Deteriorating Patient

The Deteriorating Patient Group meets monthly and is a multidisciplinary group looking at all issues relating to the deteriorating patient. The group maintains a dashboard of KPIs, mandatory training and relevant risks/incidents. It runs in association with the Regional Deteriorating Patient Group. It reports to the Quality Assurance Council. Key areas of work are summarised below:

- Updated sepsis screening tool to UK Sepsis Trust standards
- Employed deteriorating patient nurses
- Delivered Additional NEWs training, training in sepsis recognition, blood cultures.
- Review of Critical Care handover process
- Introduction of E-observations to allow remote identification of deteriorating patient
- Opening of Respiratory Support Unit
- W31 now have a Band 6 senior nurse on each shift with critical care rotation..
- Training for HCA in the early recognition and escalation of deteriorating pt.
- AKI subgroup, AKI pocket cards
- NIV monthly audit
- Regional transfer training for ITU, Emergency Department and Stroke Service
- Neurological Fast Response Team.

- Introduction of ‘Stop the clock’ to allow timely assessment of a patient who is deteriorating
- ‘Soft signs’ training for staff looking after patients in the community.
- Critical care at EAU huddle
- Deteriorating Patient Training Days

Critical Care

- Internal Mortality review of all patients who die on the unit.
- Pre operative discussions re emergency laparotomies between consultant anaesthetist and surgeon.
- Process for CCOT to refer into Critical Care.

Surgery

- M+M review of all mortalities
- Shared governance meetings with other specialties
- Return to theatre reviews

The trust was recognised to be an outlier with regard to NELA (National Emergency Laparotomy audit) in that patient who have a NELA score of >5% should be admitted to a level 2 facility >85% of the time. A collaborative approach between surgery and anaesthetics have seen significant improvements and have consistently demonstrated >95% compliance

Specialist Palliative Care

- Patients who have died are regularly discussed at the weekly MDT
- Annual NACEL (National Audit of Care at the End of Life) benchmarks end of life care in the Trust against others. Results show we perform well.
- The End of Life Steering Group (EOLSG) has brought together the key stakeholders in end of life care.
- Audits of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and Emergency Health Care Plans (EHCP) have identified areas for improvement and training such as expanding training for nurses in completing DNACPR and supporting community matrons with completing EHCPs
- The appointment of an End of Life facilitator has allowed ward based education around the care of the dying patient and improved our use of the Caring for the Dying Patient Document.
- An order set for the commonly used ‘Anticipatory’ medication at end of life has led to more accurate, efficient and safer prescribing of these drugs

Paediatrics

- All deaths are reviewed in depth in house and through the CDOP (Child Death Overview Panel) process
- The reviews prompt examination of the clinical guidance, policies and procedures in place.
- Improved recognition of acute illness – now using regional PEWS
- Children and Young People Emergency Department (CYPED) is running effectively
- Move to electronic records
- Biannual meetings with NECTAR
- Review of all transfers over past 2 years. – identified good practice and learning

Maternity

- All MBBRACE/CDOP/HSIB protocols followed
- Identified smoking as an area of concern – maternity smoking cessation work ongoing
- QI work around reduced foetal movements undertaken.

ME Themes

- Most feedback from relatives is positive about the care provided
- Identified delays in verification of death and mortuary transfer – led to further roll out of Nurse Verification of Death and the inclusion of clear standards in Care after Death policy.
- Recognition that provision of good mouth care is not consistent – this fed back to wards and to EOL facilitator

New Learning from Deaths Process

- Two Mortality Leads appointed Nov 2022, Dr Katie Elmer and Dr Julie Christie
- Work ongoing to establish robust Learning from Deaths process
- Mortality Steering Group – Membership and Terms of Reference to be established.
- Learning from Deaths Policy review underway
- Working with NHSE Better Tomorrow team we have signed up to use SJRplus Mortality Review system and dashboard.
- The Trust now has approximately 15 trained mortality reviewers from a range of professional groups (medical/nursing/AHP). Most are from Medicine – reviewers from other specialties are being actively recruited.

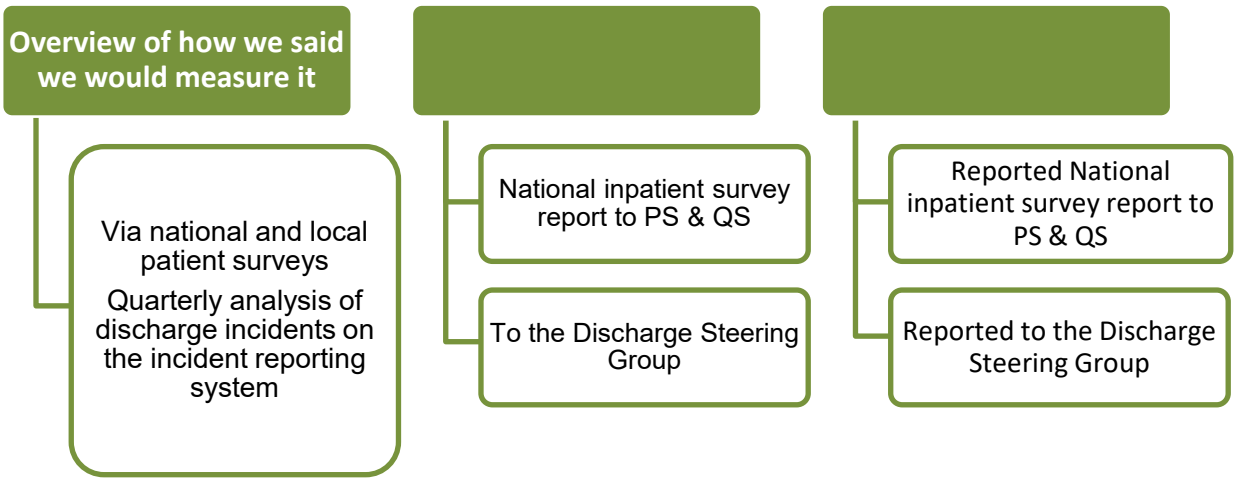
Next steps include:

- Strengthening the Learning from Deaths team with administrative support and involvement of performance and business intelligence.
- Address practicalities of review process – IT support, available space, suitable remuneration/adjustment of job plans to allow reviewers to participate.
- Implementing the process for the completion of reviews by the SJRplus process.
- SJRPlus on NHSE Applications includes standard reporting (already in use by neighbouring Acute Trusts with plans for use in Mental Health)
- SJRplus Dashboard to be linked to PowerBI to allow performance data and reports to be generated for review of progress.
- Future opportunities include:
    - Tees Valley and Regional Collaboration – sharing of learning
    - Collaboration with Mental Health Trust/NEAS
    - Community Mortality Review Process.

Priority 2: Effectiveness of Care

Discharge Processes

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



Continued consolidation of Hospital Discharge service: policy and operating model updated June 2022.

The Trust and partners in Social Care have worked together to implement the discharge policy and continue to reduce delayed transfers of care. The Trust interagency discharge policy was reviewed and ratified on 14/06/22.

The government funding for discharge continued through 2022-23 to help cover the cost of discharge recovery and support services, rehabilitation and reablement care following discharge from hospital. Which has been used to fund Community placements and other schemes

The Trust had established the trusted assessor pathways during 2020 to meet this requirement and ensure the processes are fully embedded for all people aged 18+. The trusted assessors work with patients, their families and staff on the wards to transfer patients in a safe and timely manner. The trusted assessor model has reduced the time it takes from referral to transfer. The model is fully supported by our Partners in Hartlepool & Stockton Borough Council and this continued as a Model through 2022-2023.

Through 2022-2023 there have been a range of new initiatives that supports patient flow across acute to community services working in collaboration with system partners.

Integrated Coordination Centre (ICC)

The ICC was opened in April 2022. The implementation of an ICC has supported prediction, planning and responding appropriately to patient flow. The ICC brings together:

- The Patient Flow Team (Bed Mangers/Site Managers)
- Integragrated Discharge Team
- Discharged Transport Scheduler.

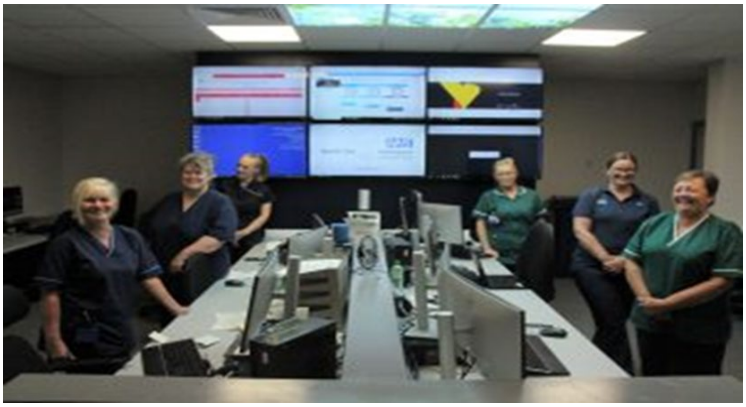
The aim is that this integration brings about the biggest reward in regards to flow. In addition, we use our electronic systems to support this decision-making at the earliest opportunity to maximise our capacity and demand response.

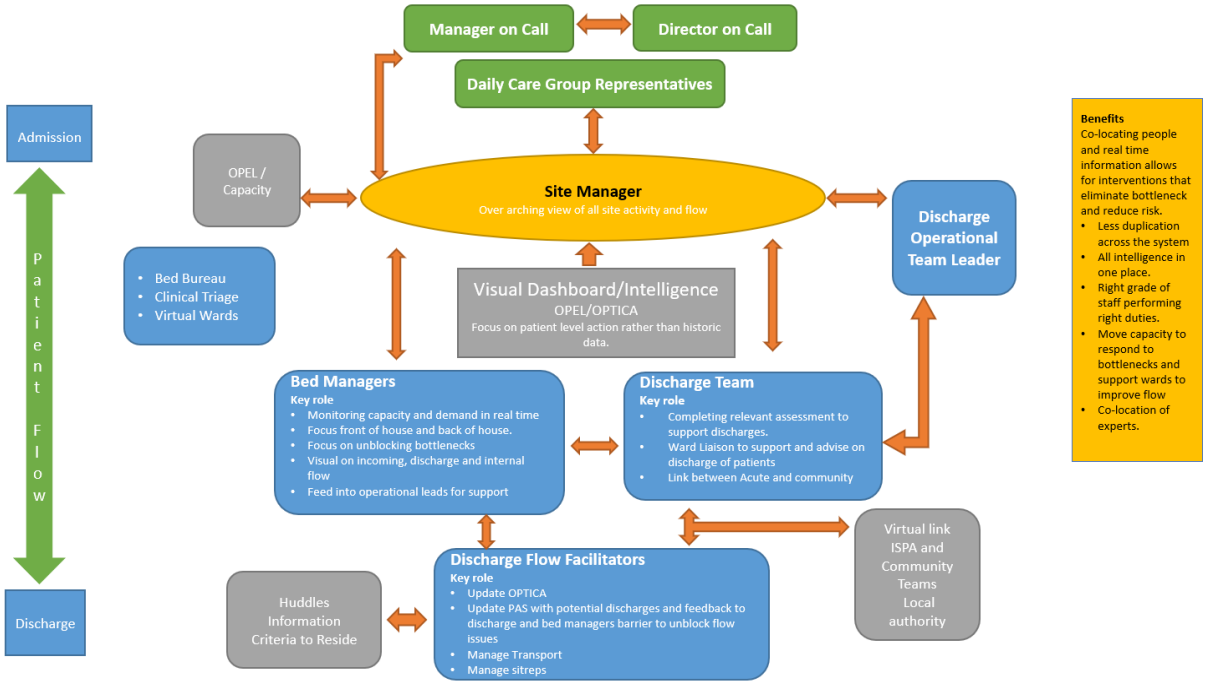
Visual management is an approach that communicates important information to those that need it in a visual and immediate manner.

There are a number of systems we have to support all of which have associated action and escalation processes:

- Ambulance stack
- EPR
- Yellowfin BI
- OPTICA Discharge Tracker

This empowers the team to make specific patient-level plans based on 'live' rather than historic data.





Optimised Patient Tracking and Intelligent Choices Application (OPTICA)

Acute hospitals must discharge all persons who no longer meet the criteria to reside in hospital as developed with the Academy of Medical Royal Colleges, as soon as they are clinically safe to do so. Daily morning ward huddles to review every person take place and a decision, informed by the criteria to reside, are the foundation for avoiding delay and improving outcomes for individuals. As a trust the daily reviews have been integrated into the electronic patient information systems; and transfers this information to OPTICA this ensures that tracking list is available for all agencies to work from and includes those patients suitable for discharge.

In April 2022 OPTICA went live in the trust after of number of months supporting its development with NECS. OPTICA NHS Foundry is a data collection, processing and visualisation platform provided by NHS England. An ecosystem of Foundry applications is planned to sit on the platform, available for providers to access directly. OPTICA (Optimised Patient Tracking and Intelligent Choices Application) is an application built on the Foundry platform by North of England Commissioning Support (NECS) with North Tees and Hartlepool Hospitals NHS FT (NTH) that tracks all admitted patients and the tasks related to their discharge in real-time through their hospital journey. The system is fully integrated with hospital Electronic Patient Records (EPR), other health data systems (including lab results) and social care data to ensure relevant information related to discharge is available to clinical teams and leaders in one place. The automated dataflows are easily augmented with updates from operational teams. OPTICA drives an efficient, shared way of working for health and social care teams, providing actionable intelligence to help care teams properly plan for timely discharges. This helps ensure avoidable delays leaving hospital are kept to a minimum and that hospital beds are not unnecessarily occupied. It enables multi-disciplinary teams to easily understand exactly where discharges from the hospital are being avoidably delayed, for how long, why, who is responsible, and attaches a proxy indication of missed opportunity cost to the organisation.

Introcution of Discharge Flow Facilitator role

Since the introduction of OPTICA in April 2022 there was a need recognised to develop the workforce who are responsible for the maintenance of information that is input on to the tool, ensuring it is a constant live version of events. We currently have 2 Discharge Flow Facilitators (DFF) that work in the ICC 8.00-17.30 Monday – Friday and 8.00-16.00 Saturday – Sunday. They communicate with all members of the Integrated Discharge Team, the Patient Flow Teams, wards, local authorities and care providers to gather information for patients discharge journey, allocating discharge checklist tasks to the responsible assignee group. The DFF escalates any tasks that extend beyond reasonable timescales (identified within OPTICA) to ensure delays are minimised.
Without the role of the Discharge Flow Facilitators the information available to all OPTICA users would be less reliable and therefore may incur unintentional delays.

PPF Winter pilot

Building on the workforce model of the Discharge Flow Facilitator, we employed a number of Patient Flow Facilitators to be based on the wards. They are trained and educated by the Integrated Discharge Team on the established discharge processes, however also support the ward in other tasks that support patient flow, not isolated to discharge from hospital. For example, chasing referrals, requesting bed cleans, liaising with different departments etc. all of which supports the clinicians to focus on clinical tasks. They form a conjugate between the wards, the site patient flow team and the IDT, communicating in a more effective manner, aiming to improve timely and safe discharges.

Reduction length of stay in hospital

OPTICA, the ICC, community developments, partner relationships and collaboration have supported the reduction in length of stays where patients no longer meet the criteria to reside in hospital. This means patients are getting home safer sooner.

Patients remaining in Hospital over 21 days is below the National 12% target 2022/23 – Year Average for North Tees is 10.92%. The average length of stay has also been maintain below national and regional averages at 3.27 days (Feb 2022-Jan 2023)

Help Force – Home but not alone scheme

A volunteer led and delivered service to support patients through the discharge process. This programme has been reintroduced to 6 wards across the Trust and recently other Discharge areas, including the Discharge Lounge, Emergency Assessment Unit and the Emergency Department .Those patients who live on their own or would like someone to talk to are referred onto the programme. Volunteers meet them, whilst they are inpatients or at the point of discharge to discuss their needs upon discharge and post discharge. Our volunteers have access to local Foodbank's emergency food parcels and clothes for those in need. Our volunteer driver service can transport these patients home following a period of hospitalisation. Drivers can also deliver medication where appropriate and can also provide transport to outpatient appointments post discharge if they are on the scheme.

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

We continue to support the original pilot areas, and have ambitions to offer the service to other areas of the trust as the number of volunteers specific to this service grows. We have developed good working relationships with local social prescribers and other befriending initiatives.

Across this last financial year the small team have supported 60 patients. At the point of discharge the team has issued emergency food parcels, patients have benefitted from the supply of emergency clothing and a number of these patients have been taken home by a volunteer. Post discharge, the team has undertaken 94 contacts. Information about community services and support has been shared with patients. 35 of which have offered completed evaluations. As part of the patient survey evaluation, 17 patients answered the question: 'How likely are you to recommend the service'. All 17 said either 'extremely likely' or 'likely'. Additional comments are recorded as follows.

"Lovely that we call her, enjoys talking to someone"

"Appreciates calls as doesn't want to worry family"

"I'm pleased there is someone who cares"

"Nice to have someone to talk to"

"Highly satisfied"

"Grateful for the calls"

"Praise for the volunteer service."

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2 hour urgent response and NEAS work

Our latest pathway is utilising urgent community 2 hour response teams to work with NEAS and intervene to stop unnecessary ambulance conveyance to the acute trust. Data demonstrates this is proving extremely effective, and we are managing to provide care to patients in the community using all of our available services, rather than a transfer the Emergency Department and other front of House assessment areas. This results in high levels of patient satisfaction and decongestion in ambulance handovers and Emergency Care performance.

We have worked with NEAS for the last few years, utilizing a push model from the stack: NEAS will alert our community teams if they get a patient with a cat4 fall. Our teams visit the patient, within 2 hours, perform an appropriate assessment, and where safe to do so, keep the patient at home with appropriate care wrapped around them.

We have recently expanded upon this push model to NEAS, providing NEAS clinicians with education and information on the wider local urgent community response offer and set up a direct electronic referral pathways linked to 111 Directory of services to enable greater access to our local community system. This approach went live on the 1 December and we have received over 30 referrals in this time

On the 1 of October 2022 a new telephone line for paramedic crews was set up to gain easier access into our local urgent community response teams to support crews on scene. Education, training and information was provided to the teams which has resulted in over 40 new patient referrals into community services as well as providing advice and guidance to many other calls that have prevented an ambulance conveyance.

In addition, we started a further project in November 2022 where our teams pull patients from the stack: we have access to the list of patients who are currently waiting for an ambulance, we identify those who might be appropriate for our services and gather further information from SystmOne (EPR). If the patient is appropriate for our service, we then take them off the stack and then provide a visit from an appropriate health care professional within 2 hours, the clinical responsibility then lies with us.

If the patient is not appropriate for our services, they remain on the stack: in a couple of cases we have expedited the transfer to the acute trust as the patient was more unwell than the initial triage suggested.

12 December to 12 February 2023

Total Patients Pulled from the stack = 73

Our local authority colleagues are involved throughout in the development of these pathways and we share ownership in managing the social requirements of some of our patients.

Early data demonstrates that at peak pressure points within the community system we are taking about 7 patients per day out of the stack and managing them entirely within the community. We have had no safety incidents. We are developing pathways as we learn from experience, for example direct pathways to urgent care to exclude (or diagnose) fractures

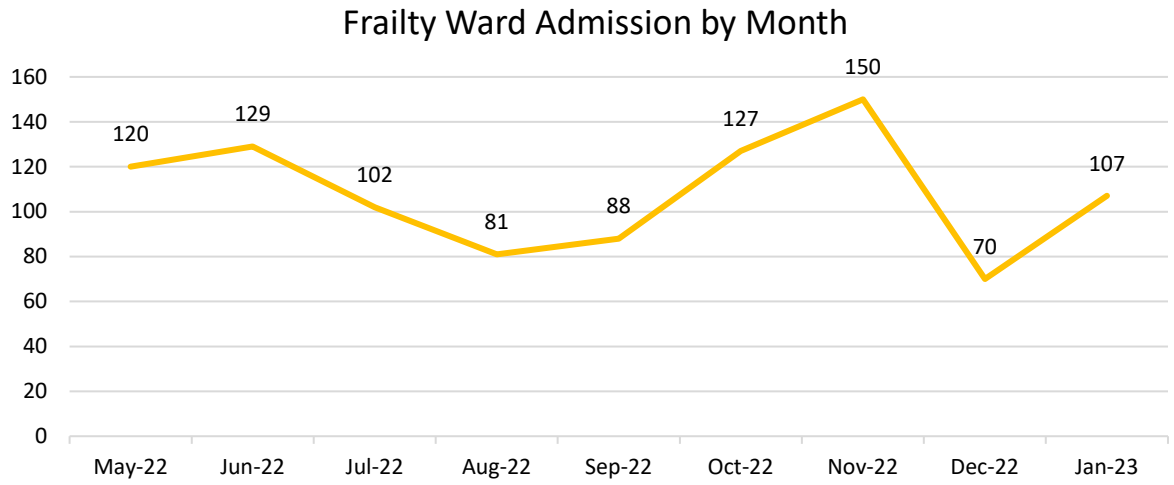
The patients have a variety of clinical and social needs: some of them get managed immediately by the teams, some are now being stepped up and managed in the virtual frailty ward. Our local authority colleagues are part of this work, so if there is an additional social need we collaborate to ensure this need is safely met.

This model has also evolved to support primary care services in that a team of clinical practitioners are now located within the bed bureau in the SPA to listen and divert avoidable admissions and provide community services where possible. The next step would be for this team to have access to NEAS Cleric systems to monitor the NEAS triage and stack within the ISPA.

Virtual frailty Ward

We have a well-established virtual frailty ward in the community, utilising the community matrons to provide acute care for patients in care homes, again with the aim of avoiding unnecessary admissions. This service has recently expanded, and is now a virtual frailty ward: we have collaborated with the GP federation and our local authorities to enable us to increase the scope of patients we can manage within this service. Our colleagues in primary care are involved in delivering this service.

Data for the Virtual Frailty ward



note that the red line denotes a change in reporting criteria

Expansion of the overnight transport

Patient transport is available 7 days a week to support patient discharge. This has been further complimented with a vehicle overnight. This has allowed us to facilitate up to 7 discharges from the Emergency Department, meaning the patient does not have an extended stay waiting for the day transport to be available.

Priority 2: Effectiveness of Care

Accessibility

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

Aim

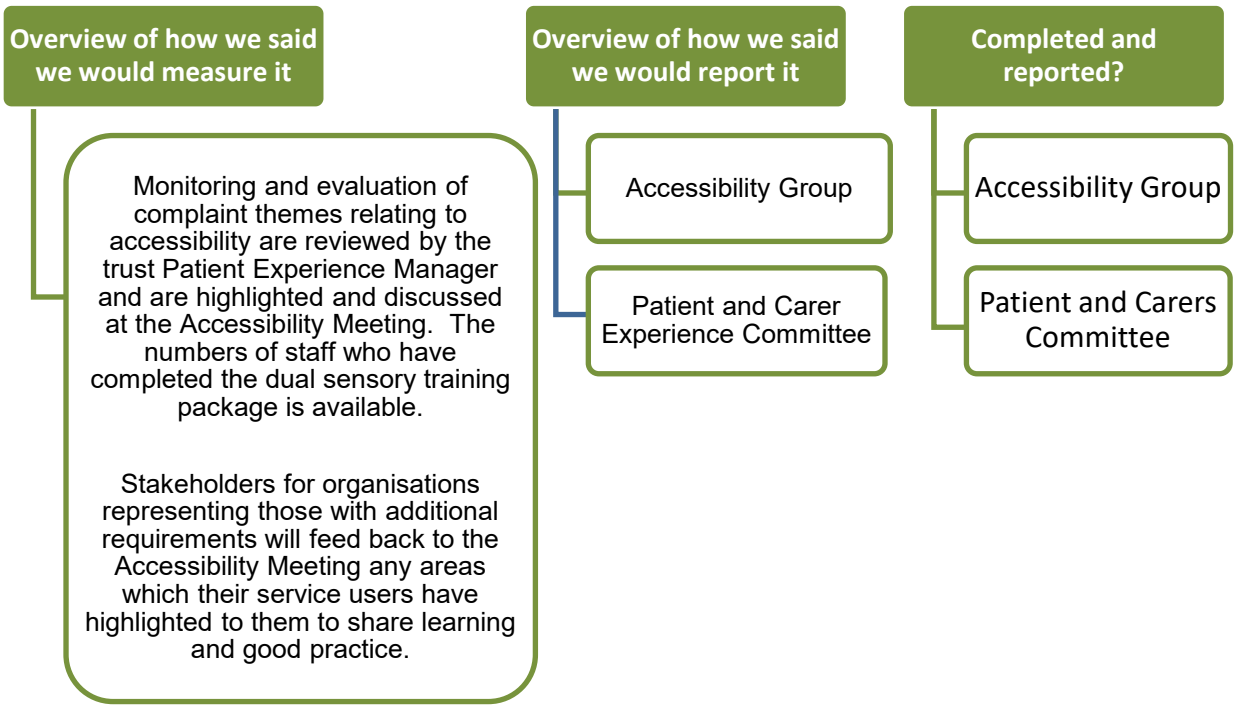
The aim is to develop a culture which learns from service user/stakeholder feedback. To provide a forum for service users/stakeholders to participate in accessibility projects and groups to ensure that their voices can be heard and that their views make a difference to the work in the trust. To ensure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

Overview of how we will do it

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

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

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



Developments and improvements 2022/2023:

- Trust webpage and accessibility

- The Trust contracted language service provider has recommenced training to Trust staff to provide guidance on best practice when working with an interpreter. Virtual training sessions have taken place and face to face training is due to commence with Ward Matrons.

- 18 Accessibility Champions have been introduced to raise awareness around accessibility and reasonable adjustments. The Champions will have received training around the Accessible Information Standards by the end of March 2023.

- The Terms of Reference for the Accessibility Meeting are being refreshed. The meeting is now Chaired by Associate Director of Nursing, Experience and Improvement. The refresh will ensure enhanced senior representation and wider representation from our stakeholders in the community.

- The Trust engaged the services of an external contractor who undertook a DDA access audit on North Tees, Hartlepool and Peterlee Hospital sites. The audit followed the journey of a patient from the car park/bus stop through to wards and departments. The recommendations from the audit have been graded according to priority level and risk level and remedial work will commence in the first quarter of 2023-24.

- The DDA access report and findings are now factored into any development work to ensure they are addressed whilst undertaking the development work.

- PLACE (Patient-Led Assessment of the Care Environment) audits are undertaken and in the most recently nationally submitted assessment suggested that the Trusts position had deteriorated , however a review identified that this was a data error. To ensure that staff, patients and families are aware of the high standard in place in the Trust monthly PLACE lite assessments are in place and the results are shown on the Trusts external website.

- A review of the Trust complaint process is underway in line with the Parliamentary and Health Service Ombudsman's Complaint Standard Framework. The revised process ensures equal access when raising a concern, complaint or providing feedback as well as a more streamlined and efficient service for all.

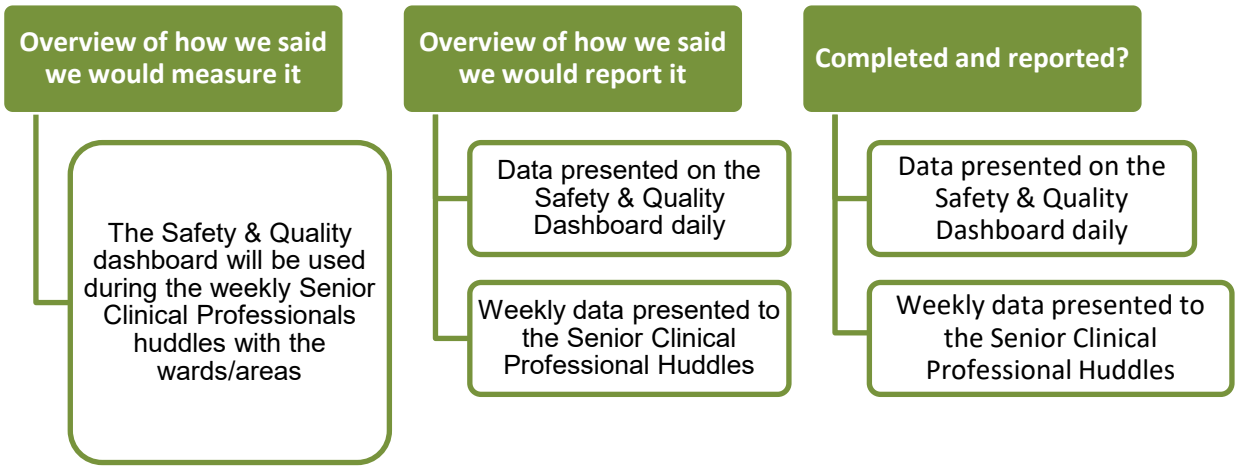
- A Patient, Public and People with Lived Experience Steering Group (PPPLE) has been set up to review and refresh the Trust's approach to engagement from full co-production of services to soft touch information giving. The Steering Group will include representation from PPPLE who require reasonable adjustments to access our services.

Priority 2: Effectiveness of Care

Violent Incidents

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

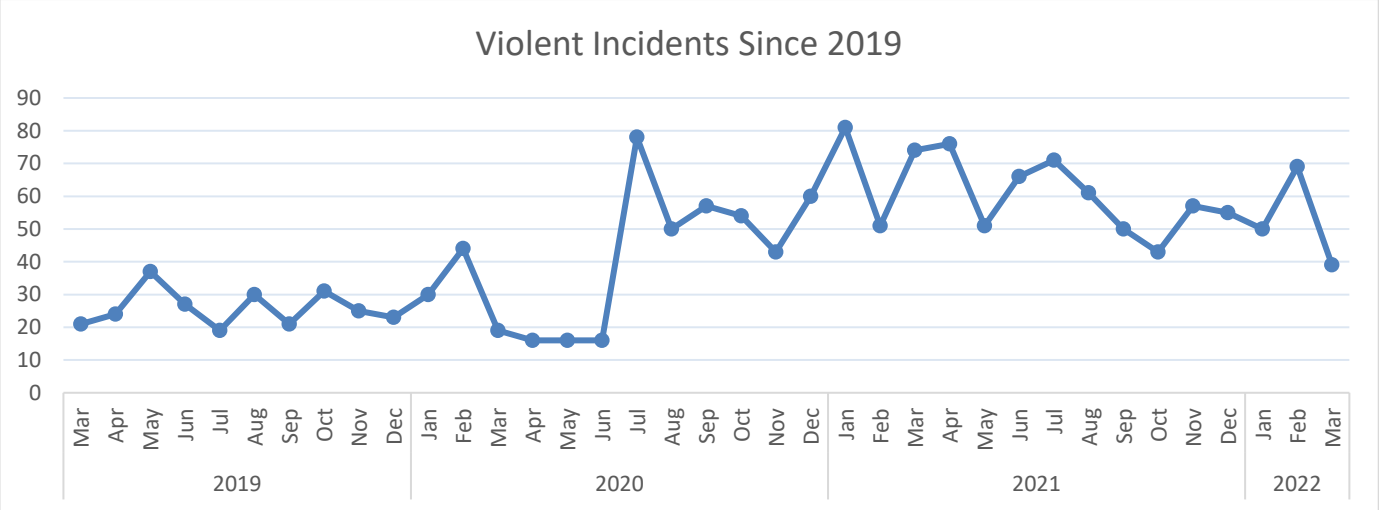
Overview of how we will do it
Utilise the Violent Incidents data held within the Trusts incidents reporting software.



Year Comparison

There has been a change in the reporting process within the Trust for 2022-23. These changes have allowed for increased reporting that were previously not being logged. Further in 2022/2023 the incident reporting system was further developed to identify causes and drivers for violent incident to support the development of strategies to manage the causes of violence in the Trust.

	Total Violent Incidents
2022-23	621
2021-22	690
2020-21	596
2019-20	330



Adverse Event	2020-21	2021-22	2022-23
Verbal abuse or disruption	213	256	295
Physical Abuse, assault or violence - unintentional	97	125	141
Disruptive, aggressive behaviour - other	155	98	64
Concerns to do with personal safety	27	95	44
Need for use of control and restraint with patient	27	57	28
Inappropriate behaviour and/or personal comments	29	27	25
Physical abuse, assault or violence - Malicious	31	11	12
Racial	11	14	7
Assault etc with a weapon	5	6	4
Sexual	1	1	1
Grand Total	**596**	**690**	**621**

To support the staff, patient and families the Keeping People Safe Group has been developed to support the development of strategies to ensure the safety of service users and staff.

Priority 2: Effectiveness of Care

Safety and Quality Dashboard

Rationale: The Safety and Quality Dashboard will support close monitoring of nurse sensitive patient indicators on a day-to-day basis. It will support sharing of best practice and speedy review of any potential areas of concern.

Overview of how we said we would do it

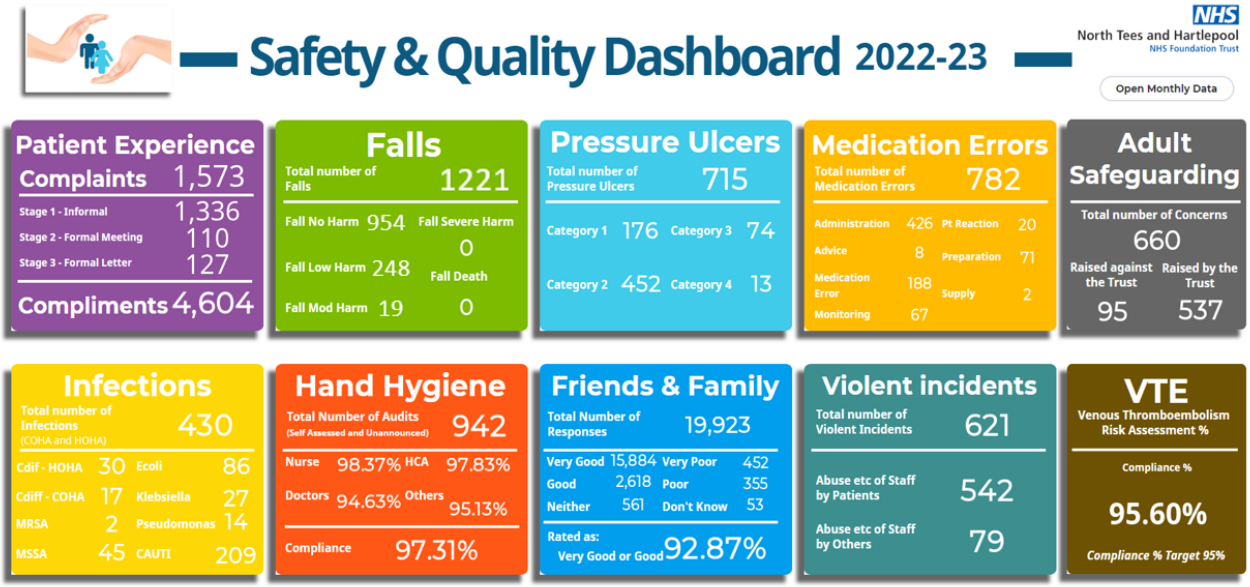
- Training will be completed and each department will evidence that their results have been disseminated and acted upon.
- Ward matrons will present their analysis on a public area of the ward for patients and staff to see. The results will be discussed and minutes taken.

The purpose of the dashboard is for the Trust to have an overview of what is going on at ward level and to identify any issues/trends identified by having all of the data located in one place.

The areas covered by the dashboard are:

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

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



Senior Clinical Professionals Weekly Huddle

The Trust also utlilises the Safety & Quality data on a weekly basis within the Senior Clinical Professionals (SCP) huddle.

Priority 3: Patient Experience

Specialist Palliative Care , End of Life Care and Chaplaincy

Rationale: The 'Ambitions for Palliative and End of Life Care: a national framework for local action 2021-2026' document outlines six key ambitions for the delivery of excellence in palliative and end of life care to help organisations prioritise and continually improve palliative and end of life care. The six ambitions are listed below and further information is available at:

NHS England » Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026

1. **Each person is seen as an individual**

   I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon. I am asked what matters most to me. Those who care for me know that and work with me to do what's possible

2. **Each person gets fair access to care**

   I live in a society where I get good end of life care regardless of who I am, where I live or the circumstances of my life

3. **Maximising comfort and wellbeing**

   My care is regularly reviewed and every effort is made for me to have the support, care and treatment that might be needed to help me to be as comfortable and as free from distress as possible

4. **Care is coordinated**

   I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time of the day or night

5. **All staff are prepared to care**

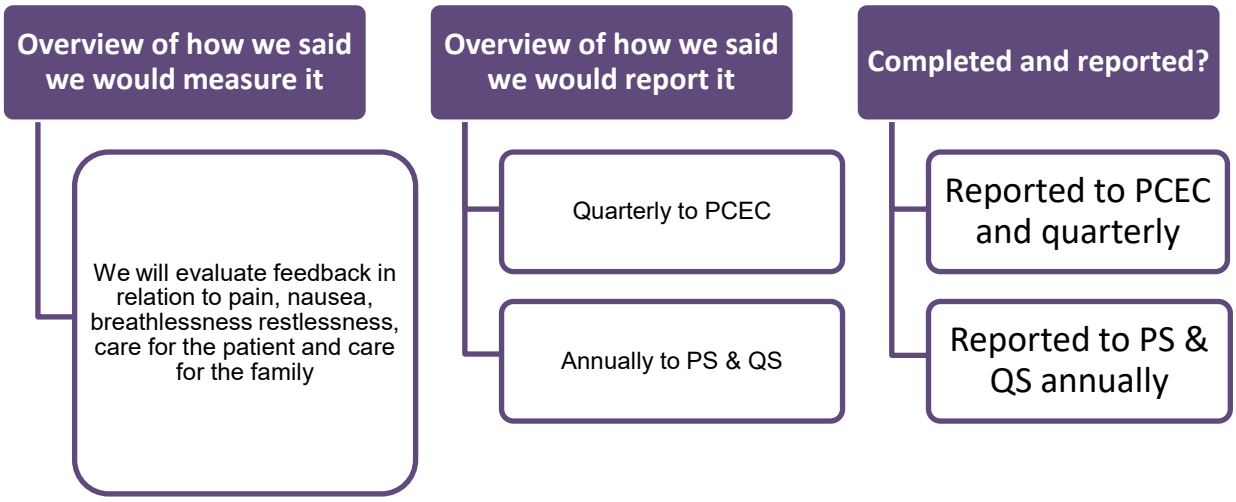
   Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident and compassionate care

6. **Each community is prepared to help**

   I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways

Overview of how we said we would do it

We will continue to use NACEL and the associated action plans, alongside feedback from patients, relatives and carers using documents such as the Family's Voice in both the hospital and community settings.



