ANNUAL QUALITY REPORT (Quality Accounts) 2016-17

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 introduce the North Tees and Hartlepool NHS Foundation Trust Quality Accounts for 2016-17 which demonstrates our continued commitment to strive for excellence and high performance in order to deliver care of the highest quality. The report focuses on our performance over the last year as well as our key priorities for 2017-18.

The 2016-17 financial year has again proven to be a very busy year where we continued to achieve high performance overall and good outcomes for patients across the Trust despite a very challenging financial budget.

As always we continue to appreciate the excellence of our staff, and in this reporting period our staff have been particularly recognised for their achievements throughout the year, having been nominated for a number of awards. It is not only our staff that deserve recognition for their hard work, but also all of our volunteers, members, governors and other partners and stakeholders.

A big improvement for 2016-17 related to our Hospital Standardised Mortality Ratio (HSMR) and Summary hospital-level mortality indicator (SHMI) mortality values, ensuring that these values reduced closer to the national mean. The Trust instigated numerous actions in relation to this, all overseen by the Deputy Medical Director. The Trusts recent HSMR and SHMI values are now within the 'as expected' range and I would like to thank all staff members aiding in this reduction, whilst maintaining high standards of care. The Trust continually works with external bodies to ensure as an organisation we have third party assurance on the work we are undertaking.

This reporting year the Trust was set a very low Clostridium difficile target by our commissioners of no more than 13 hospital acquired cases. Even though the Trust failed to meet this target, the report will outline the actions taken during this financial year with the aim to improve future infection rates.

Following the Care Quality Commission (CQC) inspection in July 2015, the Trust was rated overall as **'requiring improvement'** but achieved a good rating for safe, caring and responsive care, of the 85 individual ratings, 65 were rated as good. The report will outline the actions taken by the Trust to meet the CQC requirements for improvement and to detail the improvements so far.

The Trust held its third annual Quality Accounts Marketplace on 14 December 2016 at the North Tees site; this event was well received and attended by our stakeholders. This event produced our quality strategy and Quality Accounts priorities for 2017-18. The priorities have been developed with patients, carers, staff, governors, commissioners and with key stakeholders including health scrutiny committees, local involvement networks (Healthwatch) and Healthcare User Group (HUG).

The Trust continues to receive regular comments and reviews from patients, carers and family members on NHS Choices; the two sites are currently rated as follows:

- University Hospital of North Tees is rated at **4.5** out of 5
- University Hospital of Hartlepool is rated at **4.5** out of 5

We continue to believe and commit to Putting Patients First by making patient safety and patient experience our number one priority every day.

To the best of my knowledge the information contained in this document is an accurate reflection of outcome and achievement

Alan Foster pic

Alan Foster MBE

[Signature]

Chief Executive

What is a Quality Report/Accounts?

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

Our quality pledge

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

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

Quality standards and goals

The Trust greatly values the contributions made by all members of our organisation to ensure we can achieve the challenging standards and goals which we set ourselves in respect of delivering high quality patient care. The Trust also works closely with commissioners of the services we provide to set challenging quality targets. Achievement of these standards, goals and targets form part of the Trust's four strategic quality aims.

Listening to patients and meeting their needs

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

Over the last year we have spoken with over 45,000 patients in a variety of settings including, in 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.

Unconditional CQC Registration

During 2016-17 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.

CQC Rating

The Trust was inspected during 2015-16 by the CQC and was rated as '**requiring improvement'**, the CQC section within this report provides greater detail of the work undertaken to improve this rating.

Achievements 2016-17

Congratulations to all of our staff who picked up awards or who were shortlisted at the Hartlepool Mail Best of Health awards. They were:

Employee of the month – The winners of the Trusts employee of the month scheme which was started last year:

- **April 16** – Claire Woodhouse (Health Visitor)
- **May 16** – Lorraine Miller (Chaplain)
- **June 16** – Gail Fincken (Site clinical co-ordinator)
- **July 16** – Lyndsey Brownless (District nursing sister)
- **August 16** – Emma Brown (Associate practitioner)
- **September 16** – Andy Howard (Deputy Head porter)
- **October 16** – Jane Hird (EPAC specialist nurse)
- **November 16** – Mohammed El-Bashir (Trust registrar)
- **December 16** – Melanie Wenn (Family nurse)
- **January 17** – Lisa Tomlinson (Healthcare assistant)
- **February 17** – Junior Doctor Maria Samuels
- **March 17**

Congratulations Amanda – Successfully passed a diploma to become a qualified plaster technician

Congratulations to the two sets of winners of the Trust's clinical audit prize. First prize for use of the paediatric early warning score for unwell children went to medical trainees in A&E Gemma Foran and Sobia Hussain. Second prize for community acquired pneumonia: high frequency simulation project went to A&E consultant Kate Williamson.

Two cohorts of staff have become dementia champions

Richard Kirton and Ian Cannon helped the trust take silver best in class at Salon Culinaire Hotelympia HCA Hot Cookery Competition.

Occupational health were recognised at the North East Better Health at Work Awards at Hartlepool Borough Hall. The department was handed their third year *Continuing Excellence Award*.

Congratulations to the trust's podiatry team who won C*ommunity Research Engagement award* at the North East and North Cumbria (NENC) Research Network Quality Improvement awards.

Respiratory nurse specialist Barbara Thompson has been recognised with the prestigious title of Queen's Nurse.

Stop smoking service lead Pat Marshall has been awarded a Mayors good citizens award for her contribution to health and wellbeing to the Borough of Stockton since 2004

Healthcare assistants in accident and emergency James Sullivan and Ben Baino are among a group of our staff already completing a new apprenticeship.

The University Hospital of North Tees became the first trust in the northern region to run the national Endoscopic retrograde cholangiopancreatography (ERCP) training, which combines live cases, clinical discussion and hands-on training attracted professionals from across the country.

LIS lean leaders – The first 3 cohorts of staff to complete LIS lean

Congratulations to claims administrator Liz Bainbridge who has completed the Capsticks Diploma in Clinical Risk and Claims Management.

More health care staff at the Trust have achieved 'The Care Certificate' – an assessment which demonstrates their competency and skill in providing safe, high quality care.

- Healthcare assistants in orthopaedic outpatients UHNT
- Healthcare assistants in orthopaedic UHH
- Radiography assistants in the breast unit
- HCA's Medical rehab day unit
- Hartlepool district nursing team
- Stockton District nursing team
- Rapid response teams at Stockton and Hartlepool

The Trust's specialist palliative care team were shortlisted in the compassionate patient care category at the 2016 Health Service Journal (HSJ) Awards.

The following staff received the trust Outcome and Performance Team Award by deputy medical director Professor Jane Metcalf and medical director Dr Deepak Dwarakanath. The award is recognition of their valuable contribution towards the improvement of care and the reduction in mortality rates.

- Consultant geriatrician Helen Skinner
- Clinical coding manager Caroline Griffin
- Doctor in acute medicine Stephen Wiltshire

Nurses recruited from the Philippines completed the last part of their training; the group are all qualified nurses in the Philippines but must still pass the OSCE test - a Nursing and Midwifery Council test of competence preparation, as well as English exams.

Becky Taylor, a staff nurse in the trust's neonatal unit was awarded the Inspirational Mother award at this year's national Butterfly Awards.

Congratulations to the staff in orthopaedic outpatients who have been awarded with a certificate of excellence from the Teesside University

North Tees and Hartlepool NHS Foundation Trust have come top of the rankings for highest overall satisfaction in core general surgery training in the country, from the Messly Training Navigator, based on the General Medical Council survey of trainees

Five of the trust's apprentices were recognised for their hard work at an annual NHS estates apprentices awards evening.

- Jamie Boylan
- Jake Hopkins
- Benjamin Larkin
- Thomas Redpath
- Zach Trattles

The first two cohorts of students who have successfully completed The Royal Society of Public Health Level 3 Diploma in Anatomical Pathology Technology are celebrating their success.

A team made up of two physiotherapists, two social workers, an occupational therapist and a nurse has won best health and well-being initiative in this year's Association of Public Service Excellence Awards (APSE)

Congratulations to Health Visitor Catherine Abidi whose work was recognised at the recent Black History Youth Awards. Catherine, who is the health visitor working with newly-arrived asylum seekers and refugees in Stockton and beyond has supported, educated and comforted thousands of families.

Senior nurses Alison Hamilton, Beth Alderton and Rebecca Poyser have all qualified as surgical practitioners. They are all now able to work at a more advanced level in surgical and clinical care, after passing a demanding training programme.

Scan4Safety lead Jane Hawkes who won the GS1 UK healthcare industry champion at an awards event. This is for work the Trust is doing to roll out a new programme (Scan4Safety) which will involve scanning barcodes to trace things such as patient records and products and will lead to improvements in patient care.

Staff celebrate Armed forces day – Mark Saunders and Vivien Saunders

Finance Healthcare Financial Management Association awards

- Contract income accountant Peter Robinson won accountant of the year
- Stuart Burney, Neill Waters, Jonathan Sheldon and Dan Morris won the Northern branch small team of the year award

Congratulations to Amelia Kehoe who was awarded 'best research paper' by the Association for Medical Education in Europe, for a study carried out around the experience overseas doctors have working in the NHS

Congratulations to our procurement and supplies team who achieved the NHS Standards of Procurement Assessment level 1 accreditation.

Part 2a: 2016-17 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 2015-16. 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 and the public.

Presentations have been provided for various staff groups with the opportunity for staff to comment on and a feedback form is provided for patients views.

Progress is described in this section for each of the 2016-17 priorities.

Stakeholder priorities 2016-17

The quality indicators that our external stakeholders said they would like to see reported in the 2016-17 Quality Accounts were:

Patient Safety	Effectiveness of Care	Patient Experience
1. Mortality	1. Safety Thermometer	1. Palliative Care & Care For the Dying Patient (CFDP)
2. Dementia	2. Discharge Processes Medication	2. Is our care good? (Patient Experience Surveys)
3. Safeguarding Adults	3. Safety, Quality and Infections Dashboard (previously Nursing Dashboard)	3. Friends and Family recommendation
4. Infections		

> “Very efficient, Staff excellent and made to feel very calm, thanks to all. Maybe public should hear about the marvellous side to the NHS. We are all very lucky. [sic]”

Patient pic

Patient pic

Priority 1: Patient Safety

Mortality

1. Mortality

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

Overview of how we said we would do it

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.

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

Overview of how we said we would measure it

- We will monitor mortality within the Trust using the two national measures:
- HSMR (Hospital Standardised Mortality Ratio)
- SHMI (Summary Hospital-level Mortality Indicator)
- We will utilise nationally / regionally agreed tools to assist in assessing levels of clinical care.

Overview of how we said we would report it

- Report to Board of Directors
- Report quarterly to the Commissioners
- Report to the Trust Outcome Performance Delivery Operational Group

Completed and reported?

- Reported to Board of Directors ✓
- Reported to the Commissioners ✓
- Reported to the Trust Outcome Performance Delivery Operational Group ✓

The Trust Board of Directors has an understanding of 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 have both gone from being 'higher than expected' to 'as expected'.

The Trust's Deputy Medical Director has overall responsibility to improve processes that will aid in the reduction of mortality within the Trust.

Weekly centralised mortality reviews are now undertaken twice a week, with mortality workshops being held once a month for clinicians to attend to gain an understanding of the Trusts position and how they play a key part in future improvements

The Trust, while using national mortality measures as a warning sign, is investigating more broadly and deeply the quality of care and treatment provided. Further progress this year will be supported by the following:

- Ensuring a continued close working relationship with North East Quality Observatory (NEQOS) who provide an independent review of a number of indicators and also provide a quarterly mortality report.

- To aid in collaborative thinking the Trust remains part of the Regional Mortality Group, this group has representation from all eight North East Trusts where all key mortality issues are discussed.

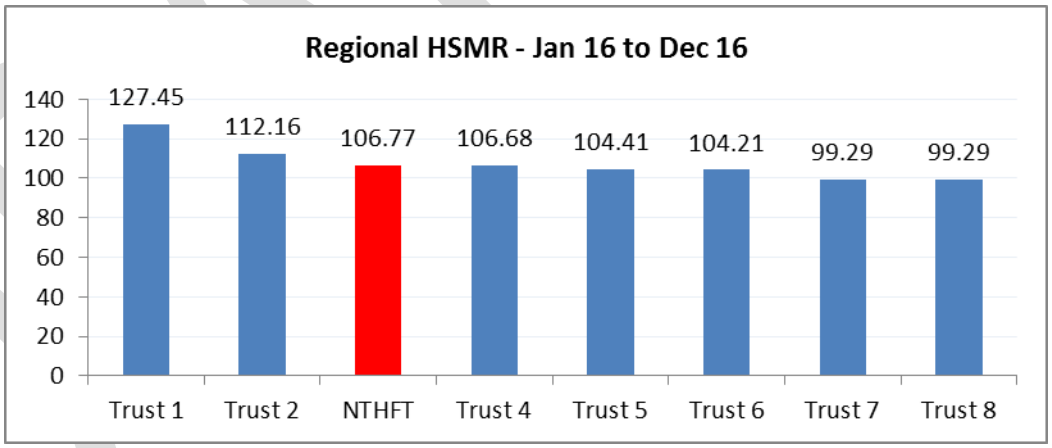
- The Trust will continue to work with partner GPs and the CCGs to examine patient pathways into and out of hospital to tackle overall improvements in end of life pathway delivery and safe discharge processes.

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)
January 2016 to December 2016

The Trust's HSMR value was at one point the 2nd highest value in the country at 128.10 for the 12 month rolling period from April 2014 to March 2015. The Trust has now managed to reduce the value to **106.77** for the reporting period from **January 2016 to December 2016**; this value now places 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 that expected.

Regional Trust Names	HSMR
Trust 1	127.45
Trust 2	112.16
NTHFT	**106.77**
Trust 4	106.68
Trust 5	104.41
Trust 6	104.21
Trust 7	99.29
Trust 8	99.29



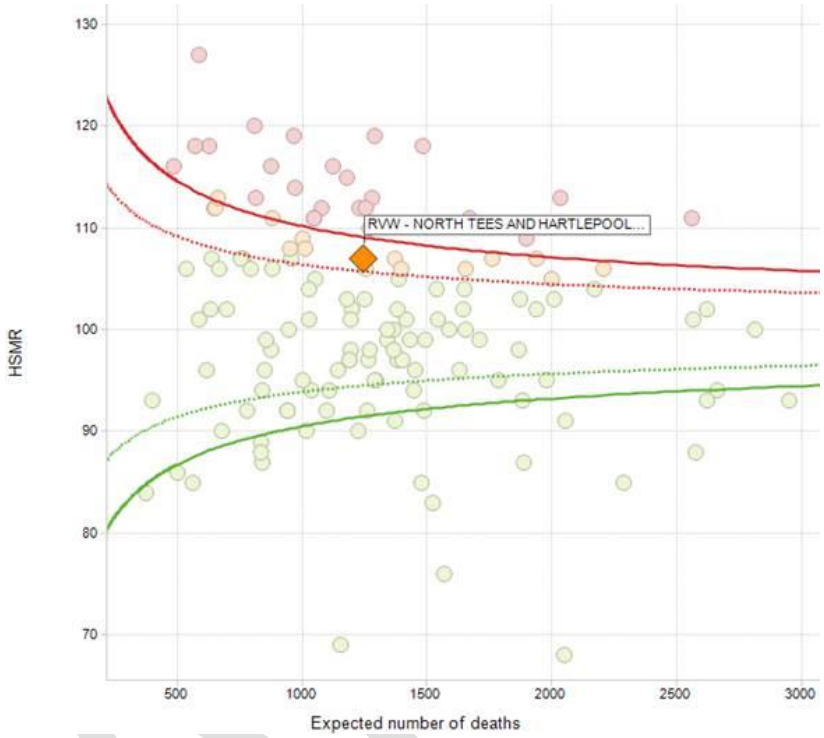
*Data obtained from the Healthcare Evaluation Data (HED)

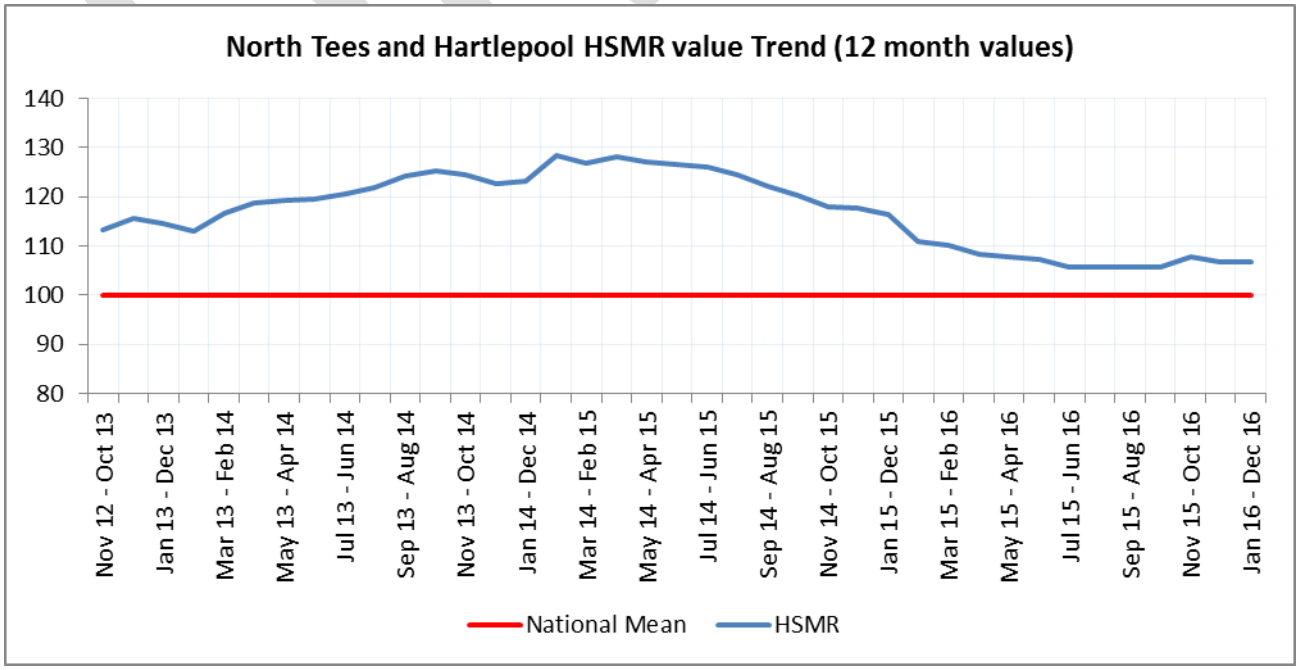
The above HSMR chart and table demonstrates the Trusts 12 month HSMR value throughout the reporting period from **January 2016 to December 2016**, benchmarked against the other North East Trusts. The Trusts 12-month average for HSMR is currently **106.77** which whilst above the national mean of 100, is within the 'as expected' range.

Trust HSMR Improvement

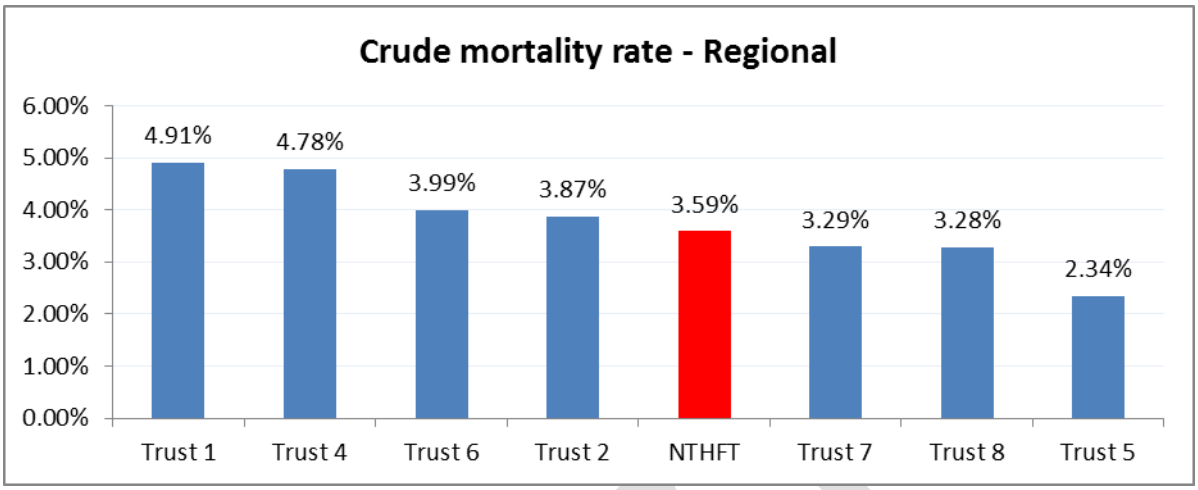
The following table and chart demonstrates, the Trust has made great strides in reducing the HSMR value to **106.77 (Jan 16 to Dec 16)** from the peak of 128.10 (Apr 14 to Mar 15), now placing the Trust in the **'as expected'** range.

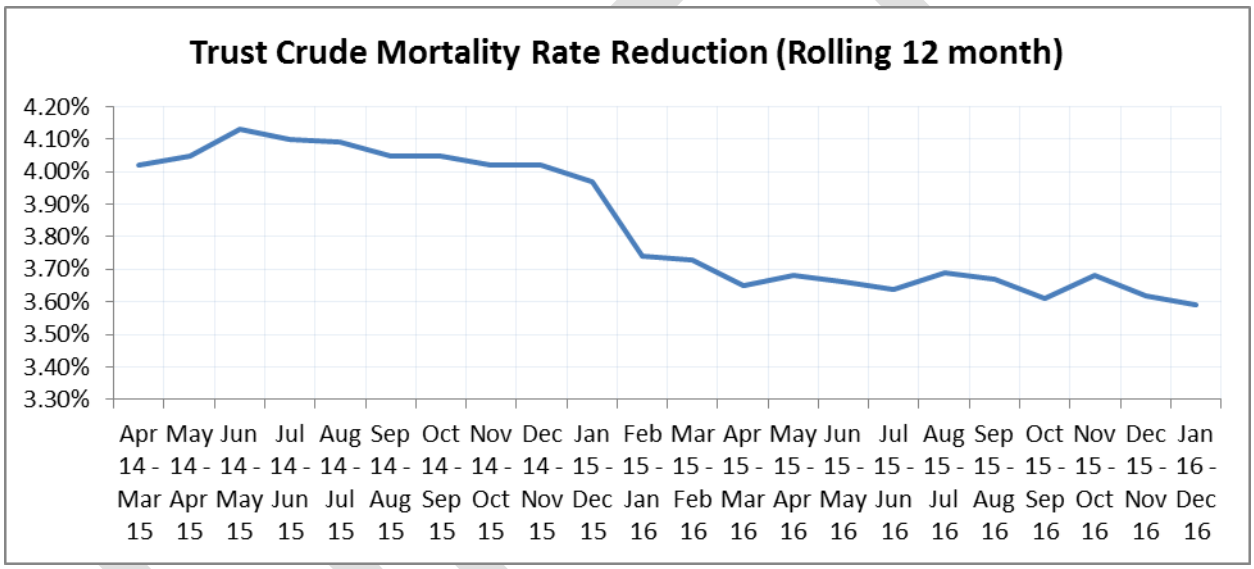
12 Month period	HSMR
Apr 14 - Mar 15	128.10
May 14 - Apr 15	127.02
Jun 14 - May 15	126.60
Jul 14 - Jun 15	125.92
Aug 14 - Jul 15	124.35
Sep 14 - Aug 15	122.21
Oct 14 - Sep 15	120.32
Nov 14 - Oct 15	117.89
Dec 14 - Nov 15	117.71
Jan 15 - Dec 15	116.36
Feb 15 - Jan 16	110.85
Mar 15 - Feb 16	110.12
Apr 15 - Mar 16	108.30
May 15 - Apr 16	107.68
Jun 15 - May 16	107.15
Jul 15 - Jun 16	105.83
Aug 15 - Jul 16	105.75
Sep 15 - Aug 16	105.69
Oct 15 - Sep 16	105.79
Nov 15 - Oct 16	107.69
Dec 15 - Nov 16	106.83
Jan 16 - Dec 16	**106.77**

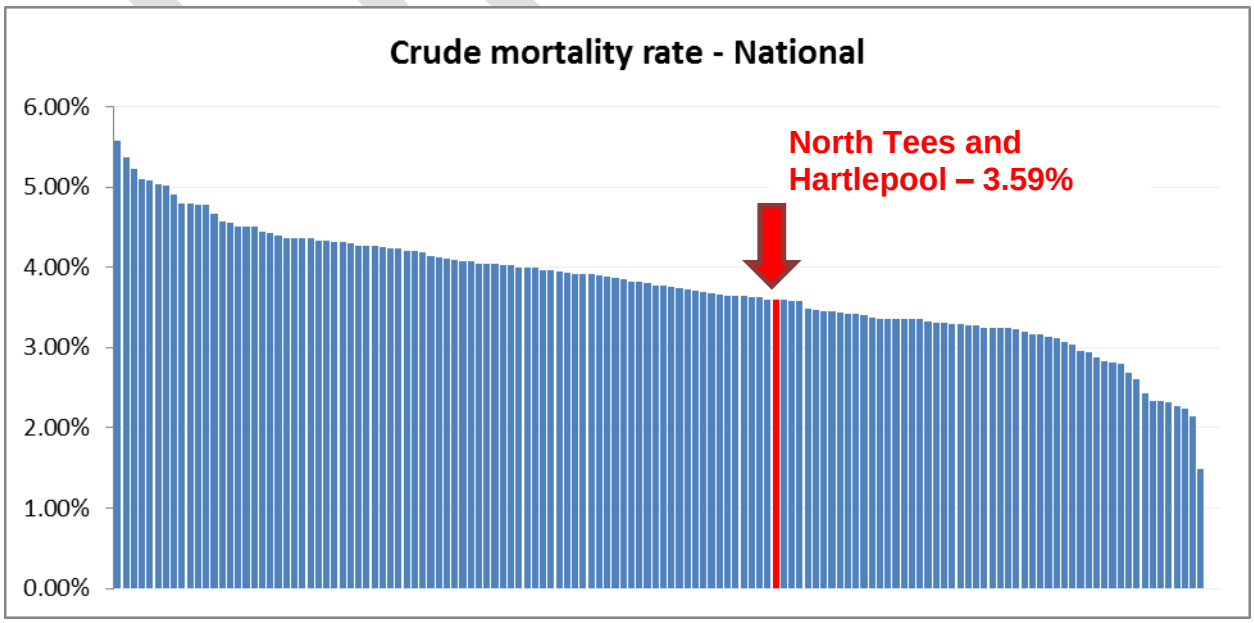




HSMR Crude Mortality Rate – 3.62%
January 2016 to December 2016







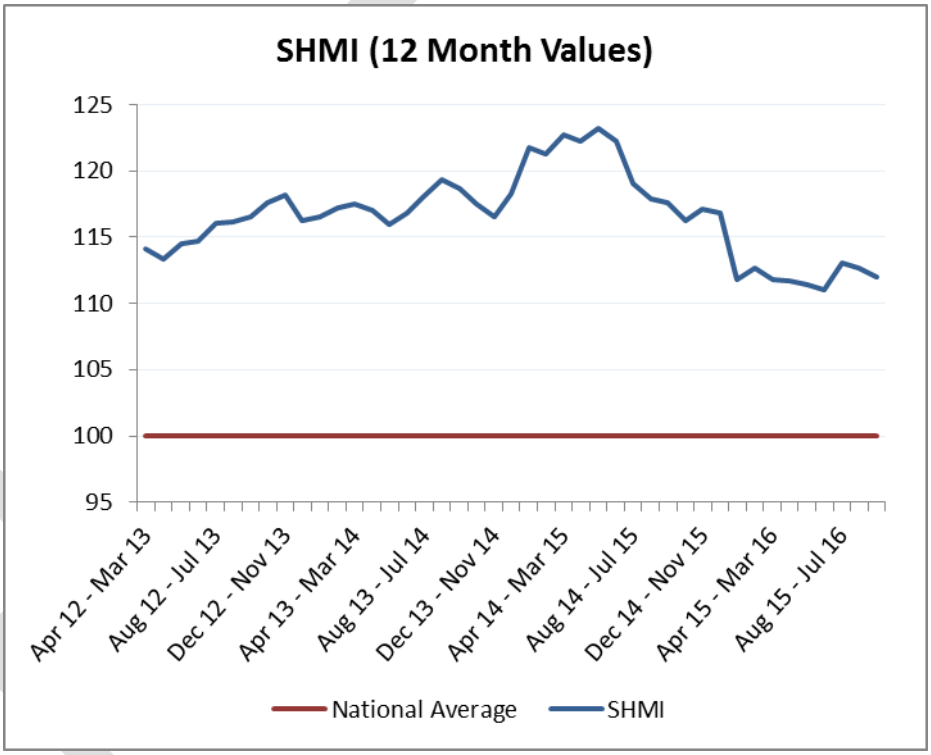
Summary Hospital-level Mortality Indicator (SHMI)
October 2015 to September 2016

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*.

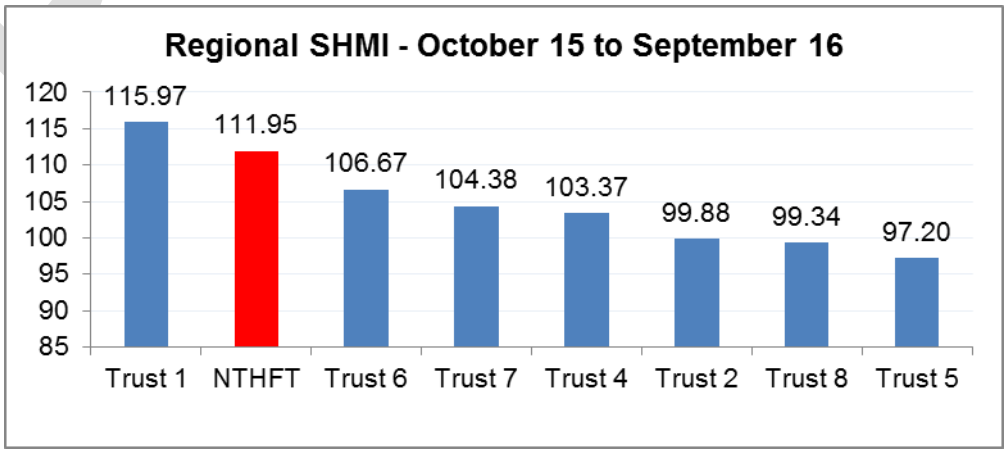
The Trust's SHMI value was at one point the highest value in the country at 122.12 for the 12 month rolling period of June 2014 to July 2015. The Trust has now managed to drive this value down to **111.95** for the reporting period of **October 2015 to September 2016**, this value now places the Trust within **'as expected'** range.

Reporting Period	SHMI
Jun 14 - May 15	123.21
Jul 14 - Jun 15	122.23
Aug 14 - Jul 15	119.09
Sep 14 - Aug 15	117.93
Oct 14 - Sep 15	117.57
Nov 14 - Oct 15	116.23
Dec 14 - Nov 15	117.15
Jan 15 - Dec 15	116.80
Feb 15 - Jan 16	111.81
Mar 15 - Feb 16	112.67
Apr 15 - Mar 16	111.82
May 15 - Apr 16	111.70
Jun 15 - May 16	111.43
Jul 15 - Jun 16	111.05
Aug 15- Jul 16	113.06
Sep 15 – Aug 16	112.66
Oct 15 – Sep 16	**111.95**



The following chart and table demonstrate the Trust current SHMI position utilising the latest time period of **October 2015 to September 2016**, the other *North East Trusts* have been anonymised.

Regional Trust Names	SHMI
Trust 1	115.97
NTHFT	**111.95**
Trust 6	106.67
Trust 7	104.38
Trust 4	103.37
Trust 2	99.88
Trust 8	99.34
Trust 5	97.20



*Data obtained from the Healthcare Evaluation Data (HED)

Priority 1: Patient safety

Dementia

2. Improving care for people with dementia

Rationale: There are currently approximately 14,000 people with a diagnosis of dementia across Co Durham & Darlington and Tees. NHS Hartlepool/Stockton on Tees has the highest projected increase of dementia across the North East by 2025. All stakeholders identified dementia as a key priority.

Overview of how we said we would do it

- We will use the Stirling Environmental Tool to adapt and audit the impact on our hospital environment
- We will ensure 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

Overview of how we said we would measure it

- The Stirling Environmental audit assessment tool will be used to monitor the difference pre and post environmental adaptation.
- The percentage of patients who receive the AMT and, where appropriate, further assessment will be reported monthly via UNIFY.
- We will audit the number of patients over 65 admitted as an emergency that are reported as having a known diagnosis of dementia, or have been asked the dementia case finding questions.
- National Audit for dementia

Overview of how we said we would report it

- Dementia Strategy Group quarterly
- Monthly UNIFY

Completed and reported?

- Reported to the Dementia and Strategy Group✓
- Reported through Commissioning for quality and innovation (CQUIN) measures✓

How has the organisation focused on patient safety?

+75 Screening

How?

All patients aged 75+ are captured via the monthly UNIFY data; this has demonstrated compliance with the first 72 hours of screening for those fitting the inclusive criteria within the Trust. This highlights the need to refer to memory services and for delirium management support from the trusts mental health provider Tees Esk Wear Valley. The screening process supports the North of Tees approach to early diagnosis enabling the person to be informed and the family of to enable decision and consideration for life planning whilst capacity is still evident.

Why?

The new draft guidance is available on the NHS England website providing a future direction for supported early diagnosis and intervention to engage the person whilst they are able to engage and retain information. This is to be part of the 2016-17 proposed dementia collaborative work stream.

Carers Support

- Carers' information packs are reviewed and updated regularly.
- This aims to reduce risk of carer breakdown, and information on how they can access individual carer's assessment
- Informs carers what services they have access to
- Increases information on how they can access individual carer's assessment
- Both Local authorities gave detailed directory of services to support the low level interventions required for people in their own homes.
- If carers feel more supported, there is less risk of admission of the people they care for
- Supports financial and social benefit
- Promoting the pilot of John's Campaign. 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 is in discussions with Parking Eye regarding parking allowances.

Dementia Assessment and Referral 2016-17

This data collection reports on the number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours in England who have been identified as potentially having dementia, who are appropriately assessed and who are referred on to specialist services.

2016-17	Number to whom case finding is applied	Percentage to whom case finding is applied	Number who had a diagnostic assessment	Percentage with a diagnostic assessment	Number of cases referred	Number with a positive or inconclusive diagnostic assessment	Percent age of cases referred
Quarter 1	1,350	100%	226	100%	60	60	100%
Quarter 2	1,327	100%	245	100%	132	132	100%
Quarter 3	1,358	100%	199	100%	99	100	99%
Quarter 4							

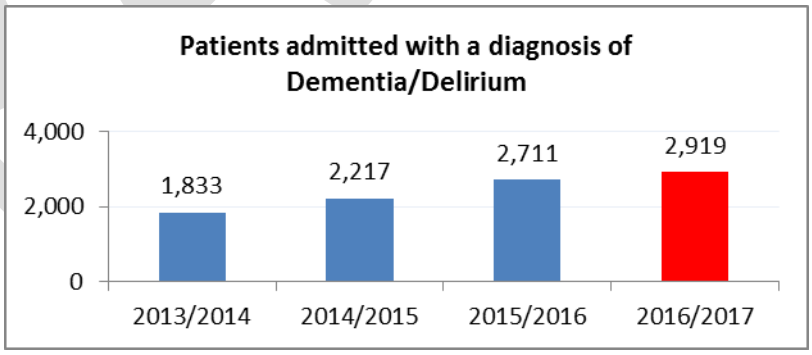
*Data obtained from NHS Digital

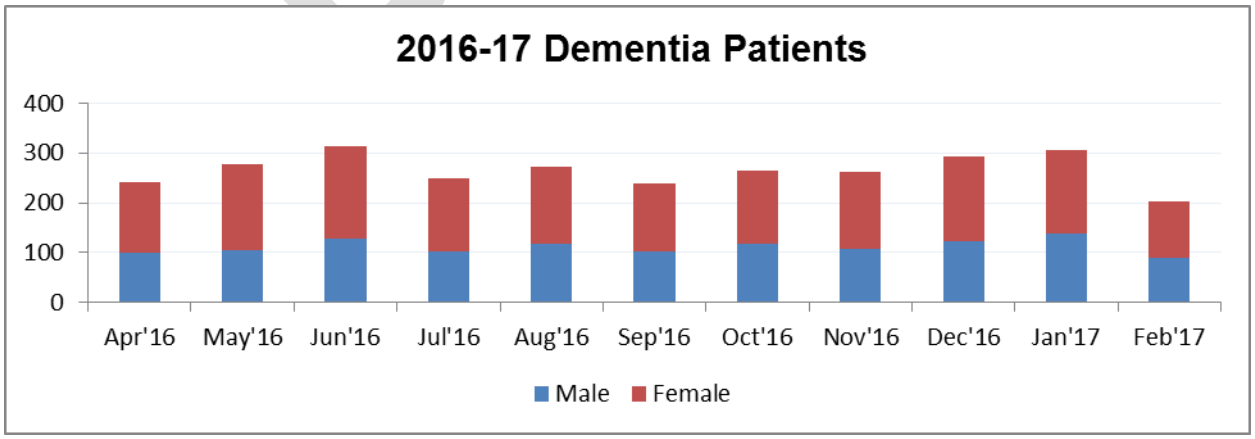
Patients admitted to the Trust with a diagnosis of Dementia/Delirium

In 2014-15 The Trust appointed a dementia nurse specialist; this post continues to reap benefits, enhancing the patient experience and support to carers.