The publication of the Priorities of Care for the Dying Person document in June 2014 provides the Trust with guidance and standards in delivering high quality end of life care. These five priorities provide the fundamental framework of care and support that patients and their families can expect to receive in their last few days and hours of life.

The Priorities for Care are that, when it is thought that a person may die within the next few days or hours

Priority	Description
PRIORITY 1	This possibility is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly
PRIORITY 2	Sensitive communication takes place between staff and the dying person, and those identified as important to them
PRIORITY 3	The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants
PRIORITY 4	The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible
PRIORITY 5	An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion

The Trust took part in the fourth round of the National Audit of Care at the End of Life (NACEL) for 2022/2023, which reviews the standard of care against these 5 priorities. These results will be cascaded throughout the organisation and themes to focus education delivery and quality initiatives will be drawn from the results.

National Audit of Care at the End of Life 2022/23
Key findings at a glance

NC337 - North Tees and Hartlepool NHS Foundation Trust - University Hospital of North Tees

*UK refers to the findings for England and Wales

(CNR – Cat 1)

95%

UK 87%

Case notes recorded that the patient might die within hours or days

(CNR– Cat 1)

100%

UK 95%

Case notes, with an individualised plan of care, recorded a discussion (or reason why not) with the patient regarding the plan of care

(CNR – Cat 1)

95%

UK 98%

Case notes recorded a discussion (or reason why not) with families/carers regarding the possibility the patient may die

(CNR – Cat 1)

76%

UK 87%

Case notes recorded extent patient wished to be involved in care decisions, or a reason why not

(CNR – Cat 1)

50%

UK 76%

Case notes recorded an individualised plan of care

(CNR – Cat 1)

61%

UK 79%

Case notes recorded patient's hydration status assessed daily once dying phase recognised

(QS)

75%

UK 54%

Families/carers were asked about their needs

(QS)

75%

UK 71%

Families/carers felt the quality of care provided to the patient was good, excellent or outstanding

(H/S)

Yes

UK 60%

Hospitals have face-to-face specialist palliative care service available 8 hours a day, 7 days a week

(SRM)

85%

UK 85%

Staff feel confident they can recognise when a patient might be dying imminently

78%

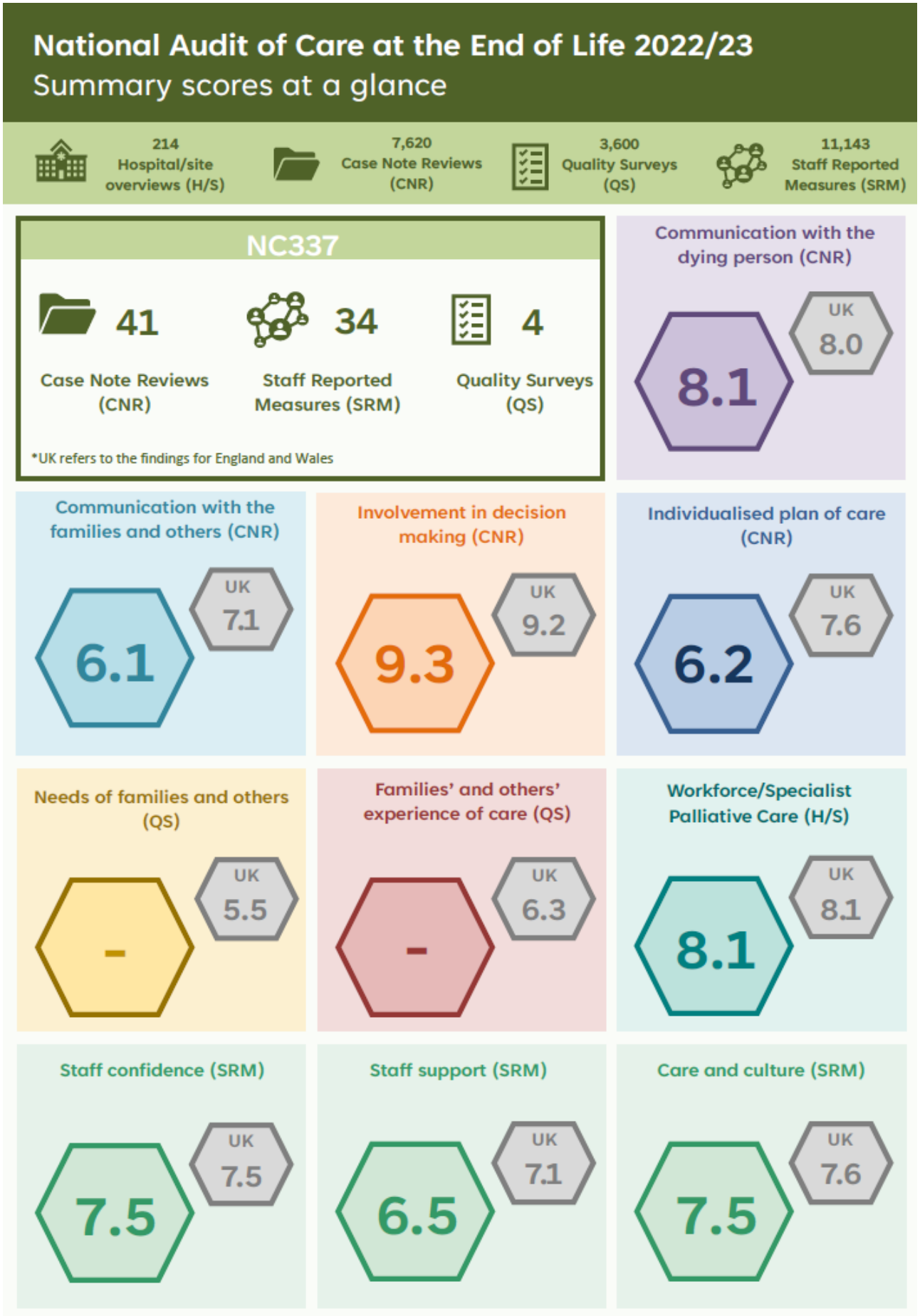
UK 82%

Staff feel supported by their specialist palliative care team

88%

UK 83%

Staff feel they work in a culture that prioritises care, compassion, respect and dignity


National Audit of Care at the End of Life 2022/23
Summary scores at a glance
214 Hospital/site overviews (H/S)
7,620 Case Note Reviews (CNR)
3,600 Quality Surveys (QS)
11,143 Staff Reported Measures (SRM)
NC337
41 Case Note Reviews (CNR)
34 Staff Reported Measures (SRM)
4 Quality Surveys (QS)
*UK refers to the findings for England and Wales
Communication with the dying person (CNR)
8.1
UK 8.0
Communication with the families and others (CNR)
6.1
UK 7.1
Involvement in decision making (CNR)
9.3
UK 9.2
Individualised plan of care (CNR)
6.2
UK 7.6
Needs of families and others (QS)
-
UK 5.5
Families' and others' experience of care (QS)
-
UK 6.3
Workforce/Specialist Palliative Care (H/S)
8.1
UK 8.1
Staff confidence (SRM)
7.5
UK 7.5
Staff support (SRM)
6.5
UK 7.1
Care and culture (SRM)
7.5
UK 7.6

The End of Life Steering Group continues to meet on a monthly basis to provide strategic leadership and guidance for the organisation. This group reports quarterly to the Quality Assurance Council and onward to Quality Assurance Committee on an annual basis.

There continues to be a significant amount of work and quality initiatives within Specialist Palliative Care and End of Life Care during 2022-2023 and the team were delighted to win the Shining Star Clinical Team Award in November 2022.

The team have introduced new referral criteria and an evidence based triage tool, which has helped to ensure that patients and / or their next of kin are contacted and assessed in a timely and standardised way. The team has also established a daily co-ordinator role, which helps to streamline requests, urgent advice and referrals into the team. This ensures that all work is prioritised and allocated accordingly.

The team have introduced an 'End of Life Care Facilitator' role, which has been fundamental to some ongoing changes to the provision of excellent end of life care across the organisation. This role continues to champion and educate on the use of the Caring for the Dying Patient Document. Alongside this, the Family Voice (written diary for families/friends of patients receiving end of life care to record their thoughts and experiences) has had a refresh as part of a funded research project and continues to be offered throughout the organisation. The research work evaluating the Family Voice is ongoing. The EOL Companions initiative is ongoing and further volunteers are being recruited to help enhance the care of dying patients throughout the Trust.

The Oasis task and finish group has been re-established and written information for patients and their next of kin is being produced. This group is also leading on the refurbishment of these rooms, including the installation of decorative ceiling lights to facilitate a more homely, non-clinical environment. Our end of life symbol, the red tree, has been refreshed and standardised signage means that all Trust staff should recognise what this represents so can offer respect, quiet and compassion.

One of our Specialist Palliative Care consultants was successful in obtaining a joint Mortality Lead post within the Trust helping to strengthen the Learning from Deaths initiative and improving end of life care.

Team members have had the opportunity to attend Palliative Care Congress in Edinburgh in March 2023 to learn, network and share best practice. The team is represented at regular meetings within the North East and North Cumbria working in partnership with other regional organisations to improve palliative and end of life care. We are an active member of the Tees Wide Exemplar work on Palliative and End of Life Care and are represented at the task and finish groups that were initiated following the draft strategy. The Trust's Palliative and End of Life Care Lead chairs the Education task and finish group.

The team is also research active and represented at regional, national and international forums.

The team continues to offer short and long-term placements to students and qualified staff from a variety of professions to enhance their awareness and knowledge of palliative and end of life care. The delivery of education by the team has increased significantly over the past year and this has led to the development of a Clinical Educator role within the team to help co-ordinate the increased activity. The education programme has included; delivery of bi annual Cancer and Palliative Care study day for qualified staff, ongoing medical education and increased DNACPR training for F2 doctors, Sage & Thyme communication skills training and the creation of an End of Life SIM education day for nursing staff.

Our specialist therapies team continue to work with Butterwick Hospice at Stockton to provide a Physiotherapy clinic with facilities including a rehabilitation gym. Three members of our specialist therapies team were successful in obtaining their Wheelchair Super Accredited Prescribing status allowing them to assess and prescribe specialist wheelchairs for patients.

We had the opportunity to trial a Virtual Reality kit for use with our patients and it was so successful that we have purchased the hire of one of these kits for 2 years with charitable funding generously donated by Seaton Carew Golf Club. The VR kit offers patients the opportunity to

experience places/scenes they may not otherwise be able to or are able to use the VR for symptom control, including breathlessness and anxiety management. This has been overwhelmingly positive and we are looking forward to the delivery of our kit later this year to offer more patients this fantastic experience.

The team have been working collaboratively with Alice House Hospice in Hartlepool who have two dedicated end of life care beds available to offer patients, who are in hospital, a rapid transfer to a bed for end of life care. Despite small numbers, this is evaluating very positively and the next phase will be to explore admitting patients directly from the community.

The team has also been working in partnership with Butterwick Hospice Care in Stockton with the goal to open end of life care beds using a Clinical Nurse Specialist led model.

Our weekly Nurse Led Clinic at Butterwick Hospice is also going from strength to strength and offers choice for our patients about where and when they would like to be seen which.

The chaplaincy team continue to work very closely with the Specialist Palliative Care team and continue to attend regular SPCT meetings as well as the weekly MDT and follow up on patient referrals in the hospital and community. The chaplaincy team welcomed two new part time chaplains into the team, one of Muslim faith and the other of Roman Catholic faith.

The Lead Chaplain in his role as Schwartz Lead has facilitated a number of successful Schwartz rounds for the Trust. The chaplaincy team were also heavily involved in supporting staff during the Queen's funeral last year.

Both teams have contributed to Dying Matters week across the organisation; a national initiative encouraging more open discussion about death and dying.

Multi Faith

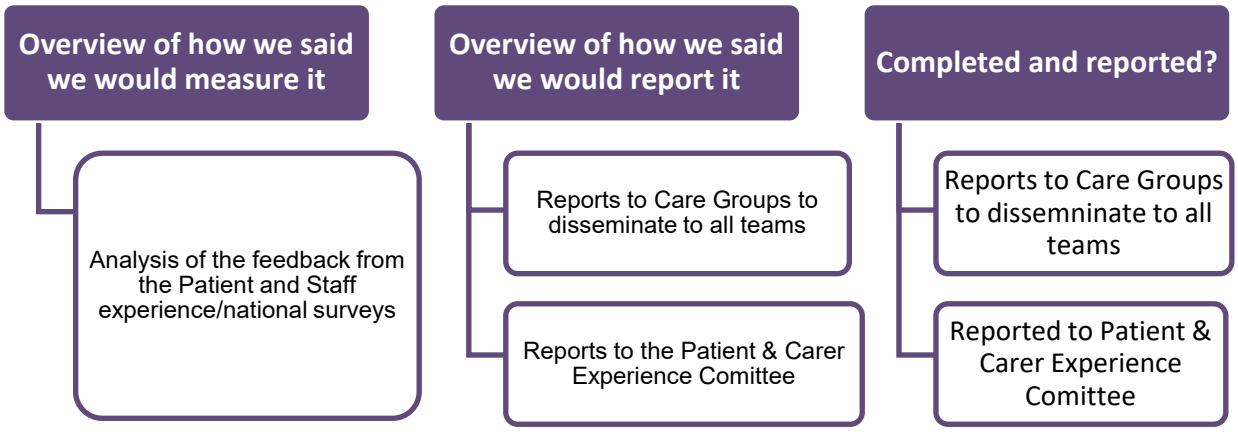
The Trust holds a directory of all the local faith groups in the area, if there is a request for the Imam (Muslim) or the Hindu Priest, Buddhist or any other faith, the chaplains would contact the Trust link person and arrange a visit.

Is our care good?

Rationale: Trust and key stakeholders believe that it is important to ask this question through internal and external reviews.

Overview of how we said we would do it

- We will ask the question to every patient interviewed in the Patient and Staff Experience Survey visit
- We will ask the question in all Trust patient experience surveys
- We will monitor patient feedback from national surveys



"The doctors/nurses and staff were excellent and always there on call to help. Cannot fault any one of them. BRILLIANT"

"Thank you to our amazing NHS! I feel very fortunate and thankful. You are all wonderful!"

"That I would like to thank everyone that helped me during my pregnancy and labour, it was an amazing experience"

"I'm fully disabled and I have a big problem, I can't sit down on the furniture that's supplied in the shower, very inadequate"

"Discharge procedure could be looked into. After being told on the morning by the doctor I would be doing home that day, it took over 9 hours for some reason before I was discharged."

Patient Experience Surveys

Below are a list of the national surveys that the Trust have started between April 2022 and March 2023. The 'current response rate' column shows the number of patients who have responded and the response rate.

National Surveys

Survey	Time frame for publication published	Current response rate
CQC National Inpatient Survey 2021	August 2021	36%
CQC National Maternity Survey 2022	December 2022	39%
National Cancer Patient Experience Survey 2021	July 2022	57%

Local Surveys

Survey	Survey results compiled	Number of Patients Surveyed
Endoscopy Patient Survey 2022	May 2022	103 patients
Alcohol Care Team Survey 2023	March 2023	64 patients
Family Health Counselling Survey	December 2022	50 patients
Cardiac Rehabilitation Survey 2023	March 2023	15 patients
Upper GI Cancer Survey 2022	December 2022	23 patients
Tissue Viability Survey 2022/23	December 2022	24 patients
Urogynaecology Patient Survey 2022	June 2022	30 patients
Echocardiogram Patient Survey 2022	June 2022	181 patients
Learning Disability Survey 2022	December 22	14 patients
Rapid Diagnostic Service – Patient Survey 22	June 22	30 patients

National Surveys

We take part in the national survey programme. This is a mandatory Care Quality Commission (CQC) requirement for all acute NHS trusts. Each question is nationally benchmarked so we can understand how we scored when compared with other trusts. The coloured bars below show how the trust scored.

Better than expected	About the same	Worse than expected

CQC National Inpatient Survey 2021 – Key results

The Trust randomly selected adult inpatients discharged during November 2021. We had a 36% response rate with 425 surveys completed. Results were published in the October 2022. ***All Scores out of 10***

Where we could do better – where scores were significantly worse than in 2020	2021
Q.2 How did you feel about the length of time you were on the waiting list before your admission to hospital?	7.8
Q.35 To what extent did staff involve you in decisions about you leaving hospital?	7.1
Q.38 Were you given enough notice about when you were going to leave hospital?	7.2
Q.41 Thinking about any medicine you were to take at home, were you given any of the following? (Explanations about purpose, side effects, how to take, written info about medicines)	4.1

Areas of good practice – where scores were better/ somewhat better than other Trusts nationally	2021
Q.10 If you brought medication with you to hospital, were you able to take it when you needed to?	8.7
Q.23 Thinking about your care and treatment, were you told something by a member of staff that was different to what you had been told by another member of staff?	8.3
Q.32 Beforehand, how well did hospital staff answer your questions about the operations or procedures?	9.3
Q.44 Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	8.9
Q.46 After leaving hospital, did you get enough support from health or social care Services to help you recover or manage your condition?	8.2

"The on duty doctor was fantastic, very open and honest with his answers of the questions I asked about my condition. The nurses who do all the checks and tests during the overnight stay I had where very respectful and kind, could no fault them at all."

"Thank you to all NHS staff for being a brilliant job done x Do not think I would still be here if it wasn't for you guys".

"I have felt nothing but total respect for all the staff, even giving the covid climate nothing was a bother to them. I felt really cared for and safe."

"I was very impressed with the care I received whilst in hospital, I was especially impressed with the lengths taken by staff to respect my privacy and dignity in a difficult hospital situation. All the staff were very knowledgeable and professional."

"Pain management after my operation was very disappointing, it did not work out very well."

"Communication between staff and to patient needs improving. Ensure patient's basic needs are given and more care."

National Cancer Patient Experience Survey 2021 – Key results

Where we could do better – *scored lower than expected*	2021
Q.5 Patient received all the information needed about the diagnostic test in advance.	87%
Q.14 Cancer diagnosis explained in a way the patient could completely understand.	72%
Q.24 Patient was definitely able to have a discussion about their needs or concerns prior to treatment	67%
Q.27 Staff provided the patient with relevant information on available support.	82%
Q.35 Patient was always able to discuss worries and fears with hospital staff.	57%
Q.54 The right amount of information and support was offered to the patient between final treatment and the follow up appointment.	69%

Areas of good practice	2021
Q.12 Patient was told they could have a family member, carer or friend with them when told diagnosis.	80%

"I am very grateful that the care and treatment was administered as quickly as possible after diagnosis – no delays. The staff were all professional, caring and efficient."

"I feel so lucky and grateful to all of the syaff that I have come into contact with during my treatment. Every person I was involved with, showed empathy and compassion throughout. Every single member of staff was kind, friendly and approachable as well as remaining professional. I can't thank the teams enough. I felt listened to and they made a horrible situation, bearable."

"Excellent. The staff at all levels were fantastic. Caring, cheerful, skill full and confident. Having bowel cancer, possible thyroid and lung cancer (still to be determined) is a horrible experience made better. By the doctors and nurses professional attitude. I don't believe that they could have tried harder."

"The last two years of appointments have been awkward in respect of not seeing the same person regularly. When first diagnosed I saw the same consultant regularly which was a great benefit to my confidence."

"A little more information in regard to what to expect in terms of side effects and emotional feelings once chemotherapy finishes."

CQC National Maternity Survey 2022 – Key results

Where we could do better – *scores lower than 2021*	2022
Being spoken to in a way they could understand during antenatal care.	9.2
Partners able to stay in hospital as much as they wanted.	2.8
Attentiveness of staff during stay in hospital.	7.8
Being given information/explanations whilst in hospital.	7.5
Midwives/other health professionals providing active support and encouragement about feeding baby.	7.8

Areas of good practice – *scoring better/somewhat better than most trusts*	2022
Receiving appropriate advice & support when first contacted a midwife or the hospital at start of labour	7.9
Given support for mental health during pregnancy	9.6
Midwife or midwifery team were aware of their or their baby's medical history (during care at home after the birth)	8.7
Being asked about mental health (during care at home after the birth)	9.9
Receiving support or advice about feeding baby, during evening/night/weekends (during care at home after the birth)	7.4
Midwives/doctors aware of medical history during antenatal check-ups	7.6
Midwives asking about mental health during antenatal check-ups	9.2
Midwives providing relevant information about feeding baby during pregnancy	7.9
Midwives/doctors aware of medical history during labour and birth	8.0

"All staff who helped deliver my twins were amazing. The 2 midwives couldn't have helped me anymore, both amazing."

"This birth has been my best birth experience. The staff were so wonderful and skilled! It was the quickest caesarean and recovery. Thank you to the wonderful doctors and nurses."

"I felt overall the care I received throughout my pregnancy journey, giving birth and the postnatal was excellent."

"Once baby was put onto my chest for skin to skin the midwife left the room again before the baby even cried. We had no idea if she was okay or not. We were so worried and felt so alone."

"I think everyone that is caring for you throughout your pregnancy should really take the time to listen to us I had a big problem with my baby's movements and I felt like no one really understand that it wasn't right."

Action plans

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

Action plans are developed by clinical teams and are presented to the Patient and Carer Experience Committee for approval.

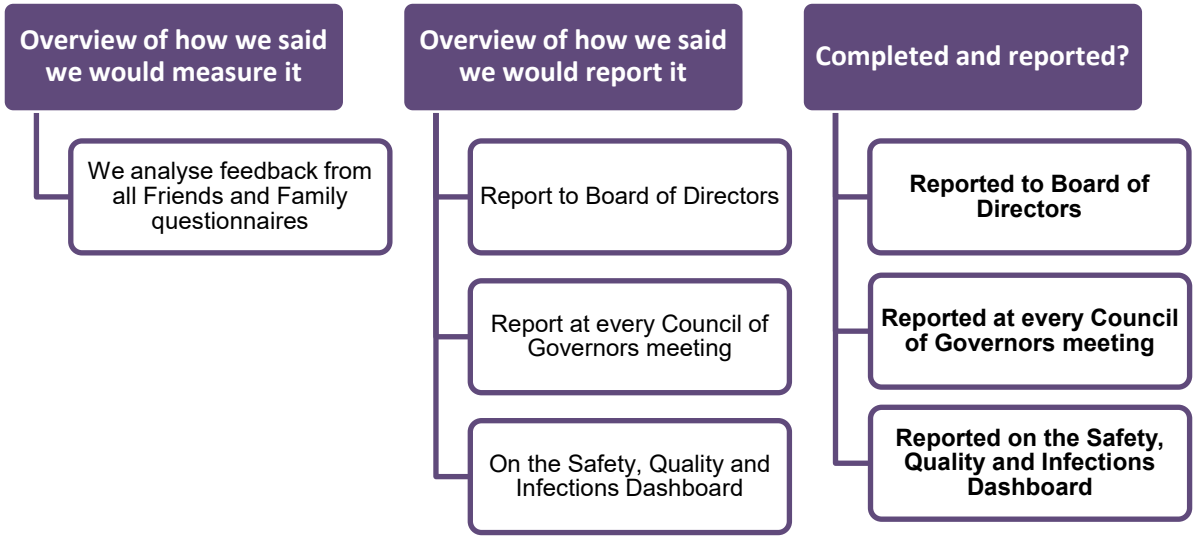
Priority 3: Effectiveness of Care

Friends and Family Test

Rationale: The Department of Health require Trusts to ask the Friends and Family recommendation questions from April 2013. Stakeholders agreed that this continues to be reported in the 2022-23 Quality Accounts.

Overview of how we said we would do it

- We ask patients to complete a questionnaire on discharge from hospital



"Great staff who are working very hard to give everyone what they need" [sic]

"After waiting an hour to see screening nurse, then advised it would be at least over 3 hours to see a doctor. So I ended up just leaving" [sic]

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

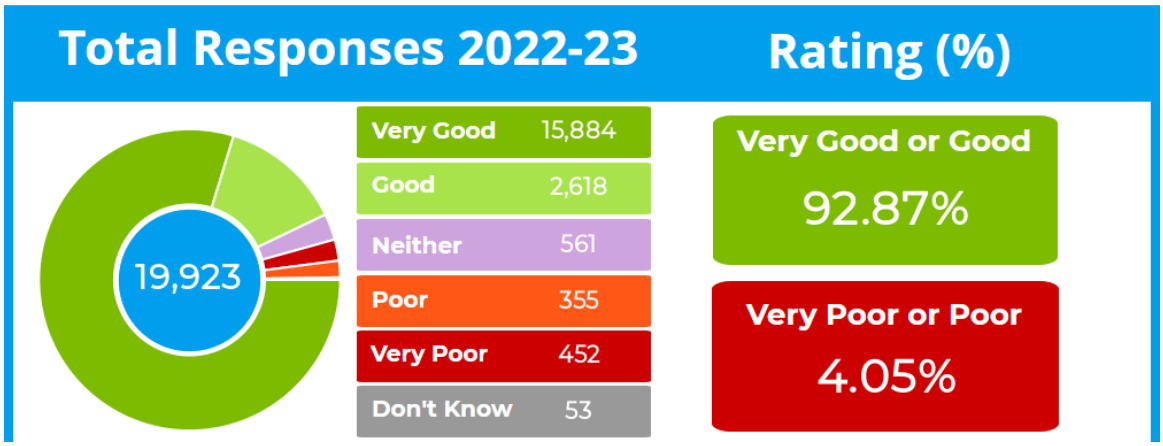
The Friends and family data can be found at:
https://www.england.nhs.uk/fft/friends-and-family-test-data/

The Trust has created and developed an in-house data collection and reporting system that covers **70** areas for Friends and Family across both sites and community.

North Tees and Hartlepool NHS Foundation Trust

Returns for 1 April 2022 to 31 March 2023

The Trust continuously monitors the positive and negative comments on a weekly basis to ensure that any similar issues or concerns can be acted upon by the ward matrons. This helps in reducing the reoccurrence of similar issues in the future.



Total Responses	Month												
FFT Response	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Total
Very Good	1,138	1,265	1,280	1,284	1,410	1,198	1,474	1,250	1,154	1,555	1,526	1,350	15,884
Good	182	259	229	218	231	178	236	202	204	214	230	235	2,618
Neither Good nor Poor	30	51	51	43	58	45	53	47	32	51	53	47	561
Poor	24	38	37	31	31	31	24	31	31	26	31	20	355
Very Poor	23	36	37	51	35	34	53	36	53	34	30	30	452
Don't know	3	3	5	5	2	4	3	7	7	5	4	5	53
Total	1,400	1,652	1,639	1,632	1,767	1,490	1,843	1,573	1,481	1,885	1,874	1,687	19,923

*Data from Trusts Friends and Family database and Inhealthcare

"Caring, compassionate, friendly and supportive in all my needs. Most of all each member of staff listened to my concerns. They are all top notch and deserve this big thank you." [sic]

"I cannot fault the service I got, was kept informed throughout my visit and was treated quickly" [sic]

"The care and attention was excellent" [sic]

"Lack of communication. Not listened to." [sic]

"Very slow service, no staff to help and very long queue of people waiting to be seen" [sic]

Part 2b: 2023-24 Quality Improvement Priorities

Introduction to 2023-24 Priorities

Due to COVID-19, the previous years key priorities for improvement were rolled over, however for 2023-24 Maternity has been added to priorities. This has been discussed with governors, Healthwatch colleagues, commissioners, local health scrutiny committees, healthcare user group and the Board of Directors.

Stakeholder priorities for 2023-24

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

Patient Safety	Effectiveness of Care	Patient Experience
Mortality	Learning from Deaths	Palliative care and care for the dying patient (CFDP)
Dementia	Discharge Provesses	Is our care good? (Patient experience surveys)
Mental Health	Accessibility	Frientds and Family Test
Safeguarding (Adult and Children's)	Violent Incidents	
Infections	Safety and Quality Dashboard	
Maternity		

Rationale for the selection of priorities for 2023-24

Through the Quality Accounts stakeholder meetings and other engagement events we provided an opportunity for stakeholders, staff and patients to suggest what they would like the Trust to prioritise in the 2023-24 Quality Accounts.

We then chose indicators from each of the key themes of Patient Safety, Effectiveness of Care and Patient Experience. The Trust will continuously monitor and report progress on each of the above indicators throughout the year by reporting to the Board.

The following details for each selected priority include how we will achieve it, measure it and report it.

Patient Safety

Priority 1 - Mortality

To reduce avoidable deaths within the Trust

Overview of how we will do it
We will review all available indicators

We will use the Healthcare Evaluation Data (HED) benchmarking tool to monitor and interrogate the data to determine areas that require improvement. We will also review/improve existing processes involving palliative care, documentation and coding process.

Overview of how will measure it
We will monitor mortality within the Trust using the two national measures of Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI).

Overview how we will monitor it
Monitored by the Mortality Dashboard

Overview of how we will report it
Report to Board of Directors meeting
Report to Council of Governors meeting
Report quarterly to the Commissioners

Priority 2 - Dementia

All hospital patients admitted with dementia will have a named nurse and an individualised plan of care

Overview of how we will do it
We will use the Stirling Environmental Tool to adapt our hospital environment.

We will make it mandatory that all patients over 65 receive an Abbreviated Mental Test (AMT) and are, where appropriate, referred for further assessment.

Patients with dementia will be appropriately assessed and referred on to specialist services if needed.

We will ensure that we have the most up to date information for patients with a diagnosis of dementia by accessing electronic record systems and the Tees Esk & Wear Valleys Foundation Trust Paris system. This will confirm if the patient has a clinical diagnosis from mental health services. If confirmed an alert will be added to Trakcare to ensure staff are aware of the diagnosis of dementia.

Overview of how we will measure it
The Stirling Environmental audit assessment tool will be used to monitor the difference pre and post environmental adaptation.

Wards 36, 37, 39 & 40 and 42 have been adapted to be dementia friendly; Wards 24, 25, 26, 27, and 29 have had the Stirling audit complete. Any improvements will be in line with the audits recommendations.

The percentage of patients who receive the Abbreviated Metal Test and, where appropriate, further assessment will be reported monthly via UNIFY.

We will continue with the prevalence audit for the number of patients that have cognitive screening over the age of 75 admitted as an emergency that are reported as having a known diagnosis of dementia, or have been asked the dementia case finding questions.

We will continue to undertake the National Audit for dementia.

Overview how we will monitor it
Monthly data from the Trust Information Management Department.

Overview of how we will report it
Vulnerability Council
Monthly UNIFY

Priority 3 – Mental Health

The Trust Mental Health Strategy, sets sets out our ambitions for the next three years and demonstrates how the Trust will work towards delivering an integrated approach to physical and mental health. To achieve high quality mental health healthcare offered to patients who access general hospital services achieving parity of physical health needs with mental health needs across the Trust; healthcare professionals in general secondary care will feel knowledgeable and confident in understanding and managing mental health conditions and knowing when and how to access mental health services for the patients they see. The integration of all healthcare professionals to provide care as needed for each patient is a crucial part of the solution to providing a higher quality of care to all patients.

The Trust will review and implement recommendations from the NCEPOD guidance Treat as One. The Trust will identify and involve all stakeholders in reviewing the Treat as One guidance and undertake a gap analysis to develop appropriate work streams; including but not exclusive to:

- Patients who present with known co-existing mental health conditions should have them documented and assessed along with any other clinical conditions that have brought them to hospital;
- Liaison psychiatry review should provide clear and concise documented plans in the general hospital notes at the time of assessment;
- All Trust staff who have interaction with patients, including clinical, clerical and security staff, should receive training in mental health conditions;
- In order to overcome the divide between mental and physical healthcare, liaison psychiatry services should be fully integrated into the Trust. The structure and staffing of the liaison psychiatry service should be based on the clinical demand both within working hours and out-of-hours so that they can participate as part of the multidisciplinary team;
- Record sharing (paper or electronic) between mental health hospitals and the Trust will be improved. As a minimum, patients should not be transferred between the different hospitals without copies of all relevant notes accompanying the patient.

Overview of how will measure it
The Trust will benchmark current and future practice against the Treat as One Guidance; undertaking further audit in relation to recommendations in line with the above and Staff and patient engagement (survey).

Overview of how we will report it
The Trust will establish a Treat as One group chaired by an Executive Board Member; this group will monitor the implementation of the Mental Health Strategy and will be reported to the Quality Assurance Committee. Relevant audit results will be reported to ACE Committee.

Priority 4 – Safeguarding

The Trust continues to work to enhance and develop standards for safeguarding adults and children.

Overview of how we will do it
Provision of specialist advice relating to implementation of The Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS) and the Human Rights Act provides added assurance that the Trust remains compliant with legislation.

The Trust has maintained a robust board level focus on Safeguarding and Looked after Children led by the Chief Nurse/Director of Patient Safety and Quality. A bi-monthly steering group, chaired by a Non- Executive Director maintains responsibility for the performance monitoring of the Children's Safeguarding work program.

The Trust has maintained membership and has made active contributions at senior level on the three Local Safeguarding Children Boards (LSCB); Stockton (SLSCB), Hartlepool (HSCB) and County Durham LSCB and on the HSCB Executive group.

Overview of how will measure it
Audits will be carried out and improvements undertaken.

Overview how we will monitor it
Monitored by audit result improvement plans

Overview of how we will report it
Audit results and improvement plans will be reported to Adult Safeguarding Group.

Audit results and improvement plans will be reported to the three Local Safeguarding Childrens Boards.

Priority 5 – Maternity

Key stakeholders asked us to report on maternity metrics in 2022-23.

Overview of how we will do it
The Trust will monitor quality of maternity services through implementation of the perinatal quality surveillance model metrics and service user feedback

Overview of how we will measure it
Will benchmark ourselves against the perinatal quality surveillance model metrics
Will benchmark ourselves against previous months
Will benchmark ourselves against national safety ambitions
Will monitor our position through the National Maternity Survey

Overview how we will monitor it
Monitored by the maternity dashboard and published results of the Maternity Survey

Overview of how we will report it
Maternity Improvement Group, Maternity Quality Assurance Council, Quality Assurance Committee, , Board of Directors meeting. Staff briefing and newsletters.

Priority 6 – Infections

Key stakeholders asked us to continue to report on infections in 2023-24.

Overview of how we will do it
We will closely monitor testing regimes, antibiotic management and repeat cases to ensure we understand and manage the root cause wherever possible.

Overview of how we will measure it
We will monitor the number of hospital and community acquired cases;
We will undertake a multi-disciplinary Root Cause Analysis (RCA) within 3 working days;
We will define avoidable and unavoidable for internal monitoring;
We will benchmark our progress against previous months and years;
We will benchmark our position against Trusts in the North East in relation to number of cases; and reported, number of samples sent for testing and age profile of patients.

Overview how we will monitor it
Monitored by the Safety and Quality Dashboard

Overview of how we will report it
Board of Director Meetings, Council of Governor Meetings (CoG), Infection Control Council (ICC), Quality Assurance Committee (QAC), To frontline staff through Chief Executive brief, Safety and Quality Dashboard and Clinical Quality Review Group (CQRG).

Effectiveness of Care

Priority 7 – Learning from Deaths

Within the National Guidance on learning from deaths there is now a mandated requirement to report learning from deaths in the Quality Accounts.

Overview of how we will do it
By undertaking twice weekly mortality review sessions
By allowing Directorates to undertake their own mortality reviews (as long as the person reviewing was not part of that patients final care episode)

Overview of how we will measure it
All data will be captured on the SJRPlus mortality learning from deaths database

Overview how we will monitor it
Monitored by the Mortality Dashboard

Overview of how we will report it
Report to Quality Assurance Committee and Board of Directors meeting

Priority 8 – Discharge Processes

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

Overview of how we said we would do it

All patients should have a safe and timely discharge.
All concerns and/or incidents raised onto the Trust's local safety reporting system.

Overview of how we said we would measure it

Via national and local patient surveys.
Quarterly analysis of discharge incidents on the local safety reporting system.

Overview how we will monitor it
Monitored by the Senior Clinical Professionals weekly huddle

Overview of how we said we would report it

National inpatient survey report to Quality Assurance Committee.
To the Discharge Steering Group.

Priority 9 – Accessibility

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

Aim

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

Overview of how we will do it

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

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

The trust will undertake a sample baseline audit of compliance with the Accessible Information Standard (AIS) to identify gaps and develop an action plan to comply with the Standards.

Overview of how we will measure it

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

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

A repeat audit for compliance against the AIS will be undertaken in Quarter 4 2023-24 to compare with the baseline data and ensure actions have been carried out.

Overview how we will monitor it

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

Overview of how we will report it

Accessibility Group
Patient and Carers Committee

Priority 10 – Violent Incidents

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

Overview of how we will do it
Utilise the Violent Incidents data held within the Trusts incident reporting software.

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

Overview how we will monitor it
Data presented on the Safety & Quality Dashboard daily.
Weekly data presented from the dashboard to the Senior Clinical Professionals Huddles.
Data specified in the Integrated Perfomance Report to Quality Assurance Commmittee and Trust Board.

Overview of how we will report it
Data presented on the Safety & Quality Dashboard daily.
Weekly data presented from the dashboard to the Senior Clinical Professionals Huddles.
Integrated Perfomance Report to Quality Assurance Commmittee and Trust Board.

Priority 11 – Safety and Quality Dashboard – Business Intelligence

The Safety and Quality Dashboard was designed to support an overview on quality of care, it comprises of a set of nurse sensitive patient indicators, from a variety of sources, which are used by services for continually improving the quality, safety care for our patients and to support the learning culture across the Trust.

Overview of how we will do it
Each clinical area displays their departments monthly Safety and Quality dashboard analysis on the welcome board for patient and staff to see, there is a plan this year to move this to a more visual approach using television screens to display this data and improvement work.

The monthly Safety and Quality Dashboard data is analysed and discussed in department meetings, and any improvement plans that are underway to improve patient outcome and experience.

The Senior management team of each care groups, discuss the last working weeks safety and quality analysis at their Senior Management meeting and Patient safety and Quality meeting, focusing on driving continuous improvement, learning and any area of concerns that require targeted support.