The challenges the Trust faces regarding patients admitted with a diagnosis of Dementia/Delirium is an unfortunate continued growing trend. The following tables trend the number of patient's admitted to the Trust since April 2013.

	Patients admitted with a diagnosis of Dementia/Delirium
2013-14	1,833
2014-15	2,217
2015-16	2,711
2016-17	**2,919**
Total	**9,680**





*Data from Information Management Department and is as of End of February 2017

National Audit of Dementia

The National Audit of Dementia is working with hospitals providing general acute inpatient services to measure criteria relating to care delivery which are known to impact on people with dementia admitted to hospital.

The Royal College of Psychiatrists has been awarded a three year contract to manage a further round of the audit, commissioned by Healthcare Quality Improvement Partnership (HQIP) and funded by NHS England and the Welsh Government. The audit will examine the care provided to people with dementia in acute hospital settings in England and Wales. The audit will include:

- A **survey of carer experience** of quality of care
- A **case note audit** of people with dementia, focusing on key elements of assessment, monitoring, referral and discharge
- An **organisational checklist** and analysis of routine data collected on delayed discharge, complaints and staff training
- A **staff questionnaire** examining support available to staff and the effectiveness of training and learning opportunities

The National Audit of Dementia has been carried out three times from 2009 to present, the Trust results are compared for all 3 cycles, with the National and Regional being available in summer 2017.

Aims and guidelines:

- Defined by the National Audit Team, based on NICE Guidance (CG 42)
- Participation will help hospitals:
  - Identify good practice and areas for improvement in hospital wards
  - Look at the experience of people with dementia and their carers
  - Define the quality of the care experience from the point of view of the patient

	Cycle 1	Cycle 2	Cycle 3
Cases audited	40	40	**59**
Timeframe	2009-10	2011-12	**2016**

The following are a selection of questions and results from sections Assessment and Discharge from all three Cycles for the Trust:

Assessment

Multidisciplinary Assessment

Question	Cycle 1	Cycle 2	Cycle 3
An assessment of mobility was performed by a healthcare professional	90%	83%	**98%**
An assessment of nutritional status was performed by a healthcare professional	83%	80%	**95%**
The assessment of nutritional status includes recording of BMI or weight	39%	94%	**96%**
Has a formal pressure ulcer risk assessment been carried out and score recorded?	100%	100%	**100%**
As part of the multidisciplinary assessment has the patient been asked about any continence needs?	85%	98%	**97%**
Has an assessment of functioning been carried out?	2%	18%	**97%**

Mental State Assessment

Question	Cycle 1	Cycle 2	Cycle 3
Has a standardised mental status test been carried out?	**38%**	**43%**	**76%**
Has an assessment been carried out for recent changes or fluctuation in behaviour that may indicate the presence of delirium?	Question not asked	**70%**	**59%**
Has the patient been clinically assessed for delirium by a healthcare professional?	Question not asked	**85%**	**91%**

Discharge

Assessment before Discharge

Question	Cycle 1	Cycle 2	Cycle 3
At the point of discharge the patient's level of cognitive impairment, using a standardised assessment, was summarised and recorded	5%	21%	46%
At the point of discharge the cause of cognitive impairment was summarised and recorded	85%	94%	94%
Have there been any symptoms of delirium?	Question not asked	55%	38%
Have the symptoms of delirium been summarised for discharge?	N/A	44%	74%

Discharge co-ordination and MDT input

Question	Cycle 1	Cycle 2	Cycle 3
Are any support needs that have been identified documented in the discharge plan/summary?	30%	36%	**96%**
Has the patient and/or carer received a copy of the plan/summary?	67%	82%	**62%**
Was a copy of the discharge plan/summary sent to the GP/primary care team on the day of discharge?	Question not asked	Question not asked	**100%**
Was discharge planning initiated within 24 hours of admission?	63%	67%	**27%**

Where the values are lower than expected, the Trust has set up an action plan to address the identified issues.

"We are extremely happy with the care of all the hospital staff - we felt our mum couldn't have had better treatment and everyone has been very attentive and given her respect and dignity. We are all very grateful and appreciate your care and attention."

[sic]

“ Staff were very considerate of needs and worked well with the family to look at plans of care with a complicated discharge. ” [sic]

Dementia Training by Staff Group

Training levels:

Tier 1 - Dementia Awareness Raising

This is mandatory to the entire workforce in health and care, involving the completion of ‘Essential Dementia Workbooks’ at the appropriate level according to job role.

The team also provide a 1.5 hour face to face training session on request. Within this we have an element of ‘Barbara’s Story’ which involves short films focussing on different aspects of Barbara’s journey through the healthcare system. Upon completion you have the opportunity to be a Dementia Friend as this training has been accredited by the Alzheimer’s Society.

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

This is the level ‘Dementia Champions’ are set.

To support this level of training we have commenced a Dementia Champion programme which runs every month (3 hours) for 11 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 guest speakers.

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

The dementia team do not deliver this but this is relevant to staff working intensively with people affected by dementia; for example, university modules / bespoke study days in relation to dementia care.

Dementia Level Training by Quarter

	Q1	Q2	Q3	Q4
Dementia Tier 1	97%	97%	98%	
Dementia Tier 2	97%	93%	91%	
Dementia Tier 3	93%	90%	89%	

*Data obtained from the Trust dementia training up to end of December 2016

The training content for tier 1 and tier 2 dementia training is reported to Health Education North East (HEE) 5 times a year. This meeting involves all NHS trusts in the North East and is used to discuss training content and numbers. This forum is also used for getting HEE approval for training. This ensures a consistency to the training across all Trusts in relation to content, it also allows Trusts to share information and discuss/advise on new content, both nationally and locally.

Dementia Screening – Monthly Data Collection – April 2016 – March 2017

The prevalence study identified a number of measures which are reported in the table below:

Question a: Number of patients 75 and above admitted as emergency inpatients, reported as having been asked the dementia case finding question within 72 hours of admission to hospital or who have a clinical diagnosis of delirium on initial assessment or known diagnosis of dementia.

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
471	474	405	434	457	436	419	407	532	520	421	

Question b: Number of patients aged 75 and above, admitted as emergency inpatients, minus exclusions.

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
472	475	405	434	458	436	419	407	532	520	421	

Question c: % of all patients aged 75 and above admitted as emergency inpatients who are asked the dementia case finding question within 72 hours of admission or who have a clinical diagnosis of delirium on initial assessment or known diagnosis of dementia.

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
99.80%	99.80%	100%	100%	99.80%	100%	100%	100%	100%	100%	100%	

Question d: Number of admissions of patients aged 75 and above admitted as emergency, inpatients who have scored positively on the case finding question or who have a clinical diagnosis of delirium reported as having had a dementia diagnostic assessment including investigations.

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
92	69	65	76	90	79	83	59	57	40	57	

Question e: Number of patients aged 75 and above admitted as emergency inpatients who have scored positively on the case finding question or who have a clinical diagnosis of delirium.

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
92	69	65	76	90	79	83	59	57	40	57	

Question f: % of all patients aged 75 and above admitted as emergency inpatients who have scored positively on the case finding question, or who have a clinical diagnosis of delirium and who do not fall into the exemption categories reported as having had a dementia diagnostic assessment including investigations.

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	

Priority 1: Patient safety

Safeguarding

3. Safeguarding Adults with Learning Disabilities (LD)

All patients with a learning disability admitted to hospital will have a named advocate and an individualised plan of care.

Rationale: The Trust and Commissioners believe that people with LD should not be in hospital unless absolutely necessary. When it is necessary to admit patients with LD, they will have an individualised plan of care and a named advocate.

Overview of how we said we would do it

- All patients with LD will be referred on admission to the LD specialist nurse
- The LD Specialist nurse will act as the named advocate and will ensure that an individualised plan of care is in place and reasonable adjustments documented

Overview of how we said we would measure it

- Audits will be carried out and results reported

Overview of how we said we would report it

- Audit results and action plans to be reported to Adult Safeguarding Group quarterly

Completed and reported?

- Audit plans and results presented to Adult Safeguarding Group quarterly ✓
- Learning Disabilities steering group ✓

Adult Safeguarding

Throughout 2016 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.

Three national objectives have been identified for the PREVENT strategy:

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

PREVENT has continued to be addressed within the adult safeguarding portfolio. We currently have **18** PREVENT trainers across the Trust who delivers the nationally agreed Workshop to Raise Awareness of PREVENT (WRAP). Global events in Syria have continued to ensure the principles of counter terrorism outlined below remain in the NHS workforce agenda. An e-learning package has also been developed for staff to complete.

Safeguarding adults

The Trust continues to work to enhance and develop standards for safeguarding adults across the hospitals and community services.

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.

In 2016-17 there has been a significant increase in DoLS to **766** from 688 in 2015-16.

During 2016-17 a high profile campaign raising awareness was undertaken in relation to this area of adult safeguarding. Safeguarding awareness week was carried out in June, to raise awareness on the wards; these sessions were carried out in the tower block, west wing at the University Hospital Hartlepool site.

The safeguarding team trained 82 safeguarding champions to give key staff more intensive training.

Training activity 2016-17

Tees-wide multi agency training is undertaken at level one via a workbook and e-learning which is distributed at induction and following completion is marked and discussed with the line manager before being signed off. The target audience for level 1 was increased this year.

Compliance with the **level one training** across the Trust is **93%**.

Compliance with the **level two** training across the Trust is **94%**.

The adult safeguarding team also deliver safeguarding champions full day (level 2) training and to date over 80 staff have been trained. This training is delivered three times a year.

Trust Reporting

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

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

The data contained in the includes:

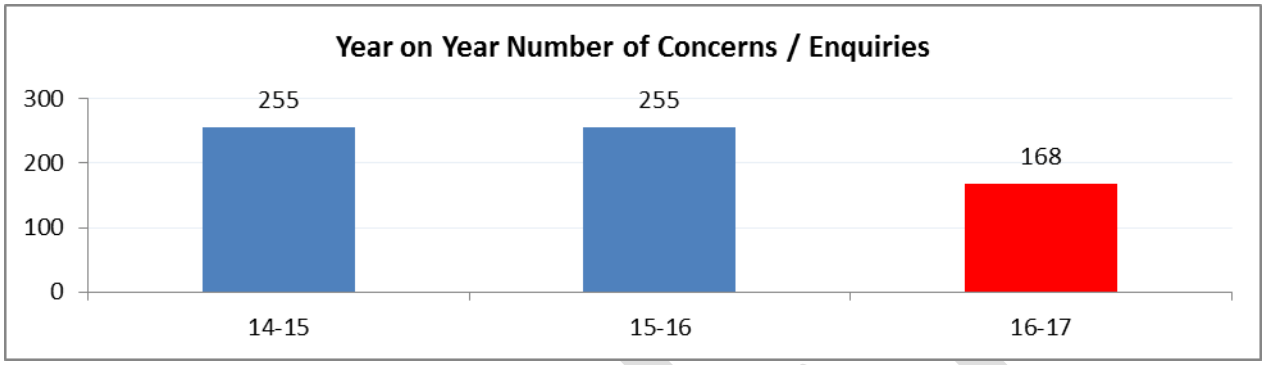
- Number of referrals
- Number of alerts raised by location
- Number of alerts raised by theme
- Incidents raised by type of abuse, Trust role and outcome

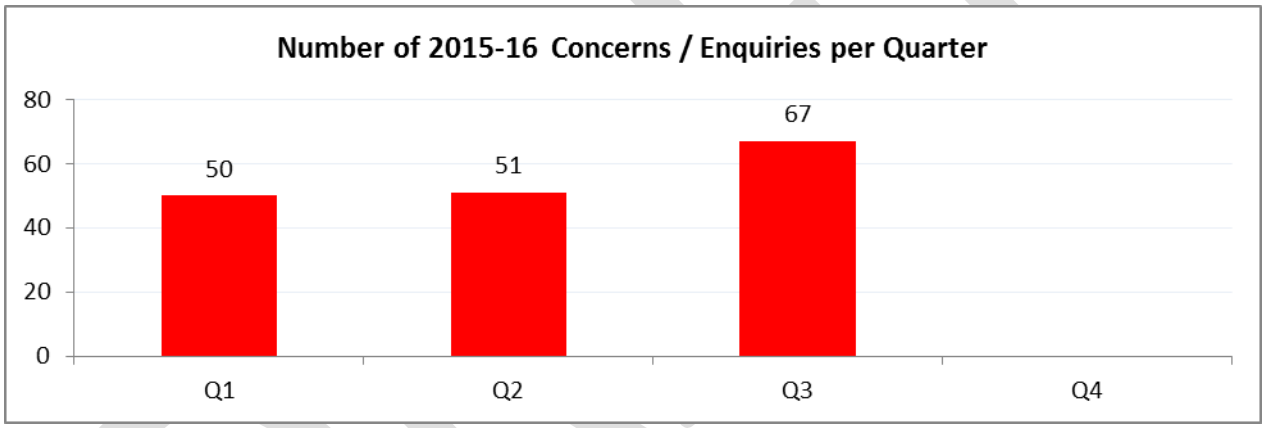
The report is shared with our Commissioners.

Numbers of Alerts

The Trust continues to use and develop further an in-house developed adult safeguarding database. This tool helps to collate, trend and theme the data. The data produced is governed through the quarterly Safeguarding Vulnerable Adults Steering Group to Patient Safety & Quality Standards Committee (PS & QS)

From **April 2016** there have been **168** Adult Safeguarding incidents across the Local Authorities of Durham, Hartlepool and Stockton.

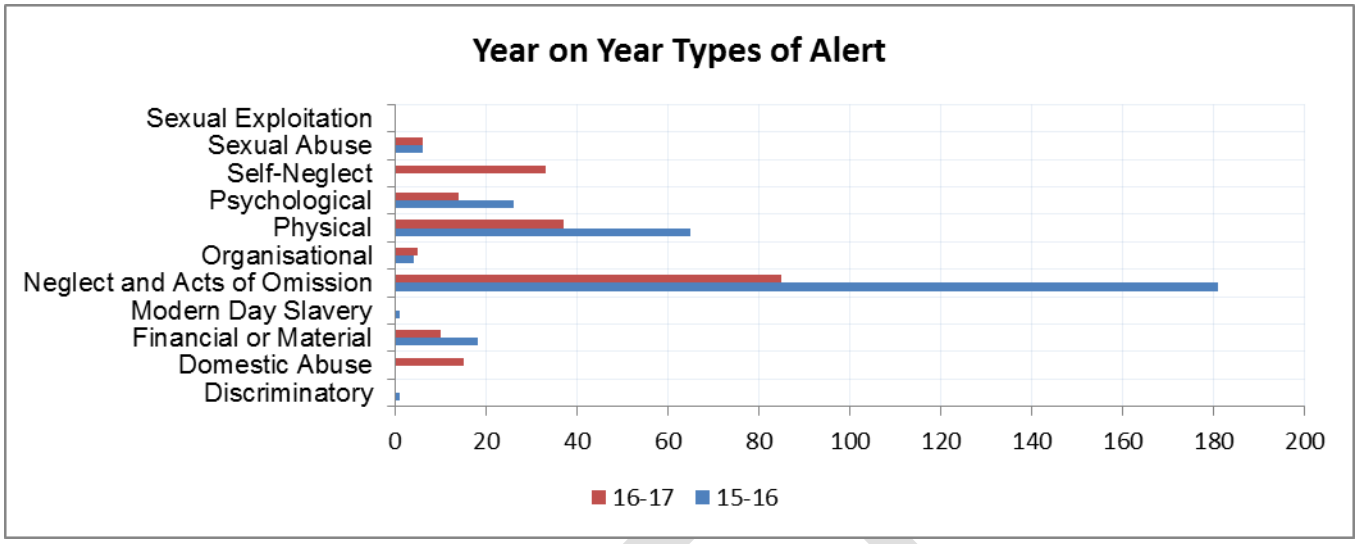




*Data from the Trusts Adult Safeguarding database

Within Quarter 3, compared to last year there has been an increase of **26.40%** in concerns and enquiries where the Trust is involved.. The Trust works closely with the Local Authorities undertaking internal investigations where concerns are raised.

Types of Alerts

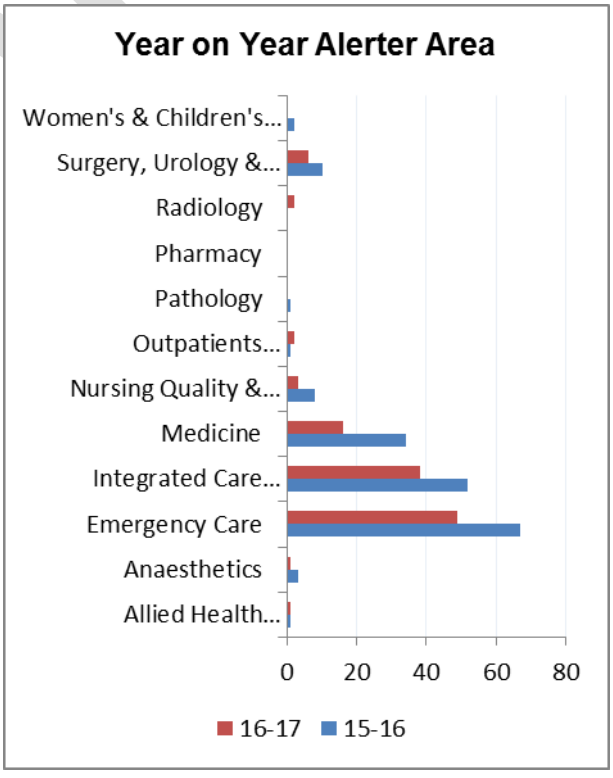


The following tables detail the allegation types raised across all three Local Authorities, it is important to note that there can be multiple allegation types per referral.

There has been a steady increase in domestic abuse, self-neglect and psychological abuse. Domestic abuse referrals this Quarter 3 doubled and self-neglect has steadily increased by 166% since Quarter 1. This is due to increased awareness of the Care Act through training of staff. Physical abuse has shown a slight decrease due to the category of Domestic Abuse.

Alerting Areas

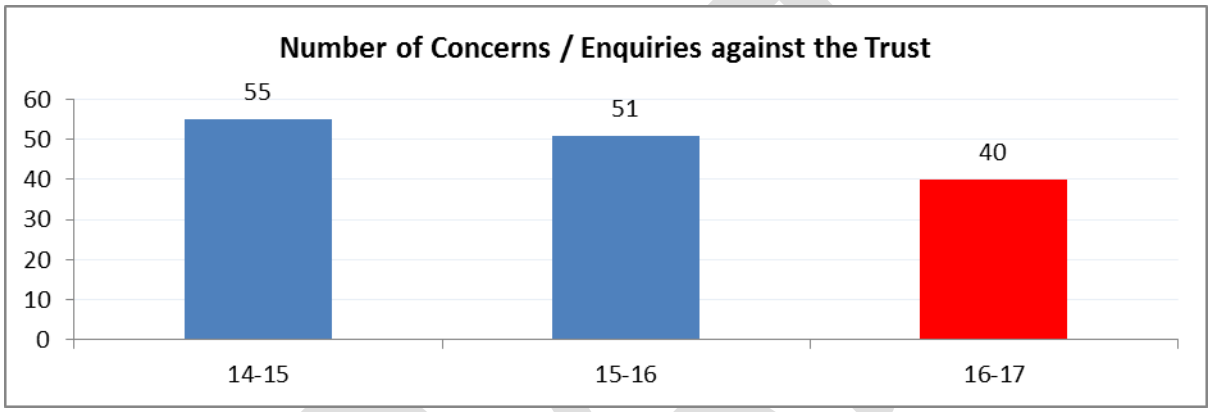
	2015-16	2016-17	Difference
Allied Health Professionals	0	0	**0**
Anaesthetics	1	1	**0**
Emergency Care	3	1	**-2**
Out of Hospital Care	67	49	**-18**
Medicine	52	38	**-14**
Nursing Quality & Patient Safety	34	16	**-18**
Outpatients Department	8	3	**-5**
Pathology	1	2	**1**
Pharmacy	1	0	**-1**
Radiology	0	0	**0**
Surgery, Urology & Orthopaedics	0	2	**2**
Women's & Children's Services	10	6	**-4**

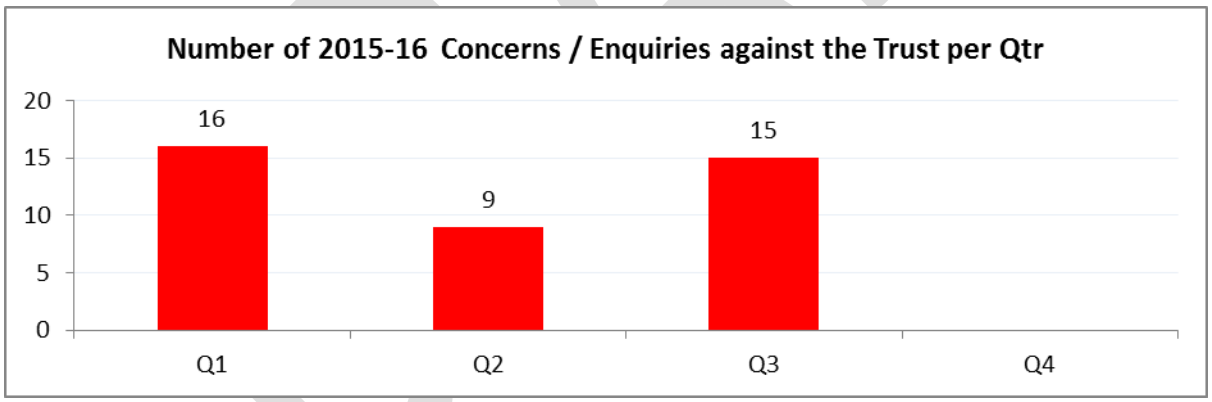


There has been an increase of 81% in the number of alerts raised by Out of Hospital Care in Q2. Face to face safeguarding training sessions have been carried out with Out of Hospital Care staff, new starters and Emergency Care staff. The Mandatory training has also been increased from once only to 3 yearly to increase awareness and provide updates from the Care Act. In Hospital Care has also increased in concerns, but is still within the expected parameters in relation to previous years.

The Named Nurse continues to carry out regular 'walk-abouts' to encourage staff to express any concerns and provide ad-hoc clinical supervision should it be required. Staff are more aware of Adult Safeguarding within the Trust, and this greater awareness has led to an increased number of referral's.

Alerts against the Trust

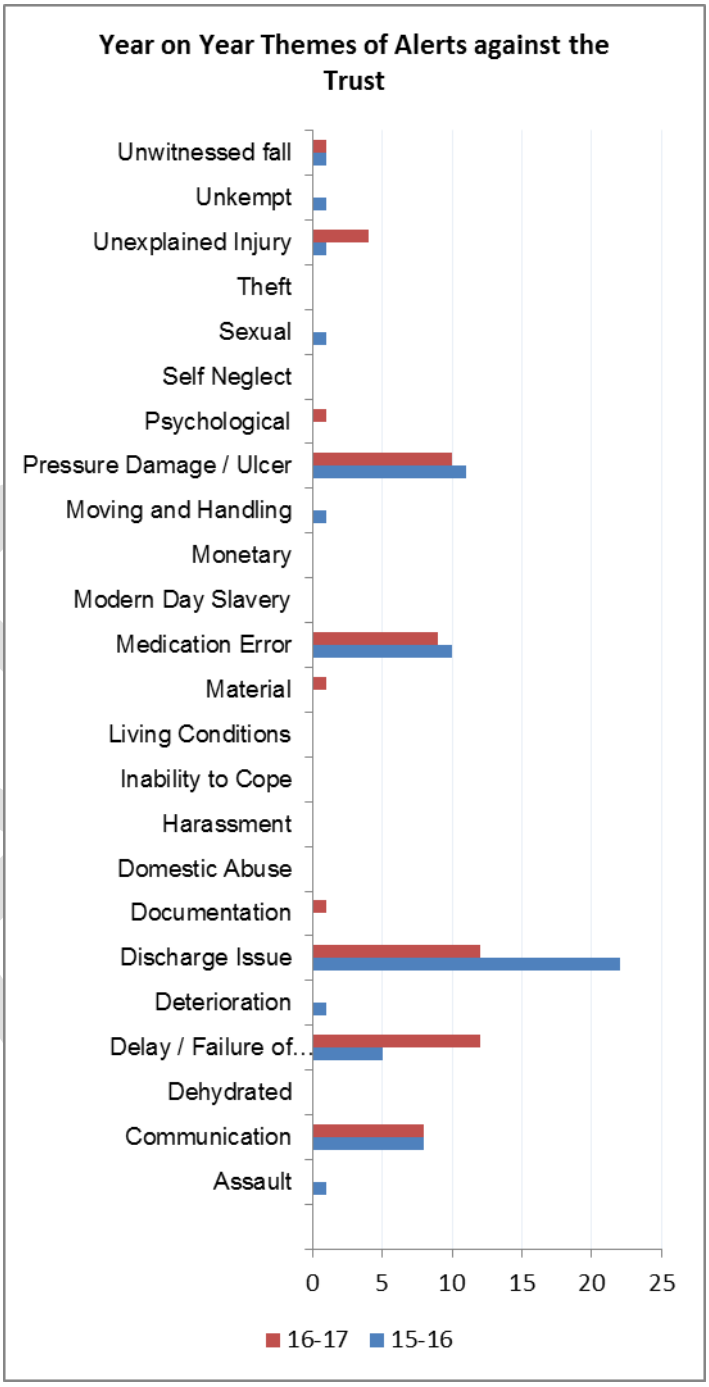




There has been an increase of 36% in Q1 and 3 in relation to the previous quarters. There has been an increase from 11 concerns last year to 15 concerns this year in Q3; however these are within the parameters we would expect

Themes of Alerts against the Trust

	2015-16	2016-17	Difference
Assault	1	0	**-1**
Communication	8	8	**0**
Dehydrated	0	0	**0**
Delay / Failure of Intervention	5	12	**7**
Deterioration	1	0	**-1**
Discharge Issue	22	12	**-10**
Documentation	0	1	**1**
Domestic Abuse	0	0	**0**
Harassment	0	0	**0**
Inability to Cope	0	0	**0**
Living Conditions	0	0	**0**
Material	0	1	**1**
Medication Error	10	9	**-1**
Modern Day Slavery	0	0	**0**
Monetary	0	0	**0**
Moving and Handling	1	0	**-1**
Pressure Damage / Ulcer	11	10	**-1**
Psychological	0	1	**1**
Self-Neglect	0	0	**0**
Sexual	1	0	**-1**
Theft	0	0	**0**
Unexplained Injury	1	4	**3**
Unkempt	1	0	**-1**
Unwitnessed fall	1	1	**0**



Please note that 1 concern can cover multiple themes.

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

Trust Adult Safeguarding Governance Arrangements

The Director of Nursing, Quality and Patient Safety is the executive lead for safeguarding adults along with the Deputy Director of Nursing who has operational responsibility.

Directorate management teams are responsible for practices within their own teams and individual clinicians are responsible for their own practice.

The Trust Adult Safeguarding Committee has been revised and includes representatives from key Trust clinical and non-clinical directorates and partners from Local Authority and Harbour who are experts in domestic abuse. The Trust Adult Safeguarding Committee reports to Patient Safety and Quality Standards Committee (PS & QS).

The Trust is represented at both Hartlepool and Stockton Local Authority Adult Safeguarding Boards and maintains strong links with Durham; the Trust is also represented at the Tees wide Adult Safeguarding Board.

The Trust Strategy groups for adult safeguarding and learning disability all have 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.

Safeguarding Adult Achievements

The Trust has a well-established Single Point of Contact system (SPOC) as well as a reporting system for internal and external safeguarding alerts. Each alert is added to a central database and progress of the vulnerable adult can be tracked and managed towards an acceptable outcome. This has been extended to include a separate equivalent system for people with Learning Disabilities and the main system now includes domestic abuse cases.

These systems enable The Trust to provide a robust process for developing reports on a regular basis across the Trust. The Adult Safeguarding Steering group now receives the report in respect of activity data each quarter and disseminates the lessons learnt to improve practice.

Communication issues within discharge have been a theme from alerts across Hartlepool and Stockton, this has led to the development of a discharge group and to date the Trust has seen a reduction in the number of discharge related incidents.

Children's safeguarding and Looked After Children (LAC)

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

North Tees and Hartlepool NHS Foundation Trust has a duty in accordance with the Children Act 1989 and Section 11 of the Children Act 2004 to ensure that its functions are discharged with regard to the need to safeguard and promote the welfare of children and young people. The Trust recognises the importance of partnership working between children/young people, parents/carers and other agencies to prevent child abuse, as outlined in Working Together to Safeguard Children and their Families, 2015. In addition arrangements to safeguard and promote the welfare of children must also achieve recommendations set out by the Care Quality Commission 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.

Governance Arrangements

The Trust has maintained a robust board level focus on Safeguarding and Looked after Children led by the Director of Nursing, Patient Safety and Quality. A bi-monthly steering group, chaired by a Non- Executive Director maintains responsibility for the performance monitoring of

the Children's Safeguarding work program. This group also brings together commissioner and provider with representation from Hartlepool and Stockton on Tees CCG (Designated Doctor and Nurse Safeguarding and Looked after Children) and Designated Nurse Safeguarding and Looked after Children Durham Darlington Easington & Sedgfield.

The Deputy Director of Nursing, Patient Safety and Quality has delegated responsibility and direct line management of the Safeguarding Children Team.

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.

The Trust has maintained representation and in some cases chairing of a number of LSCB subgroups including;

- Learning and Improving Practice sub Group (LIPSG) - Hartlepool and Stockton LSCB,
- Performance Management - Hartlepool and Stockton LSCB
- The Children's Hub implementation and strategic group for Stockton and Hartlepool
- Hartlepool and Stockton Strategic Vulnerable ,Exploited, Missing and trafficked (VEMT) group
- Tees procedures policy group
- Stockton and Hartlepool LSCB Training sub group with Trust nominated chair of the group;
- County Durham LSCB Missing Exploited group (MEG)
- County Durham MASH Board
- County Durham Early Help Sub Group
- Graded care profile task and finish group with Trust nominated chair and project lead of the group;

Representatives from across all directorates take a lead role or act as a champion for children safeguarding for example in Accident and Emergency (A&E) and Women and Children's services. Meetings take place on a monthly basis bringing together safeguarding professionals to ensure momentum of the Safeguarding and Looked after Children's agenda.

In response to the Savile enquiry and subsequent recommendations for the NHS from the Lampard report in 2015 a task and finish group was established to carry out a gap analysis and actions to meet the recommendations, the Named Nurse represents Children's Safeguarding on this group and updates are presented to the Trust Patient Safety Committee. All actions are now complete.

In February 2016 an unannounced CQC review inspection on safeguarding and looked after children services was undertaken in Hartlepool; the report was published in March 2016 and an action plan has been developed to address recommendations. Progress is demonstrated in the Safeguarding and Looked after Children Work Program and monitored via the Safeguarding Children Steering Group. Key areas highlighted in the inspection included ensuring there is identified succession planning for the Senior Nurse Looked After Children in Hartlepool who retired in April 2016; improving quality of Looked After Children health assessments and ensuring that where children are admitted to hospital as a result of self-harm, there are appropriate risk assessments in place (environmental) and that staff delivering care are appropriately trained in mental health issues. Those identified actions are now complete.

Children's Safeguarding Work Program

The Children's Safeguarding Work Program sets out and monitors progress of the work for the year at the safeguarding children steering group, it is divided into 2 parts.

Part 1 Monitors action plans from serious case reviews; learning lesson reviews, Domestic Homicide Reviews and internal incidents.

Part 2 Monitors the Trusts safeguarding children professionals' development work, the safeguarding children annual audit and assurance program and the planned response to key national drivers which may impact on the work of safeguarding children professionals in the Trust.

Part 1 – Learning Lessons from Serious Case Reviews (SCR)

There have been 2 Serious Case Reviews published in Durham (LSCB) in 2016 in which the Trust was a partner agency: Child L; And Child N; key themes from these reviews include:

- The need to properly assess the role of males within a family setting/ household who have contact with children and young people;
- Very young children have been the subject of the review;
- Limited engagement with the Team around the Family process and Early Help assessments.
- Lack of consistent information sharing and professionals working in silo.
- Over reliance upon the social worker - lack of professional challenge

Hartlepool LSCB has 2 Serious Case Reviews which were delayed due to the ongoing criminal proceedings however the findings are due to be published in March 2017. The Trust has developed an 'early learning' action plan.

Part 2 - Development Work

Children who are not brought for appointments by parents and carer's Policy

A policy has now been developed and launched across the Trust in response to a local serious case and learning lessons review. This will enable practitioners to respond appropriately and recognise possible early indicators of neglect when a child has not been brought to appointments. Work is ongoing around how the Trust can identify children whose appointments are frequently rescheduled by parents/carer alongside this.

Safeguarding Children Policy

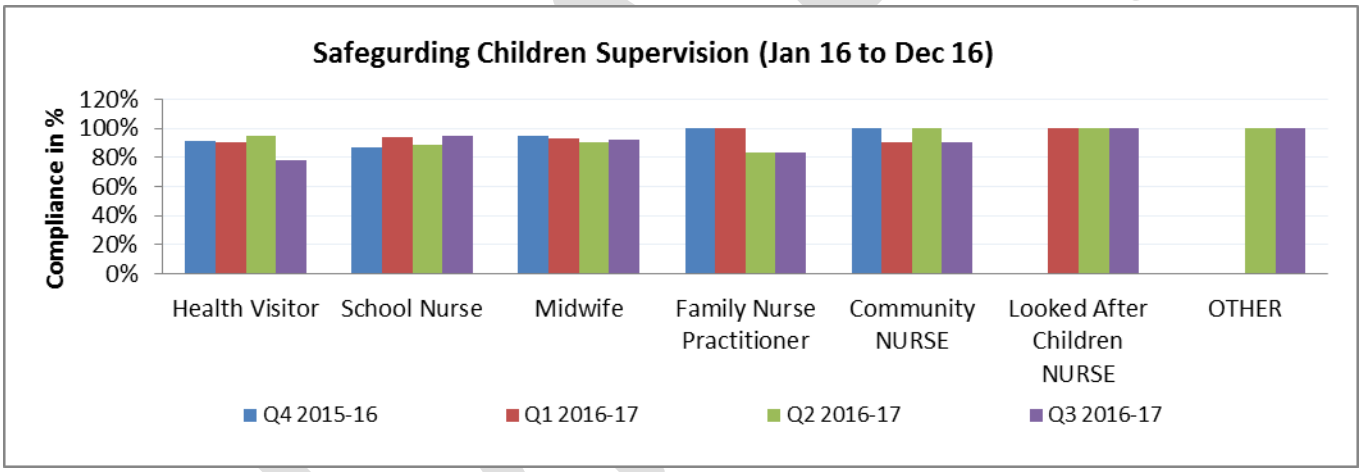
The Safeguarding Children Supervision policy and Safeguarding Policy has been revised and ratified in 2016. The main change in the Supervision Policy is a significant move away from Senior Nurse Safeguarding case management approach towards a more reflective and autonomous framework which empowers and enables the practitioner to transfer their learning from supervision to other cases within their caseload. The revised safeguarding policy also ensures that Trust staffs understand and are supported in their responsibility under current legislation to safeguard and promote the welfare of children and to enable the Trust to meet its statutory duties in this regard.

Safeguarding Children Supervision

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

1:1 supervision is undertaken with a senior nurse on a three monthly basis. Compliance is reported via the quarterly dashboard and demonstrated in the table below.

	Q4 2015-16	Q1 2016-17	Q2 2016-17	Q3 2016-17
Health Visitor	91%	90%	95%	78%
School Nurse	87%	94%	89%	95%
Midwife	95%	93%	90%	92%
Family Nurse Practitioner	100%	100%	83%	83%
Community NURSE	100%	90%	100%	90%
Looked After Children NURSE		100%	100%	100%
OTHER			100%	100%



North of Tees Children's Hub

The new Multi-agency Children's Hub North of Tees (Hartlepool and Stockton) went live in June 2016. This is an exciting development which has enhanced multi-agency working and information sharing, promoting early help and intervention. Health has been integral to the design of the HUB and a Senior Nurse from the Children's Safeguarding Team rotates into the HUB Team

Child Sexual Exploitation (CSE)

CSE continues to be a growing concern. The Stockton and Hartlepool VEMT subgroup and the Missing Exploited group (MEG) in County Durham identifies those children and young people at risk, allows for the sharing of information between practitioners and helps to put safety measures in place to attempt to reduce risk. Following the CQC CLAS inspection the Trust has developed an action plan to effectively utilise CSE risk assessment tools to assist early identification of those at risk of CSE.