Overview of how we will measure it
Patient Quality Department lead on the weekly senior Multi-professional (SCP) huddle, which takes place on a Wednesday to discuss last working week patient safety and quality indicators. The meeting focuses on improving patient outcomes, shared learning from incidents and innovative practice that has improved patient outcomes and experience.

The Quality Reference Group review all in patient area once a year and it analyses and interprets the quality indictors compliance and supports clinical teams and Care Groups to reduce unwarranted variation, improve patient outcome and, deliver local quality initiatives to improve patient outcomes.

Overview how we will monitor it
Overview on performance and improvement will monitor through Quality Assurance Council and Quality Assurance Committee

Weekly dashboard analysis is discussed at the Executive meeting, highlighting themes of practice and improvement work streams

Monthly analysis of quality indictors is presented in the Integrated board report, providing assurance if within control limits, improvement work in progress and sharing achievement to date.

Overview of how we will report it
Follow up on Quality Reference group, which will feed into Quality Assurance Council

Quality Assurance Committee

Report to Board of Directors meeting

Report to Council of Governors meeting

Patient experience

Priority 12 – Specialist Palliative Care, End of Life Care and Chaplaincy

Continue to embed the use of the Caring for the Dying Patient document and associated documents (e.g. Family's Voice) in acute and community settings. This will be helped by the creation of an electronic document on Trakcare currently under development.

Refurbishment of x3 Oasis Suites for dying patients and their families.

Promotion of the Red Tree symbol across the organisation and a package of measures designed to enhance the experience for patients and their families at the end of life, including concessionary care parking, comfort packs, End of Life Volunteer Companions, use of anticipatory medication order set on Trakcare, etc.

Palliative and End of Life Care Discharge group to create and implement processes for safe, timely and high quality discharges for patients at the end of their life to help achieve preferred place of care and death.

Overview of how we will do it

Continued partnership working with both local hospices, Alice House Hospice and Butterwick Hospice Care to provide increased choice and access for patients and their families.

Raise the profile of chaplaincy services within the organisation ensuring that patients, families and staff are aware of the breadth of the spiritual, pastoral and religious services they offer.

Bereavement Group to provide expert clinical and professional oversight of the delivery of excellent bereavement services across the organisation.

Continue to develop and expand the palliative and end of life care education offer within the organisation and local partners.

Continue to develop and strengthen collaborations and influence practice with local and regional partners through established meeting forums.

Overview of how we will measure it

NACEL audit and action plans. We will also seek valuable patient, carer and staff experiences of using specialist palliative, end of life care and chaplaincy services.

Overview of how we will monitor it

Monitored by the Quality and Safety dashboard and End of Life Steering Group

Overview of how we will report it

Quarterly to Quality Assurance and Safety Council

Annually to Quality Assurance Committee

Priority 13 – Is our care good? (Patient Experience Surveys)

Trust and key stakeholders believe that it is important to ask the Friends and Family question through internal and external reviews.

Overview of how we will do it
We will ask every patient interviewed in the Patient and Staff Experience reviews. We will also ask the question in all Trust patient experience surveys, along with monitoring patient feedback from national surveys.

Overview of how will measure it
Analysis of feedback from Staff and Patient Experience reviews along with feedback from the patient experience/national surveys.

Overview how we will monitor it
Monitored by the Safety and Quality Dashboard

Overview of how we will report it
Reports to Board of Directors

Priority 14 – Friends and Family Test

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

Overview of how we will do it
We currently ask patients to complete a questionnaire on discharge from hospital for in-patients, Accident & Emergency, Urgent Care and Maternity as well as Outpatients, Day Case Units, Community Clinics, Community Dental, Radiology and Paediatrics.

Overview of how we will measure it
We will analyse feedback from patient surveys and discharge questionnaires.

Overview how we will monitor it
Monitored by the Safety and Quality Dashboard

Overview of how we will report it
Reports to Board of Directors
Reported directly back to ward/areas.

Part 2c: Statements of Assurance from the Board

Review of Services

During 2022-23 the North Tees and Hartlepool NHS Foundation Trust provided and/or subcontracted relevant health services. The majority of our services were provided on a direct basis, with a small number under sub-contracting or joint arrangements with others.

The North Tees and Hartlepool NHS Foundation Trust has reviewed all the data available to them on the quality of care in of these relevant health services.

The income generated by the relevant health services reviewed in 2022-23 represents **100%** of the total income generated from the provision of relevant health services by the North Tees and Hartlepool NHS Foundation Trust for 2022-23.

Participation in clinical audits

All NHS Trusts are audited on the standards of care that they deliver and our Trust participates in all mandatory national audits and national confidential enquiries.

The Healthcare Quality Improvement Partnership (HQIP) provides a comprehensive list of national audits which collected audit data during 2022-23 and this can be found on the following link:

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

During 2022-23, **50** national clinical audits and **4** national confidential enquiries covered the relevant health services that North Tees and Hartlepool NHS Foundation Trust provides.

During 2022-23, North Tees and Hartlepool NHS Foundation Trust participated in **94%** of national clinical audits and **100%** of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that North Tees and Hartlepool NHS Foundation Trust was eligible to participate in during 2022-23 are as follows:

Mandatory National Clinical Audits

Project name	Provider organisation
Breast and Cosmetic Implant Registry	NHS Digital
Case Mix Programme	Intensive Care National Audit & Research Centre (ICNARC)
Elective Surgery (National PROMs Programme)	NHS Digital
Mental Health Self Harm (care in Emergency Departments)	Royal College of Emergency Medicine
Care of Older People (care in Emergency Departments)	Royal College of Emergency Medicine
Infection Prevention & Control (care in Emergency Departments)	Royal College of Emergency Medicine
Epilepsy 12 – National Audit of Seizures and Epilepsies in Children and Young People	Royal College of Paediatrics and Child Health
Fracture Liaison Service Database	Royal College of Physicians
National Audit of Inpatient Falls	Royal College of Physicians
National Hip Fracture Database	Royal College of Physicians
National Bowel Cancer Audit	NHS Digital

National Oesophago-gastric Cancer	NHS Digital
Inflammatory Bowel Disease Audit	IBD Registry
Learning Disabilities Mortality Review Programme (LeDeR)	NHS England
Maternal and Newborn Infant Clinical Outcome Review Programme	University of Oxford / MBRRACE-UK collaborative
Muscle Invasive Bladder Cancer Audit	The British Association of Urological Surgeons (BAUS)
National Diabetes Core Audit	NHS Digital
National Diabetes Foot care Audit	NHS Digital
National Inpatient Diabetes Audit	NHS Digital
National Pregnancy in Diabetes Audit	NHS Digital
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP): Adult Asthma Secondary Care	Royal College of Physicians
NACAP: Chronic Obstructive Pulmonary Disease Secondary Care	Royal College of Physicians
NACAP: Paediatric Asthma Secondary Care	Royal College of Physicians
NACAP: Pulmonary Rehabilitation	Royal College of Physicians
National Audit of Breast Cancer in Older Patients (NABCOP)	Royal College of Surgeons
National Audit of Cardiac Rehabilitation	University of York
National Audit of Care at the End of Life (NACEL)	NHS Benchmarking Network
National Audit of Dementia	Royal College of Psychiatrists
National Bariatric Surgery Registry	British Obesity and Metabolic Surgery Society
National Cardiac Arrest Audit	Intensive Care National Audit and Research Centre (ICNARC)
Myocardial Ischaemia National Audit Project (MINAP)	Barts Health NHS Trust
National Audit of Cardiac Rhythm Management	Barts Health NHS Trust
National Heart Failure Audit	Barts Health NHS Trust
National Early Inflammatory Arthritis Audit	British Society of Rheumatology
National Emergency Laparotomy Audit	Royal College of Anaesthetists
National Joint Registry	Healthcare Quality Improvement Partnership
National Lung Cancer Audit	Royal College of Surgeons
National Maternity and Perinatal Audit	Royal College of Obstetrics and Gynaecology
National Neonatal Audit Programme	Royal College of Paediatrics and Child Health
National Paediatric Diabetes Audit	Royal College of Paediatrics and Child Health
National Perinatal Mortality Review Tool	University of Oxford / MBRRACE-UK collaborative
National Prostate Cancer Audit	Royal College of Surgeons
National Acute Kidney Injury Audit	UK Kidney Association

UK Renal Registry Chronic Kidney Disease Audit	UK Kidney Association
Adult Respiratory Support Audit	British Thoracic Society
Sentinel Stroke National Audit Programme	King's College London
Serious Hazards of Transfusion (SHOT)	Serious Hazards of Transfusion
Society for Acute Medicine Benchmarking Audit (SAMBA)	Society for Acute Medicine
Trauma Audit & Research Network	The Trauma Audit & Research Network
UK Parkinson's Audit	Parkinson's UK

National Confidential Enquiries (NCEPOD)
Crohn's Disease
Transition from Child to Adult Services
Community Acquired Pneumonia
Testicular Torsion

The national clinical audits and national confidential enquiries that North Tees and Hartlepool NHS Foundation Trust participated in during 2022-23 are as follows:

Mandatory National Clinical Audits

Project name	Provider organisation
Case Mix Programme	Intensive Care National Audit & Research Centre (ICNARC)
Elective Surgery (National PROMs Programme)	NHS Digital
Mental Health: Self Harm (care in Emergency Departments)	Royal College of Emergency Medicine
Care of Older People (care in Emergency Departments)	Royal College of Emergency Medicine
Infection Prevention & Control (care in Emergency Departments)	Royal College of Emergency Medicine
Epilepsy 12 – National Audit of Seizures and Epilepsies in Children and Young People	Royal College of Paediatrics and Child Health
Fracture Liaison Service Database	Royal College of Physicians
National Audit of Inpatient Falls	Royal College of Physicians
National Hip Fracture Database	Royal College of Physicians
National Bowel Cancer Audit	NHS Digital
National Oesophago-gastric Cancer	NHS Digital
Learning Disabilities Mortality Review Programme (LeDeR)	NHS England
Maternal and Newborn Infant Clinical Outcome Review Programme	University of Oxford / MBRRACE-UK collaborative
Muscle Invasive Bladder Cancer Audit	The British Association of Urological Surgeons (BAUS)

National Diabetes Core Audit	NHS Digital
National Diabetes Foot care Audit	NHS Digital
National Inpatient Diabetes Audit	NHS Digital
National Pregnancy in Diabetes Audit	NHS Digital
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP): Adult Asthma Secondary Care	Royal College of Physicians
NACAP: Chronic Obstructive Pulmonary Disease Secondary Care	Royal College of Physicians
NACAP: Paediatric Asthma Secondary Care	Royal College of Physicians
NACAP: Pulmonary Rehabilitation	Royal College of Physicians
National Audit of Breast Cancer in Older Patients (NABCOP)	Royal College of Surgeons
National Audit of Cardiac Rehabilitation	University of York
National Audit of Care at the End of Life (NACEL)	NHS Benchmarking Network
National Audit of Dementia	Royal College of Psychiatrists
National Bariatric Surgery Registry	British Obesity and Metabolic Surgery Society
National Cardiac Arrest Audit	Intensive Care National Audit and Research Centre (ICNARC)
Myocardial Ischaemia National Audit Project (MINAP)	Barts Health NHS Trust
National Audit of Cardiac Rhythm Management	Barts Health NHS Trust
National Heart Failure Audit	Barts Health NHS Trust
National Early Inflammatory Arthritis Audit	British Society of Rheumatology
National Emergency Laparotomy Audit	Royal College of Anaesthetists
National Joint Registry	Healthcare Quality Improvement Partnership
National Lung Cancer Audit	Royal College of Surgeons
National Maternity and Perinatal Audit	Royal College of Obstetrics and Gynaecology
National Neonatal Audit Programme	Royal College of Paediatrics and Child Health
National Paediatric Diabetes Audit	Royal College of Paediatrics and Child Health
National Perinatal Mortality Review Tool	University of Oxford / MBRRACE-UK collaborative
National Prostate Cancer Audit	Royal College of Surgeons
National Acute Kidney Injury Audit	UK Kidney Association
UK Renal Registry Chronic Kidney Disease Audit	UK Kidney Association
Adult Respiratory Support Audit	British Thoracic Society
Sentinel Stroke National Audit Programme	King's College London
Serious Hazards of Transfusion (SHOT)	Serious Hazards of Transfusion
Trauma Audit & Research Network	The Trauma Audit & Research Network
UK Parkinson’s Audit	Parkinson’s UK

National Confidential Enquiries (NCEPOD)
Crohn's Disease
Transition from Child to Adult Services
Community Acquired Pneumonia
Testicular Torsion

The national clinical audits and national confidential enquires that North Tees and Hartlepool NHS Foundation Trust participated in, and for which data collection was completed during 2022-23, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Mandatory National Clinical Audits	Participation	% cases submitted
Breast and Cosmetic Implant Registry	No	-
Case Mix Programme	Yes	100%
Elective Surgery (National PROMs Programme)	Yes	100%
Mental Health: Self Harm (care in Emergency Departments)	Yes	100%
Care of Older People (care in Emergency Departments)	Yes	Delayed nationally.
Infection Prevention & Control (care in Emergency Departments)	Yes	100%
Epilepsy 12 – National Audit of Seizures and Epilepsies in Children and Young People	Yes	100%
Fracture Liaison Service Database	Yes	100%
National Audit of Inpatient Falls	Yes	100%
National Hip Fracture Database	Yes	100%
National Bowel Cancer Audit	Yes	100%
National Oesophago-gastric Cancer	Yes	100%
Inflammatory Bowel Disease Audit	No	Local system recently implemented, audit data held locally, working on first new upload.
Learning Disabilities Mortality Review Programme (LeDeR)	Yes	100%
Maternal and Newborn Infant Clinical Outcome Review Programme	Yes	100%
Muscle Invasive Bladder Cancer Audit	Yes	100%
National Diabetes Core Audit	Yes	100%
National Diabetes Foot care Audit	Yes	100%
National Inpatient Diabetes Audit	Yes	100%
National Pregnancy in Diabetes Audit	Yes	100%

National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP): Adult Asthma Secondary Care	Yes	100%
NACAP: Chronic Obstructive Pulmonary Disease Secondary Care	Yes	100%
NACAP: Paediatric Asthma Secondary Care	Yes	100%
NACAP: Pulmonary Rehabilitation	Yes	100%
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	100%
National Audit of Cardiac Rehabilitation	Yes	100%
National Audit of Care at the End of Life (NACEL)	Yes	100%
National Audit of Dementia	Yes	100%
National Bariatric Surgery Registry	Yes	100%
National Cardiac Arrest Audit	Yes	100%
Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%
National Audit of Cardiac Rhythm Management	Yes	100%
National Heart Failure Audit	Yes	100%
National Early Inflammatory Arthritis Audit	Yes	100%
National Emergency Laparotomy Audit	Yes	100%
National Joint Registry	Yes	100%
National Lung Cancer Audit	Yes	100%
National Maternity and Perinatal Audit	Yes	100%
National Neonatal Audit Programme	Yes	100%
National Paediatric Diabetes Audit	Yes	100%
National Perinatal Mortality Review Tool	Yes	100%
National Prostate Cancer Audit	Yes	100%
National Acute Kidney Injury Audit	Yes	100%
UK Renal Registry Chronic Kidney Disease Audit	Yes	100%
Adult Respiratory Support Audit	Yes	100%
Sentinel Stroke National Audit Programme	Yes	100%
Serious Hazards of Transfusion (SHOT)	Yes	100%
Society for Acute Medicine Benchmarking Audit (SAMBA)	No	An alternative audit has been adopted locally, which provides more helpful analysis for our organisation's configuration.
Trauma Audit & Research Network	Yes	100%
UK Parkinson's Audit	Yes	100%

National Confidential Enquiries (NCEPOD):

The Trust participated in all **4** national confidential enquiries (100%) that it was eligible to participate in, namely:

NCEPOD study	Participation	
Crohn's Disease	Yes	50%
Transition from Child to Adult Services	Yes	88%
Community Acquired Pneumonia	Yes	100%
Testicular Torsion	Yes	100%

National Clinical Audits

The reports of **38** national clinical audits were reviewed by the provider in 2022-23 and North Tees and Hartlepool NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Audit title	Actions taken/in progress
ICNARC	Previous audit identified need for a Clinical Educator, which was successfully addressed.
BTS National Smoking Cessation Audit 2021	Previously, the trust did not have a hospital-based smoking cessation service. This has now been set up, with all staff in place.
NHSBT National Patient Blood Management in Scheduled Surgery Audit 2021	*"Iron in your diet"* patient information leaflets have been made available at pre-assessment to give information prior to surgery.
NHSBT Medical Use of Red Cells 2019 re-audit	*"Will I need a transfusion?"* patient information leaflets have been issued to all wards and attached to all pathways. A quality improvement project is underway to look at reducing single-unit blood wastage.
National Hip Fracture Database 2021	A quality improvement project was initiated following this report to look at improving time to surgery and mobilisation.
RCEM Cognitive Impairment in Older People	An Emergency Department Physician has been identified to be in charge of completing the Delirium Bundle.
NNAP 2020 annual report	Work was undertaken to improve documentation of cord clamping time.
NACAP Paediatric Asthma Report	Some local audit and quality improvement work was undertaken to improve the number of patients receiving steroids within 1 hour of admission.
NOGCA annual report 2021	Audit identified lack of dedicated Dietitian for the service, which is being addressed.
National Prostate Cancer Audit Annual Report 2021	Audit identified a reduction in the recording of TNM status, which has since been addressed.

NJR 18th Annual Report 2021	Good clinical outcomes noted. The service has benefitted from increased resource to collect the audit data, resulting in improved completion of the registry.
NELA 7th Annual Report	Analysis showed improvement in elderly care assessment where required, compared to previous. Data completeness was rated as excellent.
National Inpatient Falls Audit Annual report 2021	Excellent trust results. The trust utilises a Falls Quality Assurance Framework to closely monitor actions and improvements to the service.
NCEPOD Out of Hospital Cardiac Arrest	Some work is being undertaken to explore cooling measures to maintain normothermia for the patient post-cardiac arrest.
NCEPOD Dysphagia in Parkinson's Disease	Some work has been undertaken to develop a pathway on how to administer medication to patients who are nil by mouth or have impaired swallow.
NABCOP Annual Reports 2021 & 2022	An issue had been identified with the linking of Chemotherapy data from our tertiary centre to the initial case information at our trust. Work is ongoing to ensure the audit database reflects the excellent clinical practices at both trusts.
Cardiac Rhythm Management Annual Reports 2021 & 2022	Audits provided assurance that the service was achieving all required clinical standards.
National Heart Failure Audit Annual Reports 2020/21 & 2021/2022	Significant improvements have been made in respect to discharge medications. Some work is ongoing to ensure cardiology follow-up is being picked up when patients are discharged back to another catchment area, having follow-up at a different trust.
National Fracture Liaison Service Annual Report 2020	The audit identified a drop in patients having a DXA scan within 12 weeks. This is being closely monitored.
NACEL3 Report 2021/22	Good results identified, with no major actions.
NACAP Pulmonary Rehabilitation Organisational Audit 2021	Services had been moved away from the hospital to community settings, and patients had been unable to use patient transport settings to get to the new venues. A service level agreement has been established to resolve this issue.
Learning Disabilities Mortality Review (LeDeR)	Clinical lead is providing training on communication issues with patients with learning disabilities.
National Diabetes Foot Care Audit	A quality improvement project has been undertaken around the "One Stop Shop". Patients attending will be offered in-depth education sessions around diabetes and foot care.
National Bariatric Surgery Database	Audit confirmed excellent clinical outcomes, with no actions required.

Trauma Audit & Research Network update	Some work is ongoing with pre-hospital teams and the ambulance service around pre-alert criteria.
RCEM 2020/21 National Audit of Fractured Neck of Femur	Management of pain and keys steps in the process are reported as much better than national average.
RCEM 2020/21 National Audit of Pain in Children	The national audit design had excluded many patients from this audit, as patients with long bone fractures are locally streamed to the Urgent Care Centre and missed the audit. The team has since fed back to the Royal College of Emergency Medicine for consideration.
RCEM 2020/21 National Audit of Infection Prevention and Control	Excellent performances noted in this audit.
NACAP Adult Asthma & COPD Organisation Audit	Standards relating to 7-day respiratory advice to all Asthma and COPD patients, and pulmonary rehabilitation within 30 days would require expansion of the service to achieve improved results. This is to be discussed further.
National Maternity & Perinatal Audit (NMPA)	A local audit of induction of labour is being undertaken to further explore the high induction rate for the trust.
MBRRACE-UK Perinatal Mortality Surveillance Report 2019/20	The trust has more younger patients than the national average, linking in with deprivation rate in the local area.
National Paediatric Diabetes Audit Annual Report 2020/21	It was noted that foot checks were undertaken within the community setting, using a different system to the rest of the audit. Improved linkage of systems is being resolved to ensure complete information is captured in future. Clinical performances were noted to be excellent.
National Cardiac Arrest Audit (2020/21 vs 2021/22)	Local outcomes were generally below national average, however noted that patients also had higher levels of multiple co-morbidities in the region.
National Comparative Audit of Blood Sample Collection and Labelling 2022	Clinical lead is looking into potential business case to implement an electronic system, to help resolve the issue of sample rejections owing to manual labelling methods.
National Audit of Inpatient Falls Annual Report 2022	Excellent results reported. A local audit of walking aids and bed rails assessment is being undertaken, in line with national best practice recommendations.
NBOCA Annual Report 2021	Audit confirmed excellent local results when compared to national average.
BTS Outpatient Management of Pulmonary Embolism	Patient information leaflets are currently being promoted and referenced within the new pathway.
Sentinel Stroke National Audit Programme Annual Report 2022	Audit results presented in August 2022 indicated the service was seeing increased numbers of more complex Stroke and TIA patients, against a shortfall in staff resource to meet demand.

	Since then, additional resource has been identified and results presented in March 2023 showed significant improvement.

All national audit reports are considered by the Audit and Clinical Effectiveness (ACE) Committee which reports to the Quality Assurance Committee and this reports directly to the Board of Directors.

Local Clinical Audits

The reports of **147** local clinical audits were reviewed by the provider in 2022-23 and North Tees and Hartlepool NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Audit title	Actions taken/in progress
Anaesthetics: Volatile Anaesthetic Gas Use	This re-audit reviewed the effectiveness of a programme within the trust to minimise the use of Desflurane, Nitrous Oxide and Entonox, as these have significant impact on the environment. It showed that there had been a marked reduction in emissions. Notably ordering and stockpiling of volatile gases had been reduced as unused bottles are still released into the atmosphere when the bottles are disposed.
Emergency Care: Poisons Antidotes	This one-day snapshot audit was a physical review of the Emergency Drugs cupboard. All drugs required in the guidance were in stock and easily accessible however one drug – Intralipid - was noted as not in stock. Investigations identified that this related to cost and lack of clinical requirement, but this was raised as an issue with Pharmacy who confirmed that it could be rapidly accessed by theatre staff if required urgently.
Paediatrics: Initial Health Assessment for Looked after Children (IHA-LAC)	The audit identified that information was being gathered correctly to inform the patient assessment along with strong evidence that the carer's concerns had been sought and recorded. There was a concern that some cases lacked documentation that the young person had been offered the opportunity to be seen alone. This issue was raised at the Safeguarding Professionals meeting as an educational intervention.
Obstetrics and Gynaecology: Maternal transfers from the Rowan Suite	This audit identified areas of good practice - existing guidance was being followed appropriately, but the audit showed that there was a need for more cohesive recording of data across sites. A new updated guideline covering transfer between hospitals has been drafted and is being ratified through the trust guidelines group.
Nursing: When to suspect child maltreatment (NICE CG89)	This audit identified that all staff were aware of the process and who to contact if they had a safeguarding concern about a child and 95% of staff were able to identify a member of the Child Safeguarding Team.

Medical Physics/Radiology: IR(ME)R Authorisation of Nuclear Medicine Studies in Medical Physics	Results from this audit were excellent with compliance at 100% in two out of the three criteria. The outstanding two areas of concern were later identified as having been authorised on paper rather than electronically. This was raised as an educational intervention at the next staff meeting.
Surgery: Surgical Antibiotic Prophylaxis	This audit identified a poor compliance with local guidelines. Guidelines have been updated and reviewed and the team have identified the need for an antibiotic stewardship champion role. In addition all staff have been contacted to emphasise the importance of documenting wound status on the operation notes
Orthopaedics: Peri-operative Transfusion in Fractured Neck of Femur (NICE NG 24 & QS 138)	This local re-audit identified improved staff knowledge following the previous audit in 20-21 which had recommended an educational intervention with nursing staff in the preparation and administration of IV iron. Outcomes confirmed the importance of recording documentation on the discharge letters.
Out of Hospital Care: Safety Checklist Audit for Nail Surgery in the Podiatry Service	Outcomes were excellent, but the audit identified a need for pregnancy status of patients to be documented. It also identified a need for sign out questions to be completed at every appointment. This was highlighted as an issue at a full staff meeting as an educational intervention.
Medicine: Local Audit of Catheterisation Laboratory Procedures in Cardiology	Good outcomes, but some areas of improvement were identified including a simplification of the safety checklist to improve processes and avoid duplication.

Clinical Research

The Trust is a partner organisation within the Clinical Research Network for the North-East and North Cumbria (CRN NENC) and supports the CRN NENC to deliver and lead high quality research as part of the National Institute for Health Research (NIHR) portfolio. In 2019 we joined a strategic Alliance with our research and development colleagues in North Tees & Hartlepool NHS Foundation Trust (NTH) to form the Tees Valley Research Alliance (TVRA) to offer an improved, efficient research service that would deliver more research opportunities to the patients of Teesside. A clear TVRA strategy and annual improvement plans outline our priorities for research in the TVRA. Our TVRA Executive comprises representation from our Chief Medical Officers, Human Resources & Finance management as well as representation from research leaders in local Public Health, Primary Care and the CRN NENC.

There is a clear link between research activity, clinical outcomes and improved patient experience. Over the last year there have been many position statements from professional bodies (Royal College of Physicians, General Medical Council, Nursing & Midwifery Council) highlighting the importance of research and the need for all health professionals to be involved in supporting research in addition to the need for Trust Board endorsement and support to enable and deliver these objectives.

The number of patients receiving relevant health services provided or subcontracted by North Tees & Hartlepool NHS Foundation Trust (NTH) in 2022/23 that were recruited during that period to participate in research approved by a research ethics committee was 3533 (across 94 studies and 19 NIHR specialties) in 2022/23. This compares favourably with the 1191 patients recruited last year across 75 studies 21 specialties representing a **196%** increase in patient recruitment and is our highest ever recruitment to date. We have opened several large recruiting studies within our "Children's" and "Reproductive health" portfolios which have contributed to this significant increase. We have established a Chief Investigator Support Service within the TVRA to provide sponsor related support and oversight for all TVRA sponsored studies and co-fund a post with MedConnect North to support the development of Med Tech and Investigator Initiated trials with an additional post planned for 2023/24. We have supported the establishment of three new Academic Research Units in the TVRA to provide specialist support and training for Chief Investigator led studies from Cardiology (Academic Cardiovascular Unit (ACU), Surgery (Academic Centre for Surgery (ACeS) and Perioperative care (https://www.southtees.nhs.uk/about/strive/research-team/academic-cardiovascular-unit/ & https://www.southtees.nhs.uk/about/strive/research-team/aces/). These Academic units have been developed in partnership with Newcastle University, Hull York Medical School, Health Sciences at the University of York and the Royal College of Surgeons (RCS) of England providing new opportunities for research fellows within the trust.

Successful contingency funding requests from the CRN NENC have enabled us to extend the already successful secondment of heart failure specialist nurses into research roles at NTH and add an additional secondment and initiate a similar scheme at STH with Band 6 nurse and Band 7 Dietician supporting Critical Care research along with B7 Trauma Practitioner and a Paediatric Advanced Practice Nurse.

Both TVRA trusts have signed up to become members of the global TriNetX platform (https://trinetx.com). This will allow greater visibility of our trusts to potential commercial research sponsors thus bringing more cutting edge trails to our populations. It will also allow our own researchers to interrogate our trust based patient information systems to support study feasibility review.

Nursing, Midwifery, AHP and Clinical Research Practitioner engagement in research

Our Cancer Trials Team Leader from STH has been appointed as the regional Clinical Research Practitioner (CRP) Lead for CRN NENC supporting CRP colleagues with accreditation and CRP

engagement. Our Clinical & Operations Manager works closely with Directors and Associate Directors of Nursing in both trusts to progress the Nursing Midwifery and Allied Health Professional (NMAHP) research agenda, embed research and develop strategies for implementing the Chief Nursing Officer strategic objectives to increase engagement in research from this large staff group. We have an active “Research Support and Best Practice Council” at STH and “Be curious about research” campaign curious about research” campaign. We are currently in discussions with Senior Nurse Leaders to extend this council to NTH. We have increased the number of non-medical Principal Investigators this last year from 15 to 24 (16 STH, 8 NTH).

Patient Engagement

Feedback from patients who have participated in NIHR studies within the Trust is sought via the NIHR “Patient Research Experience Survey” with feedback reviewed quarterly at our Research and Development Directorate meetings. This year we have received very positive feedback from 164 research participants against an annual target of 90.

We routinely appoint patient representatives to the steering committees of our NIHR grant funded studies and carry out other patient and public involvement activity to inform the development of individual trials..

Commissioning for Quality and Innovation (CQUIN)

Our level of income relating to CQUIN was set at the outset, reducing the risk and uncertainty faced by the Trust, in return for increased flexibility in delivering positive patient outcomes, both internally and as part of a wider "system". Schemes were nationally determined. As part of this, full CQUIN attainment was assumed, but with continued, albeit light touch, review by the Commissioners of achievement.

Care Quality Commission (CQC)

North Tees and Hartlepool NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is **registered without conditions for all services provided**.

The Care Quality Commission (CQC) has not taken enforcement action against North Tees and Hartlepool NHS Foundation Trust during 2021-22. North Tees and Hartlepool NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

The Trust was inspected by the Care Quality Commission (CQC) under the new regime of inspection during May 2022.

The CQC inspection looks at five domains, asking are services safe, caring, responsive, effective and well-led and rates each of them from inadequate, requiring improvement, good and outstanding.

The overall CQC rating from the recent inspection was reduced from 'Good' to **'Requires Improvement'**.

The CQC inspected maternity services at Hartlepool and North Tees hospitals, and services for children and young people at North Tees, from 3 to 5 May 2022.

The CQC did not inspect medicine, surgery, urgent and emergency care, critical care, end of life care, outpatients or diagnostics at this trust during this inspection. CQC continue to monitor the quality of these services and may re-inspect if and when appropriate.

At this inspection, the CQC found that ratings in maternity, had gone down to requires improvement since last inspection them in 2018 when they were rated as good. At this inspection, the CQC found the ratings in services for children and young people stayed the same, and were rated as good overall.

Due to the ratings given at this inspection, the trust's overall ratings of good across all domains changed to requires improvement in safe, effective and well-led. This meant that the trust's overall rating changed from good to requires improvement.

2022 - Overall ratings for the Trust

Overall rating for this Trust	Requires Improvement
Are services at this Trust safe?	Requires Improvement
Are services at this Trust effective?	Requires Improvement
Are services at this Trust caring?	Good
Are services at this Trust responsive?	Good
Are services at this Trust well-led?	Requires Improvement

The full inspection report can be found on the CQC website:
http://www.cqc.org.uk/provider/RVW

CQC Contact and Communication

The Trust has regular engagement meetings with our CQC Relationship Manager. In addition to these meetings, regular telephone contact is maintained. Prior to the engagement meetings, the Trust shares a comprehensive monitoring document. The document is based around the five domains and encompasses details related to incidents, complaints, staffing, and also allows the Trust to share any information it wishes. This has included examples of excellence in practice, awards Trust staff have been short-listed for and major developments within service delivery.

As part of the engagement meetings, there has been the opportunity for CQC staff to make informal visits to clinical areas at their request.

Some information related to the Trust's CQC actions is available to the public on the Trust's website http://www.nth.nhs.uk/patients-visitors/cqc/.

Quarterly news bulletins are being published and are available to the public on the Trust's website. http://www.nth.nhs.uk/patients-visitors/cqc/news-bulletin/

Duty of Candour

Duty of Candour is the regulatory requirement of being open and transparent with people who use the Trust's services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. The legal requirements around Duty of Candour are defined and specifically laid out in the CQC Regulation 20. All NHS Trusts are set specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

The Trust policy has been in place, and reviewed as required, since the regulations were introduced. The policy details for staff how application of the regulations should be communicated to patients and their families/carers and then recorded.

On a weekly basis the Trust's Safety Panel reviews all patient safety events where the regulations have been applied; most of these relate to events where harm has been reported as moderate harm or above. At the same panel meetings Complaints triage details are also reviewed, this includes information around formal complaints that have been received and if the duty of candour regulations are applicable. This sharing of information highlights cases to panel members, provides details of the application of the regulations within clinical areas, and where necessary, identifies any challenges in relation to applying the regulations.

The Trust e-learning package in relation to duty of candour has been updated; and this training has been mandated for all medical staff and other staff, grade 6 and above since 2018 and at the end of March 2023 81% of these staff have completed the training, this is monitored monthly through the Trusts mandatory training reports.

During 2022-23, following publication of the Trusts CQC report, it was highlighted that there were some areas for improvement in the Trusts evidence in relation to applying the regulations. The Trust has since this time undertaken a quality audit of cases where the candour regulations have been appliedCycle two of this audit is already underway to assess the overall impact of the quality improvement measures already initiated. The ongoing monitoring of compliance for the Trust

Board and contractual requirements is already reflecting an improvement in the timescales and the quality of evidence available.

Commissioners Assurance

There have been no visits during 2022-23, there are plans for external visits to recommence June 2023.

Freedom to Speak Up (FTSU)

Background to the Freedom to Speak Up Guardian (FTSUG)

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

The Francis Report raised 290 recommendations. One of the recommendations was to have a designated person who was impartial and independent working in every Trust. This role would facilitate staff to speak to in confidence about concerns at work including any public interest disclosure. It was acknowledged that staff should be listened to, taken seriously and would not suffer detriment for speaking up. The National Guardian Office (NGO) was established to train and support Guardians as well as providing appropriate resources to help establish a healthy "Speak Up, Listen Up, Follow Up" culture. All Guardians are locally employed but are trained by the NGO.

Philosophy

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

"The Freedom to Speak Up movement has been a catalyst for positive change but there is still much more to be done. Together we can build upon the foundations…and give workers and the people we serve, the services they so richly deserve".

Dr Jayne Chidgey-Clark, National Guardian for the NHS

The Trust positively encourages all employees to speak up if they have a concern about risk, malpractice or wrongdoing. Moreover, if there are any behaviours or acts which harm the

services the Trust delivers, we have both a duty and right to speak up. Examples may include (but are by no means restricted to):

- unsafe patient care
- unsafe working conditions
- inadequate induction or training for staff
- professional malpractice
- lack of, or poor, response to a reported patient safety incident
- suspicions of fraud (which can also be reported to our local counter-fraud team)
- an inappropriate culture (e.g. bullying within a team or service)
- suspicion that a bribe has been either offered, promised, agreed, requested or accepted
- conduct which is likely to damage the reputation of the Trust;
- breach of the Trust's policies and procedures
- a criminal offence has been, or is being committed, or is likely to be committed
- any misrepresentation of the true state of affairs of the Trust
- the environment has been, is being or is likely to be damaged
- deliberate concealment of any of the above matters or information which has been or may be deliberately concealed.
- anything that gets in the way of doing a great job.

Trust progress 2022 - 2023:

A full time, trained FTSUG is in post (recruited since August 2021). The FTSUG is formally registered on the NGO database, including contact details. The FTSUG completed National Guardian Office (NGO) refresher training in June 2022 which is now an annual requirement to maintain registration and practice.

For resilience and business continuity purposes, there is also a contingency Guardian who is also formally registered on the NGO database. It has been agreed the contingency Guardian will cover 2 days per week in the event of unplanned absence or availability of the full time FTSUG. The contingency Guardian has also completed refresher training and has undertaken some job shadowing for the role.

The Trust (including NTH Solutions) now has 14 Freedom to Speak up Champions which is an increase of 4 since last year. 2 of the new champions are Foundation Year Doctors which is being supported by the Medical Education Team to promote the importance for junior doctors to speak up. All FTSU champions are trained to promote the importance of a healthy speak up culture and are able to signpost staff to the available routes to speak up. Champions do not handle cases but can provide initial support and guidance. The first group meeting for the champions will be taking place in May 2023 to discuss how to further promote the ethos via this growing network.

A second freedom to speak up promotion took place in October 2022. This is an annual event, every October, and forms part of the National Freedom to Speak Up campaign. Promotion this year included communication from the CEO to re-iterate the importance of FTSU, meet and greet the NTH Solutions Champions, screensavers promoting the Speak Up, Listen Up, Follow Up ethos and the north wing building lit up green to symbolically represent the colour of the NGO logo. The FTSUG continued to meet staff at inductions but also attended a number of team meetings and floor walking opportunities across North Tees, Hartlepool and Peterlee with the Non-Executive Director for FTSU.

The FTSUG continues to attend monthly North East regional network meetings with the aim of learning, sharing best practice, peer support and working collaboratively. Networking relationships also continue with Guardians outside the region including Northern Lincolnshire and Goole NHS Foundation Trust and Shrewsbury and Telford NHS Foundation Trust for further / additional support.

The FTSUG and the FTSUG Team based at The James Cook University Hospital have established and sustained a good working alliance to work collaboratively as the Joint Partnership evolves. Both Trusts now use the same promotion material in relation to the "Speak Up" staff poster which shows the internal routes available for staff to speak up across both Trusts.

Guardians from both Trusts have also jointly presented at the FTSU Induction to Allied Healthcare Professional studying at Teesside University to ensure students are aware of FTSU before commencing placements at each respective Trust.

A new Speaking Up policy is now ready for final sign off by Clinical Governance following presentation at the Policy Review Group and Joint Forum. This is a national policy from NHSE and the NGO in which all Trusts are expected to adopt as minimum standard by January 2024. This new policy (RM36 V2) has been received with positivity by the Trust and will replace the current Speaking Up policy (RM36 V1.3).

The FTSUG role was externally audited via Audit One and the assurance rating moved from reasonable to good. Several improvements were noted including the recruitment of a full time Guardian, creation of a standard operating procedure, an easy to read staff guide to speaking up and allocation of a contingency Guardian.

The FTSUG continues to promote the role via team meetings, floor walking and ward visits and has received significantly more proactive invites during the reporting period. There is significantly more awareness of FTSU including why it exists, how to make contact and who the Guardian is. Please refer to staff feedback for further information.

All staff are actively encouraged to undertake National Guardian Office "Speak Up" and "Listen Up" Training Modules on ESR. A final "Follow Up" training module was released last year and all Exec staff and Board members have been directed and encouraged to complete this training. This is not mandatory training but all training modules are actively promoted by the Guardian and FTSU Champions.

Regular "Keep in Touch" meetings with Executive Sponsor, Non-Executive Director for FTSU and all other senior leaders have helped create a relational approach to speaking up as well progressing any concerns raised. Monthly meetings will continue with the Managing Director / Director of Finance whilst the joint partnership model evolves. The FTSUG also presents monthly updates at Executive Team Meeting and annually at Board Seminar.

The FTSUG presented the Trust's speaking up progress at Governors' Seminar and has met the new Non-Executive Directors.

The FTSUG also attends the following to promote FTSU:

- Quarterly Patient Safety Council
- Quarterly Care Group Senior Management Team meetings
- Monthly meetings with Care Group Directors for both proactive and reactive work.

- Staff network meetings (Ability, Ethic Minority and LGBTQ+)
- Staff induction, junior doctors' induction, speciality doctors' induction, preceptorship, student nurse induction and volunteers seminars.
- Joint Forum
- Schwartz Round Steering Group
- PNA / PMA group meetings

Case Data:

Between 1 April 2022 and 31 March 2023, **101** concerns were raised via the FTSUG route.

National Guardian Office 2022 -2023 Data submitted:

Q1 – 18 Cases (April 2022 – June 2022)
Q2 – 31 Cases (July 2022 – September 2022)
Q3 – 27 Cases (October 2022 – December 2022)
Q4 – 25 Cases (January 2023 – March 2023)

Total number of contacts / cases 101

95 cases have been closed, resolved or have received final outcomes.

6 cases remain open due to awaiting further discussions and / or follow up actions.

8 staff contacted the FTSUG informally i.e. for a supportive conversation only with no signposting advice requested or further action required. These cases are logged as informal contacts only and not included in formal case data.

All 23 cases which were open and carried forward from the previous reporting period (2021/2022 data) have now been closed, resolved or have received final outcomes.

Further Elements (Information required by the NGO)

92 contacts contained an element of worker safety or wellbeing
71 contacts contained an element of inappropriate behaviour or attitudes
24 contacts contained an element of patient safety
23 contacts contained an element of bullying or harassment

Method of Reporting Concerns

70 contacts were received confidentially (69.31%)
20 contacts were received openly (19.80%)
11 contacts were received anonymously (10.89%)

Anonymous reporting at the Trust is just above the national average of data reported to the NGO (10.4%). Please note, it is also the lowest percentage of all concerns received via the FTSU route, with the highest percentage of concerns being raised confidentially. This could be considered an indicator of our "speak up" culture albeit all available routes for "speaking up" in the Trust encourage staff to start with a conversation with an appropriate colleague.

69.31% of FTSU contacts requested their concerns should be raised confidentially i.e. permission is granted for their identity to be shared with the FTSUG or appropriate staff

in other services (for example, People Services) albeit their identity should not be shared outside the speaking up process unless there is a legal requirement / request to do so.

Please note, as per the NGO guidelines, all Trusts should be working towards a culture where speaking up is "business as usual". The FTSU ethos is to reduce anonymous reporting where possible and to move into a confidential – open speak up culture. It is important to note that anonymous reporting happens in many organisations and confidentiality remains an important aspect of some cases and processes. Speaking up is accepted in all formats and colleagues are encouraged to report concerns responsibly, with civility and to include any suggested outcomes / improvements if able to.

Of the 101 contacts received, specific themes emerged in the following order (both clinical and non-clinical):

- Behavioural / Relationship
- Worker Safety or Wellbeing (including staffing)
- System / Process
- Patient Safety
- Infrastructure
- Leadership
- Middle Management
- Bullying and Harassment
- Senior Management
- Cultural
- Detriment (after speaking up)

The above figures and themes also represent an increased number of individual staff making contact from a wider number of services as opposed to last year's figures (50) where collective concerns were raised (i.e. groups of staff raising the same concern from the same service area). This suggests there is a wider awareness of FTSU as an alternative / additional route to speak up and possibility the growing confidence for staff to raise concerns individually as well as in groups.

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

The FTSUG submits numbers and themes every quarter to the National Guardian Office portal and the final submission for the reporting year, Q4 data, has been submitted.

Data recording has now commenced for Q1 (April – June 2023).

Staff Feedback

For quality assurance purposes, staff are invited to provide feedback at the end of the FTSU process. Staff also to continue to offer feedback on an ad hoc and voluntary basis during the FTSU process as well as general comments in team meetings. Awareness of the role has significantly increased and the role has been proactively welcomed by several service areas including Community Staff Forum and Medical Education.

Speaking up can be a challenging, worrying and sometimes lengthy experience. Timescales for investigations, communication, outcomes as well as the ongoing impact of

employment tribunals is challenging for our staff. This means that process and / or psychological support continues to be a requirement which requires further consideration. The FTSUG offers process support to any colleague (or ex colleague) who have raised a work related concern and signposts staff accordingly for psychological support.

The FTSUG received increased requests for direct support during this reporting period i.e. a supportive space to discuss informal concerns and potential next steps as well as ongoing contact from the FTSUG during more formal speaking up processes.

Positive feedback has been received this year, in particular relating to the support offered throughout the FTSU process. Receiving follow up contact (i.e. check ins and appropriate follow up information) after the concern has been raised or signposted was also reported as a positive outcome.

The 2022 National Guardian survey indicates that staff remain concerned about disadvantageous treatment or responses (sometimes referred to as detriment) after speaking. This is an important barrier to tackle.

3 cases of detriment were recorded this year. Listen Up and Follow Up training modules are available on ESR for managerial / leadership learning and collaboration in tackling detriment as well as setting the tone for a healthy speak up culture. These are not currently mandatory modules and further consideration should be given to these as a training requirement to tackle detriment.

Final Comments

Succession planning for the current FTSUG has commenced with the aim of recruitment and handover by the end of Q2 data (September 2023).

The FTSUG would like to express thanks for the ongoing support from all colleagues who have helped promote and embed the Freedom to Speak up ethos over the last year as well as continuing thanks to all staff who have spoken up to raise concerns.

NHS number and general medical practice validity

North Tees and Hartlepool NHS Foundation Trust submitted records during 2022-23 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episodes Statistics (HES) which are included in the latest published data.

The percentage of records in the published data:

Which included the patient's valid NHS number was:	%	Which included the patient's valid general medical practice code was:	%
Percentage for admitted patient care**	**99.9%**	Percentage for admitted patient care	**100%**
Percentage for outpatient care	**100%**	Percentage for outpatient care	**100%**
Percentage for accident and emergency care	**99.6%**	Percentage for accident and emergency care	**100%**

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

Information governance (IG)

Assurance continues to be provided to the Board of Directors that systems and processes are being constantly assessed and improved to ensure that information is safe. The Data Security and Protection Standards for health and care are set out in the National Data Guardian's (NDG) ten standards and are measured though the completion of the Data Security Protection Toolkit (DSPT). All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practicing good data security and that personal information is handled correctly.

The Trusts last DSPT submission was made in June 2022, the Trust has self-assessed compliance with all 10 NDG standards and all 110 mandatory evidence items were evidenced, meeting all mandatory assertions; therefore, the Trust scored as all 'Standards Met' for the 2022 DSPT. The 2022 DSPT was also subject to external audit, a sample of thirteen of the mandatory assertions taken across the ten standards were audited by External Audit (Audit One) during May 2022 prior to the DSPT submission. The Trusts overall assessment scored as 'Substantial' across all 10 National Data Guardian Standards and against the criteria for independent veracity of the Trusts self-assessment. The Trust received no recommendations or actions as a result of the independent audit.

For the 2023 DSPT submission due in June 2023 the current position at the time of this report is that 109 of the 113 mandatory evidence items are complete (96.4%), therefore based on this current position, the Trust remains on plan to complete the full assurance submission by 30 June 2023

The Trust reported three incidents to the ICO during 2022/23 DSPT reporting period, a reduction from five in the previous period, one related to 'inappropriate access by staff', one instance of 'disclosure in error' and on instance of 'theft of personal data', all incidents have since been closed without action by the ICO and the Trust has taken appropriate action to mitigate. In order to further strengthen existing Trust policy and to prevent repeat incidents in areas where incidents have occurred the following key actions were undertaken:

Review of IG policies and standard operating procedures to ensure they reflect the specific needs and practicalities of each internal department and they reflect the changing needs of legislation in light of the updated Data Protection Act 2018 and the General Data Protection Regulations (GDPR).

Increased the programme of comprehensive quality assurance and spot checks to ensure all departments are complying with Trust polices relating to the protection of personal data.

Continue to provide annual Data Security Training inclusive of Cyber Security and the provision of targeted training in areas of non-compliance.

Robust monitoring of departmental action plans following incidents to ensure appropriate actions have been implemented via the Information Management and Information Governance Committee.

Full annual review of information assets and information flows thought the Trust within a redesigned framework to comply with GDPR requirements.

HR processes followed where repeated non-compliance has been found.

Freedom of Information (FOI)

The Trust continues to respond to Freedom of Information requests from members of the public on a range of topics across all services and departments, complying with the 20 working day limit to do so. The act is regulated and enforced by the Information Commissioners Office (ICO). The ICO hold powers to enforce penalties against the Trust when it does not comply with the Act, including but not limited to monetary fines. For the year 2022-23 the Trust received 650 requests with a compliance level, as at 31 March 2023, 98% with complete compliance data available after 30 April 2023. This was achieved despite Trust services experiencing significant pressures and demands on services.

Clinical coding error rate

Clinical coding translates medical terms written by clinicians about patient diagnosis and treatment into codes that are recognised nationally.

North Tees and Hartlepool Foundation Trust was *not subject* to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

The Audit Commission no longer audits every Trust every year where they see no issues. The in-house clinical coding audit manager conducts a 200 episode audit every year as part of the Data Security and Protection (DSP) Toolkit and also as part of continuous assessment of the auditor.

	2018-19	2019-20	2020-21	2021-22	2022-23
Primary diagnoses correct	91.00%	90.50%	90.50%	91.00%	**91.00%**
Secondary diagnoses correct	93.56%	93.72%	85.98%	89.19%	**83.13%**
Primary procedures correct	93.75%	90.82%	97.66%	90.42%	**91.21%**
Secondary procedures correct	88.33%	91.49%	82.35%	83.10%	**90.28%**

The audit is still being carried out but the services reviewed within the sample are 200 finished consultant episodes (FCEs) taken from all specialties and include day cases.

The errors include both coder and documentation errors of which the coding errors will be fed back to the coders as a group and individually. The documentation errors will be taken to directorate meetings.

Depth of coding and key metrics is monitored by the Trust in conjunction with mortality data. Targeted internal monthly coding audits are undertaken to provide assurance that coding reflects clinical management. Any issues are taken back to the coder or clinician depending on the error. The clinical coders are available to attend mortality review meetings to ensure the correct coding of deceased patients.

Our coders organise their work so that they are aligned to the clinical teams. This results in sustained improvements to clinical documentation. This supports accurate clinical coding and a reduction in the number of Healthcare Resource Group changes made. This is the methodology which establishes how much we should get paid for the care we deliver. We will continue to work hard to improve quality of information because it will ensure that NHS resources are spent effectively.

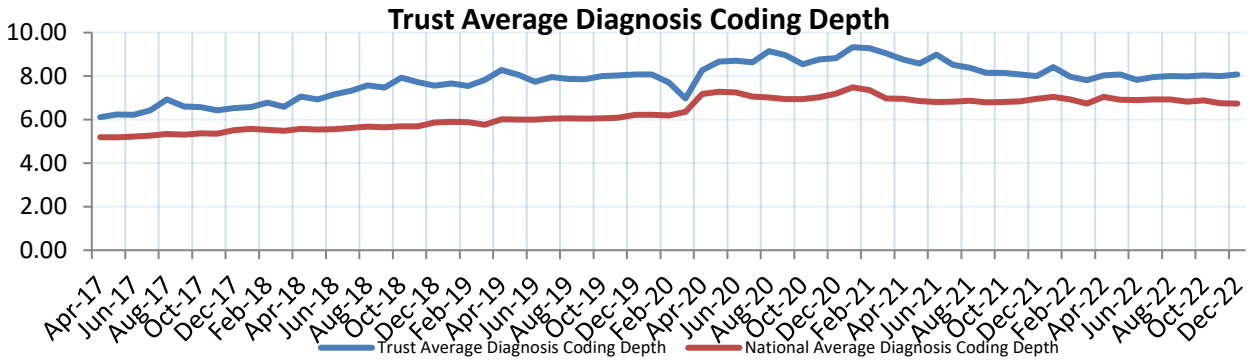
Unfortunately, due to the impact of COVID and losing three WTE coders, the department has failed to code the episodes within the required time scales. This has resulted in a backlog of workload and the difficult decision was taken to pull back from coding all medical episodes from the ACN and case notes and use the discharge summary as the source documentation. There were exceptions, however, to minimise the impact on the mortality indicators and all long stay and deceased patients continue to be coded from the case notes. A contract coder has also been employed to help to reduce the backlog. There is a recovery plan in place and it is hoped the deadlines will be back to the SUS flex deadline in the summer. The HSMR and SHMI mortality indicators are constantly being reviewed and so far, the change in coding practice, has not had a negative impact on them. When the medical coding does return to full ACN and case notes, EAU and ambulatory will still be coded from the discharge summary as the increase in daily workload coupled with the imbalance in the team dynamic means that maintaining coding accuracy while continuing to achieve 100% of coding within the mandatory time deadlines is increasingly challenging. In order to improve the flow of medical case notes being sent to the coding department a temporary red sticker has been piloted on the medical base wards. The sticker instructs whoever has the case notes at that time to send them to the coding department. The pilot was deemed a success, and the system was rolled out to all wards across the Trust.

In July 2020 the Trust went live with Active Clinical Notes (ACN). Active Clinical Notes allows traditional paper-processes and pathways to be made available digitally. This means the clinical details of patient's diagnoses and treatments are now added directly to the patient's Electronic Patient Record (EPR). Nursing pathways are currently not available electronically and are still manually completed and filed within the patient's case notes, but it is hoped nursing notes will be available electronically from the end of June 2023. As a result of this change it has allowed the coding department to introduce an opportunity for some of the coders to work from home. In June 2021 the Coding Department started a twelve week homeworking trial period. After the initial trial period the homeworkers coding was audited and the results showed the quality of coding carried out at home was on a level with the coding carried out within the trust. As a result the home working was made permanent. As more information is made available electronically it means the opportunity for home working increases and coders can spend more of their time coding from home. Continuous audits will be carried out to ensure the levels of accuracy are maintained.

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

Diagnosis Coding Depth National and Trust Trend (April 2016 to December 2022)

The Trust has continued to make great strides in improving the accuracy and depth of patient coding, the following chart demonstrates the increase (blue) against the national average (red). The Trust has improved the quality of discharge documentation and actively engaged clinicians to work closely with Clinical Coding. The latest depth of coding shows the Trust having an Average Diagnosis Depth of **8.08** (December 2022) compared with the National average of **6.74.**



Part 2d: Core set of Quality Indicators

Measure	Measure Description	Data Source
1a	The data made available to the trust by NHS Digital with regard to — the value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period **Nov 2021 – Oct 22**.	NHS DIGITAL

SHMI Definition

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It includes deaths which occur in hospital and deaths which occur outside of hospital within 30 days (inclusive) of discharge.

Summary Hospital-level Mortality Indicator (SHMI) – Deaths associated with hospitalisation, England, **November 2021 – October 2022**

Time period	Over-dispersion banding	Trust Score	National Average	Highest – SHMI Trust Value in the country	Lowest – SHMI Trust Value in the country
July 2020 – Jun 2021	**Band 2 (As Expected)**	**0.9930**	**1.00**	**1.2017**	**0.7195**
Aug 2020 – Jul 2021	**Band 2 (As Expected)**	**0.9916**	**1.00**	**1.1847**	**0.7188**
Sep 2020 – Aug 2021	**Band 2 (As Expected)**	**0.9795**	**1.00**	**1.1848**	**0.7161**
Nov 2021 – Oct 2022	**Band 2 (As Expected)**	**0.9656**	**1.00**	**1.2470**	**0.6226**

SHMI Regional – November 2021 – October 2022

Trust	Trust Score
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	1.1064
SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST	1.0769
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	1.0555
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	**0.9656**
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	0.9253
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	0.9071
GATESHEAD HEALTH NHS FOUNDATION TRUST	0.8966

The **North Tees and Hartlepool NHS Foundation Trust** considers that this data is as described for the following reason. SHMI mortality data when reviewed against other sources of mortality data including Hospital Standardised Mortality Ratio (HSMR) and when benchmarked against other NHS organisations will provide an overview of overall mortality performance either within statistical analysis or for crude mortality.

The **North Tees and Hartlepool NHS Foundation Trust** has taken the following actions to improve this indicator and so the quality of its services. The Trust continues to undertake mortality reviews over two sessions each week, this is in line with the Secretary of State for health requirements for all Trusts to undertake mortality reviews; this continues to be supported by the CQC. This has been supported by the inclusion of the mortality reviews in the quality work undertaken by all consultant staff as part of their annual appraisal. The information is input directly onto a dedicated database; this is then used to extract data for reporting.

The clinical reviews undertaken provide the organisation with the opportunity to assess the quality of care being provided as this will continue to be the priority over and above the statistical data. The Trust's review process is linked closely with the work being undertaken regionally and the Trust is working jointly with local Trusts to utilise a web based system to store mortality reviews that can be linked into the national system once this is agreed and in place. All Trusts in the region are undertaking reviews and Trust staff meet with them on a regular basis to share best practice and to also consider areas of focus across the region as well as locally.

The awareness, work and engagement has been delivered during 2022-23, this continues to make an impact on the HSMR and SHMI values, and have led to both of these statistics being reported as being "within expected" ranges. Whilst the Trust recognises that the values have maintained an excellent position over a number of months, the actions already initiated are being followed to completion and there are further areas being identified for review, and potential improvement work, from the analysis of a wide variety of data and information sources on a regular basis.

Measure	Measure Description	Data Source	Value
2	The data made available to the trust by NHS Digital with regard to the trust's patient reported outcome measures scores for— 1. Groin hernia surgery 2. Varicose vein surgery 3. Hip replacement surgery, and 4. Knee replacement surgery during the reporting period	NHS DIGITAL	Adjusted average health gain EQ-5D Index

April 20 to March 21	*Groin hernia	*Varicose vein	Hip replacement – Primary	Hip replacement – Revisions	Knee replacement – Primary	Knee replacement – Revisions
Trust Score	No data	No data	0.503	No data	0.389	No data
National Average	No data	No data	0.465	0.336	0.315	0.299
Highest National	No data	No data	0.576	0.336	0.400	0.299
Lowest National	No data	No data	0.392	0.336	0.176	0.299

Apr 20 to Mar 21, Data from NHS Digital

April 19 to March 20	*Groin hernia	*Varicose vein	Hip replacement – Primary	Hip replacement – Revisions	Knee replacement – Primary	Knee replacement – Revisions
Trust Score	No data	No data	0.468	No data	0.394	No data
National Average	No data	No data	0.459	0.307	0.335	0.295
Highest National	No data	No data	0.468	0.338	0.394	0.394
Lowest National	No data	No data	0.409	0.307	0.312	0.295

Apr 19 to Mar 20, Data from NHS Digital

The **North Tees and Hartlepool NHS Foundation Trust** considers that this data is as described for the following reasons. The Trust continues to have a lower than the national average 'adjusted average health gain' score in relation to groin hernia surgery, however the position is improving. In relation to primary knee replacement, the Trust's position continues to demonstrate good results.

The **North Tees and Hartlepool NHS Foundation Trust** has taken the following actions to improve this score and so the quality of its service. The Trust continues to carry out multiple reviews, the reviews occur at 6 weeks and 6 months with the final review being at 12 months. The reviews will be carried out by the joint replacement practitioners unless otherwise identified.

The Trust continues to use the telephone review clinics, thus ensuring that communication remains open with the patient listening and acting upon any issues/concerns that they may have.

Measure	Measure Description	Data Source
3	The data made available to the trust by NHS Digital with regard to the percentage of patients aged— (i) 0 to 15; and (ii) 16 or over. readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.	NHS DIGITAL

Age Group	Value	Emergency readmissions within 28 days of discharge from hospital Apr 2021 to Mar 2022	Emergency readmissions within 28 days of discharge from hospital Apr 2020 to Mar 2021
0 to 15	Trust Score	**12.7**	**13.0**
	National Average	12.5	11.9
	Band	W = National average lies within expected variation (95% confidence interval)	W = National average lies within expected variation (95% confidence interval)
	Highest National	109.6	163.3
	Lowest National	2.7	2.8
16 or over	Trust Score	**11.7**	**14.9**
	National Average	14.7	15.9
	Band	B1 = Significantly lower than the national average at the 99.8% level	B1 = Significantly lower than the national average at the 99.8% level
	Highest National	284.5	322.5
	Lowest National	1.3	1.0

The **North Tees and Hartlepool NHS Foundation Trust** considers that this data is as described for the following reasons. The Trust monitors and reports readmission rates to the Board of Directors and Directorates on a monthly basis. The January 2023 position (latest available data) indicates the Trust has an overall readmission rate of 8.73% against the internal stretch target of 7.70%, indicating the Trust's readmission rates have slightly decreased by 1.06% from the same period in the previous year (9.79% - January 2022).

The **North Tees and Hartlepool NHS Foundation Trust** has taken the following actions to improve the rate and so the quality of its service. The Trust recognises further work is required to reduce potential avoidable readmissions and so a revised process has been agreed which has seen the development of a standardised template to capture data which will be clinically led. Results will be presented to the Learning and Improvement Committee and Business Team. Patient pathways continue to be redesigned to incorporate an integrated approach to collaboration with health and social care services. Initiatives continue including: a discharge liaison team of therapy staff to actively support timely discharge, social workers within the hospital teams to facilitate discharge with appropriate packages of care to prevent readmission; utilisation of ambulatory care and rapid assessment facilities; emergency care therapy team in A&E to facilitate discharge and prevent admissions; community matrons attached to care homes and the community integrated assessment team supporting rehabilitation to people in their own homes including care homes. These actions have seen a significant reduction in stranded patients and delayed transfers of care which have assisted in the successful management of winter pressures.

Measure	Measure Description	Data Source
4	The data made available to the trust by NHS Digital with regard to the trust's responsiveness to the personal needs of its patients during the reporting period.	NHS DIGITAL

Period of Coverage	National Average	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST (out of 100)
2022-23	Not Available	Not Available
2021-22	Not Available	Not Available
2020-21	Not Available	Not Available
2019-20	67.10	62.60
2018-19	67.20	65.20
2017-18	68.60	68.70
2016-17	68.10	67.20
2015-16	69.60	67.70
2014-15	68.90	68.10

*2019-20 & 2020-21 data not available at the time of print

Benchmarked against over North East Trusts for 2019-20;

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

NB: Average weighted score of 5 questions relating to responsiveness to inpatients' personal needs (Score out of 100)

The scores are out of 100. A higher score indicates better performance: if patients reported all aspects of their care as "very good" we would expect a score of about 80, a score around 60 indicates "good" patient experience. The domain score is the average of the question scores within that domain; the overall score is the average of the domain scores. The Trust has worked hard in order to further enhance its culture of responsiveness to the personal needs of patients.

The **North Tees and Hartlepool NHS Foundation Trust** considers that this data is as described for the following reasons. The Trust has developed its Patients First strategy and understanding patient views in relation to responsiveness; and personal needs helps us to understand how well we are performing.

The **North Tees and Hartlepool NHS Foundation Trust** has taken the following actions to improve this score and the quality of its services, by delivering accredited programmes that focus on responsiveness of patient and carers for both registered and unregistered nurses. We use human factors training to raise awareness of the impact and of individual accountability on patient outcomes and experience. When compared against the national average score the Trust continues to be rated well by patients.

Measure	Measure Description	Data Source
5	The data made available to the trust by NHS Digital with regard to the percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	NHS DIGITAL

All NHS organisations providing acute, community, ambulance and mental health services are now required to conduct the Staff Friends and Family Test each quarter.

The aim of the test is to:

- "Encouraging improvements in service delivery" – by "driving hospitals to raise their game"

The Trust believes that the attitude of its staff is the most important factor in the experience of patients. We will continue to work with staff to develop the leadership and role modeling required to further enhance the experience of patients, carers and staff.

National NHS Staff Survey

Question: If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust

	Survey Year					
Trust Name	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	77	83	88	87	84	80
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	58	59	61	66	60	52
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	**67**	**71**	**72**	**74**	**70**	**65**
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	89	90	91	91	85	83
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	69	71	64	76	76	68
GATESHEAD HEALTH NHS FOUNDATION TRUST	81	81	82	80	75	73
SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST			70	71	65	61
North East	72	74	75	78	74	69
England	70	70	71	74	68	63
National High	**86**	**95**	**-**	**92**	**-**	**-**
National Low	**47**	**41**	**-**	**48**	**-**	**-**

Peoples Pulse – Staff

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

	April	July	*Sep	Jan
Percentage Recommended – Care	55%	57%	65%	61%

**From Staff Survey Data*

Work: 'How likely staff would be to recommend the NHS service they work in to friends and family as a place to work'.

	April	July	*Sep	Jan
Percentage Recommended – Work	53%	51%	63%	52%

**From Staff Survey Data*

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

	April	July	*Sep	Jan
Percentage Recommended – Care	69%	67%	79%	67%

**From Staff Survey Data*

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

The **North Tees and Hartlepool NHS Foundation Trust** has taken the following actions to further improve this percentage, and so the quality of its services, by involving the views of the staff in developing a strategy for care. We have a range of opportunities for staff to be involved in develop changes across the organisation which ensures we each have a voice that counts with clear linkage to the NHS People Plan.

National Staff Survey

In the last 12 months I have not personally experienced harassment, bullying or abuse at work from colleagues (National Staff Survey)

2021	*2022	2022 National Average
86.08%	**85.65%**	**81.30%**

*2022 released In March 2023

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

2020	*2021	2022 National Average
64.88%	**63.24%**	**56.00%**

*2022 released In March 2023

Measure	Measure Description	Data Source
6	The data made available to the trust by NHS Digital with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	NHS DIGITAL

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

The VTE data collection and publication is currently suspended to release capacity in providers and commissioners to manage the COVID-19 pandemic. This was communicated via **this letter** on 28th March 2020

Venous thromboembolism (VTE) mandatory training 2022-23	93%

*Data obtained from the Trust training department

Measure	Measure Description	Data Source
7	The data made available to the trust by NHS Digital with regard to the rate per 100,000 bed days of cases of C difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.	NHS DIGITAL

	Rate per 100,000 bed-days for specimens taken from patients aged 2 years and over				
Reporting Period	Trust C difficile cases	*Trust Rate	*National Average	*Highest National rate	*Lowest National rate
*Apr 2022 – Mar 2023	No Data				
**Apr 2021 – Mar 2022	104	67.70	43.73	138.40	0.00
Apr 2020 – Mar 2021	49	16.38	12.27	41.53	0.00
Apr 2019 – Mar 2020	53	13.20	10.71	64.61	0.00
Apr 2018 – Mar 2019	31	16.40	12.20	79.97	0.00
Apr 2017 – Mar 2018	35	17.90	13.70	91.00	0.00
	39	18.80	13.20	82.70	0.00

* 2022-23 numbers as of 30 March 2023, additional detail not available at the time of print
** 2021-22 numbers include Hospital-onset, healthcare associated and Community-onset, healthcare associated

The **North Tees and Hartlepool NHS Foundation Trust** considers that this data is as described for the following reasons. The Trust has a robust reporting system in place and adopts a systematic approach to data quality checks and improvement.

The **North Tees and Hartlepool NHS Foundation Trust** has taken the following actions to improve this rate, and so the quality of its services:

- Enhanced ward cleaning and decontamination of patient equipment, including the use of steam, hydrogen peroxide and Ultraviolet (UV) light.
- Exploration of new patient products such as commodes to ensure they are easy to clean and fit for purpose.
- The continued use of the mattress decontamination service to reduce the risk of infection and improve quality of service to patients.

- Raised awareness and audit of antimicrobial prescribing and stewardship including the identification of antibiotic champions for each directorate and the introduction of competency assessments for prescribers. The Trust again participated in European Antibiotic Awareness day with displays for staff around prudent prescribing. Awareness has also been raised via the CQUIN scheme to reduce overall antibiotic consumption and ensure that prompt review of antibiotics takes place.
- Continued emphasis on high standards of hand hygiene for staff and patients, utilising hand hygiene champions and a monthly RAG report.
- Monitoring of the management of affected patients to support ward staff and ensure guidance is being adhered to.
- The continuation of annual update training in infection prevention and control for all clinical staff.
- Review of all hospital onset cases by an independent panel to ascertain whether the infection was avoidable and to ensure all learning has been identified.
- Collaborative working with partner organisations to standardise guidance and promote seamless care for patients who move between care providers.

The Trust will continue with these measures and will explore every opportunity to minimise C difficile cases in the future.

Measure	Measure Description%	Data Source
8	The data made available to the trust by NHS Digital with regard to the number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	NHS DIGITAL

Reporting and understanding patient safety incidents is an important indicator of a safety culture within an organisation.

Provider: Acute (Non Specialist) – Organisational incident data by organisation in 6-month period, **October 2019 – March 2020**

	Based on occurring dataset (Degree of Harm – All)		National			Our Trust	
			Degree of harm Severe or Death			Degree of harm Severe or Death	
Report period	Number of incidents occurring	Rate per 1000 Bed Days	Average %	Highest %	Lowest %	Number of incidents	%
Oct 19 – Mar 20	**3,820**	**41.60**	**0.16**	**0.49**	**0.01**	**26**	**0.30**
Oct 18 – Mar 19	1,580	16.90	0.16	0.49	0.01	15	0.16
Oct 17 – Mar 18	4,582	44.80	0.15	0.55	0.00	18	0.18
Oct 16 – Mar 17	3,087	29.80	0.15	0.53	0.01	5	0.05

Regional Benchmarking

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

*Data for Oct 19 – Mar 20

The **North Tees and Hartlepool NHS Foundation Trust** considers that this data is as described for the following reasons. The Trust endeavours to foster and promote a positive and open culture of reporting across all teams and services. This is enhanced by encouraging timely reporting of patient safety events and incidents, regardless of level of harm. The Trust has also been reinforcing that the purpose of reporting is to learn and improve; the addition of a "near miss" category within the electronic reporting system has allowed staff to identify when harm may have been avoided because of a safety measure implemented by the staff involved. By gathering this information the Trust can not only interrogate details of events where harm has occurred; but it supports analysis of what "went well" and avoided harm from occurring. The review or investigation of incidents promotes the development of systems and processes to prevent future

patient harm. The quality of the incident reporting is checked at various stages of the reporting and investigation process.

The **North Tees and Hartlepool NHS Foundation Trust** has taken the following actions to improve the proportion of this rate and so the quality of its services. It is acknowledged that a positive safety culture is associated with increased reporting and as such, the Trust continuously monitors the frequency of incident reporting and strives to increase reporting in all areas. The Trust is targeting the reporting of no and low harm incidents, which can provide valuable insights into preventing future incidents of patient harm. In relation to frequently occurring incidents such as falls and pressure damage, the Trust have developed templates within the incident reporting system to identify contributory factors of incidents, identify trends, develop improvements and evaluate the impact of these. For some specific areas there has been additional focus with the identification of strategic leads for falls, pressure ulcers and deteriorating patient, and the relevant improvement work. The leads have developed Assurance Frameworks that help identify areas of focus from the thematic review of the relevant safety events; detailing the control measures that are in place and details of evidence available providing assurance. The frameworks also identify any gaps in evidence where improvement plans are in place in relation to controls or assurance.

All reported incidents are reviewed internally within the local departments for accuracy in regards the level of harm, and there are various processes in place in the organisation to provide assurance that the recorded level of harm reflects the nature of the incident.

The weekly multidisciplinary Safety Panel reviews all incidents of moderate harm or above, the panel agrees the level of investigation and reviews the application of Duty of Candour regulations by the clinical directorates. Where there is any discrepancy, the investigating team are asked to provide further details for review and discussion. In complex cases, where the identification of the required level of investigation is unclear, the incident, and all evidence collated through the investigation to date, is reviewed by the Chief Medical Officer and / or Chief Nurse/Director of Patient Safety and Quality for a decision.

Incidents of significant harm or those identified as serious incidents are currently managed within the National Framework for Serious Incidents. Following the publication of the National Patient Safety Strategy in 2019, the Trust has been reviewing its current policies and processes to support the implementation of the requirements of the new strategy The overall move to the new strategy has been influenced significantly as a result of the Coronavirus pandemic; with the main changes being delayed until 2023-24. The Trust has a project plan in place to support the overall implementation and changes in practices.

On conclusion of a Serious Incident investigation, the weekly Safety Panel reviews and approves the Comprehensive Investigation report and reviews the actions that have been initiated to seek assurance that these will reduce the risk of future recurrence. Once agreed by the panel, the reports and action plans are forwarded to the Integrated Care Board for external review and approval prior to closure. Information in relation to the fundamental contributing factors of an incident, the recommendations made following investigation and improvement actions initiated are recorded on the national Strategic Executive Information System (STEIS). This allows NHS Improvement and the Care Quality Commission (CQC) to review overall learning and identify any trends that may require inclusion in national action.

The Trust works in close collaboration with the local CQC inspectors in relation to incident reporting and regularly communicates in relation to serious incident investigations and also overall trend in incident reporting.

Where an incident does not meet the criteria within the national framework for serious incidents, but the Trust identifies that lessons can be learnt locally within a team or wider across the

organisation, an internal process of investigation is initiated which mirrors the national framework. This proactive approach to safety and quality allows the Trust to internally consider areas of service provision with recourse to escalate more serious concerns if they become apparent through the investigation.

The Trust reports all patient related reported incidents into the National Learning and Reporting System (NRLS), this allows a national view to be obtained in relation to all patient safety incidents reported, regardless of harm level. This national system is to be changed during 2023-24, with a move to Learning From Patient Safety Events (LFPSE) as part of the national strategy; the Trust has been examining the requirements of reporting into the new system and reviewing the current processes and how they will need to change.

The national analysis of this information provides information for NHS Improvement to review and consider where actions need to be taken in relation to national trends in lower level incidents. This analysis can lead to a national safety alert being published; the Trust is fully compliant with all of the National Patient Safety Alerts that have been published in relation to this analysis. Processes are in place to ensure there is continual review of processes in order to provide on-going assurances.

Part 3a: Additional Quality Performance measures during 2022-23

This section is an overview of the quality of care based on performance in 2022-23. In addition to the three local priorities outlined in Section 2, the indicators below further demonstrate that the quality of the services provided by the Trust over 2022-23 has been positive overall.

The following data is a representation of the data presented to the Board of Directors on a monthly basis in consultation with relevant stakeholders for the year 2022-23. The indicators were selected because of the adverse implications for patient safety and quality of care should there be any reduction in compliance with the individual elements.

Patient Safety

Falls

Whenever a "fall" occurs this is recorded per the local incident reporting system. A fall is defined as an unexpected event in which the participant comes to rest on the ground, floor or lower level.

A post falls checklist is completed and is used to help categorise the fall into the classification of No Harm, Low Harm, Moderate Harm, Severe Harm or Death.

Falls with No Harm

During **2022-23** the Trust has experienced **954** falls resulting in No Harm; this has *decreased* from **995** in the 2021-22 reporting period.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019-20	74	90	76	67	87	77	82	67	69	57	64	52	**862**
2020-21	59	55	74	74	74	74	91	85	100	91	78	82	**937**
2021-22	**64**	**76**	**65**	**97**	**106**	**72**	**86**	**79**	**110**	**90**	**75**	**75**	**995**
2022-23	**87**	**84**	**84**	**85**	**106**	**65**	**65**	**81**	**88**	**66**	**71**	**72**	**954**

*Data obtained via the Trust's Incident Reporting database – Mar 23

Falls with Low Harm

During **2022-23** the Trust has experienced **248** falls resulting in Low Harm; this has *increased* from **182** in the 2021-22 reporting period.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019-20	19	21	21	21	20	17	12	17	21	14	19	11	**213**
2020-21	15	8	14	14	16	22	13	17	35	17	16	14	**201**
2021-22	**16**	**28**	**13**	**8**	**7**	**20**	**13**	**14**	**15**	**22**	**12**	**14**	**182**
2022-23	**9**	**13**	**22**	**14**	**29**	**21**	**17**	**27**	**26**	**20**	**23**	**27**	**248**

*Data obtained via the Trust's Incident Reporting database – Mar 23

Falls with Moderate Harm

During **2022-23** the Trust has experienced **19** falls resulting in Moderate Harm; this has *decreased* from **20** in the 2021-22 reporting period.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019-20	1	2	0	0	1	0	0	5	0	1	5	2	**17**
2020-21	0	0	1	1	0	1	1	3	2	1	2	0	**12**
2021-22	**5**	**3**	**2**	**0**	**2**	**0**	**3**	**1**	**1**	**1**	**1**	**1**	**20**
2022-23	**1**	**1**	**0**	**3**	**1**	**0**	**2**	**1**	**4**	**1**	**3**	**2**	**19**

*Data obtained via the Trust's Incident Reporting database – Mar 23

Falls with Severe Harm

During **2022-23** the Trust has experienced **0** falls resulting in Severe Harm; this has *decreased* from **1** in the 2021-22 reporting period.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019-20	0	2	0	2	0	2	0	0	0	0	5	0	**12**
2020-21	0	0	0	0	0	1	1	0	0	0	0	0	**2**
2021-22	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
2022-23	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

*Data obtained via the Trust's Incident Reporting database – Mar 23

The Trust has a robust system in place to understand the background to all falls that result in significant injury; these incidents are shared with staff for future learning.