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. A Domestic Abuse policy has been launched across the Trust. Routine and selective enquiry training has been rolled out.

Local Authority Designated Officer (LADO)

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

Signs of Safety

Hartlepool and Stockton Local Authorities have implemented the Signs of Safety model in the assessment of risk and safety planning process when working with cases that reach the threshold for children's social care intervention. Frontline community health practitioners are attending training to equip them with the knowledge and skills in using this approach with children and families. The Senior Nurses in the Children's Safeguarding Team have been identified as practice leads and attend regular updates with the local authority.

Joint working with Adult Safeguarding

Joint training has been delivered between Adult and Children's safeguarding Teams in relation to Female Genital Mutilation, Prevent, Forced marriage and modern slavery and plans to work jointly in delivering safeguarding training is being developed.

Audit

The Trust work program includes a rolling schedule of audits with a strong focus on quality and improving outcomes for children and young people.

The mnemonic 'ACHILD' was created following a recommendation from a local serious case review which is a trigger to alert staff to a concern when children attend A&E with injuries. The audit undertaken in 2016 has resulted in changes in the use and frequency of the tool and will also allow identification of vulnerable older children aged 16-18 years

A Risk Assessment Tool for adults who attend A&E/Minor Injuries Unit (MIU) with key risky behaviors including domestic abuse, substance misuse and mental health. The tool is used to risk assess and inform care planning for adults and guides practitioners to identify if the patient has care of any children. This helps ensure that vulnerable families have access to specialist services, as well as promote good holistic care, in order to effectively safeguard children and young people.

Key Achievements 2016

- Temporary Appointment of additional 0.5 WTE safeguarding children's trainer to support implementation of the Graded Care Profile
- Provision of bespoke professional challenge training in response to lessons from serious case reviews.
- Appointment of a 1 WTE Specialist Safeguarding Midwife

- Launch of Children Not brought for appointments by parents / carers policy
- Development of a Safeguarding Children Resource Pack for Out of Hours Managers in the Trust
- Senior Nurses now rotating into the children's Hub to facilitate multi-agency decision making

Key Priorities 2016-17

1. Continued monitoring and audit of completed actions from the recommendations from the CQC CLAS review inspection in Hartlepool;
2. Align key priorities to the priorities of the 3 LSCBs
3. Continue to work closely with partner agencies to drive forward the Early Help Agenda;
4. Achieve 100% compliance for all local safeguarding children quality requirements
5. Continue to work in partnership with Hartlepool and Stockton local authorities in the North of Tees children's hub;
6. Enhance the Trust safeguarding children training program
7. To continue to raise awareness of the VEMT agenda in the Trust utilizing agreed risk assessment tools to improve outcomes for children and young people who may be vulnerable, exploited, missing or trafficked

Safeguarding Children Training Programme

Throughout 2016 into 2017 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 (2014) and the Trust's Safeguarding Children Training Policy. High levels of compliance and standards have been maintained.

Overall Trust Compliance for Safeguarding Children Training

Training compliance is monitored by the Safeguarding Steering Group and an action plan has been developed to address the reduced compliance.

Month	Level 1	Level 2	Level 3
Apr-16	99%	95%	94%
May-16	99%	94%	93%
Jun-16	99%	94%	91%
Jul-16	99%	89%	91%
Aug-16	99%	85%	90%
Sep-16	99%	86%	90%
Oct-16	99%	85%	93%
Nov-16	99%	84%	94%
Dec-16	99%	83%	93%
Jan-17	99%	83%	93%
Feb-17	99%	84%	93%
Mar-17			

Looked After Children (LAC)

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

- LAC health provision is an integral part of the Trust Safeguarding and LAC Steering Group work programme which reports to the Trusts Children’s Safeguarding Steering Group and Patient Safety Committee.

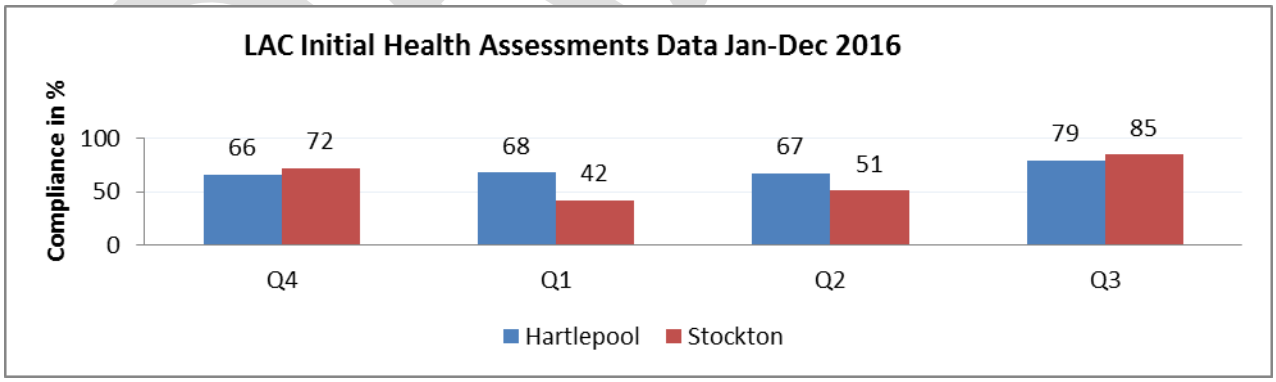
- To ensure quality in provision of service a Trust wide performance group has been established. Attendance includes Lead Paediatricians, Named Nurse for Safeguarding & LAC; Senior Nurses for LAC and General Manager Women and Children’s Services. Effective from March 2016 the Named Nurse now has direct line management responsibilities for the LAC Senior Nurses to promote strong leadership within the team.

- The Trust continues to be represented and is an active member of the Multi-Agency Looked After Partnership (MALAP) in Stockton.

Looked After Arrangements and Provision

Initial Health Assessments (IHA) are a statutory requirement. All LAC must be offered an IHA by a suitably qualified medical practitioner, which should result in a Health Care Plan by the time of the child’s first Looked after Review (LAR) 20 working days after becoming LAC.

Table 1 below demonstrates compliance when children are notified to the service that they are in care:



It was recognised that as demand for IHA’s increased there was a subsequent fall in compliance however this is now being addressed by regular LAC Performance Management Team Meetings which identify any predicted increases in service demand so that resilience plans can be implemented to ensure sufficient capacity to respond. The Trust is also actively seeking to recruit additional Community Paediatricians in response to increasing demand. Points to note in relation to reduced compliance include:

- Not receiving timely and appropriate consent for IHA’s affects the overall compliance rate; however the escalation process introduced early in 2016 has improved compliance

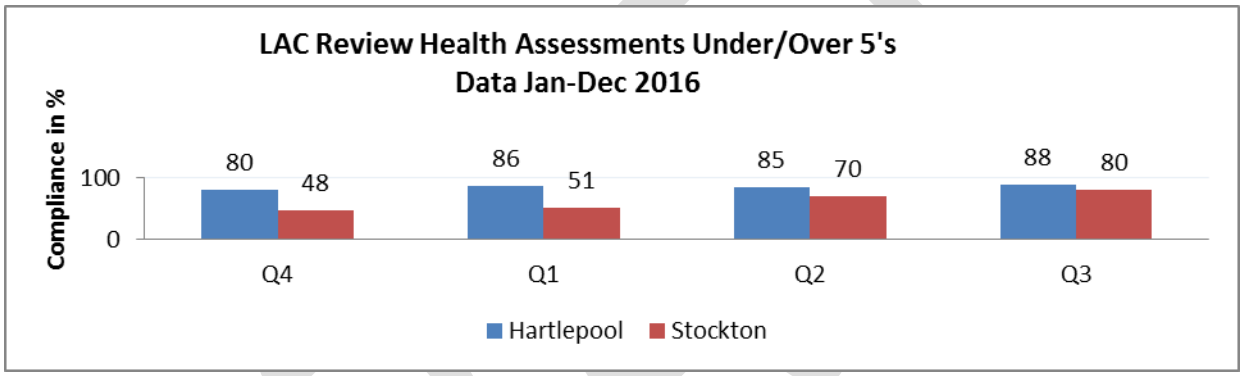
- Cancellations by carers continues to affect the rates of compliance; electronic monitoring and analysis of the reasons why carers cancel ensures these issues are addressed with partner agencies and carers at the time;

Review Health Assessments

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

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

Table 2 below demonstrates compliance of review health assessments and Children & Young People registered with services.



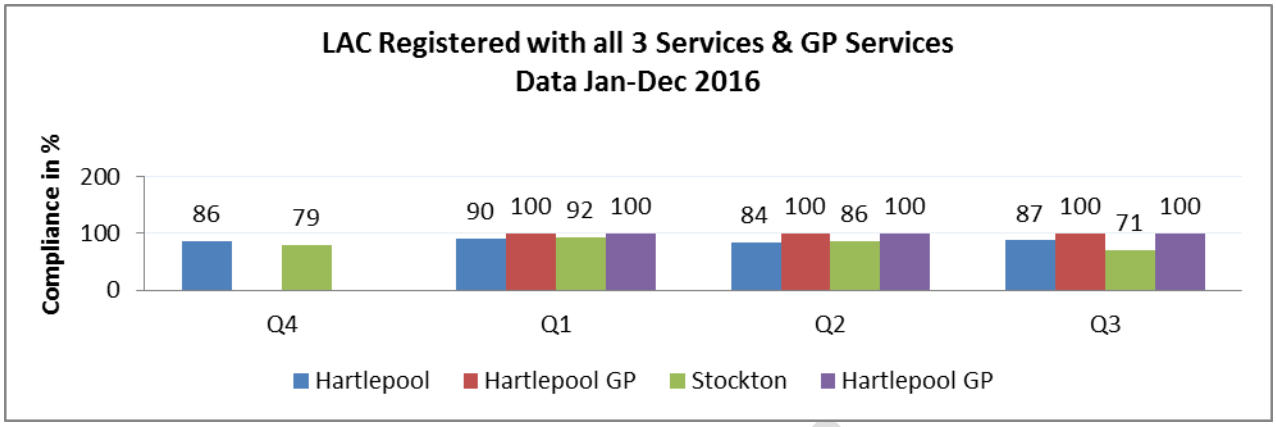
The data has identified a number of issues where compliance has not been maintained and include:

- Capacity in other services such as school health both in local services and those provided by other Trusts to undertake the RHA;

- Review assessments cancelled by carers;

- Children being unwell at the time of the appointment and movement of placement;

In response to the issues identified a process for standardised recording of information across Stockton and Hartlepool IT Systems has been developed alongside a robust action plan which will provide improved quality and consistency of data. This process was introduced through a series of awareness sessions with groups of health staff delivered by the LAC team. Compliance has now significantly improved.



The above table demonstrates the number of children registered with services including GP, Optician and Dentist. It is of note that children under the age of two would not routinely be registered with either an Optician or Dentist unless there is an identified need. Those children have been included in the overall total figure which can account for the reduced compliance.

Summary

Key Achievements 2016

- Ongoing updates and improvements to the Electronic Health Care Record to improve the LAC processes and communication with other health services
- Implementation of a Health Passport for Care Leavers in Stockton;
- Successful implementation of a rolling program of safeguarding supervision for the LAC Senior Nurses;
- A significant improvement in the completion of IHA's and RHA's within statutory timescales.

Sensory Loss

Legal Duties to meet individual's information and communication and support needs.

The Equality Act became law in October 2010 and is aimed to improve and strengthen patient's experiences by ensuring all service providers take steps or make reasonable adjustments in order to avoid putting a disabled person at a disadvantage when compared to a person who is not disabled and/or has some degree of sensory loss or impairment. The Act is explicit in including the provision of information in an accessible format as a reasonable step to be taken.

The Care Act 2014 details specific duties for local authority colleagues concerning provision of advice and information, additionally the NHS Constitution states that " You have the right to be involved in discussions and decisions about your health and care and to be given information to enable you to do this ".

The Accessible Information Standard launched by NHS England in 2016 builds upon the existing legal duties which public sector bodies and all service providers are already obligated to follow, the aim being to improve healthcare for millions of people with sensory loss and other disabilities.

The Standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patient's, service users, carers and parents where their needs relate to a disability, impairment or

sensory loss. The Standard required all NHS and adult social care organisations to meet the communication needs of people with a disability, impairment or sensory loss by 31st July

The Trust set up a task and finish group to oversee implementation of the Standard and is working with colleagues to meet the key milestones and to ensure compliance and achievement of the Standard where the Trust has control.

The Trust continues to make improvements to the care provided to patients with sensory loss, these include:

Identifying Patients with Sensory loss

Significant changes have been made to Core Admission Documentation to identify more clearly patients who have a sensory loss / impairment. The planning of care has also been improved to include documenting the reasonable adjustments required to support the patient during their hospital stay, with the associated care plans put into place and reviewed as part of daily intentional rounding processes. Work is also progressing to update current electronic systems used in acute and community settings to facilitate the requirements of the Accessibility Standard i.e. identifying, recording, flagging, sharing and meeting the information and communication support needs of patient's, service users, carers and parents where their needs relate to a disability, impairment or sensory loss.

Patient Experience

Work has started to develop posters for all clinical areas to raise awareness of the different ways to communicate in addition to developing picture cards appropriate for the clinical area to aid communication needs.

Quarterly meetings are held with the current provider of Interpretation and Translation services, Specialist Mental Health Nurse for patients with sensory loss and Hartlepool Deaf Centre to work together on issues raised by patients and thus support service development.

Specialist Equipment

An audit of fixed hearing loop provision throughout the Trust was performed, the results highlighted which equipment required maintenance and re-siting of equipment to maximise its use in addition to raising awareness amongst staff of the equipment in their clinical areas.

The audit of portable hearing loops highlighted gaps in staff awareness and accessibility of these systems by staff. The portable hearing loops were then removed from the wards and stored in the medical equipment library so they are available to all when needed on a 24 hour basis. A Portable hearing loop is also kept in the resilience offices on both sites for emergency use.

Celebrating deaf/ blind week

On an annual basis charities and local partner agencies hold information stalls at both hospital sites to raise awareness of sensory loss and celebrate the work taking place to support patients and their families. Groups involved over the course of the week include Health watch, Hartlepool Deaf Centre, Action on Hearing Loss, Guide Dogs for the Blind and local authority partners. In addition to having stalls and displays some of the restaurant food menus were presented in Braille during the week.

Staff Support

Communication is sent to staff using quarterly Trust bulletins sharing updates about the Accessibility Standard and its implications for staff, patients, carers and service users.

A eLearning package about communication needs is being developed and is planned to be rolled out to all staff during 2017.

The Accessible Information Standard Review – Survey March 2017

The survey is part of the post –implementation review of the Standard. The purpose of the review is to assess the impact of the standard and ensure it is, and continues to be, " fit for purpose". Following the review, all of the feedback will be analysed and a report will be produced. Depending on the findings, revised versions of the Specification and / or Implementation Guidance for the Standard might be issued. However it is envisaged there will be no substantive changes to the overall scope of the Standard.

All surveys are anonymous and are for health and care professionals, teams, and departments providing or commissioning NHS care or publically funded adult social care. Additionally surveys are being sent to patients, service users, carers, patients and other representative bodies.

Priority 1: Patient safety

Infection Control

4. Infection Prevention and Control

Rationale: Key stakeholders asked us to continue to report on infections of Clostridium difficile, Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia, Methicillin-sensitive Staphylococcus Aureus (MSSA) and Escherichia coli (E.coli) in 2016-17 as these remain high on the patient safety agenda.

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.

Overview of how we said we would measure it

- We will monitor the number of trust and non-trust attributed cases
- We will undertake a multi-disciplinary Root Cause Analysis (RCA) within 3 working days for all trust attributed cases.
- We will benchmark our progress against previous months and years.
- We will benchmark our position against Trusts in the North East and peers across England in relation to number of cases reported and number of samples tested.

Overview of how we said we would report it

- Board of Directors meetings
- Council of Governor meetings (CoG)
- Infection Control Committee (ICC)
- Patient Safety and Quality Standards Committee (PS & QS)
- To frontline staff through Chief Executive brief.
- Safety, Quality and Infections Dashboard
- Clinical Quality Review Group (CQRG)

Completed and reported?

- Reported at every Board of Directors meeting ✓
- Reported at every Council of Governors meeting ✓
- Discussed at each Infection Control Committee ✓
- Discussed in detail at Audit Committee and Directorate meetings ✓
- Reported in detail to NHS Improvement ✓
- Safety, Quality and Infections Dashboard contains infection data ✓

Infection totals for 2016-17 – Hospital Acquired

Infections Category	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total
C diff	2	4	4	3	3	3	3	5	2	4	2	2	37
MRSA						1							1
MSSA	4	4	2	1	3		2	2	1		2		21
E.coli	8	4	3	4	3	4	1	6	1	7	5	2	48
Grand Total	14	12	9	8	9	8	6	13	4	11	9	3	107

Infections Category	2015-16	2016-17	Year to year Difference
C diff (Monitor Breach 13)	36	37	1
MRSA	2	1	-1
MSSA	24	21	-3
E.coli	44	48	4
Grand Total	106	107	1

*Data as of end of 28 March 2017

Clostridium difficile infection (CDI)

Clostridium difficile is a bacterium that is found in the gut of around 3% of healthy adults. It seldom causes a problem as it is kept under control by the normal bacteria of the intestine. However certain antibiotics can disturb the bacteria of the gut and Clostridium difficile can then multiply and produce toxins which cause symptoms such as diarrhoea.

During 2016-17 the Trust did not achieve the Clostridium difficile target having reported **37** Trust attributed cases against a trajectory of **13** cases. This is disappointing given the reductions achieved in previous years and the continued efforts by staff, but not entirely unexpected as the trajectory was always going to be challenging. The Trust continues to work hard to control and reduce opportunity 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 important areas of our environment including enhanced decontamination with hydrogen peroxide vapour and the development of a mattress decontamination facility. A greater focus has been placed on antimicrobial stewardship with the identification of 'champions' across all directorates. The importance of adherence to high standards of hand hygiene has Been highlighted by the introduction of hand hygiene champions with a monthly 'champions challenge'

The Trust improvement plan has been developed in conjunction with clinical staff and reviewed monthly. Progress against the plan is reported to the Healthcare Associated Infection Operational Group and Infection Control Committee and the document is regularly shared with commissioners.

A CDI 'summit' was held in October 2016, during which RCA documents were reviewed and a set of core standards agreed, which are now being implemented across all ward areas. The summit included Board members, governors and representatives from local commissioning groups.