Falls with Death

During **2022-23** the Trust has experienced **0** falls resulting in Death; this has decreased from ***1*** in the 2021-22 reporting period.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019-20	0	0	0	0	0	0	0	0	0	0	0	0	**0**
2020-21	0	0	0	0	0	0	0	0	0	0	0	0	**0**
2021-22	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**1**
2022-23	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

*Data obtained via the Trust's Incident Reporting database – Mar 23

Reporting for 2022-23 indicates that there has been a slight increase in the number of falls when measured against the same period in 2021-22. Whilst the majority of falls result in no or low harm there has been a slight decrease in moderate harm.

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

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

Never Events

The Trust continues to work hard to improve patient safety therefore stakeholders and the Board wanted to reflect the low numbers of Never Events in the organisation.

Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event.

Since 2016 the Trust has had **10** Never Events and they are broken down as follows:

2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
1	0	1	1	1	3	**4**

The NHS England report can be accessed via:
https://improvement.nhs.uk/resources/never-events-data/

There has been **4** Never Events reported in the period of 2022-23 which were:

- Two cases of wrong site procedure
- One case of an incorrect prosthesis being inserted
- One retained foreign object post-surgery

Effectiveness of Care

Medication Errors

Work is on-going to increase awareness around medicines incident reporting and improve the way we manage the investigation process. The aim of this work is to ensure we learn from medicines incidents; share good practice and ultimately improve our processes and patient safety.

In **2021-22** there were **628** medicines incident reports via the Trust incident reporting system. In **2022-23** there has been **782** incident reports. A small number of these incidents originate from external organisations such as GPs and care homes.

Type of Incidents	2020-21	2021-22	2022-23
Administration or supply of a medicine from a clinical area	301	349	426
Medication error during the prescription process	143	160	188
Preparation of medicines / dispensing in pharmacy	41	57	71
Monitoring or follow up of medicine use	34	48	67
Patient's reaction to Medication	14	7	20
Advice	7	5	8
Supply or use of Over The Counter medicines	0	2	2
Total	**540**	**628**	**782**

* Data from the Trusts incident reporting system

The reporting rate of medication incidents was mostly around 4-5% in 2021/22 and it has improved to 6-7 % in 2022/23. The % of medication incidents that caused severe harm remained at zero from April 2022 to March 2023. High incident reporting rates with low levels of harm is an indicator of good safety culture.

Medicines Safety Committee (MSC), incident learning and control measures in place

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

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

Incident learning and control measures in place

- Trust medication errors are discussed weekly in the Senior Clinical Practitioner (SCP) meeting for awareness/action.
- The quarterly updates of medication incidents are presented in the Patient Safety Council meeting and MSC meeting to highlight incidents trends and themes as well as sharing learning points/ recommendations.
- Quarterly Medicines Safety Hotspots Bulletin that shares national medication safety updates and incident learning in the trust.
- Medication incidents or relevant medicines safety information/initiatives from national and regional MSO (Medication Safety Officer) network will also be shared in the MSC meeting or other platforms as appropriate.
- Liaised with Medicines Optimisation Pharmacist Lead (NENC ICB Tees Valley) about Trust medicines incidents reported onto Safeguard Incident and Risk Management system (SIRMS) by primary care providers to understand the medication incidents occurred at the interface between primary and secondary care.
- Quarterly Trust Controlled Drugs(CD) incident reports submitted to regional CD LIN (local intelligence network) for feedback and monitoring. This provide opportunities for shared learning and support across the locality to work together with the implementation of safety initiatives.
- Review and complete Trust Never event assurance framework/never event proforma around mis-selection of strong potassium solution and insulin overdose due to abbreviation and incorrect device - provides information about current control/risk reduction plan in place (monitoring, planned outcomes and progress evaluation).
- We also collaborate with relevant stakeholders to plan and coordinate actions required by any National Patient Safety Alert in relation to medication across their organisation, with executive oversight. This would help to reduce the medication error risk by having appropriate measures in place.
- Analyse medication incidents themes and prepare Quality and Safety reports for individual ward annually to raise awareness about the key areas of improvements.
- Dissemination of drug alert memo to all clinical areas to communicate risk of medication errors from look-alike sound-alike drugs and supply disruption.
- Contribute to Quality Reference Group (QRG) review of documents for medicines storage/audit/Controlled Drugs (CD) checks - provides guidance on safety measures/escalation process.
- ‘Focus on Feedback’ newsletter- provides information on the lesson learnt from the cases discussed in the Incident Review Panel.

Medicines optimisation nurse is in post to promote safe practice in medicines administration, support ward staff or managers in the analysis of medication related incidents, monitor trends, participate in developing action plans to maximize learning/ reduce recurrence of these errors; and coordinate multidisciplinary work within the trust.

Pharmacy service improvements in promoting medicines safety

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

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

- Improve prescribing by encouraging more standardised prescribing (i.e. units, frequencies, formulary choices, tall man lettering etc.)
- Prioritisation of patients for pharmacy review using drugs classes
- Work ongoing to improve data reporting (including missed doses reports etc.)
- Integration with pharmacy system to reduce the amount of transcription and save time
- Use of Discharge medicines to improve patient safety at discharge
- Work ongoing to digitise paper charts. Warfarin completed, insulin is in development
- Process to move ITU to EPMA has started
- Process to allow infusions to be prescribed on EPMA
- Improvement in the prescribing of transdermal patches

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

The pharmacy department continues to lead on supporting the roll-out of Omnicell cabinets in clinical areas. Omnicell technology provides a real-time solution to support staff in locating critical medicines, with the potential to prevent missed doses and supply medicines in a lean manner.

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

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

- Ongoing work with Informatics Lead Pharmacist to support safer prescribing of medicines, e.g. expanding use of order sets/sentences to reducing errors during the prescribing process, additional cautions/warning with regards to high risk medicines, introduction of questionnaires as a prompt/prescribing aid
- Introduction of a full time ICU Pharmacist to support with the complex patients treated on the unit.
- Expanded use of PharmOutcomes to support DMS project and safer transfer of care back to primary care/community pharmacy where patients have has changes made to their medications.

- New role implemented for a Pharmacist to support the Frailty team. The role is continually growing, but work to date has included active involvement and contribution to the Virtual Frailty Ward round, supporting deprescribing, development of a medication review linked to falls and medication review of frail patients.
- Expansion of OPAT via Accufuser devices to support earlier discharge of patients with the most appropriate IV therapies
- Continuation of and securing of recurrent funding to support the pilot project for ward-based discharge team for Maternity, enabling timely and appropriate discharge, with additional safety checks of VTE scores and appropriate LMWH dose/duration.
- An agreed pilot project to review how a Specialist Pharmacist Prescriber can contribute to the management of patients who are diagnosed/being treated for a TIA.
- Ongoing work to provide an interface between TrakCare and Ascribe, to remove errors during the transcribing process and make the ordering process more lean.

Clinical Effectiveness Indicators

These indicators for Clinical Effectiveness are covered under the section of Effectiveness of Care. The Trust has decided to include more detail around some of the Clinical Effectiveness indicators; this will be built on year on year, including more detailed data around the Monitor Compliance Framework.

For this report the Trust has chosen high risk Transient Ischemic Attack (TIA) and Stroke indicators.

The following table demonstrates the full financial year performance with a benchmark position against 2021-22 data and against the 2022-23 performance target.

	2021-2022 Performance	2022-23 Target	2022-23 Performance
Stroke – 80% of people with stroke to spend at least 90% of their time on a stroke unit	89.59%	**80.00%**	**91.93%**
Percentage high risk TIA cases treated within 24 hours	71.80%	**75.00%**	**59.06%**

*Data from Trust Clinical Effectiveness Team

A decline in performance can be seen in 2022-23 for the ***Percentage high risk TIA cases treated within 24 hours***. Whilst relatively small numbers, general themes are a result of appointment availability and patients unable to make appropriate travel arrangements at short notice. That said all breaches are discussed within the clinical team.

"Well looked after from start to finish, everything explained very clearly, well pleased" [sic]

Patient Experience

Complaints

The Trust continues to work hard to improve customer satisfaction through patient experience.

We do recognise that we don't always get things right and this is why we have a dedicated **patient experience team** to listen to and ensure concerns and complaints are investigated.

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

Number of Complaints – 2022-23

The Trust received **1,573** complaints in 2022-23.

Stage 1 - Informal	1,336	Total 1,573
Stage 2 - Formal	110	
Stage 3 - Formal	127	

*Data for 2022-23 obtained from the Trust Business Intelligence Platform - Yellowfin

2022-23 Complaints by complaint type:

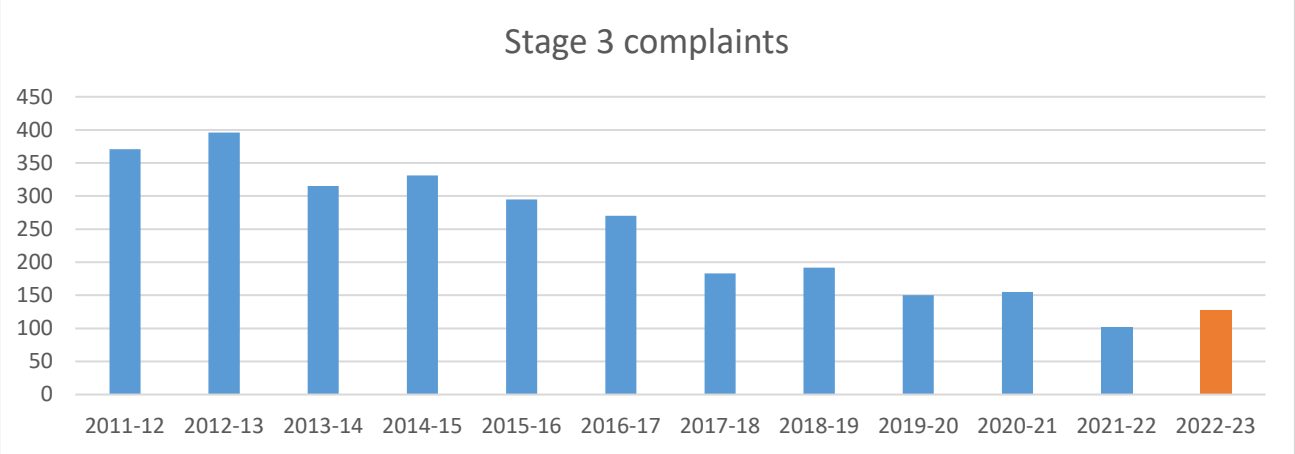
Please see the following breakdown for the Top 10 primary complaint themes from the **127 Stage 3** complaints received in 2022-23

Sub-subject (primary)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Care and compassion	1	2		1	2		3	1	2	1	1		14
Competence of staff member	2	1		2	2		2	1	1		2	1	14
Timeliness of discharge	1	1	1	3				1		1			8
Attitude of staff	1	1	2		2			1					7
Discharge arrangements	1	1		1	1		2			1			7
Treatment and procedure delays		1	1	1	1					2	1		7
Delay to diagnosis	1	1		1				1		1		1	6
End of life concerns incl DNAR		1		2	2	1							6
Incorrect diagnosis		2			1		2	1					6
Communication - Verbal					2	0	1	0		2			5

*Data obtained from the Trust incident reporting system at end of March 2022

Since April 2022, the Trust has received **1,573** complaints of which **127** have requested a formal written complaint response, this equates to **8.07%** of the complaints.

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



*Data obtained from the Trust incident reporting system up to March 2022

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

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

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

Number of complaints

The number of complaints received into the Trust has increased for 2022-23 to 1,516 from 1,404 the previous year. The number of stage 3 complaints has increased for the year from 102 for 2021-22 to 125 for 2022-23. Stage 3 complaints accounted for 8% of the total complaints received during 2022-23 indicating the vast majority of complaints are managed locally as a Stage 1 concern with faster resolution for complainants or a Stage 2 meeting.

Complaints upheld by Trust

The number of Stage 3 complaints upheld is below:

Upheld – 13
Partly upheld – 68
Not upheld – 30
Open - 14

Referred to PHSO

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

Complaints upheld by PHSO

During 2022-23 there were no cases upheld during this financial year.

Action taken to improve services

The Trust takes all complaints raised seriously and actions are taken to improve service issues identified. The most common theme identified from complainants for 2021-22 was staff attitude.

Patient feedback from Friends and Family Test, Compliments and Complaints are discussed weekly in forums attended by senior staff from all Care Groups. This ensures areas of concern are addressed immediately. Where there are concerns regarding specific staff such as their attitude/communication with service users and relatives then this is investigated and raised with staff directly, via their line manager. Additionally, the Trust are rolling out leadership courses as part of a 3 year leadership strategic plan. The training is for all staff leaders, regardless or role or grade or whether they have a formal position to manage or lead people, with the initial session titled 'It all Starts with me', to develop leadership awareness, skills, knowledge and behaviour.

The Trust are currently reviewing the Complaint process in line with the PHSO Complaint Standards Framework to improve the process from a patient's perspective. Progress is well underway with an Improvement Panel in place and the introduction of a senior quality lead for

each Stage 3 written response. Early indications from the evaluation of Stage 3 show that the length of time to investigate has been significantly reduced. Completion of the review of the remaining processes is due for completion by the end of Quarter 2 2022-23.

Complaint training has been delivered by an external company to key stakeholders within the organisation with further sessions arranged. In addition, all staff involved in complaint management will have the opportunity to attend Complaint training which is due to be rolled out by the PHSO.

The revised Complaint process will ensure the Trust comply with the PHSO Standards which are based on the NHS Complaint Regulations 2009.

Compliments

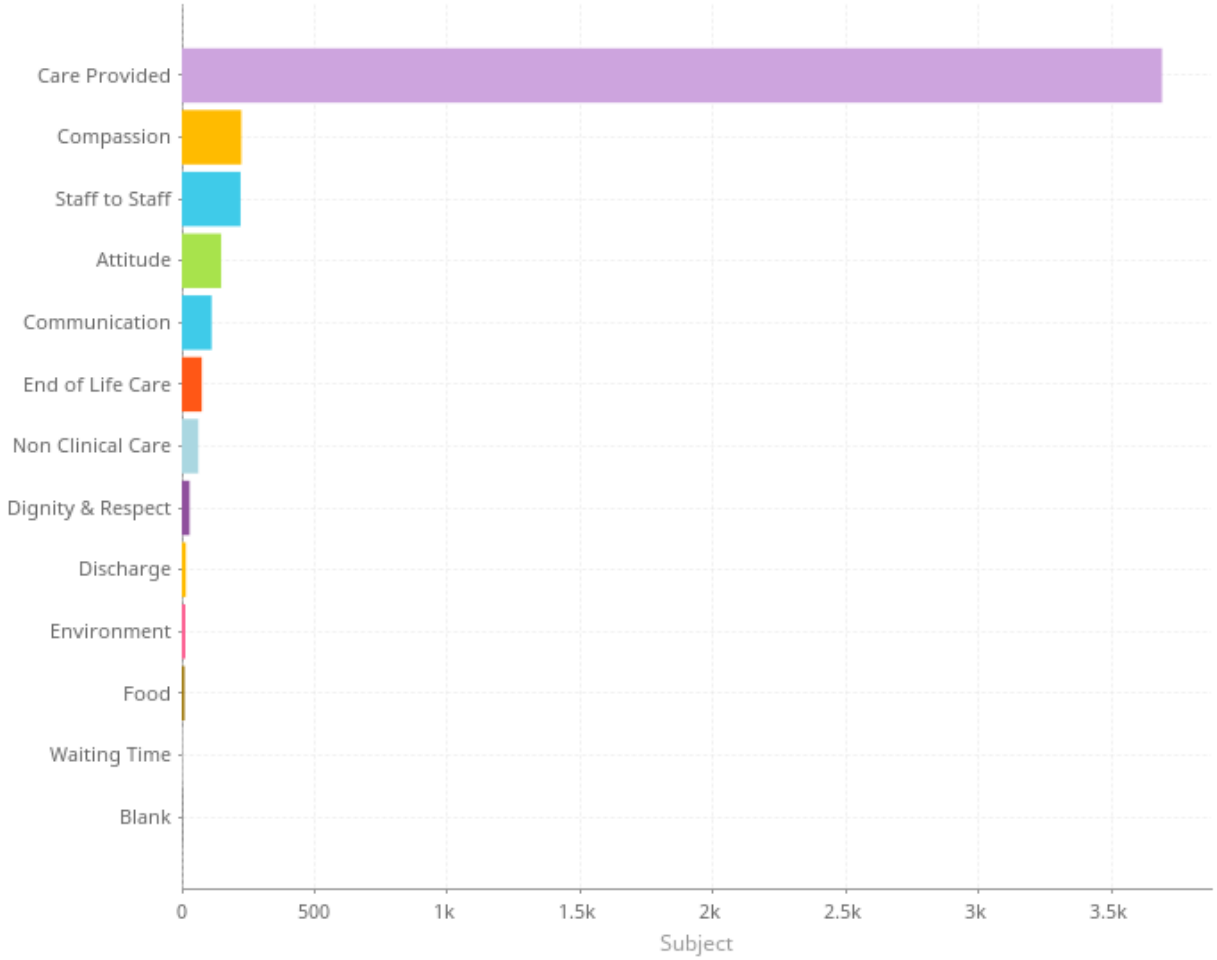
The Trust records the number of **compliments** received within each area. The trends in the number of compliments received can be seen in the following table and chart.

Financial Year	Number of Compliments
2020-21	2,087
2021-22	4,071
2022-23	**4,604**

*Data obtained via the Trusts Compliments (PALS) module within the Trust incident reporting system.

"Every member of staff is so welcoming and helpful, from the moment you walk in the door. The whole hospital is immaculate, cleanliness is very very good" [sic]

Compliment Subject



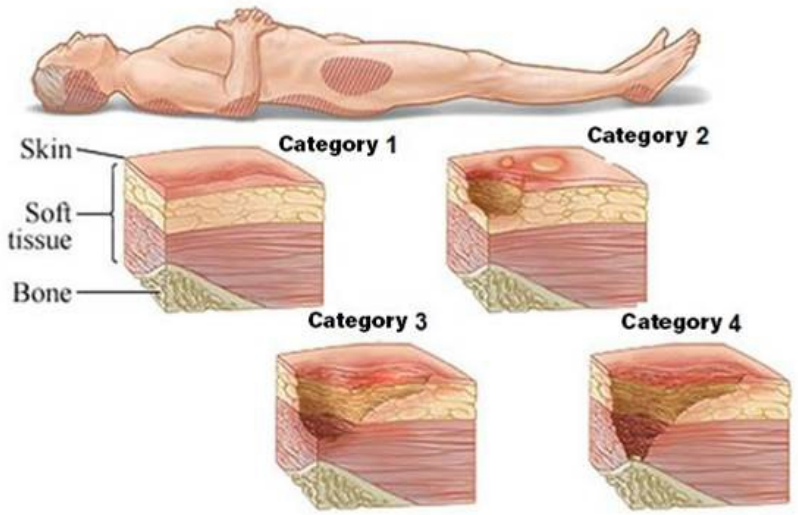
To improve the numbers and qualitative data around compliments, the Trust has established a Greatix system within the existing incidents platform to capture the relevant data.

"Very nice welcoming hospital. Always treated politely by staff in all sectors. Keep up the good work." [sic]

"Thank you so much for all the care and attention given to me during my hospital stay. Your care and dedication is second to none" [sic]

Pressure Ulcers

Pressure ulcers, also known as **pressure sores**, **bedsores** and **decubitus ulcers**, are localized damage to the skin and/or underlying tissue that usually occur over a bony prominence as a result of **pressure**, or **pressure** in combination with shear and/or friction.



Year on Year Comparison – In-*Hospital Acquired*

Reporting Period	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Category 1	39	38	54	92	64	48	74
Category 2	128	189	198	299	233	272	231
Category 3	9	20	35	34	14	16	19
Category 4	1	2	2	3	3	2	0
Total	**177**	**249**	**289**	**428**	**314**	**338**	**324**

*Data obtained via the Trusts Incident Reporting database. 2022-23 figures (Apr 2022 - February 2023)

Year on Year Comparison – Out of Hospital *Acquired*

Reporting Period	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Category 1	68	159	55	59	50	41	39
Category 2	253	359	173	152	128	153	103
Category 3	36	85	69	75	46	51	40
Category 4	5	21	9	19	12	14	8
Total	**362**	**624**	**306**	**305**	**236**	**259**	**190**

*Data obtained via the Trusts Incident Reporting database. 2022-23 figures (Apr 2022 - February 2023)

Actions taken by the Trust:

Pressure damage is one of the top five reported incidents within the Trust; with risk assessment, prevention and management being guided through the application of NICE guidelines and quality standards. The incidents are reported via the Trust incident reporting system and the Trust has developed a checklist within the system to capture the overall data in relation to pressure ulcer incident reporting. The checklist also supports colleagues reviewing such incidents by providing a consistent approach towards decision making in relation to the level of investigation required.

All pressure related incidents are validated, by the Tissue Viability Nurses. The numbers of pressure ulcer incidents are discussed at the Senior Clinical Professionals Huddle each week and monitored through the Tissue Viability Operational Group and throught the Quality Reference Group as part of the Clinical Quality Arrurance Framework and the sharing of best practice and learning informs the monthly Leadership Council.. The secondment of a new Band 6 Skin Integrity Nurse has promoted a focus on improving education and training to improve validation of pressure ulcers, compliance with risk assessment and care planning. The Skin Integrity nurse is able to support clinical staff at the point of care and is guiding wards to take part in the Skin Integrity Collaborative that is currently taking place on four inpatient wards. Future plans for 2023-24 include extending the collaborative to more inpatient areas to ensure that harm to patients is prevented and outcomes are improved.

The Tissue Viability Operational Group has the remit of reviewing the Trust's functioning programs of improvement, Trust policies and guidelines. Quarterly audits by the directorates are undertaken and the TVN and quality teams are looking at enhancing the use of internal audit data, presented on the Trust dashboards, to continue to improve quality. An annual pressure ulcer prevalence audit is also undertaken for patients on the community nurse caseload and patients in hospital in-patient beds. Following the moderation of results, an improvement plan is negotiated with the Care Group Leads to provide assurance that there is evidence of continuous improvement and performance. The Trust continues to focus on quality improvement, with an aim to improve patient, relatives and carers outcomes and experiences at its heart. Therefore, as part of this journey the Trust has developed a Pressure Ulcer Assurance Framework which aims to drive and demonstrate progression of excellent practice within pressure ulcer prevention as well as identifying any areas of improvement needed. Staff continue to be educated and empowered through ongoing support to reduce unwarranted variation and provide the very best care to every patient, every day. The agenda for pressure ulcer prevention is underpinned by evidence, research and best practice with measurable outcomes ensuring we do the right thing at the right time. The TVN team are also participating in the 2023-24 CQUIN (12) in the aim to continue to evaluate the care that we provide and reduce the number of pressure ulcers nationally.

Education remains a key focus for the Tissue Viability Team, so working with the clinicalstaff and managers is critical in the maintenance of a network of Tissue Viability Champions who meet for updates on wound care and all matters related to tissue viability. This meeting is alternative months and is well attended. The training topics at the meeting are chosen by the Champions themselves and delivered by either the Tissue Viability team or colleagues from the wound care industry, they also align to elements of the new competency framework. The competency framework, developed by the TVN team aims to enhance the skills of the TVN champions and provide specialist skills to their clinical areas. The annual "Stop the Pressure" event was again very successful in November 2022 with a well-circulated campaign. The "Stop the Pressure" event will be repeated in 2023 and the team hope to be able to showcase the Skin Integrity Collaborative work that has been ongoing in two ward areas. There are information and resources for staff available on the Trust intranet site which provides advice to staff on a full range of tissue viability topics. The tissue viability "Learning Hub" continues to develop with key topics being showcased via video links from the intranet site. The TVN team offer planned and bespoke training events throughout the year on a rolling program to address the needs of the developing workforce. There has also been some newly developed sessions with combining training of different types to maximise attendance. A measure of the success of the training delivered by the TVN team, and industry, is reflected by very complex wounds being managed in the community that would not have been possible to manage a decade ago, and in-patients quickly being commenced on correct treatment plans without the need of direction of the TVN team members - as the skills now exist in the workforce.

Communication between services continues to be improved in order to provide seamless holistic care for our patients moving between hospital and community. A key element of this is ensuring

wound care information is passed onto the next care provider. The Tissue Viability service have developed their SystmOne functionality to allow those that are able to access the patients' health care record to see the input of the TVN team regardless of which clinical area the patient is in when they are seen by the TVN team. This has already helped with continuity of care for these patients that move between services. The TVN team continue to explore further ways of enhancing communication between services.

The Trust has moved to a new pressure ulcer risk assessment tool, Purpose T. A robust training plan has been delivered to staff members across the trust in the new risk assessment tool (Purpose-T), including ESR training programs and voice over training presentations, as well as planned question and answer sessions to ensure the workforce are comfortable with the new risk assessment tool before implementation. The risk assessment tool benefits the patient by delivering patient centred care and allows the assessor to select the appropriate care plans and equipment with the aid of the equipment selection guideline.

Section 3b: Performance from key national priorities from the Department of Health Operating Framework

Appendix B of the compliance framework

The Trust continued to deliver on key cancer standards throughout the year; two week outpatient appointments, 31 days diagnosis to treatment and 62-day urgent referral to treatment access targets. The Trust demonstrated a positive position with evidence of continuous improvement against the cancer standards introduced in the Going Further with Cancer Waits guidance (2008).

www.connectingforhealth.nhs.uk/nhais/cancerwaiting/cwtguide7.pdf

The compliance framework forms the basis on which the Trusts' Annual Plan and in year reports are presented. Regulation and proportionate management remain paramount in the Trust to ensure patient safety is considered in all aspects of operational performance and efficiency delivery. The current performance against national priority, existing targets and cancer standards are demonstrated in the table with comparisons to the previous year.

Single Oversight Framework Indicators	Standard/Trajectory	2022-23 Performance	2021-22 Performance	Achieved (cumulative)
Cancer 31 day wait for second or subsequent treatment – surgery (Apr 22 to Mar 23 Provisional)	94%	91.77%	92.43%	X
Cancer 31 day wait for second or subsequent treatment – anti cancer drug treatments (Apr 22 to Mar 23 Provisional)	98%	99.25%	99.71%	✔
Cancer 62 Day Waits for first treatment (urgent GP referral for suspected cancer) (Apr 22 to Mar 23 Provisional)	85%	60.97%	76.89%	X
Cancer 62 Day Waits for first treatment (from NHS cancer screening service referral) (Apr 22 to Mar 23 Provisional)	90%	84.84%	86.94%	X
Cancer 31 day wait from diagnosis to first treatment (Apr 22 to Mar 23 Provisional)	96%	95.64%	97.41%	X
Cancer 2 week wait from referral to date first seen, all urgent referrals (cancer suspected) (Apr 22 to Mar 23 Provisional)	93%	86.62%	90.95%	X
Cancer 2 week wait from referral to date first seen, symptomatic breast patients (cancer not initially suspected) (Apr 22 to Mar 23 Provisional)	93%	92.94%	92.32%	X
Maximum time of 18 weeks from point of referral to treatment in aggregate, patients on incomplete pathways (Mar-23)	92%	78.36%	85.58%	X
Referral to Treatment 52 Week Waits (Mar 23 frozen)	0	38	45	X

Number of Diagnostic waiters over 6 weeks (Apr 22 to Mar 23 Provisional)	99%	75.04%	92.25%	X
Community care data completeness – referral to treatment information completeness (Arp 22 to Feb 23)	50%	97.61%	97.64%	✔
Community care data completeness – referral information completeness (Apr 22 to Feb 23)	50%	96.81%	97.06%	✔
Community care data completeness – activity information completeness (Apr 22 to Feb 23)	50%	94.61%	97.51%	✔
Community care data completeness – patient identifier information completeness (Shadow Monitoring) (Apr 22 to Feb 23)	50%	94.61%	97.51%	✔
Community care data completeness – End of life patients deaths at home information completeness (Shadow Monitoring) (Apr 22 to Feb 23)	50%	84.49%	83.79%	✔
Compliance with access to healthcare for patients with learning disabilities	100%	Full compliance	Full compliance	✔
Other National and Contract Indicators	**2020-21 Target**	**2022-23 Performance**	**2021-22 Performance**	**Achieved**
Cancelled Procedures for non-medical reasons on the day of op (2022-23)	0.80%	0.44%	0.46%	✔
Cancelled Procedures reappointed within 28 days (Apr 22 to Feb 23)	100%	79.52%	91.17%	X
Eliminating Mixed Sex Accommodation (2022-23)	Zero cases	0	0	✔
A&E Trolley waits > 12 hours (2022-23)	Zero cases	172	40	X
Stroke – 90% of time on dedicated Stroke unit (Apr 22 to Feb 23)	80%	91.93%	89.59%	✔
Stroke – TIA assessment within 24 hours (Apr 22 to Feb 23)	75%	59.06%	71.88%	X
VTE Risk Assessment (Apr 22 – Mar 23)	95%	95.84%	94.46%	✔
Sickness Absence Rate (Feb 2023)	4.0%	5.80%	6.44%	X
Mandatory Training Compliance (Mar 2023)	90%	86.90%	89.19%	X
Turnover Rate (Mar 2023)	10.0%	9.94%	12.10%	✔

Operational Efficiency Indicators	2020-21 Target	2022-23 Performance	2021-22 Performance	Achieved
New to Review Ratio (Apr 21 – Feb 22)	1.45	1.3	1.25	✔
Outpatient DNA (Combined) (2022-23)	9.20%	9.96%	8.24%	X
Length of Stay Elective (Apr 21 to Mar 22)	3.14	2.10	2.03	✔
Length of Stay Emergency (Apr 21 to Mar 22)	3.35	3.39	3.55	X
Readmission Elective (Apr 22 to Jan 23)	0.00%	3.96%	4.22%	X
Readmission Emergency (Apr 22 to Jan 23)	9.37%	12.53%	13.66%	X
Occupancy (Trust) (Apr 22 to Mar 23)	85%	92.96%	89.91%	X
Quality Indicators	**Standard/Trajectory**	**2022-23 Performance**	**2021-22 Performance**	**Achieved**
Clostridium Difficile – variance from plan (objective) (Apr 22 – Mar 23)	54	47	50	✔
Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia (Apr 22 – Mar 23)	0	2	0	X
Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia (Apr 22 – Mar 23)	30	46	38	X
Escherichia coli (E.coli) (Apr 22 – Mar 23)	73	86	78	✔
Klebsiella species (Kleb sp) bacteraemia (Apr 22 – Mar 23)	21	26	15	X
Pseudomonas aeruginosa (Ps a) bacteraemia (Apr 22 – Mar 23)	12	15	14	X
Trust Complaints - Formal CE Letter (Stage 3) (Apr 22 – Mar 23)	<110	92	102	✔
Trust Falls with Moderate Harm (Apr 22 – Mar 23)	<25	19	20	✔
Trust Falls with Severe Harm (Apr 22 – Mar 23)	<5	0	1	✔
In Hospital Pressure Ulcers Grade 4 (Apr 22 – Mar 23)	1	0	1	X
Medication Error (Apr 22 – Mar 23)	<615	782	617	X
Friends and Family Test - Very Good/Good (Apr 22 – Mar 23)	95%	92.87%	92.36%	X

Never Events (Apr 22 – Mar 23)	0	2	3	X
Hand Hygiene (Apr 22 – Mar 23)	95%	97.31%	97.58%	✔
Hospital Standardised Mortality Ratio (HSMR) (Feb 22 – Jan 23)	< 102	92.91	85.28	✔
Summary Hospital-level Mortality Indicator (SHMI) (Nov 21 – Oct 22)	< 102	96.56	96.12	✔

Additional Assurance:

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

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

Annex A: Third party declarations

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

Commissioner Statement – June 2023

Commissioner Statement from North East and North Cumbia Integrated Care Board (NENC ICB) North Tees and Hartlepool NHS Foundation Trust Quality Account 2022-23

The Integrated Care Board commissions healthcare services for the population of Darlington, Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton-On-Tees. The Integrated Care Board take seriously their responsibility to ensure that the needs of patients are met by the provision of safe, high-quality services and therefore welcome the opportunity to submit a statement on the Annual Quality Account for North Tees and Hartlepool NHS Foundation Trust (NTHFT).

The quality of services delivered, and associated performance measures are the subject of debate and discussion at the Clinical Quality Review Group (CQRG) meetings. The meetings are well attended and provide an opportunity to gain assurance that there are robust systems in place to support the delivery of safe, effective and high-quality care.

The Integrated Care Board are pleased to note from the 2022/23 Quality Account that the Trust continues to be a strong performer in relation to the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) mortality values. The values continue to report within the 'as expected' range and below the national average. Furthermore, the Trust established a clinical link between consultants and the Trusts Coding Department, this work throughout 2022-23 continues to reap great rewards in respect of depth of coding and has provided greater understanding of patient's level of sickness.

The Integrated Care Board would like to express gratitude to staff who continue to contribute towards maintaining this position in challenging times of COVID-19 recovery work and industrial action. Commissioners will continue to provide robust scrutiny and challenge in relation to mortality outcomes during 203/24 and will continue working with the Trust to identify opportunities for shared learning across the health economy.

The Integrated Care Board acknowledge the extensive work the Trust has undertaken in relation to Dementia care including the development of a new North Tees and Hartlepool Dementia Strategy, which will monitor improvements through National audit of dementia reports and feedback from carers and patients living with dementia. The Trust has also effectively implemented dementia training, continued the HEE framework dementia

champions course, participating in National Audit and worked collaboratively with the Trusts across the Northeast and Cumbria. The Trust's intention to continue this work throughout 2023/24 is noted and the Integrated Care Board look forward to seeing the impact of this work over the coming year.

Mental Health remains a priority for the Trust, the Integrated Care Board acknowledges the focus upon a change in staff culture and the initiatives the Trust aim to implement this. The Commissioners highly anticipate the outcomes from the Trust's three key objectives, ensuring that mental health is centrally focused on all aspects of health care.

The Integrated Care Board acknowledges the work the Trust continues to embed and showcase in relation to Safeguarding both Adults and Children. There are robust systems insitu, that the Integrated Care Board endeavours to rigorously monitor. Noted that the Trust now has the services of an Independent Domestic Violence Advisor and that the Domestic Abuse policy had been updated to reflect the changes within the Domestic Abuse Act 2022. Furthermore, the Trust has reflected upon the learning gained from Rapid Reviews to ensure that the Child not Brought policy also encompasses appointments that are frequently scheduled.

The Integrated Care Board welcomes the review of the Safeguarding Children's Policy and additionally, the Bruising in Immobile Babies Policy which is currently being appraised and how this transcribes into clinical assessment. The Integrated Care Board is pleased to note the compliance figures for Safeguarding Children clinical supervision. Encouragingly, the Trust continue to respond to the recommendations identified from the CQC report 'Not Seen, Not Heard' which are embedded within the Safeguarding Children's Foundation, yearly update and e-learning training including prompts within assessment to include the 'voice of the child'.

Other key achievements that the Integrated Care Board are encouraged to read is the induction of the Child Protection Medical Suite to support children, their families and professionals having to undergo Child Protection Medicals. The delivery of the Genital Injuries Training was delivered in September 2023 following the introduction of the Genital injuries' pathway in response to local learning. This pathway is now fully embedded to support both Child Young People Emergency Department / Paediatricians and Gynaecology staff to understand risks and appropriate response and assessment needs for children who attend with Genital injuries, aligning with the Forensic network guidelines.

The Trust, continue to promote joint working with Adult and Children's Safeguarding within the provision of training to include Domestic Abuse, Female Genital Mutilation (FGM), Prevent, Forced Marriage and Modern Slavery and Trafficking. Additionally the Adult Vulnerability Committee and Children's Steering Group have been brought together into the Safeguarding Committee to facilitate the 'Think Family' approach at a Strategic level.

The Integrated Care Board recognises the Trust reporting system in relation to the recording of Safeguarding concerns. There has been 660 concerns the Trust has been involved with in 2022-23, the Trust raised 453 (12% increase) of these concerns. This trend demonstrates that there has been an increase in concerns in 2022-23. Noted, one area of increased incidents involves Domestic Violence which links to the work the Trust is implementing, and the Integrated Care Board welcomes the results of this.

The Children's Safeguarding Work Program sets out the work for the year including, action plans from Rapid Reviews / Children's Safeguarding Practice Reviews, learning lesson reviews, Domestic Homicide Reviews and any internal incidents and the safeguarding children annual audit and assurance programme. The Integrated Care Board, also welcomes

additional key priorities including the review of out of hours multiagency professional challenge pathway,

The Trust's management and reporting systems in relation to infections are clearly outlined within the report and the Integrated Care Board are encouraged to read that the Trust also undertake a multidisciplinary Root Cause Analysis (RCA) within 3 working days for all Trust attributed cases.

Post COVID-19, the Trust are now reporting all healthcare-associated cases regardless if the onset was in hospital or in the community. This is in line with the criteria that is used for *Clostridioides difficile*, which means that data from 2022-23 is the first comparable data that the Trust is able to showcase. The Integrated Care Board notes that the trajectory set for 2022-23 for *Clostridioides difficile* was reduced from 64 cases to 54. Currently the Trust is reporting 48 trust-attributable cases for the 2022-23 period. Actions to reduce *Clostridioides difficile* are within an integrated Health Care Associated Infection improvement plan and Board Assurance Framework (BAF) covering all infections and practices and is reviewed quarterly. Progress against the plan is reported to the Healthcare Associated Infection Operational Group and Infection Control Committee and is regularly shared and discussed with commissioners.

The Trust has also reported two hospital-associated cases of MRSA bloodstream infection and an increase of *Methicillin-Sensitive Staphylococcus Aureus* (MSSA) cases to 47. Escherichia coli cases, at present, are 87, which disappointingly is higher than the set trajectory of 73. In relation to *Methicillin-Sensitive Staphylococcus Aureus*, the Integrated Care Board is encouraged that the Trust has analysed each case and that a high proportion of cases were difficult to prevent. However there has been a link to chest or hepatobiliary sources with an increase in those associated to intravascular devices. Therefore the Trust have commenced dedicated work on cannula insertion, maintenance and early removal of devices, which supports antibiotic stewardship, with IV to oral antibiotic switches and a move to non-ported intravascular devices with the intention of reducing infections supported with a robust education and training package for staff. The Integrated Care Board welcome this focused piece of work and highly anticipate the outcome of this within the coming year.

The threshold set for 2022-23 for *Klebsiella* Species was reduced from 24 cases to 21 and unfortunately the Trust is reporting 28 healthcare-associated cases for the 2022-23 period. Similarly, the base set for 2022-23 for *Pseudomonas Aeruginosa* was increased from 11 cases to 12 and currently the Trust is reporting 15 healthcare associated cases for the 2022-23 period.

Positively, the number of catheter-associated urinary tract infections (CAUTI) has reduced to 209 which is a welcome reflection on the continuous work the Trust has implemented. The Integrated Care Board highly anticipates the Trust's initiatives to promote early removal of catheters and ensuring that diagnostic testing and antibiotic prescribing is in line with recommended national guidance. The Trust recognises that despite there not being any set targets, a reduction in CAUTI will have a positive impact on the gram-negative bacteraemia cases.

Between 17 March 2020 and 31 March 2023, the Trust had 6,139 number of COVID-19 positive patients and sadly 790 deaths. The Integrated Care Board recognises that the Trust still experiences a number of COVID-19 positive patients (36 at the end of March 2023) and now the focus has shifted towards continuing to implement the NHS recovery plan whilst ensuring the learning from deaths are identified and applied into practice.

The Integrated Care Board are pleased to note the overall improvement work the Trust have undertaken in relation to the deteriorating patient and learning from deaths. The Trust has showcased extensive work that spans across critical care, palliative care, paediatrics, maternity and surgery.

The Trust have also demonstrated that they were a recognised outlier regarding National Emergency Laparotomy (NELA) audit in that patient who have a NELA score of >5% should be admitted to a level 2 facility >85% of the time. Encouragingly, a collaborative approach between surgery and anaesthetics have seen important improvements and have consistently exhibited >95% compliance.

The Integrated Care Board highly anticipates the Trust's future aspirations which include the reinforcing the Learning from Deaths team with administrative support and involvement of performance and business intelligence, concentrate on the practicalities of review process – IT support, available space, suitable remuneration/adjustment of job plans to allow reviewers to participate. Additionally commence the process for the completion of reviews by the SJRplus process which is already implemented in neighbouring Acute Trusts with plans for utilisation in Mental Health). Furthermore the SJRplus Dashboard to be linked to PowerBI to allow performance data and reports to be generated for review of progress.

Priority two: Effective in Care comprised of the Trust ensuring that all patients had a safe and timely discharge. The Integrated Care Board notes that the Trust and partners in Social Care have worked collaboratively to implement the discharge policy with the aim to reduce delayed transfers of care. The Trust interagency discharge policy has been reviewed and was ratified on 14/06/22.

The Integrated Care Board are encouraged to note that there have been a range of new initiatives that supports patient flow across the Acute to Community services working in collaboration with system partners including Integrated Coordination Centre (ICC) and the Optimised Patient Tracking and Intelligent Choices Application-(OPTICA). In conjunction, the Trust has implemented the Help Force – Home but not alone scheme, Virtual Frailty ward and are working with North East Ambulance Service (NEAS) in the implementation of a new pathway to utilise an urgent community two hour response teams with the ambition to stop unnecessary ambulance conveyance to the Acute Trust.

The Integrated Care Board are encouraged to receive the updated outcomes the Trust have implemented to ensure that the Accessible information standard is met and all of the services that are provided have reasonable adjustments for those in need. The introduction of an Accessibility Group, an e-learning package to increase staff awareness and the initiation of 18 Accessibility Champions are several initiatives the Trust have implemented to meet this standard.

The Integrated Care Board are assured to note that the Trust continue to monitor the number and category of Violent Incidents via their Incident Reporting system. The Integrated Care Board acknowledge that the number of incidents has significantly increased which is attributed to changes within the reporting criteria.

The Integrated Care Board are encouraged by the implementation of The Safety and Quality Dashboard to assist in the close monitoring of nurse sensitive patient indicators and its role to support communicating best practice and a rapid review of any possible areas of concern.

The Trust and the Stakeholders have identified Palliative Care and Care For the Dying Patient, Priority Three, that focuses on the Care For the Dying Patient (CFDP) and Family's Voice documentation needs remain as a Priority for next year. The Integrated Care Board appreciate the initiatives the Trust has implemented including the introduction of an End of Life Care facilitator role, a new referral criteria for the Specialist Palliative care team and an evidence based triage tool, to ensure that patients and / or their next of kin are assessed in a opportune and standardised way.

Encouragingly the Trust has showcased their collaborative working with local hospices and the Integrated Care Board welcome these partnerships and look forward to the potential benefit this may have for the local population. The Integrated Care Board also acknowledge that the Trust have participated in the National Audit of Care at the End of Life (NACEL) for 2022/2023. The results are to be cascaded throughout the organisation and themes to form the education delivery and quality initiatives.

The Integrated Care Board acknowledges that the Trust utilises several means of collating staff and patient feedback about the services provided. The Trust recognises that there are several areas of practice that could be improved and the Integrated Care Board are encouraged that there is a robust system in place to ensure that this addressed.

The Integrated Care Board acknowledge the Trust's Priorities for 2023/4 are

Patient Safety

- Mortality
- Dementia
- Mental Health
- Safeguarding (Adult & Children's)
- Maternity
- Infections

Effectiveness of Care

- Discharge
- Processes Safety and Quality Dashboard
- Learning from Deaths
- Violent Incidents
- Accessibility

Patient Experience

- Palliative Care & Care For the Dying Patient (CFDP)
- Is our care good? (Patient Experience Surveys
- Friends and Family Test

The Integrated Care Board are pleased to note the Trust participated in 94% of national clinical audits and 100% of national confidential enquired which it was eligible to participate in. Future clinical audit work is welcomed, and the ICB looks forward to seeing those outcomes in due course.

The Trust was inspected by the Care Quality Commission (CQC) under the new regime of inspection during May 2022. The CQC inspection looked at five domains, asking are

services safe, caring, responsive, effective and well-led and rates each of them from inadequate, requiring improvement, good and outstanding. The overall CQC rating from the recent inspection is **'Requires Improvement'**. The Integrated Care Board supports the work the Trust continues to implement within those areas and anticipate the associated outcomes.

It is disappointing to note that the Trust has had **four** Never Events reported in the period of 2022-23.The Integrated Care Board acknowledge the work the Trust is undertaking as a result of the learning identified within these events and all Serious Incidents. Additionally the Trust is to be commended for it's positive and open culture of reporting across all teams and services. of all patient safety events and incidents, regardless of level of harm.

The Trust received 1,573 complaints in 2022-23 which is an increase from previous years, it is however encouraging that the Trust are currently reviewing the Complaints process in line with the Parliamentary and Health Service Ombudsman (PHSO) Complaint Standards Framework to improve the process from a patient's perspective. The Integrated Care Board commends the Trust in the increase of compliments received and the establishment of the Greatix system to encapsulate relevant qualitative information.

The Integrated Care Board acknowledges the varying results in terms of Pressure Ulcers and welcomes the associated work in the overall reduction of numbers with education for all staff being pivotal. The Integrated Care Board welcomes the opportunity to review this within the Clinical Quality Review Group meetings

The Integrated Care Board can confirm that, to the best of their ability, the information provided within the Annual Quality Account is an accurate and fair reflection of the Trust's performance for 2022-23. It is clearly presented in the format required and contains information that accurately represents the Trust's quality profile and is reflective of quality activity and aspirations across the organisation for the forthcoming year.

Yours sincerely,

Chris Piercy
Director of Nursing
NENC ICB (Tees)

Annie Topping
Director of Nursing
NENC ICB (Durham)

Hartlepool Healthwatch – June 2023

Healthwatch Hartlepool – Response to Annual Quality Account of

North Tees and Hartlepool NHS Foundation Trust

First, may I put on record our sincere thanks for providing Healthwatch Hartlepool with such a detailed presentation in respect of the Trust's Quality Accounts earlier this year prior to the publication of the Draft Quality Accounts 2022 - 23.

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

Overall members felt that the information provided was incredibly informative. Our members suggested that 'Accessibility' would be a welcome addition to future publications under 'Effectiveness of Care'. One of the long-standing issues we wish to alert the Trust to again is concerns around communication that was accepted when we published our report into hospital discharge. We would wish to highlight that performance monitoring in respect of transfers of care needs to feature within the account going forward as at present only discharge from final destination hospital is monitored when some patients could have had a lengthy stay in hospital prior to being transferred to another hospital for treatment.

Our members were concerned regarding admission of patients with a diagnosis of dementia/delirium. They could see data suggested this was increasing they were still not at the levels pre covid.

Communication could be improved around signage at the hospital sites to reflect actual the wards and purpose. There is a need for appropriate & improved signage for patients especially those living with a disability. Access routes should be clearly identified and appropriate signage displayed / use of plain English and easy read where possible; accessible toilets/changing places conveniently located to promote dignity and independence. We also would request that a greater emphasis need to be made on ensuring the availability of patient leaflets and equality of access to patients who may be Deaf/ Blind /Visually impaired or with dual sensory loss.

Finally, we would like to seek a review of the Friends & Family forms. At present these are not issued to patients who have previously had an admission/appointment within 14 days or been subject to a transfer of care. There needs to be some flexibility as to when it may be appropriate to issue such forms especially for in patient care that results in a transfer rather than a discharge. Also, for those patients who may have a dual diagnosis and have multiple appointments but for differing departments.

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

Yours Sincerely,

Christopher Akers-Belcher

Chief Executive - Healthwatch Hartlepool

Stockton Healthwatch – June 2023

Healthwatch Stockton-on-Tees are pleased to provide feedback on the 2022/23 Quality Accounts and note the achievements and the clear useful data explaining how North Tees and Hartlepool NHS Foundation Trust is performing against other Trusts in the region and nationally. The report is comprehensive and provides an excellent overview of how the Trust demonstrates quality of healthcare, its general performance and how it manages its services. It was pleasing to note that the Trust has maintained ongoing involvement with Healthwatch Stockton-on-Tees and taken account of our thoughts and recommendations where they were helpful.

We noted the Covid-19 pandemic having had a considerable impact on the management and staffing across the Trust and we share our sincere condolences with the families and friends of those affected.

We were disappointed to see the Trust had a recent CQC inspection which moved their "Good" overall rating to one of "Requires Improvement" and this is disheartening as last year there was a plan to follow through on recommendations with the expressed aim of achieving "Outstanding" in the future. However, it was pleasing to note the Trust remains "Good" in the areas of caring and responsiveness. We also noted that nearly 93% of respondents to the Friends and Family Test indicated services were good or very good and only 4% felt services were poor or very poor. With regard to staff feedback, it was noted that only between 51%- 63% of staff would recommend the NHS service they work in to their friends and family, but 67% would recommend the care of patients/service users as the organisation's top priority.

We noted the ongoing positive work on identifying and supporting a growing number of people with dementia whilst in hospital and noted a completed and promoted dementia strategy. It was also pleasing to read about the ongoing staff training focusing on supporting people with mental health issues alongside a 3-year vision to achieve cultural change across the organisation and reduce the stigma surrounding mental health issues.

We were concerned to see that "Never Events" had increased to 4 events, with two cases of wrong site procedure and one each of incorrect prothesis inserted and retained foreign object post-surgery. These "Never Events" could have led to tragic consequences for the people involved. In addition, we noted there were a growing number of medication errors with 782 recorded cases. Of additional concern for Stroke patients was a 16% shortfall against the target of 75% to treat high risk cases within 24 hours, blamed on appointment availability and patients being unable to make appropriate travel arrangements. We noted the overall increase in reported Safeguarding concerns, mainly around neglect and acts of omission but with rising concerns about physical and domestic abuse, but see this as a positive indication of the improvements in staff training and awareness raising.

We welcome the focus on the recording of Falls and noted that although there were increases in the number of recorded falls where low or moderate harm happened, there were no falls resulting in severe harm or death and an overall increase in falls with no harm recorded.

We also noted an overall reduction in deaths to 1,550 occurring in hospital in 2022/23 with the learning from deaths process leading to improvements for patients and their families and identifying where staff could do more to help. The introduction of a Deteriorating Patient Group and the introduction of an End-of-Life Care Facilitator and an End-of-Life Steering Group will hopefully bring about positive change.

We complement the Trust on the work undertaken to bring down the average length of stay to 3.27 days which is below the national and regional average and has a positive impact on the patient's and carers wellbeing.

We noted improvements in the processing and quality of data and the demonstration of useful and accessible information via automated Safety and Quality dashboards. This is providing close monitoring of nurse sensitive patient indicators on a day-to-day basis and has a visual impact for quickly reviewing areas of concern. The quality focus around patient safety, effectiveness of care and patient experience is also developed through regular quality improvement audits and associated work to action recommendations alongside an increasing number of national and local clinical audits. We noted the audit work which the Trust were involved in increased to 38 national clinical audits and 147 local clinical audits.

Regarding some of the available data we noted improved results with a marked drop in the number of violent incidents and reductions in verbal abuse/disruption and concerns to do with personal safety. It was noted that overall complaints were increased from the previous year including Stage 3 complaints. On a more positive note, the number of compliments increased significantly especially around the care received by patients.

Healthwatch Stockton-on-Tees welcomes the continuing strong working relationship we've had with the Trust over recent years and we will continue to work with and support the Trust over the coming 12 months with the aim of further improving the quality of services provided and maximising a positive person experience.

The Trusts Council of Governors – June 2023

In order to enable the Council of Governors to hold the Non-Executive Directors to account and gain assurance regarding the performance of the Trust, detailed compliance, regulatory and performance information is presented at each Council of Governors meeting. In addition, regular updates regarding the wider system working are provided following the continued evolvement of the new NHS structure of Integrated Care Systems and associated collaborative working. The provision of this information facilitates constructive challenge and discussion between the Council of Governors and members of the Board. Key aspects of the performance information that Governors are appraised of form part of the Trust's Annual Quality Account.

The Council of Governors are kept fully informed in respect of priority areas of the Trust's performance, including any areas requiring greater scrutiny as well as service and pathway developments. This information is disseminated through a number of fora, which include the formal Council of Governor meetings, development sessions, and the sub-committee structure.

During 2022/23, some of the Trust's key meetings continued to be held using a hybrid model of face to face and virtual attendance. Development sessions facilitated for Governors, included the Trust Charity, role of Freedom to Speak Up, Care Quality Commission Improvement Plan and Discharge Protocols including the Home First initiative. A programme of joint Governor meetings with South Tees Hospitals NHS Foundation Trust commenced in January 2023 covering a development session delivered by NHS Providers around the role of Governors and collaborative working, which was well received. It is planned to continue such meetings throughout the year.

The schedule of reports provided for Council of Governor meetings are regularly reviewed to ensure relevant information is shared in a timely manner and agendas continue to remain fit for purpose to assist the Council of Governors to hold the Board collectively to account. A structured pre-meeting takes place prior to every meeting, which provides Governors with the opportunity to review the meeting papers and highlight any areas of concern or requiring further clarity. A formal response is provided and recorded at the main Council of Governors meeting. During 2022/23 a number of new board appointments were made including a new Vice Chair, as well as a new Lead Governor providing the opportunity for refreshed ways to seek assurance.

Within the sub-committee structure the Strategy and Service Development Committee reviews new developments and strategic plans. At this Committee presentations were provided in respect of the development work undertaken in Maternity Services, the draft revised Code of Governance documents and the Corporate Strategy. These meetings provide the opportunity for detailed debate and interaction with the Governors to seek their views. The other Sub-Committees include the Membership Strategy Committee, Nominations Committee, and the External Audit Working Group, which meets as required.

Aside from formal meetings, regular communication is maintained with Governors regarding key developments and Trust announcements via bulletins to ensure they remain informed.

Hartlepool Borough Council – Audit and Governance Committee – June 2023

Joan Stevens
Statutory Scrutiny Manager
Civic Centre
Hartlepool
TS24 8AY

Tel: 01429 284142
www.hartlepool.gov.uk
Our Ref:
Your Ref:

11th May 2023

Keith Wheldon
Business and Intelligence Manager
North Tees and Hartlepool NHS Foundation Trust

Dear Keith

Audit and Governance Committee – Third Party Declaration 2022/23

Following consideration of the North Tees and Hartlepool NHS Foundation Trust Quality Accounts on 16th March 2023, Hartlepool Borough Council's Audit and Governance Committee agreed the following:

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

- Priorities for 2023/24

The committee expressed support for the priorities identified and proposed no changes.

Yours faithfully

Joan Stevens

Joan Stevens
STATUTORY SCRUTINY MANAGER

Stockton Borough Council – Adult Social Care and Health Select Committee - June 2023

NTHFT Quality Account 2022-2023 – Third-Party Declaration

As always, the Committee is grateful for another opportunity to comment on key elements of the latest North Tees and Hartlepool NHS Foundation Trust (NTHFT) Quality Account. Due to limitations imposed by the forthcoming local elections in May 2023, this statement does not have the usual benefit of reflecting upon the content of the Trust's draft Quality Account document. Instead, the following observations are based on the annual presentation given to the Committee (in March 2023) which highlighted developments in relation to the Trust's performance during 2022-2023.

Focusing firstly on the 'Patient Safety' priority, Members welcomed the positive data in relation to the Trust's mortality measures which continue to compare well against both the regional and national position. NTHFT raw mortality (people dying in hospital) numbers remain consistent, though the COVID-impacted spikes in April 2020 and December 2020 / January 2021 were acknowledged.

The increasing trend in patients admitted with a dementia / delirium diagnosis was being maintained, with a slight rise in 2022-2023 cases compared to the same period in 2021-2022. Responding to a Committee query around adequate resourcing to meet this demand, NTHFT representatives outlined the use of enhanced care workers to ensure patients were assisted individually, the development of staff skills for those who work on wards with higher levels of dementia / delirium patients, and the community care it provides (unless more specialised support was required in a nursing home).

In terms of infection control, it was encouraging that both *Clostridium difficile (C Difficile)* measures had seen reductions for 2022-2023 when compared to the same period in 2021-2022 (both below the national average). However, for other infection types, all-but-one of the recorded measures had increased since the previous year, with *Methicillin-Sensitive Staphylococcus Aureus (MSSA)* (up 65%) and *Klebsiella species (Kleb sp) bacteraemia* (up 57%) seeing the most significant rises. On a more positive note, catheter-associated urinary tract infections (CAUTI) had reduced by 21%. The Committee acknowledge the rise in people requiring complex surgery, on antibiotics, and / or higher levels of patient acuity, meaning that individuals could be picking-up infections more easily.

In related matters, the Committee was pleased to hear that the treatment of patients with COVID-19 in the Intensive Therapy Unit (ITU) was now rare, and that the number of COVID-19-positive patients in NTHFT hospitals had declined significantly in the past year – that said, Members reiterated their wish to learn more about the Trust's long-COVID clinic. More alarming were the pressures experienced by NTHFT with regards flu at the end of 2022 and start of 2023, a situation which led to some patients requiring ITU treatment.

A key aspect within the 'Effectiveness of Care' priority was the inclusion of data around emergency activity which had seen a significant increase in recent months (attendances to A&E and Urgent Care were up 45% when comparing December 2022 with December 2021). In response to Committee concerns around staff stress, Trust representatives assured Members that a winter plan was always prepared and actioned, with extra beds made available for the anticipated rise in demand. Extra staffing support also formed part of the plan, and expert practitioners further assisted emergency teams. Reference was also made to a recent presentation by the North East Ambulance Service NHS Foundation Trust (NEAS) to the Tees Valley Joint Health Scrutiny Committee which showed NTHFT in a positive light compared to nearby Trusts in relation to ambulance waits. A by-product of being a strong performer in terms

of lower ambulance waits was that the Trust were sent patients from other hospitals where waits were generally higher – indeed, NTHFT received 144 diverts / deflections in December 2022 alone.

Recorded violent incidents towards staff during 2022-2023 were broadly similar to the same period for 2021-2022, and the Committee repeated past frustrations that too many people still think it appropriate to direct aggression towards hospital personnel. Assurance was given that staff were supported in relation to dealing with such conduct from patients and visitors, and the police were called to assist where required.

Data regarding the 'Patient Experience' priority demonstrated a continuing high proportion of positive feedback via the Friends and Family Test, with further evidence that complaints were being resolved earlier without the need for escalation through more formal routes. The Committee understood that the overall increase in the number of complaints received could possibly be attributed to the restrictions on visiting caused by COVID-19 and, more recently, industrial action which led to the cancellation of treatment (though it was noted that the Trust was progressing well on elective procedures). Balancing complaints data against the increasing number of compliments gave an encouraging picture of the general level of satisfaction of the Trust's service provision.

Whilst the Committee was encouraged by large parts of the Trust's performance, it was also mindful that NTHFT had been downgraded by the health and social care regulator to 'requires improvement' following an inspection in May 2022 – addressing these findings, particularly around leadership, culture, and governance, will and should be a central 2023-2024 priority for NTHFT. Further to the shortcomings raised by the Care Quality Commission (CQC), and issues recently reported to Members around community midwifery provision, the Committee proposed that maternity services be added to the list of the Trust's Quality Account priorities for 2023-2024. Members also expressed concern over the reported increases in collaborative working with South Tees Hospitals NHS Foundation Trust (STHFT) and the fear that this was a potential move to the loss of local services which could be transferred to the James Cook University Hospital, Middlesbrough.

As the 2019-2023 Council term concludes, the Committee would like to thank NTHFT for its openness and willingness to engage during the last four years – maintaining this transparency will be vital moving forward as the Committee membership changes following the forthcoming local elections. Members wish NTHFT well in its ongoing recovery from COVID and urge the continuation of the well-established partnership-working between the Trust, Stockton-on-Tees Borough Council, and other local health and care providers, the benefits of which cannot be understated.

Healthcare User Group (HUG) – June 2023

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

The group also represents the public by attending several of the Trust committees including the Trust Resilience Forum (TRF), Audit & Clinical Effectiveness Group (ACE), Information Review Group (formerly the Clinical Governance Committee), Patient & Carer Experience Committee*[1] (PCEC), Discharge Steering Group, Infection Control Committee*[2] (ICC) and Patient Quality & Safety Standards Group*[3] (PS&QS), Organ Donation Committee, Research and any other groups created to improve patient treatments and choice.

2022-2023 was the year when Coronavirus was no longer the main topic of conversation, and gladly, with WHO declaring the Pandemic as officially over earlier this year, we can now treat it as a serious viral infection but thanks to new treatments and a better understanding of the virus, can be treated like any other viral infection which we have to endure. Hopefully, as long as people continue to accept the offered vaccinations, we will not have to return to those dark days of 2020-2022.

We have reviewed the Quality Accounts and conclude they are a true representation of the position the Trust finds itself at the end of yet an even more chaotic year as the Trust tries to keep operating, at a time when household budgets are stretched, with a cost-of-living crisis and ever increasing price rises and a national workforce (both within and without the NHS) fighting for higher wages after years of wage-fixing austerity.

With clinical staff, nurses, junior doctors, ambulance workers and soon, the consultants, all fighting for higher wages, this has and will inevitably lead to disruption to services. Remarkably, thus far, the Trust has managed to cope well with these disruptions and it is to be hoped that soon this will all be history.

The Trust has carried forward the previous years' priorities for improvement with the addition of Maternity. The 14 priorities have already been discussed in this quality accounts, detailing how they will be implemented, measured and reported. The Healthcare User Group support the Trust's approach and will continue to help in any way we can.

With the lifting of restrictions to ward areas we finally began to re-visit wards and services, completing visits to Wards 24, 26, and 32, and Main Outpatients, and Orthopaedic Outpatients departments. It was very rewarding to hear actual patients talk of their experiences within the hospital wards and departments. There were many compliments and some complaints, but it is positive to hear relatives of patients talking warmly of the reception they receive from staff, especially when from outside our local catchment area.

Our thanks again go out to all those people working in the Trust, for their commitment to giving us the best care they can possibly deliver. Even in difficult times such as these, a friendly face and welcoming smiles are always warmly received.

Healthcare User Group
June 2023

[1] - Patient and Carer Experience Council
[2] – Infection Control Council
[3] – Patient Safety and Quality Standards Committee is now known as Quality Assurance Committee

Annex B: Quality Report Statement

Statement of Directors' Responsibilities in Respect of the Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust boards should put in place to support data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2022-23* and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2022 to April 2023
  - papers relating to Quality reported to the Board over the period April 2022 to April 2023
  - feedback from commissioners dated June *2023*
  - feedback from governors dated June *2023*
  - feedback from local Healthwatch organisations dated June *2023*
  - feedback from the Adult Services and Health Select Committee and Audit and Governance Committee dated June *2023*
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated *Q4 2022-23*
  - the latest national patient survey *2021*
  - the latest national staff survey *2022*
  - the Head of Internal Audit's annual opinion over the Trust's control environment dated 16
  - CQC Quality Report – Inspection Report 16 September 2022
  - the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered;
  - the performance information in the Quality Report is reliable and accurate;
  - there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
  - the data underpinning the measures of performance in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
  - the Quality Report has been prepared in accordance with NHS Improvements annual reporting guidance (which incorporates the Quality Accounts Regulations) as well as the standards to support data quality for the preparation of the quality report

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board

Chief Executive

Chairman

Annex C: Independent Auditors' Limited Assurance Report

Independent Auditors' Limited Assurance Report to the Council of Governors of North Tees and Hartlepool NHS Foundation Trust on the Annual Quality Report

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

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

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

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

Patient Experience Team

North Tees & Hartlepool NHS Foundation Trust

Hardwick Road

Stockton-on-Tees

Cleveland

TS19 8PE

.....

Thank you for your time.

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

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

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

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

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

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Alternatively you can email us at: **nth-tr.PatientExperience@nhs.net** with the Subject **Quality Accounts**

Glossary

A&E	Accident and Emergency
ACE Committee	Audit and Clinical Effectiveness Committee – the committee that oversees both clinical audit (i.e. monitoring compliance with agreed standards of care) and clinical effectiveness (i.e. ensuring clinical services implement the most up-to-date clinical guidelines)
ACL	Anterior Cruciate Ligament – one of the four major ligaments of the knee
AKI	Acute Kidney Injury
AHP	Allied Health Professional
AMT	Abbreviated Mental Test
AQuA	Advancing Quality Alliance
BI	Business Intelligence
CAB	Citizens Advice Bureau
CABG	Coronary Artery Bypass Graft (or “heart bypass”)
CAUTI	Catheter-associated urinary tract infection
CFDP	Care For the Dying Patient
CCG	Clinical Commissioning Group
CCOT	Critical Care Outreach Team
CDI	Clostridium difficile Infection
CHKS	Comparative Health Knowledge System
CIAT	Community integrated assessment team (CIAT)
Clostridioides Difficile (infection)	A type of bacteria that can cause diarrhoea. It often affects people who have been taking antibiotics. It is easily spread and can be acquired in the community and in hospital
CLRN	Comprehensive Local Research Network
CMR	Crude Mortality Rate
CNS	Clinical Nurse Specialist
COHA	Community onset Healthcare Associated
COPD	Chronic Obstructive Pulmonary Disease
CLIP	Complaints Litigation Incidents Performance
CPIS	Child Protection Information System
CPMS	Central Portfolio Management System
CSE	Child Sexual Exploitation
CSP	Co-ordinated System for gaining NHS Permission
CQC	The Care Quality Commission – the independent safety and quality regulator of all health and social care services in England
CQRG	Clinical Quality Review Group

CQUIN	Commissioning for Quality and Innovation – a payment framework introduced in 2009 to make a proportion of providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care
DAHNO	Data for Head and Neck Oncology (Head and Neck Cancer)
DARs	Data Analysis Reports
DH	Department of Health
DLT	Discharge Liaison Team
DNA	Did Not Arrive
DNACPR	Do Not Attempt Cardio Pulmonary Resuscitation
DoLS	Deprivation of Liberty Safeguards
DSCP	Durham Safeguarding Children Partnership
DSPT	Data Security Protection Toolkit
DToC	Delayed Transfer of Care
DVLA	Driver and Vehicle Licensing Agency
EAU	Emergency Assessment Unit
E coli (infection)	Escherichia coli infection
ED	Emergency Department
EMSA	Eliminating mixed sex accommodation
EPMA	Electronic Prescribing and Medication Administration
EPR	Electronic Patient Record
EOL	End of Life
ESR	Electronic Staff Record
EWS	Early Warning Score – a tool used to assess a patient's health and warn of any deterioration
FCE	Finished Consultant Episode – the complete period of time a patient has spent under the continuous care of one consultant
FGM	Female Genital Mutilation
FICM	Faculty of Intensive Care Medicine
FOI (act)	The Freedom of Information Act – gives you the right to ask any public body for information they have on a particular subject
FFT	Friends and Family Test
FSCO	First Stop Contact officer
FTSU	Freedom To Speak Up

FTSUG	Freedom To Speak Up Guardian
Global trigger tool (GTT)	Used to assess rate and level of potential harm. Use of the GTT is led by a medical consultant and involves members of the multi-professional team. The tool enables clinical teams to identify events through triggers which may have caused, or have potential to cause varying levels of harm and take action to reduce the risk
GCP	Good Clinical Practice
GM	General Manager
HCAI	Health Care Acquired Infection
HED	Healthcare Evaluation Data (A major provider of healthcare information and benchmarking)
HEE	Health Education England
HENE	Health Education North East
HES	Hospital Episode Statistics
HLSCB	Hartlepool Local Safeguarding Children Board
HMB	Heavy Menstrual Bleeding
HOHA	Hospital Onset Healthcare Associated
HQIP	Healthcare Quality Improvement Partnership
HRG	Healthcare Resource Group – a group of clinically similar treatments and care that require similar levels of healthcare resource
HSCB	Hartlepool Safeguarding Children Boards
HSMR	Hospital Standardised Mortality Ratio – an indicator of healthcare quality that measures whether the death rate in a hospital is higher or lower than you would expect
HSSCP	Hartlepool and Stockton Safeguarding Children Partnership
HUG	Healthcare User Group
IBD	Inflammatory Bowel Disease
ICC	Infection Control Council
ICE	
ICNARC	Intensive Care National Audit and Research Centre
ICO	Information Commissioners Office
ICS	Intensive Care Society
IG	Information Governance
IHA	Initial Health Assessment
IMR	Intelligent Monitoring Report tool for monitoring compliance with essential standards of quality and safety that helps to identify where risks lie within an organisation
LD	Learning Difficulties
ICE	Integrated Clinical Environment

IG	Information Governance
Intentional rounding	A formal review of patient satisfaction used in wards at regular points throughout the day
IPB	Integrated Professional Board
IPC	Infection Prevention and Control
ISPA	Integrated Single Point of Access
Kardex (prescribing 154ardex)	A standard document used by healthcare professionals for recording details of what has been prescribed for a patient during their stay
KEOGH	Sir Bruce Keogh
Kleb sp	Klebsiella Species (type of infection)
KPI	Key Performance Indicator
LAC	Looked After Children
LADO	Local Authority Designated Officer
LAR	Looked After Review
LD	Learning disabilities
LeDeR	Learning Disabilities Mortality Review
Liverpool End of Life Care Pathway	Used at the bedside to drive up sustained quality of care of the dying patient in the last hours and days of life
LMS	Local Maternity System
LPMS	Local Portfolio Management Systems
LPS	Liberty Protection Systems
LQR	Local Quality Requirements
LSCB	Local Safeguarding Children's Board
MARAC	Multi Agency Risk Assessment Conferences
MATAC	Multi Agency Tasking and Co-ordination
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK
MCA	Mental Capacity Act
MDT	Multidisciplinary Team
ME	Medical Examiner
MEG	Missing Exploited Group
MHA	Mental Health Act
MHRA	Medicines and Healthcare products Regulatory Agency
MIU	Minor Injuries Unit
MINAP	The Myocardial Ischaemia National Audit Project

MRSA	Methicillin-Resistant Staphylococcus Aureus
MSSA	Methicillin-Sensitive Staphylococcus Aureus
MUST	Malnutrition Universal Screening Tool
NCEPOD	The National Confidential Enquiry into Patient Outcome and Death
NCPES	National Cancer Patient Experience Survey
NCRN	National Cancer Research Network
NDG	National Data Guardian
NEAS	North East Ambulance Service
NEEP	North East Escalation Plan
NEPHO	North East Public Health Observatory
NEQOS	North East Quality Observatory System
NEWS	National Early Warning Score
NHS Improvements	The independent regulator of NHS foundation Trusts
NICE	The National Institute of Health and Clinical Excellence
NICOR	The National Institute for Cardiovascular Outcomes Research
NIHR	National Institute for Health Research
NNAP	National Neonatal Audit Programme
NQB	National Quality Board
NRLS	National Learning and Reporting System
NTHFT	North Tees and Hartlepool Foundation Trust
OD Banding	Overdispersion (statistical indicators)
OFSTED	The Office for Standards in Education
PalCall	Palliative care, out-of-hours telephone helpline for patients and carers registered with our services
PALS	Patient Advice and Liaison Service
PAS	Patient Administration System
Patient Safety and Quality Standards (Ps&Qs) Committee	*Now Quality Assurane Committee* - The committee responsible for ensuring provision of high quality care and identifying areas of risk requiring corrective action
PET	Patient Experience Team
PHE	Public Health England
PIC	Patient Identification Centre
PICANet	Paediatric Intensive Care Audit Network
PMRT	Perinatal Mortality Review Tool
PREVENT	the government's counter-terrorism strategy
PROMs	Patient Reported Outcome Measures
Psa	Pseudomonas Aeruginosa (Type of Infection)
Pseudonymisation	A process where patient identifiable information is removed from data held by the Trust

QAF	Quality Assessment Framework
QAC	Quality Assurance Committee – *previously Patient Safety and Quality Standards Committee (PS&QS)* - The committee responsible for ensuring provision of high quality care and identifying areas of risk requiring corrective action
Quality Improvement	
R&D	Research and Development
RA	Recruitment Activity
RAG	Red, Amber, Green chart denoting level of severity
RCA	Root Cause Analysis
RCOG	The Royal College of Obstetricians and Gynaecologists
RCPCH	The Royal College of Paediatric and Child Health
REPORT-HF	International Registry to assess Medical Practice with longitudinal observation for Treatment of Heart Failure
RESPECT	"Responsive, Equipped, Safe and secure, Person centered, Evidence based, Care and compassion and Timely" – a nursing and midwifery strategy developed with patients and governors aimed at promoting the importance of involving patients and carers in all aspects of healthcare
RHA	Review Health Assessments
RMSO	Regional Maternity Survey Office
SBAR	Situation, Background, Assessment and Recommendation – a tool for promoting consistent and effective communication in relation to patient care
SCM	Senior Clinical Matron
SCMOoH	Senior Clinical Matron Out-of-Hours
SCR	Serious Case Review
SEPSIS	Life-threatening reaction to an infection
SHA	Strategic Health Authority
SHMI	Summary Hospital Mortality-level Indicator – a hospital-level indicator which reports inpatient deaths and deaths within 30-days of discharge at Trust level across the NHS
sic	The Latin adverb ***sic*** ("thus"; in full: *sic erat scriptum*, "thus was it written"), inserted immediately after a quoted word or passage, indicates that the quoted matter has been transcribed exactly as found in the source text, complete with any erroneous or archaic spelling, surprising assertion, faulty reasoning, or other matter that might otherwise be taken as an error of transcription.
SINAP	Stroke Improvement National Audit Programme
SLSCB	Stockton Local Safeguarding Children Board
SMPG	Safety Medical Practices Group
SOF	Single Oversight Framework
SOP	Standard Operating Procedures
SPA	Single Point of Access
SPC	Specialist Palliative Care

SPCT	Specialist Palliative Care Team
SPEQS	Staff, Patient Experience and Quality Standards
SPICT	Supportive & Palliative Care Indicator Tools
SPOC	Single point of contact
SSKIN	Surface inspection, skin inspection, keep moving, incontinence and nutrition
SSU	Short Stay Unit
STAMP	Screening Tool for the Assessment of Malnutrition in Paediatrics
STEIS	Strategic Executive Information System
STERLING	Environmental Audit Assessment Tool
SUS	Secondary User Service
TEWV	Tees, Esk and Wear Valleys NHS Foundation Trust
TIA	Transient Ischemic Attack
TNA	Training Needs Analysis
Tough-books	Mobile computers aim to ensure that community staff has access to up-to-date clinical information, enabling them to make speedy and appropriate clinical decisions
TRAKCARE	Electronic Patient Record System
TSAB	Tees-Wide Safeguarding Board
UCC	Urgent Care Centre
UHH	University Hospital of Hartlepool
UHNT	University Hospital of North Tees
UKST	UK Sepsis Trust
UNIFY	Unify2 is an online collection system used for collating, sharing and reporting NHS and social care data.
UTI	Urinary Tract Infection
UV	Ultra Violet
VEMT	Vulnerable, exploited, missing, trafficked
VSGBI	The Vascular Society of Great Britain and Ireland
VTE	Venous Thromboembolism
WRAP	Workshop to Raise Awareness of PREVENT
WTE	Whole Time Equivalent - is a unit that indicates the workload of an employed person in a way that makes workloads or class loads comparable
4at delirium assessment tool	Bedside medical scale used to help determine if a person has positive signs for delirium

North Tees and Hartlepool NHS Foundation Trust

University Hospital of North Tees

Hardwick, Stockton-on-Tees, TS19 8PE

www.nth.nhs.uk

Meeting of the Board of Directors

Title of Report:	Safeguarding Annual Report 2022-23
Date:	5 October 2023
Prepared by:	Kathy Fitzwater, Named Nurse Safeguarding Adults Lorraine Mulvey, Named Nurse Safeguarding Children
Sponsor:	Chief Medical Officer/Chief Nurse, Director of Patient Safety & Quality
Purpose of the report	To provide an annual update on the work of the Vulnerability Unit including • Data regarding safeguarding concerns raised, actions taken and lessons learned, locally/ regionally and nationally. • Mandatory safeguarding training compliance and monitoring of this. • How the unit seeks assurances around quality of safeguarding activity through auditing and improvement plans. • The actions of the Domestic Abuse service, Learning Disabilities service and Dementia service. • The report includes a summary of the Deprivation of Liberty Safeguard applications made by the Trust, and the ongoing work regarding Mental Health education and support. • Information sharing with our Safeguarding Partnerships to support collaborative Strategic response to emerging risks and within operational multiagency risk conferences to support the protection of children and adults.