How did we do?

The following table identifies the numbers of trust attributed cases of Clostridium difficile cases reported by the Trust against the target for that period. The table also identifies the number of non-trust attributed cases of Clostridium difficile reported by our laboratory.

Number of Trust Attributed **Clostridium difficile** cases

	Q1	Q2	Q3	Q4	Total
2015-16	8	10	7	11	**36**
2016-17	**10**	**9**	**10**	**8**	**37**

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

Clostridium difficile cases 2013-17

	Trust Attributed	Non-Trust Attributed
2013-14	30	95
2014-15	20	71
2015-16	36	68
2016-17	**37**	**26**

*Data obtained from HCAI data capture system

Clostridium difficile cases and rate per 100,000 Bed Days for North East Trusts 2016-17

Trust Name	C diff Cases	C diff Rank in North East	C diff count rate per 100,000 beds	C diff count rate per 100,000 beds Rank
Trust 1	64	1	16.99	2
Trust 2	32	2	12.57	5
NTHFT	**29**	**3**	**18.35**	**1**
Trust 4	25	4	14.76	3
Trust 5	18	5	14.34	4
Trust 6	18	5	7.75	7
Trust 7	14	7	5.98	8
Trust 8	7	8	8.19	6

*Data obtained from the Healthcare Evaluation Data (HED) – data from April 2016 to December 2016

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 colonization. It is important that we screen 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 them going on to develop an infection.

How did we do?

In 2016-17 our organisation reported **1 (one)** Trust attributed MRSA, an improvement on the previous year when two cases were reported. This exceeds the national zero tolerance trajectory However following investigation the case was found to be unavoidable and the Trust had followed policy in terms of screening and treatment for the patient.

MRSA bacteraemia cases 2013-17

	Trust Attributed	Non-Trust Attributed
2013-14	0	4
2014-15	1	2
2015-16	2	3
2016-17	**1**	**2**

*Data obtained from HCAI data capture system

MRSA bacteraemia cases and rate per 100,000 Bed Days for North East Trusts 2016-17

Trust Name	MRSA Cases	MRSA Rank in North East	MRSA count rate per 100,000 beds	MRSA count rate per 100,000 beds Rank
Trust 2	6	1	2.36	2
Trust 4	5	2	2.95	1
Trust 1	5	2	1.33	3
Trust 6	3	4	1.29	4
Trust 7	3	4	1.28	5
NTHFT	**1**	**6**	**0.63**	**6**
Trust 8	0	7	0	7
Trust 5	0	7	0	7

*Data obtained from the Healthcare Evaluation Data (HED) – data from April 2016 to December 2016

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.

How did we do?

In 2016-17 we reported **21** cases of trust attributed MSSA bacteraemia. Each case is subject to a root cause analysis and the analysis of these investigations has shown that there are no apparent trends in terms of linked cases or frequently seen sources of infection. In many cases the source has been a chest or skin infection which would have been difficult to prevent.

However, the trust recognises that improvement is needed in this infection and increased emphasis on clinical practices continues to be a focus of for the future in an attempt to reduce the number of MSSA bacteraemia. An increase in non-trust attributed cases was also seen this year.

MSSA bacteraemia cases 2013-17

	Trust Attributed	Non-Trust Attributed
2013-14	13	30
2014-15	18	41
2015-16	24	64
2016-17	**21**	**57**

*Data obtained from HCAI data capture system

MSSA bacteraemia cases and rate per 100,000 Bed Days for North East Trusts 2016-17

Trust Name	MSSA Cases	MSSA Rank in North East	MSSA count rate per 100,000 beds	MSSA count rate per 100,000 beds Rank
Trust 1	72	1	19.12	1
Trust 2	27	2	10.60	4
Trust 7	21	3	8.97	5
NTHFT	**19**	**4**	**12.02**	**2**
Trust 4	18	5	10.62	3
Trust 6	15	6	6.46	6
Trust 8	5	7	5.85	7
Trust 5	3	8	2.39	8

*Data obtained from the Healthcare Evaluation Data (HED) – data from April 2016 to December 2016

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

How did we do?

The numbers of E coli bacteraemia (blood stream infection) reported across by the trust for the year are shown in the table below. As the majority of these cases are those that are identified within the first 48 hours of hospital admission work is required across all healthcare settings to achieve improvements.

Root cause analysis is completed for all cases deemed to have been trust attributable 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 they may be potential for improved practices.

E.coli bacteraemia cases 2013-17

	Trust Attributed	Non-Trust Attributed
2013-14	22	169
2014-15	28	176
2015-16	44	227
2016-17	**48**	**263**

*Data obtained from HCAI data capture system

The following tables identify the performance against the eight North East Trusts in 2016-17. For E.coli, the data in the following table encompasses both Trust and Non-Trust attributed cases.

E.coli bacteraemia cases and rate per 100,000 Bed Days for North East Trusts 2016-17

Trust Name	E.coli Cases	E.coli Rank in North East	E.coli count rate per 100,000 beds	E.coli count rate per 100,000 beds Rank
Trust 2	343	1	134.70	4
Trust 1	322	2	85.50	8
Trust 6	317	3	136.44	2
Trust 7	285	4	121.78	6
Trust 4	231	5	136.35	3
NTHFT	**228**	**6**	**144.27**	**1**
Trust 5	133	7	105.94	7
Trust 8	107	8	125.12	5

*Data obtained from the Healthcare Evaluation Data (HED) – data from April 2016 to December 2016

Priority 2: Effectiveness of Care

Safety Thermometer

1. Safety Thermometer

Rationale: The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care.

Overview of how we said we would do it

- The NHS Safety Thermometer provides a quick and simple method for surveying patient harms and analysing results so that you can measure and monitor local improvement and harm free care over time.

Overview of how we said we would measure it

- This indicator will continue to be audited on one day per month across the Trust and community services and the data submitted to NHS Digital.

Overview of how we said we would report it

- Report at every Board of Directors meeting
- Report at every Council of Governors meeting
- On the Safety, Quality and Infections Dashboard

Completed and reported?

- Reported at every Board of Directors meeting ✓
- Reported at every Council of Governors meeting ✓
- Reported on the Safety, Quality and Infections Dashboard ✓

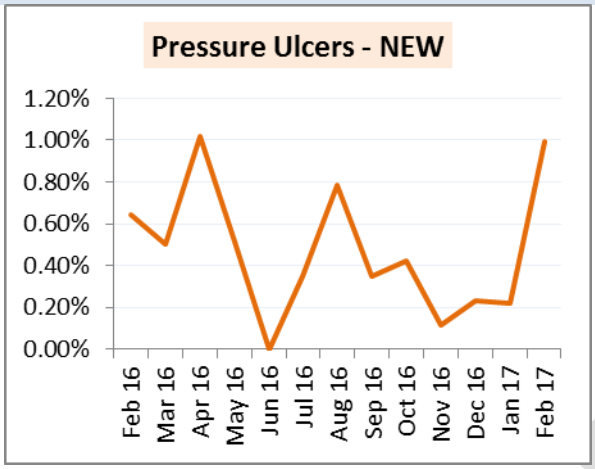
National Safety Thermometer Data can be found at:

http://content.digital.nhs.uk/searchcatalogue?q=title%3A%22nhs+safety+thermometer+data%22&area=&size=10&sort=Most+recent

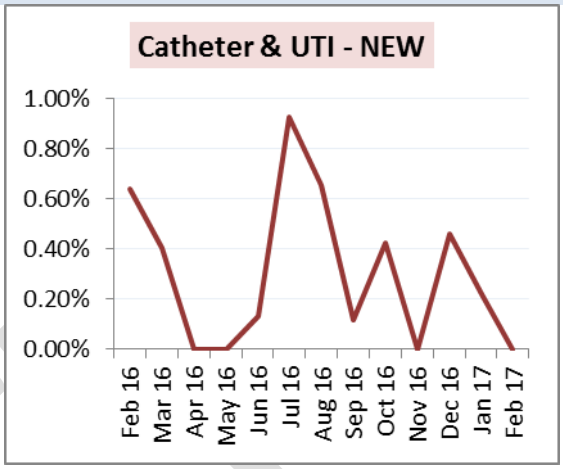
Safety Thermometer Data (classic) – February 2015 to February 2016

The following data is provided by NHS Digital:

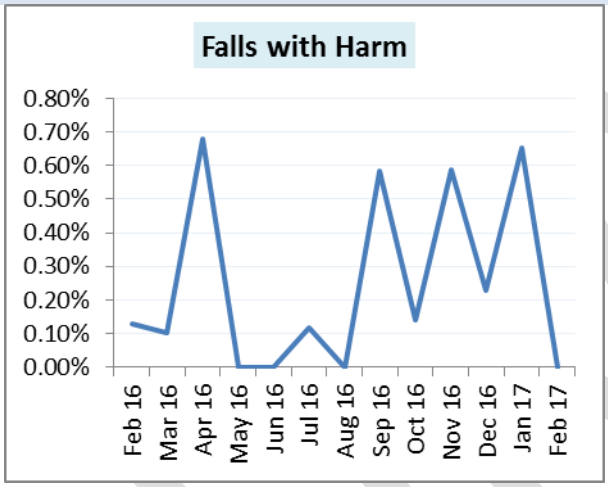
Pressure Ulcers – NEW



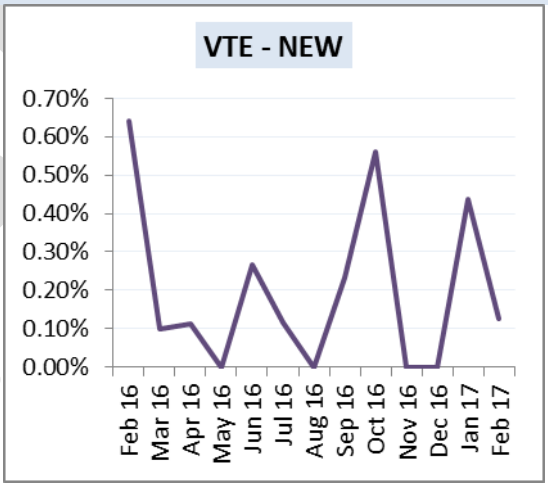
Catheter and Urinary Tract Infection – NEW



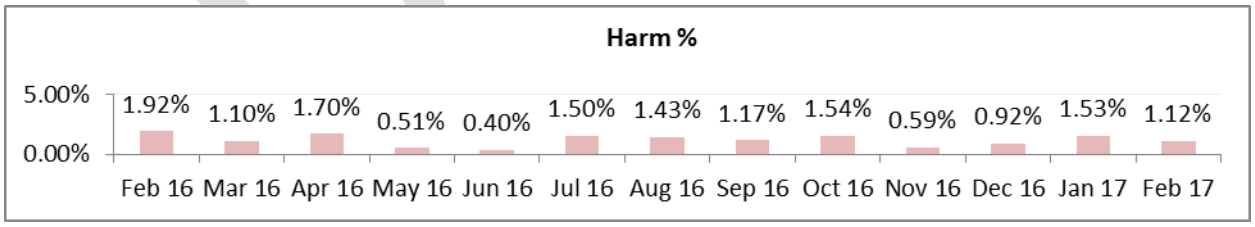
Falls with HARM



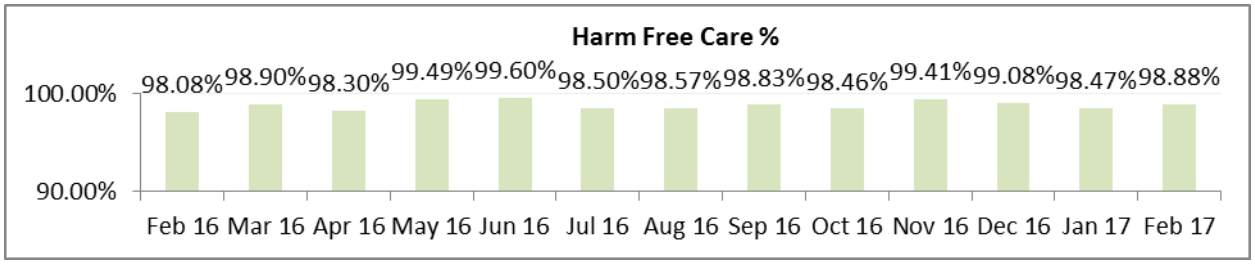
Venous Thromboembolism – NEW



Harm % Trend



Harm FREE % Trend



In addition to the Classic Safety Thermometer (see previous data), in 2016-17 additional safety thermometer measures called " new Generation Safety thermometer " are being piloted across acute and community areas of the Trust. These safety measures all harm but have specific indicators according to the specialist area, namely Medication safety thermometer, Maternity safety thermometer, Children and young people s safety thermometer. .

Medication

The Medication Safety Thermometer is a measurement tool for improvement that focuses on Medication Reconciliation, Allergy Status, Medication Omission, and Identifying harm from high risk medicines in line with Domain 5 of the NHS Outcomes Framework. This is currently being piloted in 2 acute areas (medicine and surgery) and community rapid access areas with view to rolling out across all areas during 2017.

Maternity

The Maternity Safety Thermometer has been designed to measure commonly occurring harms within maternity care and allows maternity teams to take a temperature check on harm and records the proportion of mothers who have experienced harm free care. Data collected focuses on maternal infections, perineal trauma, post-partum haemorrhage, term babies Apgar score and unexpected transfer and patients perception of safety. It supports improvements in patient care and patient experience, prompts immediate actions by healthcare staff and integrates measurement for improvement into daily routines. Currently both acute an community areas are piloting the Maternity Safety Thermometer as part of everyday activities.

Children and Young Peoples Services

The Children and Young People's Safety Thermometer is a national tool that has been designed to measure commonly occurring harms in children and young people's services. These harms include deterioration, extravasation, pain and skin integrity and it is currently being piloted in acute children's ward areas.

Current feedback from all New generation Pilot areas have resulted in changing of the national measuring templates within agreed limits to support them being more user friendly and thus improving accuracy of data and return of data. It is envisaged the roll out for all areas will continue throughout 2017 with view to support improvements in patient care and patient experience, prompting immediate actions by healthcare staff and integrated measurement for improvement into daily routines.

Discharge Processes - Medication

2. Discharge processes – Medication

Rationale: The latest national patient experience survey identified that the Trusts still have work to do with regards to medication discharge processes.

Overview of how we said we would do it

- All patients will receive information about medication side-effects to watch out for at home.

Overview of how we said we would measure it

- Via national and local patient surveys

Overview of how we said we would report it

- Local audit reports reported to Drug and Therapeutic committee
- National inpatient survey report to PS & QS

Completed and reported?

- Reported to PS & QS✓
- Reported to the Drug and Therapeutic committee✓

> “Ward staff are extremely helpful. Downside is discharge arrangements where upon being informed I could go home it was 6 hours waiting for pharmacy tablets. [sic]”

The National In-patient and Out-patients Surveys are undertaken and include questions about medicines, including one for patients receiving information regarding which medication side-effects to watch out for at home.

Medicines are dispensed mainly as Original Packs to ensure patients will receive information leaflets to inform them of any possible side effects that the medication may cause. Medicines are also dispensed with green sheets to show what medication has been dispensed and a web link to access further information.

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.

Medicines Safety

In **2015-16** there were **609** medicines related incidents reported which originated within the Trust. In **2016-17** there have been **660** medicines related incidents reported which originated within the Trust

Type of incidents	2013-14	2014-15	2015-16	2016-17
Prescribing	124	147	224	**133**
Administration	256	314	321	**397**
Dispensing	41	43	48	**70**
Other	56	50	16	**60**
Total	**477**	**554**	**609**	**660**

* Data from the Trusts Datix system and as of 21 March 2017

2016-17 Trust Medication Error Categories

Trust Medication Error Category	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Administration or supply of a medicine from a clinical area	24	39	40	30	31	42	33	43	21	37	32	25	**397**
Medication error during the prescription process	11	11	9	12	13	14	10	10	14	10	8	11	**133**
Preparation of medicines / dispensing in pharmacy	5	6	8	7	1	6	9	6	5	5	10	2	**70**
Monitoring or follow up of medicine use	2	5	1	8	4	3	5	6	3	2	5	2	**46**
Patient's reaction to Medication			1	1	1					2	2	1	**8**
Advice		1							1	1		1	**4**
Supply or use of Over the Counter medicines				1		1							**2**
Total	**42**	**62**	**59**	**59**	**50**	**66**	**57**	**65**	**44**	**57**	**57**	**42**	**660**

* Data from the Trusts Datix system and as of 21 March 2017

Safe Medication Practices Group

- Medications Safety Officer appointed
- Analyse and theme incidents
- Introduce system changes to reduce errors
- Engage with users

As a Trust we are using technology to improve safety and reduce delays in medication administration. One example is electronic medicine cupboards (Omnicell) with biometric access which have been introduced in a number of areas. This has improved services through:

- Keys no longer necessary – accessed via fingerprint
- Increased access to pre-labelled medicines outside of pharmacy hours
- Guiding lights improves safety and reduces time searching for items
- Stock controlled by pharmacy allowing nurses to spend more time with patients and reduces waste through appropriate stock levels

Automated Cupboards

Omnicell Cupboards reduce administration through:

- Fingerprint access means staff no longer having to search for keys
- Cupboards reduce delayed discharges by allowing increased access to pre-labelled medicine outside of pharmacy hours
- Organisation and Guiding Lights improves safety and reduces time searching cupboards

Priority 2: Effectiveness of Care

Safety, Quality and Infections Dashboard
Previously Nursing and Midwifery Dashboard

3. Safety, Quality and Infections Dashboard

Rationale: The Safety, Quality and Infections 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

Overview of how we said we would measure it

- Senior Clinical Matrons (SCMs) will monitor ward areas to ensure that data is up to date, accurate and displayed in a public area

Overview of how we said we would report it

- Reported at every Board of Directors meeting ✓
- Reported at every Council of Governors meeting ✓

Completed and reported?

- Reported at every Board of Directors meeting ✓
- Reported at every Council of Governors meeting ✓

In December 2016 the Trust commenced roll out a new Safety, Quality and Infections Dashboard replacing the existing Nursing and Midwifery Dashboard.