Action required:	Approve	x	Assurance	x	Discuss	x	Information	x
Strategic Objectives supported by this paper:	Putting our Population First	x	Valuing 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:

- There is no substantive Designated Nurse Safeguarding children or Designated Doctor Safeguarding Children in post at the ICB. This is currently mitigated by support from the Named Doctors and Named Nurses across the region. This remains on the Trust Risk register, and has been escalated.
- The Liberty Protection Safeguards implementation has been delayed beyond the life of this Parliament and has therefore been removed from the Trust risk register
- The resourcing for TEWV Liaison Psychiatry services remain on the risk register. This is being monitored through quarterly updates to the Quality Assurance Committee and through the newly established Mental Health Review Group to provide a framework to progress the Trusts new Mental Health Strategy.
- Autism provision remains on the risk register and is currently being mitigated by the Learning Disability nurse providing support for reasonable adjustments, completion of national audit and LeDeR reviews. This is a gap in the service that is to be reviewed, and resolved during 2023-24.
- Deprivation of Liberty Care Quality Commission notifications are challenging to achieve within prescribed time frames. This is currently being supported utilising NHS Professional provision using unfilled vacancy hours in the service; a job description is being finalised for a more permanent solution to support the service.

- Training compliance is not at the Trusts contractual target of 100%; the local quality requirements are currently being agreed. The service is developing a proposal to combine both training programmes to mitigate risk of non-compliance; this will be supported by the continuation of the online training packages.
- Safeguarding adult's lessons learned are shared from those reviewed locally and nationally.
- Ongoing dissemination of learning from Children's Safeguarding local, regional and national reviews.
- Implementation of action plans and dissemination of learning themes identified through Patient Safety processes.
- Continue to audit compliance to policies and procedures to monitor and address areas of non-compliance.

Decisions taken re next steps

- Continued provision of safeguarding services for both adults and children, to support Trust staff to meet its statutory requirements.
- Continued commitment to multiagency work, participation in subgroups and dissemination of learning locally, regionally and nationally.
- Complete a whole service establishment review to establish workforce priorities.
- Safeguarding Children and adult training will be combined to embed a 'Think Family' approach. This will include development of a rolling program of simulation training for staff around Safeguarding, SUDIC and Abduction.
- Collaborate with regional services to develop an Adult Not Brought policy to reduce the risk of harm to those unable to bring themselves to appointments.
- Continue to capture meaningful Safeguarding data across the Trust to inform targeted responses to quality improvements. This will include refreshed Adult Safeguarding and Mental Capacity Act audits.
- Continue to develop and review policies and pathways informed by legislation, local and national learning and statutory safeguarding guidance and standards.
- Ongoing development of the Dental Neglect Pathway to support access and feedback to practitioners for our vulnerable children.
- Development of a new fracture review pathway for children in response to lessons learned through incidents.
- Consideration to children's autism/learning disabilities and transitional safeguarding senior nurse role in response to NHS Plan.

Items for Escalation

There are no specific items to be escalated to the Board in relation to the information within this report; however there is ongoing close monitoring of the compliance with the mandatory safeguarding training levels.

The information in relation to Safeguarding is escalated through the Safeguarding Council and up to the Quality Assurance Committee for all actions to be agreed, implemented and monitored.

Identification of Risk an Board Assurance Framework affected:

Safeguarding risks are reviewed and included in BAF 1A – Patient Safety and Improved Outcomes:

- 6579 - Lack of specialist autism clinician. Current level: moderate.
- 6607 - Level of service by Psychiatric liaison to NTH reduced therefore potentially affecting patient safety and outcomes. Current level: moderate.
- 5792 - Not all cancelled and rearranged appointments are being brought to the attention of clinicians in order to support risk / impact assessment re child's medical needs.

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or disability	X	Reputational	X
Workforce	X	Environmental	
Financial/value for money		Estates and Facilities	
Commercial		Compliance/Regulatory	X
Quality, safety, experience and effectiveness	X	Service user, care and stakeholder involvement	X

Recommendation	• The Board are asked to gain assurance that mandatory safeguarding training is provided to support embedding a "Think Family" approach through combining children's and adult safeguarding training and cross pollinating learning from both adult and children local, regional and national reviews. The training compliance is monitored closely and areas of variance escalated to the QA Committee. • The Board are asked to gain assurance that in-depth multidisciplinary and multiagency working is utilised to provide learning from safeguarding concerns through dissemination of Partnership training. • The Board are asked to gain assurance that patients are lawfully deprived of their liberty through the monitoring of Deprivation of Liberty Safeguards applications and the CQC are notified as required by the team. • The Board are asked to gain assurance that Mental Health provision receives parity of esteem within the Trust with ongoing work to support the new Mental Health Strategy. • The Board are asked to gain assurance that appropriate support is provided for patients with a learning disability to enable equitable treatment, via identification and reasonable adjustments. Ongoing work continues to provide additional support to Autistic patients. • The Board are asked to gain assurance that patients with dementia are supported to have their individual needs met by identification via electronic flagging, additional Champions training and support for carers. • The Board are asked to gain assurance that the PREVENT agenda is adhered to via mandatory training. • The Board are asked to note the provision of domestic abuse services in with partnership with Harbour. • Board members are asked to discuss safeguarding concern reporting and lessons learned with staff members when they are undertaking departmental visits.

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

5 October 2023

Safeguarding Annual Report 2022-23

Report of the Chief Medical Officer and Chief Nurse, Director of Patient Safety & Quality

1. Introduction/Background

1.1 This report sets out the work carried out by North Tees and Hartlepool NHS Foundation Trust (NTHFT) Vulnerability Unit in providing assurance that the Trust discharges its statutory responsibilities in promoting and protecting the welfare of children, young people and adults with care and support needs, who use Trust services. Acting in their best interest at all times and behaving as an advocate by enabling their voice to be heard across all levels of the trust.

1.2 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 differ in application. Therefore, specialists within each field have been maintained within the team, in line with mandated statutory responsibilities.

1.3 The Vulnerability team is managed by both the Named Nurse Children' Safeguarding and the Named Nurse Adult Safeguarding. The Named Professionals are supported by Specialist Safeguarding Nurses for both adults and children. These roles include Children's Specialist Midwives, an Adult Safeguarding and Learning Disabilities Advisor, a Dementia and Safeguarding Advisor, an Independent Domestic Abuse Advisor and Safeguarding Trainers.

The Team work collaboratively with the Trust Named Doctors in providing governance, leadership, education and support to all staff across the trust. Any safeguarding practice issues and concerns are escalated through the Associate Director of Nursing & Patient Safety, and where necessary, to the responsible executive, the Chief Nurse / Director of Patient Safety & Quality.

1.4 The governance of investigations, actions and learning from safeguarding activity involves direct challenge and scrutiny by the Safeguarding Council, prior to reporting at Quality Assurance Committee (QAC, formally Patient Safety & Quality Standards Committee).

1.5 The Trust continues to actively contribute at a senior level to the Hartlepool and Stockton Safeguarding Children Partnership (HSSCP), Durham Safeguarding Children Partnership (DSCP) and the Teeswide Safeguarding Adults Board (TSAB), with the appropriate presence being maintained in all relevant subgroups.

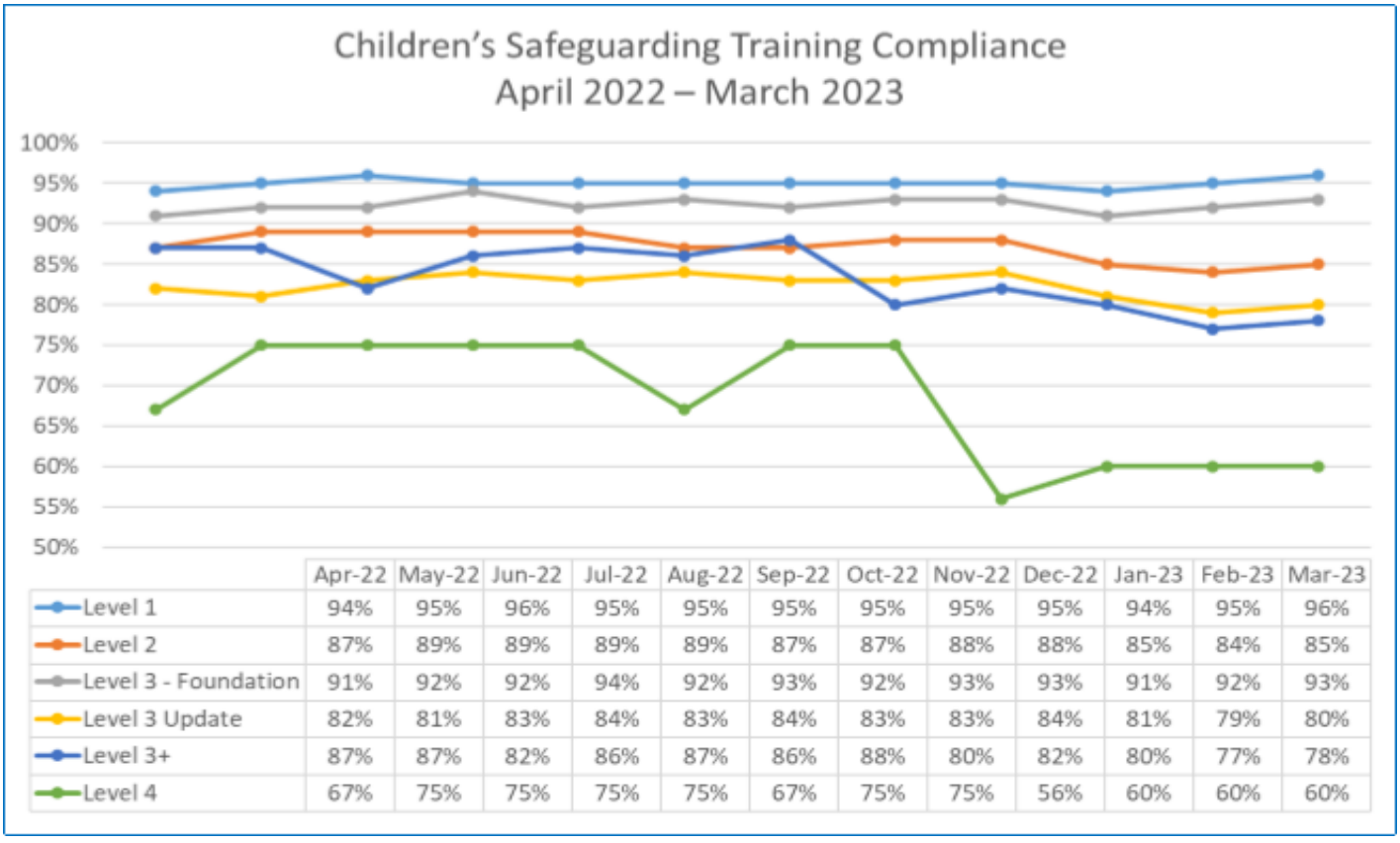
2. Safeguarding Training and Development

2.1 The Trust provides mandatory children and adult safeguarding training to ensure that staff working within the trust have the necessary knowledge and skills to identify, respond to, and manage risk. Training requirements are specified within the intercollegiate documents: *Safeguarding Children and Young people: roles and competences for health care staff (2019; & Adult Safeguarding: Roles and Competencies for Health Care Staff Intercollegiate document (2018).*

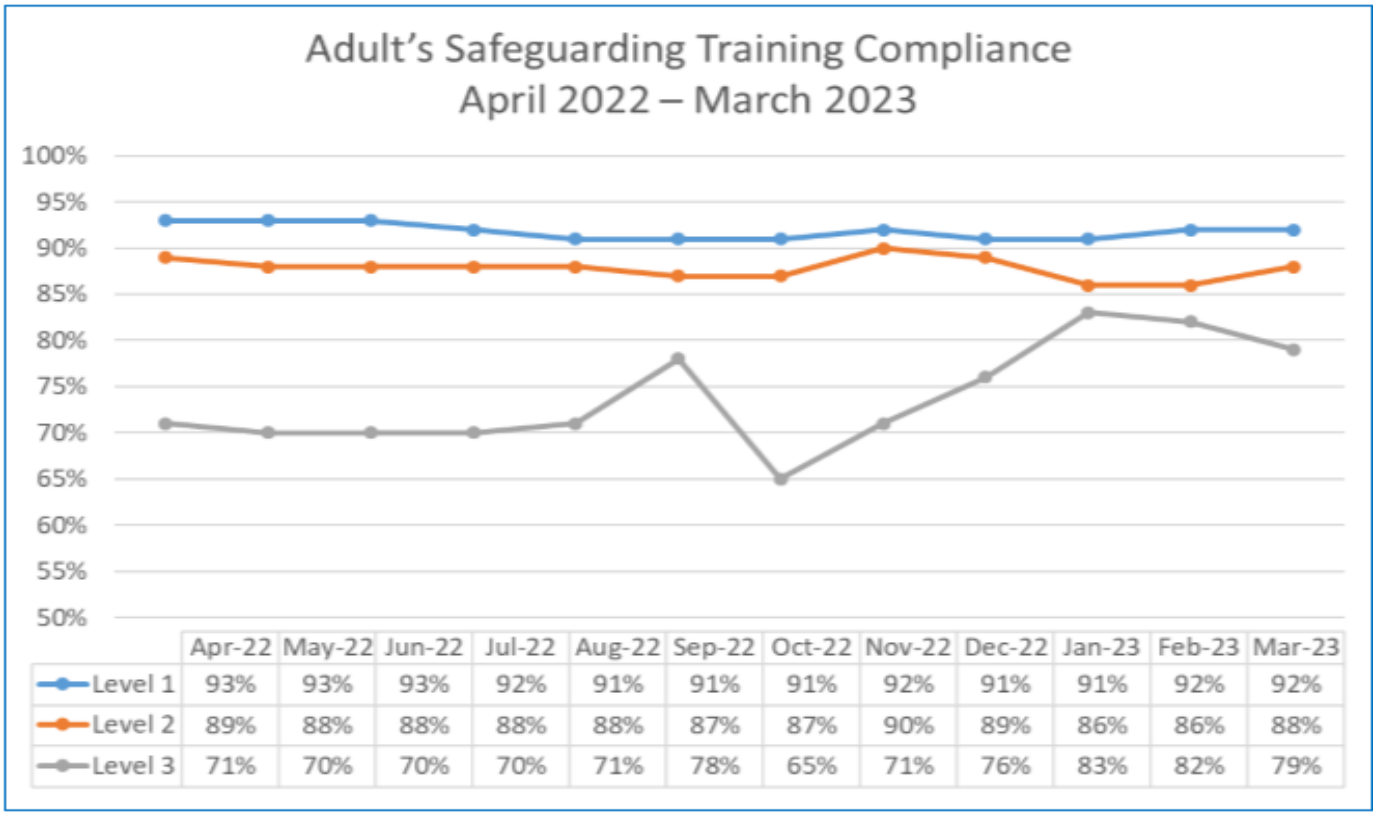
The Safeguarding Learning and Development Policy, has been updated during 2023 and provides the framework to achieving compliance. The aim of this policy is to ensure that all Trust staff are equipped with the appropriate knowledge and skills to effectively safeguard adults, children and young people accessing services within the organisation. The policy will also ensure the Trust meets its legislative responsibility to equip staff to work together effectively both on an intra-agency and inter-agency basis to safeguard and promote the welfare of adults, children and young people. Training provision is reviewed annually, or as required, to reflect legislative changes or and also to include learning generated from reviews and audits.

2.2 Compliance for the training is monitored through the Trusts Electronic Staff Record (ESR) and each of the Care Groups are required to review their compliance levels and provide a summary to the operational safeguarding meetings with the relevant action plans to impact on any variances. Exceptions are escalated to the Safeguarding Council and to the Quality Assurance Committee, as required. The Integrated Care Board (ICB) also monitors training compliance and ongoing safeguarding education through locally agreed quality requirements (LQRs). Currently the contractual safeguarding training targets are being reviewed by the ICB, having previously been set at 100% compliance across all training requirements.

2.3 A Safeguarding induction package was introduced in 2023, which provides an introduction to safeguarding for all new starters to the Trust. This supports compliance with the intercollegiate documents. Provision of bespoke safeguarding training and ongoing education is available on request to wards/departments and for any members of multi-professional teams.



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Level 1	94%	95%	96%	95%	95%	95%	95%	95%	95%	94%	95%	96%
Level 2	87%	89%	89%	89%	89%	87%	87%	88%	88%	85%	84%	85%
Level 3 - Foundation	91%	92%	92%	94%	92%	93%	92%	93%	93%	91%	92%	93%
Level 3 Update	82%	81%	83%	84%	83%	84%	83%	83%	84%	81%	79%	80%
Level 3+	87%	87%	82%	86%	87%	86%	88%	80%	82%	80%	77%	78%
Level 4	67%	75%	75%	75%	75%	67%	75%	75%	56%	60%	60%	60%



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Level 1	93%	93%	93%	92%	91%	91%	91%	92%	91%	91%	92%	92%
Level 2	89%	88%	88%	88%	88%	87%	87%	90%	89%	86%	86%	88%
Level 3	71%	70%	70%	70%	71%	78%	65%	71%	76%	83%	82%	79%

3. Keeping People Safe Key Achievements

3.1 As empowerment is a key principle to safeguarding children and adults, a QR code was developed and is now displayed in the Children's and Young Peoples Emergency Department and the Emergency Department (CYPED / ED). This was developed to support self-help, giving easy and hopefully early access to advice and help lines around all aspects of abuse and has been recognised as good practice by the Trust as part of the Celebrating Excellence event.

3.2 Safeguarding Supervision is the provision of professional support and learning, which enables practitioners to develop knowledge and competence in identifying and analysing risk and harm. It facilitates the practitioner to further taking responsibility for their own practice and respond to the needs and risks presented by children, young people and adults with care and support needs.

3.3 Safeguarding Children's Supervision is facilitated via groups or 1:1 sessions, depending on service needs. The Morrison's 4x4x4 model, has been well established within Children's Safeguarding, and has now been introduced to the Safeguarding Adult team members holding an Adult Safeguarding caseload. Since its implementation in Q4 2022-2023, Adult Safeguarding Supervision has achieved 80% compliance. The Integrated Care Board (ICB) monitors training compliance through agreed LQRs. Safeguarding Children's Supervision compliance remains consistently high at 94%

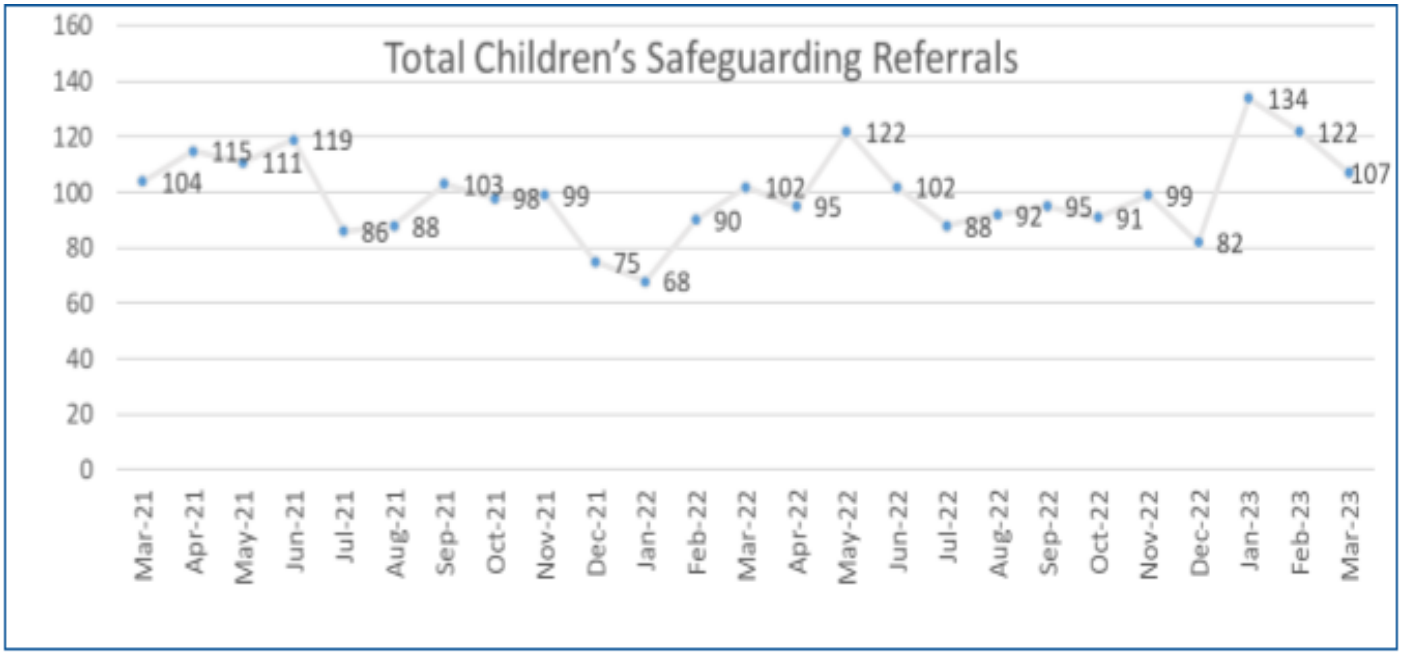
3.4 The Safeguarding Team works closely with Workforce to ensure appropriate communication is made with either the Police or the Local Authority Designated Officer (LADO) in relation to significant safeguarding issues, ensuring Workforce promote a 'Think Family' approach in considering and acting upon the risk to both adults and children when disclosures or allegations are made. There has been an increase over the year of disclosures of domestic abuse and staff as perpetrators of domestic abuse; this has required an increased level of support from the children safeguarding service for workforce and managers to consider children as victims in their own right and requiring referrals alongside any adults that are identified as being at risk. Summary

information has been reported to the Safeguarding Council to provide assurance to collaborative working between the team / workforce and trust managers.

3.5 Policies and guidance updated during 2022-2023 include:

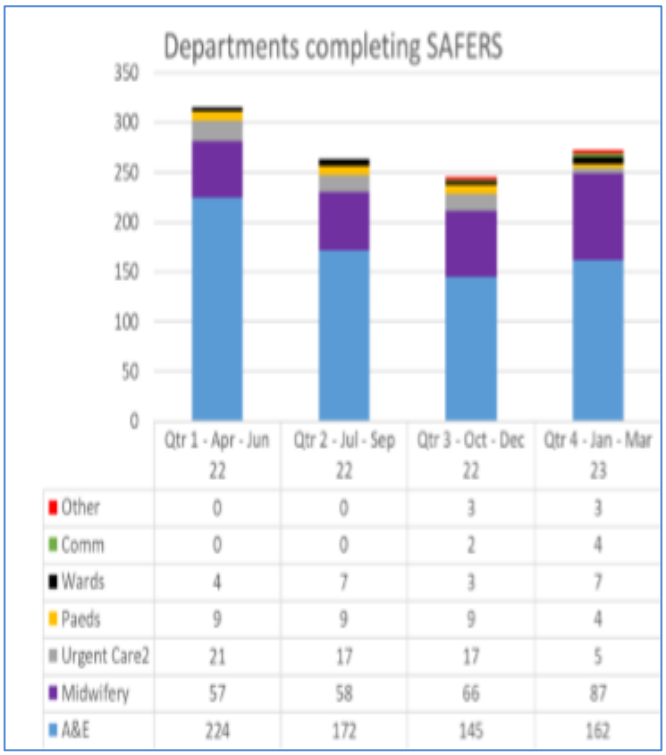
- Guidance covering Johns Campaign
- Covert Medication guidance
- Domestic Abuse Policy
- Safeguarding Learning and Development Policy
- Children's Safeguarding Supervision Policy
- Child Not Brought Policy.
- An extension was granted on the Mental Capacity Act/DoLS policy to enable the addition of proposed changes instigated by The Mental Capacity Act 2005 (amended 2019)
- The Children's Safeguarding Policy has been updated and is going through the process of sign off.

4. Safeguarding Children Activity

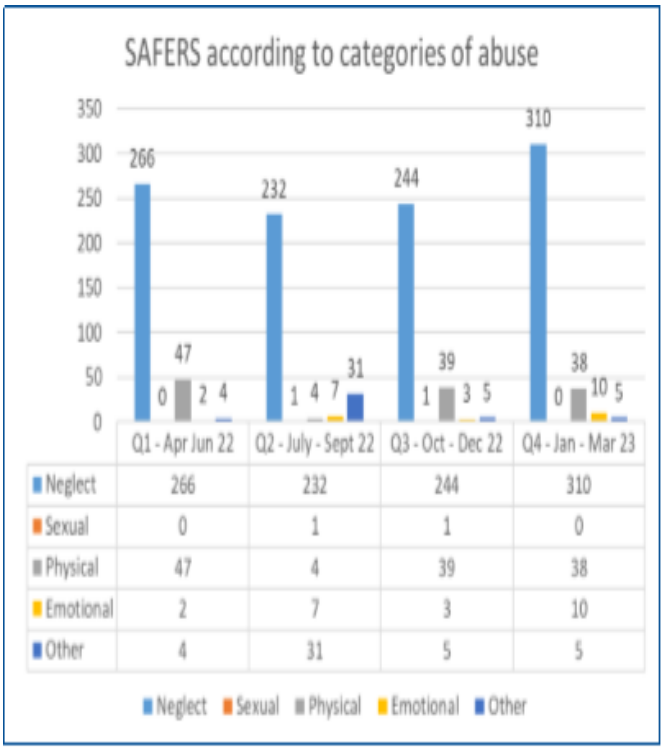


4.1 The Emergency Department (ED), Maternity and perinatal services continue to generate the majority of the Trust's child safeguarding referrals. In response to this, the safeguarding team provide daily liaison with the ED team for support and advice. "Neglect" continues to feature in the majority of the Children's Safeguarding referrals and is a feature in the raised numbers in January, February and then March 2023 noted in the above graph. This increase can be correlated to self-harm cases in our young children; which has prompted some additional collaborative working being undertaken with our Children and Adolescent mental health services (CAMHS).

4.2 The teams' Specialist Safeguarding Midwives attend all multiagency strategy discussions, pre-birth meetings, and some pre-discharge meetings to support and formulate a risk assessment through 'antenatal alerts' and 'Birth Response Plans' to ensure risks are managed throughout pregnancy, at birth and on discharge.



	Qtr 1 - Apr - Jun 22	Qtr 2 - Jul - Sep 22	Qtr 3 - Oct - Dec 22	Qtr 4 - Jan - Mar 23
Other	0	0	3	3
Comm	0	0	2	4
Wards	4	7	3	7
Paeds	9	9	9	4
Urgent Care2	21	17	17	5
Midwifery	57	58	66	87
A&E	224	172	145	162



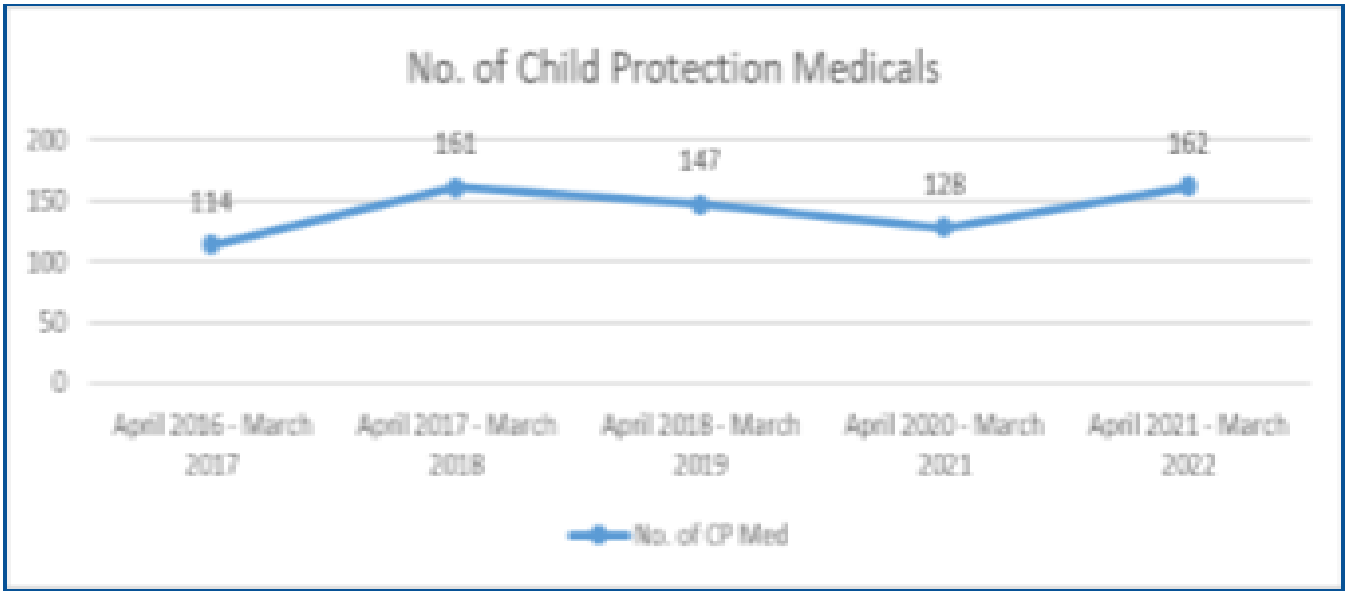
	Q1 - Apr Jun 22	Q2 - July - Sept 22	Q3 - Oct - Dec 22	Q4 - Jan - Mar 23
Neglect	266	232	244	310
Sexual	0	1	1	0
Physical	47	4	39	38
Emotional	2	7	3	10
Other	4	31	5	5

Neglect Sexual Physical Emotional Other

4.3 The Children's Named Doctor and Named Nurse have worked closely to ensure safeguarding remains central to all care delivery. The Trust continues to maintain positive working relationships with all multiagency partners to support each other in navigating the increasing complex and challenging way in which we need to respond to risk and harm inside, and increasingly outside, the family home.

4.4 A dedicated Child Protection Suite opened in October 2022, and has received positive feedback from Social Workers and Police colleagues, in providing a confidential space for parents and their children who have to attend for child protection (CP) medicals.

There has been no significant increase in CP medicals over the last five years.



4.5 Royal College Paediatrics and Child Health (RCPCH) Service Standards (October 2020):

- Six monthly audits have been completed after changes were made in response to a gap analysis following the RCPCH publications of new standards in 2020. The audit outcomes have been extremely positive evidencing that the new standards are well embedded and being sustained.

- All relevant staff have now received training in Chaperoning and understanding their role in supporting families/children, and Paediatric colleagues, through the stressful experience of being involved in a CP medical.

4.6 The Trusts Named Doctor for children's safeguarding has secured three safeguarding good practice initiatives developed by the Trust, of which the abstracts are to be presented at the national RCPCH conference. Funding has been secured for trainee doctors to enhance their understanding around safeguarding.

4.7 The CQC recognised, in their report following the Trusts inspection in May 2022; the implementation of improvements by both the Named Children's Safeguarding Nurse and Children's Named Doctor, the trust's monitoring and management of children safeguarding to both process and patient experience within the trust. Acknowledging the maintained attention on learning from the perspective of children's safeguarding through reviews and audits that continue to drive the focus of embedding children's safeguarding as "everyone's business".

4.8 The Genital Injuries pathway is now fully embedded to support both CYPED, Paediatricians and Gynaecology staff to understand risks, appropriate response and assessment needs for children who attend with genital injuries, aligning with the regional Forensic network guidelines.

4.9 Daily tracking of any children admitted to adult wards has continued and this also includes increasing the visibility of the Children's Safeguarding Specialists nurses through ward visits to review any safeguarding needs. This increased visibility of the team has been captured in a NICE 89 audit, where all members of the children's safeguarding team were identified by name. This also further supports promoting a 'Think family' approach across the organisation.

4.10 The Multiagency interface group continues to be well attended and supports collaborative partnership working by emergency access services from all agencies. Members now include representatives from the ED, CYPED, and Urgent Care; with Social Care's Emergency Duty Team, Social Care Children's Hub, CAMHS and Police Specialist Safeguarding Nurses for the Trust. This multi-professional approach improves collaboration and helps to break down barriers to sharing of information in a timely way.

4.11 The Dental Neglect Pathway pilot commenced in January 2023 and a 3-month pilot is now complete, evaluation and audit of this pathway is presently underway. Initial feedback from focus groups held by NHS England have been very positive to support improved access for our vulnerable children (following child protection medicals and our Children in Care).

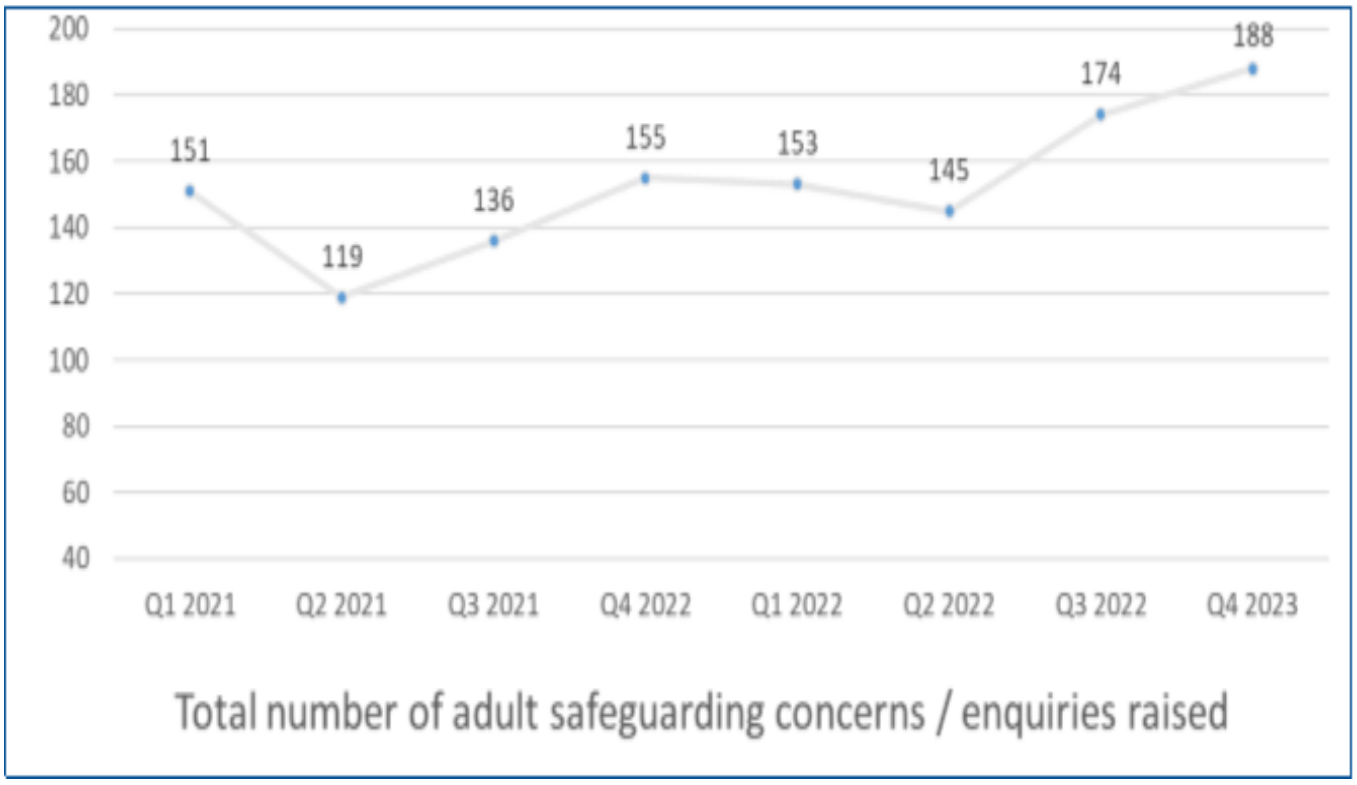
4.12 Where indicators of Fabricated Induced Illness (FII) and Perplexing Presentation are suspected for our children, these prove to be extremely complex cases that require careful management to ensure that addressing this form of harm is done safely. Despite the complexities associated with managing these cases, this is further complicated by national reports by the Royal College of Paediatric Child Health (RCPCH) and the British Association of Social Worker guidance not complimenting one another or supporting good 'working together' practices. The Teeswide Procedures have been updated to reflect changes, although a recent review has identified there is further training required by social workers to understand how to assess and manage complex family dynamics.

4.13 The Trust Named Doctor chairs a National Fabricated or Induced Illness - Special Interest Group (FII-SIG) that the team support administratively. There are over seventy-five Named and Designated Doctors from all over the United Kingdom, who meet every other month (virtually) to peer review live potential FII/PP cases. This is the only network in the country to provide this support, and the initiative is widely appreciated by the fraternity. Although internal FII audits results were found to be positive and the new guidance was supporting Paediatricians; it has been recognised that a multi-centred audit would be beneficial and this being explored by the group.

4.14 A Multiagency conference on Fabricated Induced Illness was hosted by the Trust in October 2022 and attended by over 100 delegates both locally and nationally, to support better understanding of the new RCPCH new FII guidance published end of 2020.