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:

- Nurse Staffing Rates
- Complaints, Stage 1 to 6
- Pressure Ulcers Grade 1 to 4
- Patient Falls
- Classic Safety Thermometer
- Unannounced Hand Hygiene
- Infection Control
- Friends and Family Test
- Staff, Patient Experience and Quality Standards (SPEQS)
- Medication Errors

Safety, Quality and Infections Dashboard 2016-2017

Heat Map | Print Screen | Contact Details

Select are from list below:

Trust Position

Refresh Dashboard

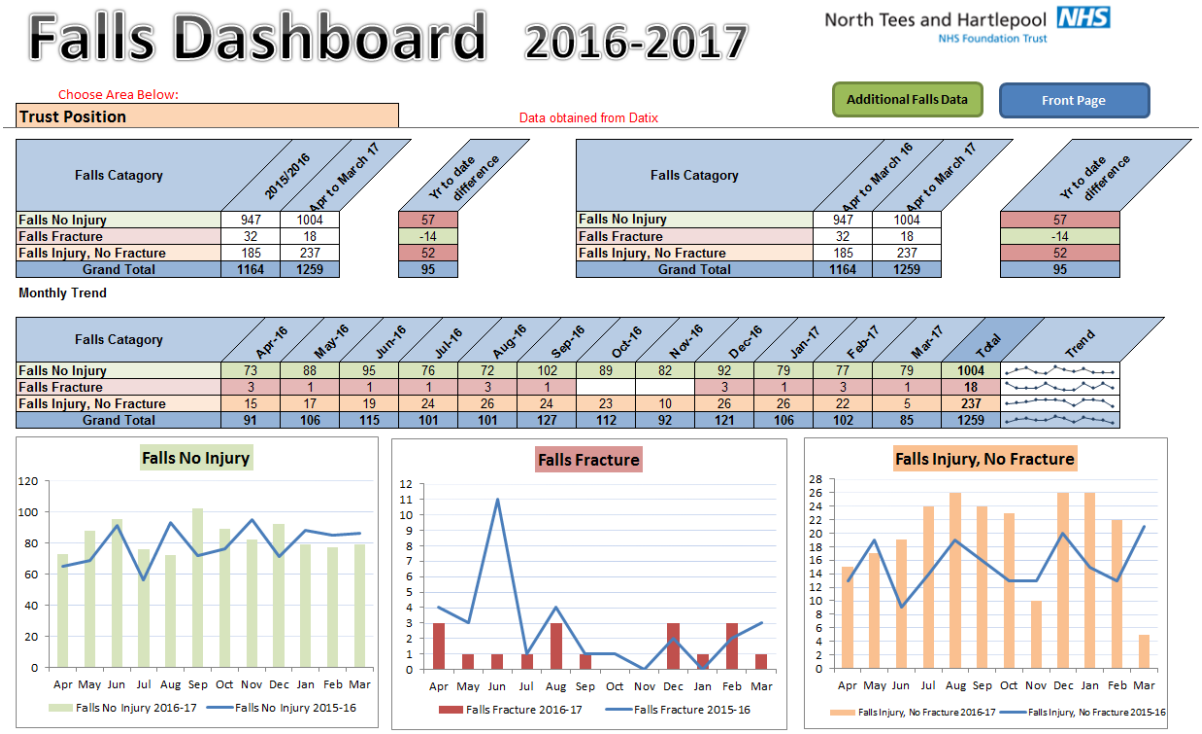
Last updated: 28/03/2017 11:10

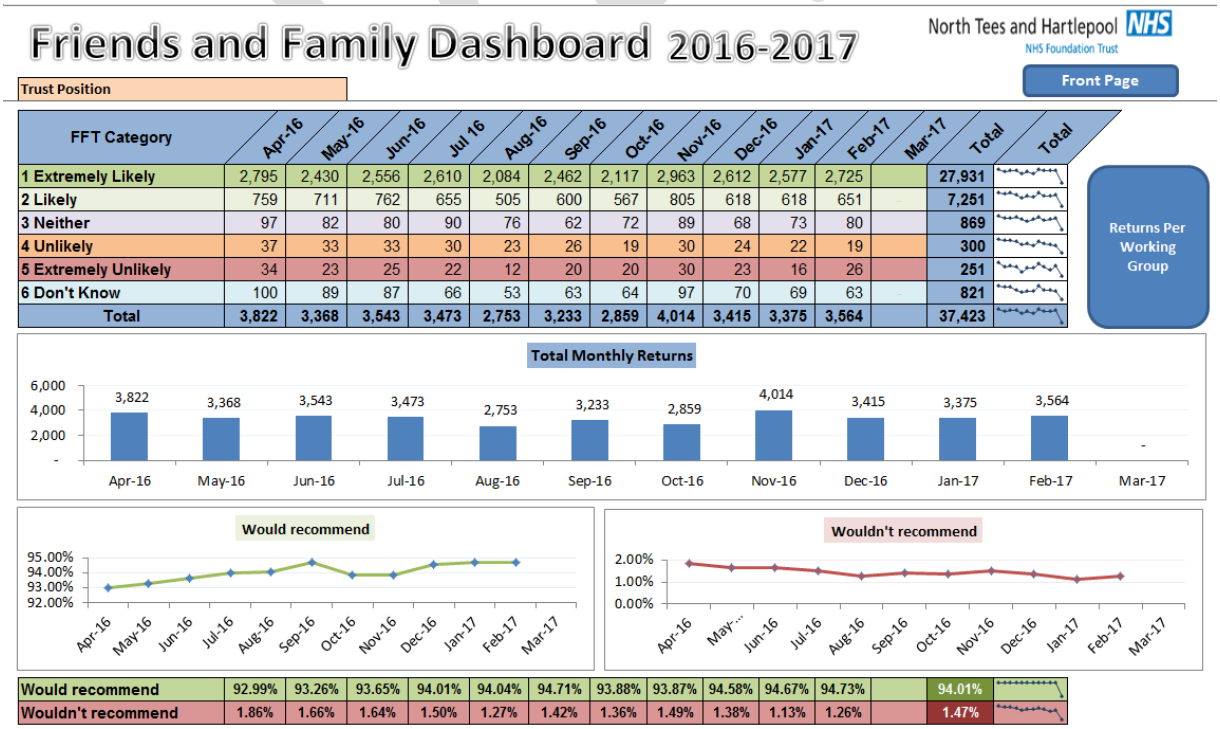
North Tees and Hartlepool NHS
NHS Foundation Trust

ID	Measure	Previous Period	Previous Value	Latest Period	Latest Value	vs Previous Period	Trend	2016/2017 Total (or Avg)	Drill Down
1	Fill Rate - RN Day	Jan 17	82.26%	Feb 17	81.04%	↓		80.47%	UNIFY Detail
2	Fill Rate - RN Night	Jan 17	92.18%	Feb 17	90.79%	↓		94.33%	
3	Fill Rate - HCA Day	Jan 17	118.95%	Feb 17	123.84%	↑		122.59%	
4	Fill Rate - HCA Night	Jan 17	133.69%	Feb 17	130.05%	↓		144.62%	
5	Stage 1 Complaint - Concern	Feb 17	63	Mar 17	50	↓		858	Complaints Detail
6	Stage 2 Complaint - Formal Meeting	Feb 17	2	Mar 17	3	↑		70	
7	Stage 3 Complaint - Formal Letter	Feb 17	30	Mar 17	25	↓		270	
8	Stage 4 Complaint - Consent	Feb 17	3	Mar 17	7	↑		14	
9	Stage 5 Complaint - Other Trusts	Feb 17	0	Mar 17	0	→		8	
10	Stage 6 Complaint - Duty of Candour	Feb 17	0	Mar 17	1	↑		6	
11	**Total Complaints**	**Feb 17**	**98**	**Mar 17**	**86**	↓		**1,226**	
12	Pressure Ulcer Grade 1	Feb 17	13	Mar 17	6	↓		52	Pressure Ulcer Detail
13	Pressure Ulcer Grade 2	Feb 17	41	Mar 17	30	↓		159	
14	Pressure Ulcer Grade 3	Feb 17	4	Mar 17	0	↓		10	
15	Pressure Ulcer Grade 4	Feb 17	0	Mar 17	1	↑		2	
16	**Total Ulcers**	**Feb 17**	**58**	**Mar 17**	**37**	↓		**223**	
17	Fall No Injury	Feb 17	77	Mar 17	79	↑		1,004	Falls Detail
18	Fall Fracture	Feb 17	3	Mar 17	1	↓		18	
19	Fall Injury, No Fracture	Feb 17	22	Mar 17	5	↓		237	
20	**Total Falls**	**Feb 17**	**102**	**Mar 17**	**85**	↓		**1,259**	
21	Safety Thermometer - NEW Pressure Ulcers	Jan 17	0.22%	Feb 17	1.00%	↑		0.48%	Safety Thermometer Detail
22	Safety Thermometer - Catheter & UTI - NEW	Jan 17	0.22%	Feb 17	0.00%	↓		0.00%	
23	Safety Thermometer - Falls with Harm	Jan 17	0.65%	Feb 17	0.00%	↓		0.26%	
24	Safety Thermometer - VTE - NEW	Jan 17	0.44%	Feb 17	0.12%	↓		0.21%	
25	**Safety Thermometer - Harm Free Care %**	**Jan 17**	**98.47%**	**Feb 17**	**98.88%**	↑		**98.79%**	
26	**Safety Thermometer - New Harm %**	**Jan 17**	**1.53%**	**Feb 17**	**1.12%**	↓		**1.21%**	
27	UA Hand Hygiene Nurses	Feb 17	96.41%	Mar 17	96.54%	↑		92.02%	Hand Hygiene Compliance Detail
28	UA Hand Hygiene Doctors	Feb 17	79.63%	Mar 17	96.59%	↑		88.96%	
29	UA Hand Hygiene HCAs	Feb 17	85.14%	Mar 17	90.95%	↑		92.02%	
30	UA Hand Hygiene Physio's/Visiting Doctors	Feb 17	100.00%	Mar 17	93.56%	↓		94.69%	
31	UA Hand hygiene Others	Feb 17	92.05%	Mar 17	100.00%	↑		95.30%	
32	**UA Hand Hygiene Compliance Avg**	**Feb 17**	**89.21%**	**Mar 17**	**93.92%**	↑		**92.11%**	
33	Infection Control - C Diff	Feb 17	2	Mar 17	2	→		37	Infections Detail
34	Infection Control - MRSA	Feb 17	0	Mar 17	0	→		1	
35	Infection Control - MSSA	Feb 17	2	Mar 17	0	↓		21	
36	Infection Control - Ecoli	Feb 17	5	Mar 17	2	↓		48	
37	Friends & Family - Would Recommend %	Jan 17	94.67%	Feb 17	94.73%	↑		94.01%	Friends & Family Detail
38	Friends & Family - Wouldn't Recommend %	Jan 17	1.13%	Feb 17	1.26%	↑		1.47%	
39	**Friends & Family - Positive Comments**	**Jan 17**	**4,475**	**Feb 17**	**4,798**	↑		**49,955**	
40	**Friends & Family - Negative Comments**	**Jan 17**	**122**	**Feb 17**	**113**	↓		**1,410**	
39	SPEQS - Safe	Feb 17	91.82%	Mar 17	90.34%	↓		89.44%	SPEQS Detail
40	SPEQS - Effective	Feb 17	86.40%	Mar 17	85.20%	↓		87.90%	
41	SPEQS - Caring	Feb 17	95.37%	Mar 17	92.88%	↓		91.75%	
42	SPEQS - Responsive	Feb 17	88.79%	Mar 17	86.90%	↓		84.65%	
43	SPEQS - Well-Led	Feb 17	88.15%	Mar 17	76.98%	↓		81.50%	
44	**SPEQS - Avg Total**	**Feb 17**	**89.61%**	**Mar 17**	**87.24%**	↓		**88.24%**	
45	Medication Errors	Feb 17	58	Mar 17	54	↓		673	Medication Errors Detail

The drill down options on the front page allow for greater detail of the individual measures to be displayed:

The following two images illustrate the greater depth of information available.





Priority 3: Patient Experience

Palliative Care and Care For the Dying Patient

1. Palliative Care and Care For the Dying Patient

Rationale: The Trust used the Care For the Dying Patient (CFDP) and Family's Voice. Stakeholders and the Trust believe that this needs to remain a priority in 2016-17 both in hospital and in the community.

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

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

Overview of how we said we would do it

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

Overview of how we said we would measure it

- We will evaluate feedback in relation to pain, nausea, breathlessness restlessness, care for the patient and care for the family

Overview of how we said we would report it

- Quarterly to IPB
- Annually to PS & QS

Completed and reported?

- Reported to IPB and quarterly ✓
- Reported to PS & QS annually ✓

"Our mam, who is 95 and dying, has received the best care. Her son and his wife have been treated with care and respect. The staff have been understanding and maintained mam's dignity until the very end. [sic]"

Specialist Palliative Care

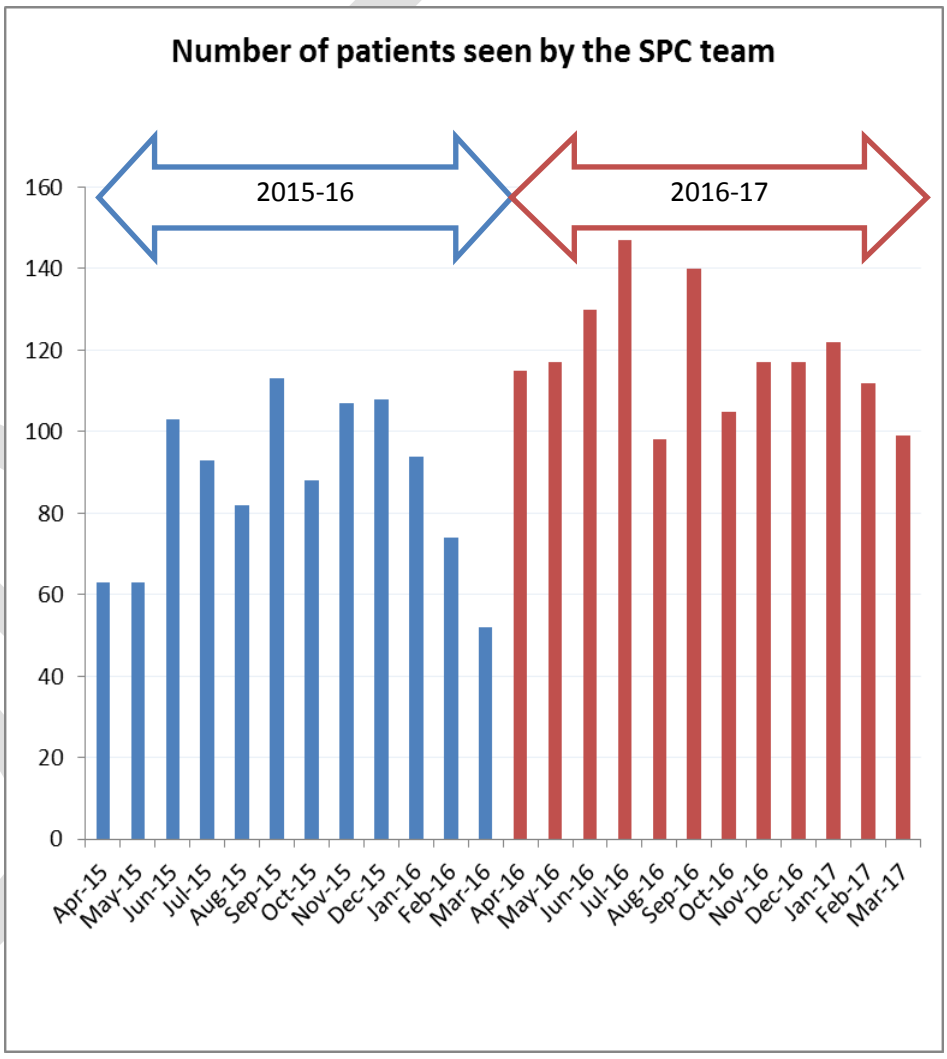
Trust instigated a number of changes to the palliative care process and team during 2016-17, to improve patient experience, quality of care given and more accurate data collection

The following table demonstrates the year on year comparison from 2014-15 to 2016-17 for number of patients seen by the Specialist Palliative Care Team.

	Q1	Q2	Q3	Q4	Total
2014-15	131	129	163	181	**604**
2015-16	229	288	303	220	**1,040**
2016-17	**362**	**385**	**339**	**333**	**1,419**

*Q4 data for 2016-17 as of 28 March 2017

Month	Patients Seen
Apr-15	63
May-15	63
Jun-15	103
Jul-15	93
Aug-15	82
Sep-15	113
Oct-15	88
Nov-15	107
Dec-15	108
Jan-16	94
Feb-16	74
Mar-16	52
Apr-16	115
May-16	117
Jun-16	130
Jul-16	147
Aug-16	98
Sep-16	140
Oct-16	105
Nov-16	117
Dec-16	117
Jan-17	122
Feb-17	112
Mar-17	99



*Data obtained from the Trusts SPC team as of 28 March 2017

Educational Strategy for Palliative Care

North Tees and Hartlepool NHS Foundation Trust recognises the importance of giving the best possible care to palliative patients and patients in the last days of life. Over the last year we have worked with our partners locally, regionally and nationally to ensure that we look to provide the very best care and continue to develop our strategy and trust focus around palliative and end of life care.

Good communication skills are essential and underpin the care given. Health care professionals caring for all patients need to be trained in communication skills. However the importance of good communication becomes even more pronounced when caring for palliative patients and patients in the last days of life due to the sensitive nature of discussions. An understanding of the importance of a holistic assessment is essential. It is important that a patient's physical, psychological, spiritual and social needs are addressed and that the family and carers are well supported.

Health care professionals need to be aware of appropriate medication prescribing in palliative patients and to follow guidance on advance care planning and the management of palliative emergencies. Following funding from Macmillan Cancer Support, the trust Specialist Palliative Care Team has established a diary of study days, aimed at nursing and medical staff from all settings, primary and secondary care, with a view to raising the profile of care delivery for patients who are in a palliative or end of life phase. In addition to this, the trust now has Palliative and End of Life Care as a full day element of it's Preceptorship programme. In an effort to support staff with difficult conversations, the SPCT also facilitate the SAGE & THYME Foundation level in communication skills on the preceptorship programme.

Aims:

- For staff to have increased knowledge and skills whilst caring for palliative and dying patients and their families.
- For staff to feel more confident in providing care for palliative patients and their families.
- For staff to feel more confident in providing care for dying patients and their families.
- To improve the care of palliative patients and their families provided by staff employed by The North Tees and Hartlepool NHS Foundation Trust.
- To improve the care of dying patients and their families provided by staff employed by The North Tees and Hartlepool NHS Foundation Trust.
- To comply with national standards for training and education around caring for palliative patients and patients in the last days of life.

Secondments with specialist palliative care team

Following a successful bid to Macmillan Cancer Support, the trust initiated a Macmillan Development Nurse Programme, which has been funded for two years. The year 2 secondees are about to take up post in their development roles, both staff communing from our Out of Hospital directorate. In addition, the 2 secondees from year 1, a community nurse from the trust and a ward sister from the trust, have both been successful in obtaining permanent positions within the Specialist Palliative Care Team as Macmillan Nurses, as part of effective succession planning.