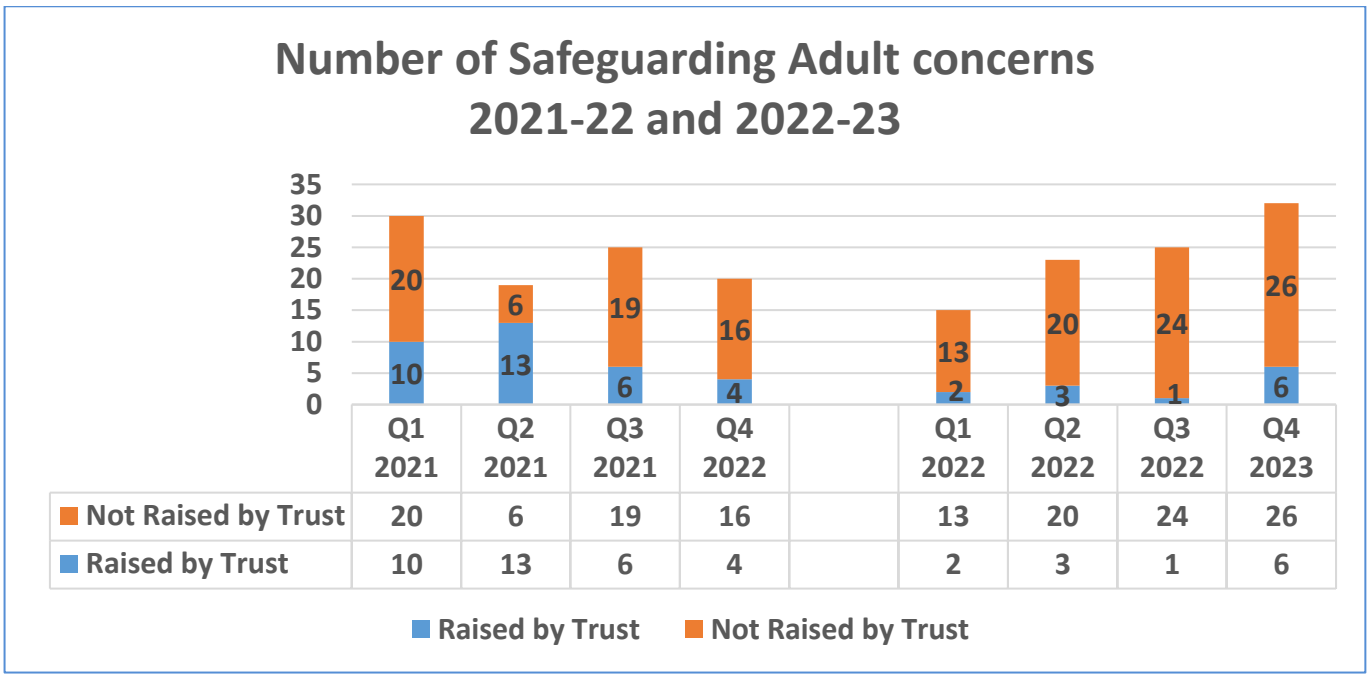
5. Safeguarding Adults Activity

5.1 Safeguarding adults' activity continues to increase. Although there is an upward trend in numbers of concerns raised, although this can be multifactorial, it is hypothesised by the Teeswide Safeguarding Adults Board (TSAB), that this reflects greater awareness of safeguarding issues and processes.



5.2 Neglect and acts of omission are the main category for concerns raised in relation to core services delivered by the Trust. The most common themes relate to discharge, communication, pressure ulcers and medication incidents.

The increase in the number of concerns reflect the upward trend in all concerns being raised, however the total number of concerns reported during 2022-2023 remains static at 94. Moving forward, the team plan to collate the number of safeguarding concerns raised that do not progress to Section 42 enquires, as not all concerns meet the safeguarding threshold.



5.3 The Trust has participated in nine Safeguarding Adult Reviews (SAR) in 2022-2023, some are still awaiting publication. Locally within the Teesside area, there have been recurrent themes around diabetes, homelessness, storage of medication, overdosing to secure accommodations, coercive control (controlling access to medication).

National learning has been identified from the 'Eileen Dean' SAR, where lack of reporting and sharing of information regarding violent incidents on discharge, led to the death of a care home resident. This has been shared widely, and the Trust Discharge Team are using their OPTICA system to identify safeguarding/violent incidents via the incident reporting system, to share with clinicians planning discharges.

Organisational abuse has been identified within the executive summary from the Whorlton Hall review, however full publication of the report is delayed due to ongoing criminal prosecution. Adult N identified themes of domestic abuse and sexual exploitation, which closely mirrors the learning from the local "Molly" SAR. In response the Trust is working with the TSAB to develop a tool to identify sexual exploitation.

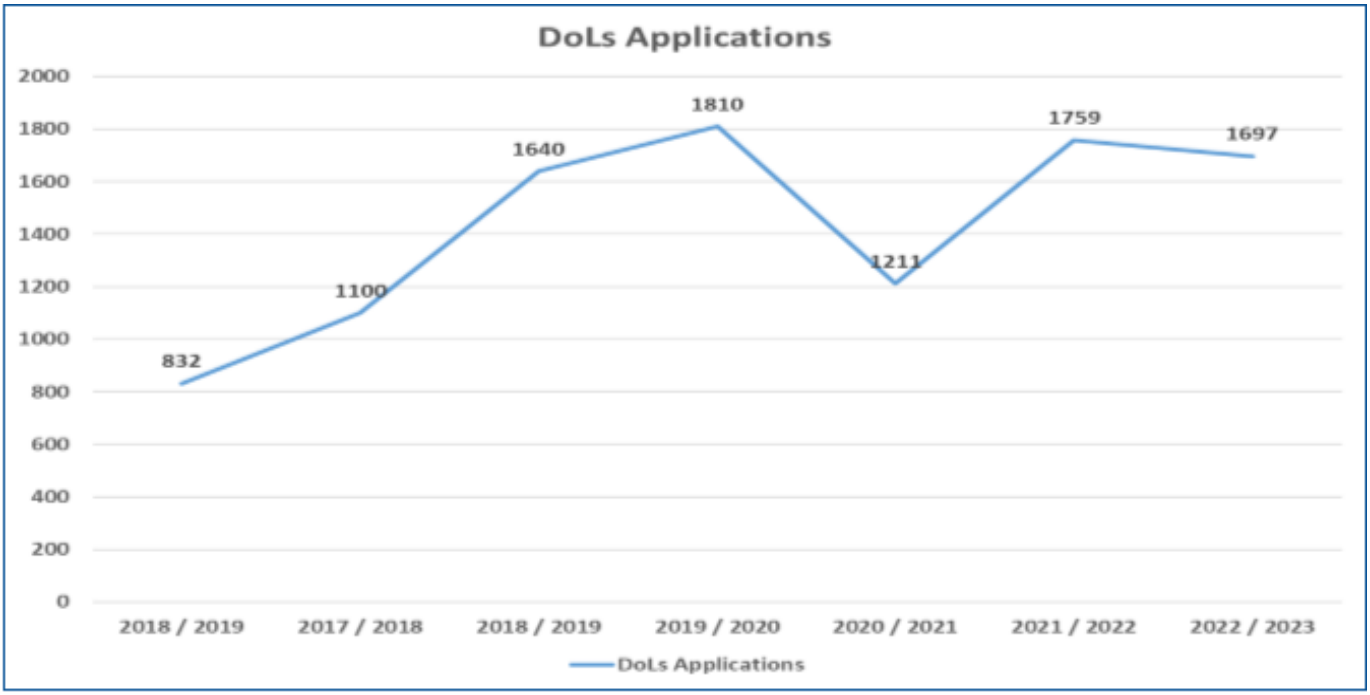
5.4 The service have introduced weekly situation reports (SITREPS) to share safeguarding concerns raised, outstanding actions required, and rapid sharing of any learning or themes emerging. These are sent to the Senior Clinical Matrons' and Associate Directors of Nursing to give them oversight and to disseminate widely within their teams. Safeguarding Training compliance is also shared on SITREPS to ensure areas are aware of their compliance.

5.5 The safeguarding children and adult champions are now a combined role, to further embed the 'Think Family' approach. Additionally, quarterly safeguarding briefings are prepared to share themes and learning with the champions who can disseminate this information into their areas. This assists in providing assurance in relation to learning and actions following safeguarding concerns regarding the Trust. SMART action plans developed from cases are now a regular feature of safeguarding reports and these are added into the action plan module on the incident reporting system to aid monitoring and tracking to completion.

5.6 Deprivation of Liberty Safeguards (DoLS) came into being following the Supreme Court rulings in "*P v Cheshire West and Chester Council and another*" and *"P and Q v Surrey County Council*". The Supreme Court ruling provided 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, is under continuous supervision and control and they are not free to leave, then they are being deprived of their liberty. DoLS are the legal framework that enable the Trust to lawfully deprive a person, who lacks capacity to consent to their care and accommodation, of their liberty.

5.7 DoLS applications made by the Trust have remained consistent following a dip during Covid restrictions. The DoLS database is well established and all applications are flagged on Trakcare with their expiry dates. Notifications of applications are sent to the CQC, although due to the significant increase in activity, this remains challenging to achieve within the statutory 28 days. This is currently being supported utilising NHS Professional provision using unfilled vacancy hours in the service; a job description is being finalised for a more permanent solution to support the service.



5.8 Proposed national changes to move to Liberty Protection Safeguards, from the Mental Capacity Act 2005 (amended 2019) have been stood down for the life of this Parliament, and will not be implemented. The previously identified risk related to this for the Trust has subsequently been removed from the risk register.

5.9 The Adult Safeguarding team includes a Specialist Dementia Nurse/Safeguarding Advisor for people with Dementia. The Dementia Nurse confirms any dementia diagnosis for patients and adds an electronic flag the electronic record system to support recognition of their ongoing care needs. The number of flagged patients is now circa 5,420. In 2022-23, 61 referrals were received from wards to support patients with dementia, and their carers, via a telephone referral system. Mandatory Dementia Awareness training compliance remains above target; this is delivered via an online package on ESR.

Dementia Training 2022-2023		
	Target compliance	Trust compliance
Level 1	80%	95%
Level 2	80%	92%
Level 3	80%	96%

The Dementia Nurse also provides face-to-face Health Education England (Tier 2/3) training for Dementia Champions. All clinical areas have at least two dementia champions to provide additional support for their patients, a further 34 Dementia Champions were trained in 2022-23, this is a significant increase.

The National Audit of Dementia (NAD) round five has been completed; supported by the Clinical Effectiveness Team, with results are due for publication in August 2023. The NAD aims to identify and improve the patient care and experience of those living with dementia, which in turn support and enables the Trust to work towards achieving its Dementia Strategy, 2022-26.

5.10 The Adult Safeguarding team includes a Specialist Learning Disability Nurse and Safeguarding Advisor for people with learning disabilities. The Learning Disability Nurse proactively identifies appropriate patients within the acute setting via the use of a virtual ward, and provides specialist advice on reasonable adjustments, planning discharges, also supporting and facilitating Best Interest meetings.

5.11 Electronic flagging is vital for early identification and the subsequent provision of interventions for patients with learning disabilities who require reasonable adjustments to reduce health inequalities and promote individualised care. The Trust has worked with Tees, Esk and Wear Valley NHS Trust (TEWV) to share diagnosis of Learning Disability and Autism via a service level agreement. This will enable us to flag people accessing Trust services, who have a learning disability and/or Autism. The Trust has circa 2,126 patient flagged electronically as having a learning disability, and 384 flagged as Autistic/Autism.

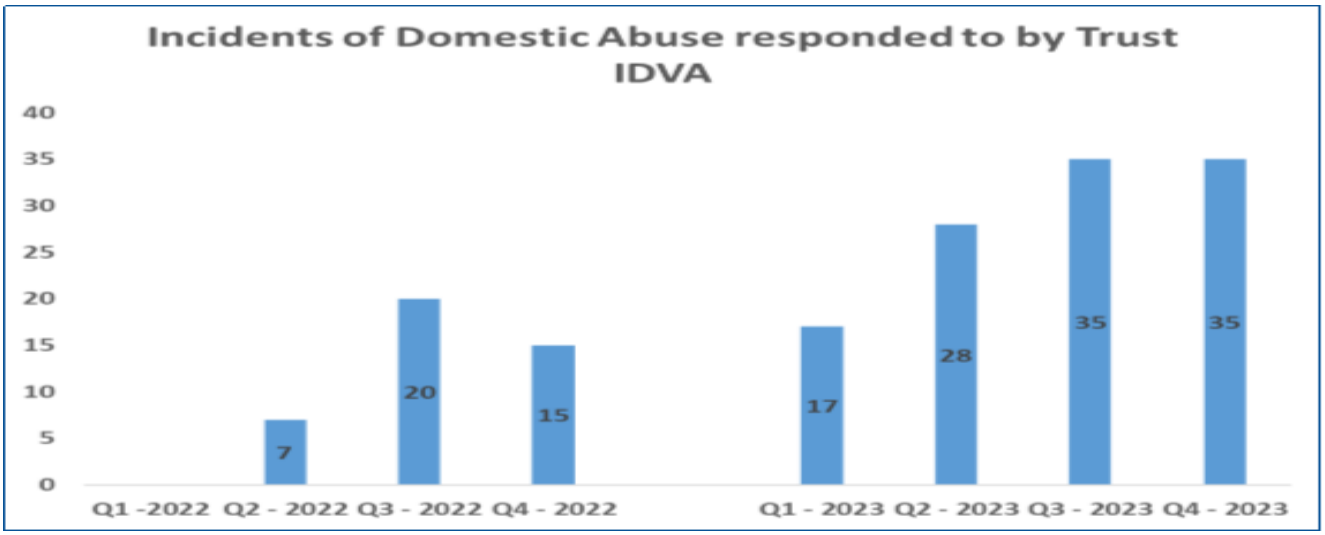
5.12 The Learning Disability Nurse now receives daily reports for out of hours' attendances of patients with Learning Disabilities, this has aided the identification of patients using ED services rather than contacting GP and supports them being signposted appropriately.

5.13 Learning from Lives and Deaths; People with a Learning Disability and Autistic People (LeDeR) is a national initiative to review the deaths of all people with learning disabilities and/or autism. It aims to identify any learning that can reduce health inequalities for this group of people who live less long than the general population. The Trust is actively involved in contributing to this process to ensure any learning from deaths of people with learning disabilities is shared. During 2022-23, twelve reviews were carried out; this had been a slight increase to the ten carried out in 2021-22. This increase may reflect the more recent inclusion of Autistic people. Again, learning from LeDeR is shared via operational and council meetings, via SITREPS and quarterly safeguarding briefings. Learning is also shared with the Trusts Mortality leads for inclusion in the Learning from Deaths report.

5.14 The Learning Disability Nurse completed the NHSI Learning Disability Standards national clinical audit to enable benchmarking and identify areas for development to further reduce health inequalities for this vulnerable group.

The current service does not specifically include specialist Autism provision; this is a gap in the service that will be reviewed as part of business planning 2023-24.

5.15 The Adult Safeguarding team includes an Independent Domestic Violence Advisor (IDVA), funded via Harbour. The IDVA, with consent, can: offer safety advice and risk assessment, make referrals into Multi-Agency Risk Assessment Conferences (MARAC), organise refuge support, complete safeguarding concern forms, offer housing support, support and signpost individuals to access other services.



5.16 The increase in referrals as outlined in the above chart reflects increased awareness of the role and support that can be offered. This service aims to reduce risk to patients, improves their experience and reduces frequency of social admissions due to early intervention. This also reduces time in inpatient beds/ED due to expediting discharge through the IDVA contacts and support.

Domestic abuse is "flagged" on Trakcare to enable victims to be identified and supported.

The Trust has not been involved in any Domestic Homicide Reviews for the period of this report.

5.17 The Trust utilises the government e-learning training package for the PREVENT agenda for staff. This training is currently being refreshed to reflect new ideologies and terminologies, and will be made available to staff once released. 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.

Training Level	Target compliance	Trust compliance
PREVENT Levels 3,4 &5 (WRAP)	80%	92%
Basic PREVENT Awareness Levels 1 & 2 (BPAT)	80%	83%

The Named Nurse for Safeguarding Adults is an active member of the regional PREVENT networks and provides updates to the Safeguarding Operational and Council meetings.

5.18 A Service Level Agreement (SLA) is in place with TEWV to provide Mental Health Act advice. There is currently a potential risk from Liaison Psychiatry services being unable to meet required timescales to assess patients, due to staffing issues. However, there have been no reported incidents of delay in assessments.

5.19 The Trust has recently approved its first Mental Health Strategy 2023-26; this document sets out the ambitions for the next three years and demonstrates how the Trust will work towards delivering an integrated approach to physical and mental health.

The NHS Long Term Plan articulates the need to improve the provision of mental health services and to ensure parity in the delivery of physical and mental health care. This will be achieved by working towards the integration of services to enable a whole person approach across systems. The increasing presentation of patients who require mental health support and the commitment to better support patients with long-term physical conditions is a driver in further developing the skills of our staff to provide the best patient care.

A Mental Health Review Group has been convened to identify and mitigate risks for patients experiencing Mental Health disorders within the trust. This currently meets monthly and reports to the Safeguarding Operational Group and is monitored by the Safeguarding Council.

A SLA is also in place for TEWV to provide Mental Health Act Training for lead professionals on behalf of the Trust. This training has been planned for the upcoming year and will be delivered via teams. An updated Mental Health Resource pack is also now available on SharePoint to provide Trust staff with current information and support.

6.0 Learning from Local, Regional and National Safeguarding Reviews

6.1 Between March 2022 – 2023, the Trust has contributed to four Rapid Reviews facilitated by Hartlepool and Stockton Children's Safeguarding Partnership in response to notification of serious safeguarding incidents where a child has suffered significant harm. Three of these four children died as a result of indicators of harm. None of these Rapid Reviews progressed to a Local Safeguarding Practice Review (LSCPR) as agreed by the National Panel, learning and actions were robustly analysed within the rapid review and it was felt no new learning would come from an LSCPR.

Contextual safeguarding was central to one of the reviews resulting in the death of a young adolescent due to exploitation, there was no significant learning for the Trust. Sudden unexpected deaths in infants (SUDI) featured in two separate reviews of babies where further indicators of neglect, historical domestic abuse, substance misuse and previous social care involvement were identified. Unsafe sleeping practices were significant contributing factor however all appropriate health promotion was provided by the Trust around safe sleeping. There was no significant learning that was identified from these reviews that would indicate that any change in practices would have prevented these deaths. A facilitated learning review is waiting to be carried out in response to the death where there were features of the child not being brought to appointments. There have been no Rapid Reviews during this year with our Durham Safeguarding Children's Partnership where the Trust has been involved.

6.2 The Trust has participated in nine Safeguarding Adult Reviews in 2022-2023, some of which are still awaiting publication. Locally there have been recurrent themes around diabetes, homelessness, storage of medication, overdosing to secure accommodations, coercive control (controlling access to medication), (also covered in section 5.3).

National learning for adult safeguarding which directly impacts the Trust has been identify through 'Eileen Dean' where lack of reporting and sharing of information regarding violent incidents on discharge, led to the death of a care home resident. The Trust Discharge Team use a system called OPTICA which can pull through safeguarding concerns to their clinicians.

Organisational abuse has been identified within the executive summary around the Whorlton Hall review. Full publication of the report is delayed due to ongoing criminal prosecution.

Adult N - The learning from this included Domestic Abuse, Sexual exploitation. This closely mirrored the learning from "Molly". The Trust has embedded the Stockton Domestic Abuse Strategy so there are "no wrong doors" when domestic abuse is disclosed.

6.3 All actions identified for the trust through learning reviews are shared and monitored through appropriate safeguarding operational groups and Safeguarding Council.

7. Items for escalation

7.1 There are no specific items to be escalated to the Board in relation to the information within this report. The information in relation to Safeguarding is escalated through the Safeguarding Council

and up to the Quality Assurance Committee for all actions to be agreed, implemented and monitored.

8. Key issues, significant risks and mitigations

8.1 The Liberty Protection Safeguards implementation has been delayed beyond the life of this Parliament and has therefore been removed from the Trust risk register

8.2 The resourcing for TEWV Liaison Psychiatry services remain on the risk register. This is being monitored through quarterly updates to the Quality Assurance Committee and through the newly established Mental Health Review Group to provide a framework to progress the Trusts new Mental Health Strategy.

8.3 Autism provision remains on the risk register and is currently being mitigated by the Learning Disability nurse providing support for reasonable adjustments, completion of national audit and LeDeR reviews. This is a gap in the service that is to be reviewed, and resolved during 2023-24.

8.4 Deprivation of Liberty CQC notifications are challenging to achieve within prescribed time frames. This is currently being supported utilising NHS Professional provision using unfilled vacancy hours in the service; a job description is being finalised for a more permanent solution to support the service.

8.5 Training compliance is not at the Trusts current contractual target of 100%; the local quality requirements are currently being agreed. This is being monitored closely by the Safeguarding Council and escalated to QA Committee as needed. The service is developing a proposal to combine both training programmes to mitigate risk of non-compliance; this will be supported by the continuation of the online training packages.

8.6 There is no substantive Designated Nurse Safeguarding children or Designated Doctor Safeguarding Children in post at the ICB. This is currently mitigated by support from the Named Doctors and Named Nurses across the region. This remains on the Trust Risk register, and has been escalated.

8.7 As contextual safeguarding (harm outside the home through exploitation within the community and online) and domestic abuse continue to be an increasing challenge for our children and young people, robust sharing of information and working together practices continue to be paramount. The team continue to work collaboratively with other partner agencies to ensure the trust identifies risk early, consider the wider context of safeguarding children in creating safe spaces and places for our children.

8.8 There is an increasing long awaited focus on challenges to supporting our children between 14 – 24 years old, transitioning between children and adulthood services. Acknowledging the additional extra support that they require in negotiating risk, especially for those with additional vulnerabilities such as those children with autism and learning difficulties. Our challenge as a trust is to acknowledge the very different needs of this age group through the creation of a transitional safeguarding role. This role can challenge transitions of care and increase the awareness of health professionals to be more trauma informed with the need to understand the impact of adverse childhood experience. This supports getting the right help in early childhood to mitigate risk taking behaviour and the need to safeguard within adulthood.

8.9 There have been three independent Review of Children's social care in the last year:

- The Independent review of children's social care highlighting love and importance of relationships at the heart of social care delivery and has led to Stable Homes, built on love implantation strategy and consultation published in February 2023.

- The Children's Safeguarding practice review in to the tragic deaths of Arthur Labinjo-Hughes and Star Hobson recognising ongoing failings in the way services collectively and effectively safeguard children.

- The competition markets authority review highlighting that we are not good enough at ensuring the right homes in the right places for children who come into care. These call for fundamental reform and provide an opportunity for our trust to be involved in supporting our social care colleagues in resetting children's Social Care, and has resulted in updates to Working Together to Safeguard Children consultation in how we can all achieve this together, ready for publication in Autumn 2023.

9. Conclusion/Summary/Next steps

9.1 The Trust continues to operate safe services in relation to discharging its statutory responsibilities to safeguarding services for both adults and children and meet its statutory requirements. The Trust remains committed to multiagency work, participation in subgroups and dissemination of learning locally, regionally and nationally. There are areas of excellent practice including the work on perplexing presentations and fabricated or induced injuries; dementia training; safeguarding champions; the development QR codes, and collaborative working. As we move forward, focus will be maintained on the parity between mental health and physical health, and on autism support and transitional safeguarding.

9.2 A whole service establishment review will be completed to establish workforce priorities to incorporate emerging specific needs of adolescents.

9.3 Await the confirmation of the required training compliance levels from the ICB, continue to plan to combined Safeguarding Children and adult training to enhance and embed a 'Think Family' approach. This will include development of a rolling program of simulation training for staff around Safeguarding, SUDIC and infant / child abduction.

9.4 A collaborative regional approach will develop an "Adult Not Brought policy" to reduce the risk of harm to those who are dependent on others and are unable to bring themselves to appointments.

9.5 The Safeguarding team will continue to capture meaningful Safeguarding data across the Trust to inform targeted responses to quality improvements. This will include refreshed Adult Safeguarding and Mental Capacity Act audits. Policies and pathways will be continue to be updated and developed where necessary, informed by evidence, legislation, local and national learning and statutory safeguarding guidance and standards.

10. Recommendation

10.1 The Board are asked to gain assurance that mandatory safeguarding training is provided to support embedding a "Think Family" approach through combining children's and adult safeguarding training and cross pollinating learning from both adult and children local, regional and national reviews. That the mandatory training compliance is monitored closely and areas of variance escalated to the QA Committee.

10.2 The Board are asked to gain assurance that in-depth multidisciplinary and multiagency working is utilised to provide learning from safeguarding concerns through dissemination of Partnership training.

10.3 The Board are asked to gain assurance that patients are lawfully deprived of their liberty through the monitoring of Deprivation of Liberty Safeguards applications and the CQC are notified as required by the team.

10.4 The Board are asked to gain assurance that Mental Health provision receives parity of esteem within the Trust with ongoing work to support the new Mental Health Strategy.

10.5 The Board are asked to gain assurance that appropriate support is provided for patients with a learning disability to enable equitable treatment, via identification and reasonable adjustments. Ongoing work continues to provide additional support to Autistic patients.

10.6 The Board are asked to gain assurance that patients with dementia are supported to have their individual needs met by identification via electronic flagging, additional Champions training and support for carers.

10.7 The Board are asked to gain assurance that the PREVENT agenda is adhered to via mandatory training.

10.8 The Board are asked to note the provision of domestic abuse services in with partnership with Harbour.

10.9 Board members are asked to discuss safeguarding concern reporting and lessons learned with staff members when they are undertaking departmental visits.

Lindsey Robertson
Chief Nurse / Director of Patient Safety and Quality

Excellence as our standard

North Tees and Hartlepool NHS Foundation Trust

Quality Committee

Title of Report	Assurance Report of the Quality Committee										
Date:	28 September 2023										
Prepared by:	Fay Scullion, Non-Executive Director, Chair Quality Committee										
Executive sponsor:	Lindsey Robertson, Chief Nurse, Director of Patient Safety and Quality										
Purpose of the report	The purpose of this report is to provide the Board with an update in relate to Patient Quality and Safety: - Identifying key emerging themes and trends that may have an impact on Quality and Safety - Risks for the Board to note - Provide reassurance to the Board										
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 Patient Quality strategy provides the framework to ensure that we achieve the highest quality of services for patients. Each meeting commences with the patient story, as this ensures that what we are striving to achieve has an impact on the population that we serve and demonstrates steps in delivering the strategy. Integral to the Quality Meeting is the designated representative from the population that we serve.

At the beginning of each meeting The Board Assurance Framework is a standing agenda item in the Quality Assurance Committee, which generates scrutiny and discussion. In addition, there are standing reports regarding Infection Prevention and Control, Integrated Performance Report and Executive Summary Reports.

As part of the QC workplan there are a series of annual reports that are provided as an annual update, or a quarterly update. A recent change in focus has resulted in these reports highlighting key achievements and areas for exception reporting and escalation / risk, rather than verbatim reports.

The Board Assurance Framework is the primary agenda item ensuring that the Strategic Risks are discussed early in the committee and that they are considered as the Committee progresses and other item items are tabled and discussed.
this paper provides a position on progress in relation to the three areas of Safety, Experience, and Effectiveness as the core elements of quality. A core and fundamental element of this work is the sustained focus on clinical risk and the Associate Director of Nursing and Risk, this work is monitored via the Risk Management Group and an update is included.

Whilst significant progress is being made there are areas for the board to note:

- Pharmacy workforce issues present a risk to the delivery of the CQUIN concerned with appropriate switching from IV antibiotics to oral administration.
- There are three overdue audit reports to be presented at ACE Council. These have been escalated to the Audit Lead in Responsive Care and include the National Diabetes Audit, National Audit of Seizure Management and Myocardial Infarction National Audit.
- There remains a risk of non-compliance with CNST Maternity Safety actions 4, 5, and 8 with mitigating actions in place and monitored.
- Mental Health Liaison services pose a risk to patient care and impact on the delivery of the mental health strategy
- Cancer standards have fallen and now meeting only 4 and this will have an impact on treatments and clinical outcomes. Industrial action and staff vacancies have contributed to this and action needs to be taken
- The CQC must have and should actions are now complete

Strategic Risk linked to the Board Assurance Framework this report relates to:

The Committee reflects on the three BAF objectives and August position was presented at the September meeting. The BAF objectives are:

1a Patient Safety
1b Patient Experience
1d EPRR

No changes to current Risk status linked to BAF

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*

Equality, diversity and or disability		Reputational	x
Workforce	x	Environmental	
Financial/value for money	x	Estates and Facilities	
Commercial		Compliance/Regulatory	x
Quality, safety, experience and effectiveness	x	Service user, care and stakeholder involvement	x

Recommendation

The Board is asked to approve the report and be assured that the work continues in line with the Trust portfolio.

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NHS North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Assurance Report of the People Committee										
Date:	5 October 2023										
Prepared by:	Gary Wright, Deputy Chief People Officer										
Executive sponsor:	Susy Cook, Chief People Officer / Director of Corporate Affairs										
Purpose of the report	The purpose of this report is to provide the Board of Directors an overview of the work of the people Committee and specifically the committee meeting held on 28 September 2023.										
Action required:	Approve		Assurance		Discuss		Information	X			
Strategic Objectives supported by this paper:	Putting our Population First		Valuing People	X	Transforming our Services		Health and Wellbeing	X			
Which CQC Standards apply to this report	Safe		Caring		Effective		Responsive		Well Led	X	

Executive Summary and the key issues for consideration/ decision:

A summary of the key points from the People Committee held on 28 September 2023:

BAF - The Trust's Board Assurance Framework (BAF) sets out the strategic objectives of the organisation and the BAF contains a section that specifically relates to People (BAF Reference: 2A). Whilst the People section of the BAF links to all other sections of the BAF, the key link is to Strategic Aim: To ensure every member of our staff feel valued (Corporate Strategy and People Plan) / Principal Objective: to have a workforce that is compassionate and inclusive, recognised and rewarded, has a voice that counts, are safe and healthy and always learning (People Plan). The People Committee will continue to receive a monthly update regarding the BAF and assurance on the management and mitigation of strategic risks. There are currently four strategic risks included on BAF 2A. The BAF 2A is aligned to the four pillars of the NHS People Plan:

- Risk of not looking after our people
- Risk of staff not having a sense of belonging
- Risk of not growing a workforce for the future
- Risk of not developing and embedding new ways of working and delivering care.

It was agreed that these four themes will be revised to be more meaningful for our trust whist aligning to the NHS People plan.

In summary terms, the following key causes of risk (though not exhaustive) are included in the BAF;

- Not having appropriate levels of staff with the right skills to deliver safe services
- Not having adequate processes in place to manage sickness absence management
- Not having plans and support for staff in place during periods of industrial action
- Not having robust / consistent processes in place in relation to managing people practice cases
- Not having relevant staff trained
- Not having in place leadership and talent management processes across the Trust

The committee agreed the following:
1, to merge BAF 2A and 2B
2, consider the risk appetite

3, Invite the owner of BAF 4A (health and wellbeing) to present / provide assurance at the next committee meeting.
4, to refresh the four themes of the People BAF to ensure more meaningful to out Trust whilst aligning to the NHS People plan.
5, Write to AuditOne via Audit Committee regarding outstanding People practices audit from Q3 22//23.

People Metric – The committee received a report outlining the key metrics monitored by the people directorate including:

- Appraisal
- Mandatory training
- Turnover
- People practice cases
- Occupational health
- recruitment

The position for appraisal compliance from August 2023 Trust RAG report stands at 87.24% which is an increase of 0.68% on the previous month.

Mandatory training compliance for August 2023 is 90.18%, which represents a decrease on the previous month of 0.64%.

The sickness absence rate increased from 4.94% in June 2023 to 5.39% in July 2023.

Turnover for August 2023 is 9.30% which is 0.12% lower than July 2023.

There are currently seven live cases. This is below the target with the internal estimated metric of nine formal cases.

No new cases are reported in the current month. The total number of cases by percentage of Trust head count (5099) is 0.13%, which is an improvement by comparison from the 2022 rate of 0.22%

The Trust's time to hire metric for August 2023 is reported at 70.8 days against a target of 60.5 days.

Organisation Development - OD interventions are the programmes and processes which are designed to solve a specific problem. The purpose of these interventions is to improve an organisations efficiency and help leaders manage more effectively. These interventions can be categorised into five types. The Organisation Development team provide support for each of the five areas of interventions:

1, Individual
2, Team
3, Departmental
4, Organisational
5, Pan-organisational

The committee acknowledged the range of complex interventions currently underway supported by the OD team in conjunction with AQUA and NECS.

Guardian of Safe Working – The committee received the Guardian of Safe Working annual report 22/23. The role of the guardian includes:
1, ensure the confidence of doctors that concerns will be addressed
2, require improvements in working hours and rotas
3, champion safe practices and exception reporting

4, provide assurance to the Board that junior medical safe are safe to work, identify risk and advise on required response			
Board Assurance Framework/Corporate Risk Register risks this paper relates to:			
BAF 2A and 2B			
Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or inclusion		Reputational	
Workforce	X	Environmental	
Financial/value for money		Estates and Facilities	
Commercial		Compliance/Regulatory	
Quality, safety, experience and effectiveness		Service user, care and stakeholder involvement	
Board Subcommittee meetings where this item has been considered (specify date)		Management Group meetings where this item has been considered (specify date)	
People Committee 28/09/23		N/A	
Recommendation	The Board of Directors are requested to note the work of the People committee, specifically the links to the Board Assurance Framework 2A and 2B.		

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North Tees and Hartlepool NHS Foundation Trust

Report to the Trust Board

Title of report	Report of the Resource Committee										
Date	5th October 2023										
Prepared by	Chris Macklin, Non-Executive Director (Chair)										
Executive sponsor	Kate Hudson-Halliday, Acting Director of Finance Linda Hunter, Director of Planning and Performance Neil Dobinson, Interim Deputy CITO Michael Houghton, Transformation Director										
Purpose of the report	To provide assurance to the Trust Board regarding the efficiency and effectiveness of the Resource Committee, meeting that took place on the 26th September 2023.										
Action required	For Decision		For Assurance	X	For Information	X					
Strategic Objectives supported by this report	Putting our Population First	X	Valuing People	X	Transforming our Services	X	Health and Wellbeing	X			
CQC Domain(s) supported by this report	Safe	X	Caring	X	Effective	X	Responsive	X	Well Led	X	

Executive Summary and the key issues for consideration/ decision:

The meeting was confirmed as quorate with 2 NEDs present in accordance with the Terms of Reference, the Chair agreed the meeting could proceed.

The Chair noted this was the first Resource Committee meeting merging the Finance Committee, Digital Strategy Committee, Performance, Planning and Compliance Committee and Transformation Committee. The last minutes from previous meetings were confirmed as accurate.

The agenda for the meeting allowed each item to be discussed in detail and any issues agreed to be taken forward.

Matters for Escalation

There were no matters for escalation to Board.

Key Issues Discussed

Minutes of the meeting held for the final separate committee meetings were approved as accurate and signed off.

A wide range of issues were discussed including:

- TOR for the Resource Committee
- Board Assurance Framework and Risk Update Report – Planning and Performance.
- Board Assurance Framework and Risk Update Report – Finance
- Board Assurance Framework and Risk Update Report – Digital Strategy

- Board Assurance Framework and Risk Update Report – Transformation
- Integrated Performance Report
- Protecting and Expanding Elective Capacity Gap Analysis
- Operations Report
- Financial Position – Month 5
- Financial Management Performance Framework – Month 5
- CIP Update
- I&TS Update & Assurance Report August 2023
- Transformation Update Report

Decisions Made

- The Resource Committee approved to remove separate BAF domains for Transformation (3B & 3E) and instead, controls assurance and planned actions would transfer to other relevant BAF domains. Transformation is a standard agenda item on each of the Committees and the Director of Transformation attends each meeting.
- Decision made in principle of the Terms of Reference and these are to be circulated to the members following the first meeting and complete sign off in the October 2023 meeting.

Strategic Risk linked to the Board Assurance Framework this report relates to:
This report links to section 1C (Performance), 3B (Transformation), 3C (Finance), 3D (Digital) and 3E (Transformation external).

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and inclusivity	x	Reputational	x
Workforce	x	Environmental	x
Financial/value for money	x	Estates and Facilities	x
Commercial	x	Compliance/Regulatory	x
Quality, safety, experience and effectiveness	x	Service user, care and stakeholder involvement	x

Committees/ Groups where this item has been presented before
The minutes from the Resource Committee meeting on 26th September 2023 will be brought to approval by the Committee October 2023.

Recommendation	The Board of Directors is requested to note this summary report of the meeting of Resource Committee held on 26th September 2023.

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North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report	Assurance Report of the Risk Management Group										
Date	5 October 2023										
Prepared by	Stuart Irvine, Director of Strategy, Assurance & Compliance										
Executive sponsor	Neil Atkinson, Managing Director										
Purpose of the report	To provide assurance to the Board of Directors regarding the Risk Management Group meeting on 29 September 2023.										
Action required	For Decision		For Assurance	X	For Information	X					
Strategic Objectives supported by this report	Putting our Population First	X	Valuing People	X	Transforming our Services	X	Health and Wellbeing	X			
CQC Domain(s) supported by this report	Safe	X	Caring	X	Effective	X	Responsive	X	Well Led	X	

Executive Summary and the key issues for consideration/ decision:

Due to a number of Trust commitments, the meeting of the Risk Management Group that was planned to take place on 29 September 2023, was conducted virtually, rather than standing the meeting down.

Matters for Escalation

One new operational high risk has been identified in August 2023, relating to neonatal and Children & Young People's acute service delivery (and associated pathways) due to potential Consultant vacancies. The risk is being managed operationally within the Care Group and monitored through the Paediatric Standards and Improvement Group. The risks are referenced within the Board Assurance Framework and was discussed within the Committee structure and this will be re-assessed monthly.

This is in addition to the existing two red risks relating to the Trust's ageing estate and delivery of savings.

Key Issues Discussed

Minutes of the meeting held on 4th July 2023 will be confirmed at the next meeting of the Risk Management Group on Friday 27th October 2023.

The content of the papers for the meeting on 29 September 2023, included the following key areas;

- Risk Register Report (to 31st August 2023)
- Committee Updates
- Risk Management Enabling
- Risk Management Education and Training
- Risk National Picture
    - Price Cooper Waterhouse - National Risk Profile
    - Participation in TIAN National benchmarking
- Committee Forward Plan

Future Action

Price Waterhouse Cooper (PWC) Top Ten NHS Risks will be utilised for benchmarking purposes and will be considered to inform the future content of the Trust's Board Assurance Framework.

Strategic Risk linked to the Board Assurance Framework this report relates to:
This report links to all domains in the Board Assurance Framework.

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and inclusivity	X	Reputational	X
Workforce	X	Environmental	X
Financial/value for money	X	Estates and Facilities	X
Commercial	X	Compliance/Regulatory	X
Quality, safety, experience and effectiveness	X	Service user, care and stakeholder involvement	x

Committees/ Groups where this item has been presented before
N/A.

Recommendation	The Board of Directors is requested to note this summary report.