The development programme has covered a variety of clinical areas, allowed the development nurses opportunities to attend national conferences, link with cancer site specific teams both in and out with the trust and to attend MDT and GSF meetings across the locality. Their development experience has led to them being able to hold a caseload of patients under the supervision of a Band 7 Macmillan Clinical Nurse Specialist and afforded them the skills and experience to commence their careers as Macmillan Clinical Nurse Specialists.

In addition to this, a recent 6 month secondment exchange between the trust Out of Hospital Directorate and Butterwick Hospice was undertaken. A community nurse gained 6 months of experience at Butterwick Hospice, whilst a Hospice Palliative Care Nurse gained 6 months experience within the Specialist Palliative Care Team at the trust. It is hoped that we can develop ion this programme further.

Palliative Care Register and Virtual Wards

Within the Trust there is an area of development called the Trust based palliative care register. The Trust has two virtual wards.

1. A register that identifies and monitors the palliative care patients expected to be in the last year of life.
2. The virtual end of life ward.

The Trust has seen approximately 350 patients who have received end of life care on our wards in the last year. When patients are on the register they are given a green swan (identifier) on Trakcare which is the Trusts Electronic Patient Record System. The flag ensures that clinical teams are aware and can think before acting about who they are treating. Over the year the Trust has reduced the length of stay for these patients form an average of a 11 days to 4, making sure patients are in hospital no longer than they should be.

For comparison, in January 2016 of this group on the register 498 (52%) died in the hospital and 455 48% died outside home hospice nursing residential home. In March 2017 it is reversed, 587 (48%) died in hospital and 629 (52%) died outside of hospital.

Care For the Dying Patient (CFDP)

The Family's Voice diary continues to be given out to relatives within the Trust and the community.

Between April 2016 and March 2017, the Trust has handed out **171** diaries; this is the same as the previous reporting year, currently the average score has reduced to **20.40** from the previous average of 20.80.

The Trust continues to be busy with unprecedented pressures. Two research papers have been sent for publications which reports on the sixth year of this project development, with one of the papers being multi-agency.

The Trust has endeavoured to improve the uptake of the CFDP with greater support from the chaplains who review every patient on the Care of the Dying Document. If the document has not been given out, it is pointed out and the next occasion they offer to accompany the staff in giving it out. We have also added the process of the diary to the SPEQS it asks about the diary being introduced and are the blues cupboards full.

The following are results since April 2011; these results demonstrate that a **high standard of care continues** to be provided by the Trust.

Reporting Period	Number of Patients	Average Daily Score (Max 24.00)
April 2011 to March 2012	193	20.80
April 2012 to March 2013	242	21.10
April 2013 to March 2014	170	21.60
April 2014 to March 2015	131	21.10
April 2015 to March 2016	167	20.80
April 2016 to March 2017	**171**	**20.40**

*Data obtained from the Trusts Family's Voice database

The Trust complaints for end of life care increases when the diary is not introduced the level of complaints still remains below the national average of between 3-7%. The aim is also to make ward managers directly responsible for reviewing the diaries and loading the data base.

Training

We have continued to emphasize the Family Voice work in our level 1 Communications skills training using the national model of Sage and Thyme.

Sage and Thyme 2016-17

February 2017 27 attendees

October 2016 25 attendees

Quotes from family members/carers for the dying patient

"No nothing more could have been done The move to the Oasis room was timely. Dad passed away at 13. 50. Many thanks from …son. [sic]"

"Brilliant Compassionate staff very attentive, but still wouldn't put a bar in the corner of the room for us. LOL At this time there can still be time for humour, mum would have loved that. [sic]"

"Sadly mum passed away tonight. Fortunately we were all at her bedside at the time. We can't fault the kindness, professionalism care and attention by gail and the team. Thank you very much. [sic]"

Spiritual and emotional care of patients at the end of their life

In November 2011, the National Institute of Health and Clinical Excellence (NICE) published guidance describing the importance of spiritual and religious support to patients approaching end of life. The guidance specifically referred to the role of chaplains in end of life care. We were very pleased to read the guidance because it promotes the approach that our Trust has taken since July 2009 to meet the needs of patients and families when faced with the knowledge that end of life is near.

Actions taken by the Trust:

Since July 2009, the Trust has routinely referred patients on the end of life care pathway to the chaplaincy team. During 2016-17, **369** patients were referred by our staff to this pioneering service provided by the Trust chaplains. They provide **spiritual, pastoral and emotional support** to patients, families and staff. Only **3** patients declined support during the reporting year. **281**

patients welcomed and received multiple visits. This service offers added value to the quality of overall care provided to patients and their loved ones and has highlighted the importance of this aspect of support to the dying patient.
The Trust continues to address the spiritual and pastoral needs of patients in the community. Initially, this was for patients on or near the end of life, but practice has indicated that the service needs to be offered to patients earlier in the palliative care stage, in order to build up a relationship with the patient and offer a meaningful service. Perhaps because of management restructuring in the community, referrals have been less frequent than in the acute trust, but they are now beginning to gather momentum.

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

Chaplain Referrals, Received more than 1 visit and Declined Support

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total
Referrals	45	33	36	43	18	37	24	26	20	38	49		**369**
Received more than 1 visit	35	26	27	31	14	27	20	21	17	28	35		**281**
Declined Support	1	1	0	0	0	0	0	0	0	0	1		**3**

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

	2013-14	2014-15	2015-16	2016-17
Referrals	397	424	437	**369**
Received more than 1 visit	233	272	274	**281**
Declined Support	3	1	3	**3**

*data from the Trusts chaplain service

Multi Faith

The Trust holds a directory of all the local faith groups in the area, with a list of contacts. If someone from a different faith group wants to talk with the chaplains we would do this for all people of faith or no faith. If they request from the chaplains the Imam (Muslim) or the Hindu Priest, Buddhist or any other faith, the chaplains would contact our link person and arrange a visit.

Priority 2: Effectiveness of Care

Is our care good?

3. Is our care good? (Patient Experience)

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 Staff, Patient Experience and Quality Standards (SPEQS) visits
- We will ask the question in all Trust patient experience surveys
- We will monitor patient feedback from national surveys

Overview of how we said we would measure it

- Analysis of the feedback from SPEQS and patient experience/national surveys

Overview of how we said we would report it

- Reports to Board of Directors

Completed and reported?

- Reported to Board of Directors✓

> “After my surgery was cancelled for the second time (on my birthday), the nursing staff got me a cake, it really made my day. All staff on the ward have been brilliant, nothing was too much trouble. [sic]”

> “Not enough Staff. Nurses over-worked, waited over 6 hours for pain relief, asked 3 different Nurses and got ignored. [sic]”

> “Even though you can see exhaustion in your faces, you are all there with smiles on your faces to try make us feel better, no matter what is thrown at you all. You’re all diamonds thank-you. [sic]”

Patient Experience Surveys

Below are a list of the surveys that the Trust carried out between April 2016 and March 2017. The 'Number of patients surveyed' column shows out of how many patients were eligible to take part.

National Surveys

Survey	Month Survey published	Number of Patients Surveyed
National Cancer Patient Experience Survey 2016	July 2017	667 Current responses (69%)
CQC National Inpatient Survey 2016	June 2017	1,250 (41.2%)
CQC National Maternity Survey 2016	Late 2017	Fieldwork to start April 2017
CQC National Children's & Young Peoples survey 2016	October 2017	Fieldwork to start Jan 2017
CQC National Emergency Survey 2016	July 2017	1,177 (24.8%)

Local Surveys

Survey	Month Survey published	Number of Patients Surveyed
Local Assisted Reproduction Unit Survey 2016	Dec 2016	76/169 (45%)
Local Endoscopy Patient Survey 2016	June 2016	216/500 (43.2%)
Local Endoscopy Patient Survey 2017	June 2017	Fieldwork Feb 17
Local Acute Oncology Survey 2016	Nov 2017	28 surveys
Local Bariatric Surgery Survey 2016	Dec 2016	36/72 (50%) surveys
Local Upper GI Cancer Survey 2016	Oct 2016	35/100 (35%)
Local IBD Survey Cycle III 2017	May 2017	Fieldwork to start Feb 17
Local Chemotherapy Survey 2017	May 2017	42/200 (data collection phase)
Local Scan for Safety Survey 2017	Feb 2017	Fieldwork Feb 17 TBA
Local Hospital at Home Service Survey 2016-17	Feb 2017	85/270 (31%) (data collection phase)
Local John's Campaign Relative/Carer Survey 2017	May 2017	TBA
Local Nurse Led Bone Marrow Biopsy Survey 2017	March 2017	24/46 (52%) (data collection phase)
Discharge Drop In Sessions for relatives and carers – Survey 2017	February 2017	26 patients (data collection phase)

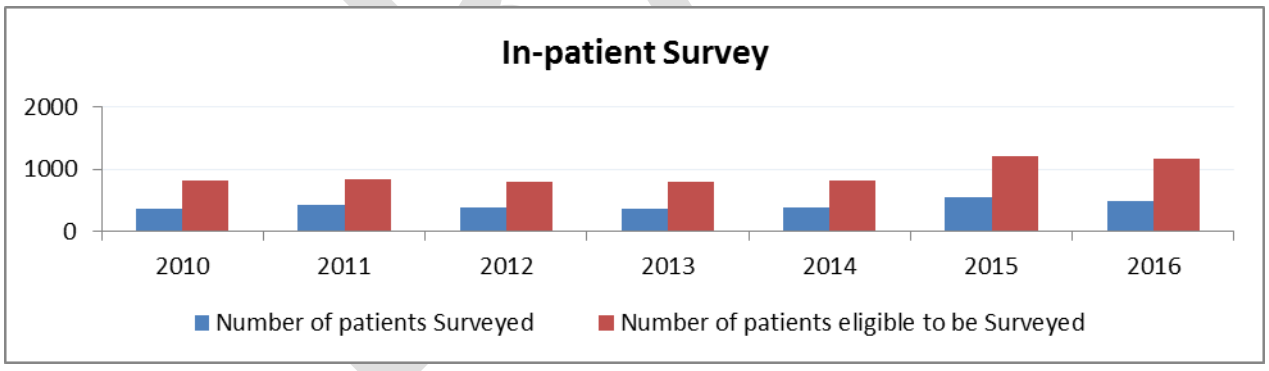
“Very efficient, Staff excellent and made to feel very calm, thanks to all. Maybe public should hear about the marvellous side to the NHS. We are all very lucky.” [sic]

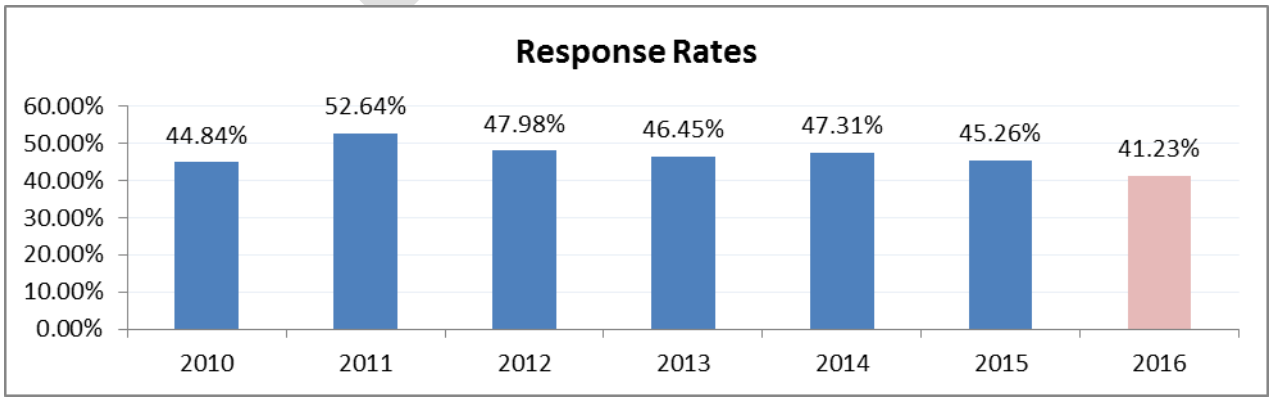
National Surveys

CQC National Inpatient Survey data for 2016

This survey is a Care Quality Commission (CQC) requirement for all Acute NHS Trusts. Each Trust randomly selected adult inpatient admissions during July and August 2016 (age over 16 years).
There were **484** responses from the patients that received a survey, this equates to a response rate of **41.2**3%

Survey Period	Number of patients Surveyed	Number of patients eligible to be Surveyed	Response Rate
2010	369	823	44.84%
2011	438	832	52.64%
2012	381	794	47.98%
2013	373	803	46.45%
2014	387	818	47.31%
2015	545	1,204	45.26%
2016	**484**	**1,174**	**41.23%**





National Cancer Patient Experience Programme 2016 National Survey

Fieldwork closes at the end of March 2017. To date we have a **69%** response rate against the current national response rate of 58%.

The survey was conducted with patients with a primary diagnosis of cancer who had an inpatient or day case attendance who were discharged during April, May and June 2016.

As the survey results are not expected to be published until summer 2017 here is a sample of the type of comments the Trust received in regards to cancer treatment taken from the previous National Cancer Patient Experience Programme 2015.

National Cancer Patient Experience Survey 2015

The survey was conducted in 2015-16. It was sent to all adult patients with a confirmed diagnosis of cancer discharged after an inpatient or day case patient attendance for a cancer related treatment during April, May and June 2015.

Questions	2013-14	2015-16
Patient found it easy to contact their Clinical Nurse Specialist	92%	94% Scored better than expected
Hospital staff gave information about impact cancer could have on work/education	76%	84%
Hospital staff gave information on getting financial help	60%	65% Scored better than expected
Hospital staff told patient they could get free prescriptions	75%	84%

“Specialist Breast care nurse was excellent, reassuring, professional, anticipating any needs, readily available. Exactly what a new patient needs. [sic]”

“I cannot fault any of the hospital staff. They did a first rate job and took care of any problems concerning my cancer. [sic]”

“More space needed for patients undergoing chemotherapy. Sitting in a chair whilst receiving your medication is not always comfortable. Some beds could be provided. [sic]”

“As a terminal patient my treatment was fantastic. Thank you. [sic]”

Priority 3: Patient Experience

Friends and Family recommendation

4. Friends and Family recommendation

Rationale: The Department of Health require Trusts to ask the Friends and Family recommendation questions from April 2013. Stakeholders agreed that this remains being reported in the 2016-17 Quality Accounts.

Overview of how we said we would do it

- We ask patients to complete a questionnaire on discharge from hospital

Overview of how we said we would measure it

- We analyse feedback all Friends and Family questionnaires

Overview of how we said we would report it

- Report to Board of Directors
- Report to Council of Governors
- Safety, Quality and Infections Dashboard

Completed and reported?

- Reported at every Board of Directors meeting ✓
- Reported at every Council of Governors meeting ✓
- Safety, Quality and Infections Dashboard ✓

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:
http://www.england.nhs.uk/statistics/statistical-work-areas/friends-and-family-test/friends-and-family-test-data/

How 'would recommend' and 'wouldn't recommend' % is calculated

Would recommend

$$\frac{\text{Extremely likely + likely}}{\text{Extremely likely + likely + neither + extremely unlikely + don't know}} \times 100$$

Wouldn't recommend

$$\frac{\text{Extremely unlikely + unlikely}}{\text{Extremely likely + likely + neither + extremely unlikely + don't know}} \times 100$$

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	
In-patients	Acute Cardiac Unit
	Ambulatory
	Discharge Lounge
	EAU
	Maternity (Ward 18/19)
	Mobile Rehab Day Unit
	Neonatal (Ward 23)
	Paediatric (Ward 15)
	Rheumatology
	Surgical Decisions Unit
	Ward 24
	Ward 25
	Ward 26
	Ward 27
	Ward 28
	Ward 29
	Ward 30
	Ward 31
	Ward 32
	Ward 33
	Ward 36 (SSU)
	Ward 37
	Ward 38
	Ward 39
	Ward 40
	Ward 41
	Ward 42
Outpatients	Day Case Unit
	Endoscopy
	Lung Health
	Main Outpatients
	Orthopaedics
	Physio (Tatchell)
	Radiology (BRS)
	Radiology (MXR)
	Radiology (USM)
	Speech And Language Therapy
	Walker Unit
	Wheelchair services
	Women's Outpatients
A&E	Accident and Emergency

Hartlepool	
In-patients	Elective Care Unit -Ward 4
Outpatients	Day Case Unit
	Endoscopy (RMU)
	Main Outpatients
	Medical Physics
	One Life Centre
	Orthopaedics
	Paediatric
	Pregnancy Advisory Clinic
	Radiology (MXR)
	Radiology(BRS)
A&E	Minor Injuries Unit
COMMUNITY CLINICS	Audiology
	Children's Speech &Language
	Diabetics
	Dietetics
	Holdforth (Ward 3)
	Muscular Skeletal
	Orthotics
	Physiotherapy
	Podiatry
	Pulmonary Rehab
	Retinal Screening
COMMUNITY DENTAL	Eston Health Centre
	Guisborough Hospital
	Lawson Street
	North Ormesby Health Village
	North Tees
	One Life Centre

North Tees and Hartlepool NHS Foundation Trust – Returns for April 2016 to February 2017

FFT Category	1 Extremely Likely	2 Likely	3 Neither	4 Unlikely	5 Extremely Unlikely	6 Don't Know	Total	Would recommend	Wouldn't recommend
Apr-16	2,795	759	97	37	34	100	**3,822**	**92.99%**	**1.86%**
May-16	2,430	711	82	33	23	89	**3,368**	**93.26%**	**1.66%**
Jun-16	2,556	762	80	33	25	87	**3,543**	**93.65%**	**1.64%**
Jul 16	2,610	655	90	30	22	66	**3,473**	**94.01%**	**1.50%**
Aug-16	2,084	505	76	23	12	53	**2,753**	**94.04%**	**1.27%**
Sep-16	2,462	600	62	26	20	63	**3,233**	**94.71%**	**1.42%**
Oct-16	2,117	567	72	19	20	64	**2,859**	**93.88%**	**1.36%**
Nov-16	2,963	805	89	30	30	97	**4,014**	**93.87%**	**1.49%**
Dec-16	2,612	618	68	24	23	70	**3,415**	**94.58%**	**1.38%**
Jan-17	2,577	618	73	22	16	69	**3,375**	**94.67%**	**1.13%**
Feb-17	2,687	645	80	19	26	62	**3,519**	**94.69%**	**1.28%**
Mar-17									
Total	**27,893**	**7,245**	**869**	**300**	**251**	**820**	**37,378**	**94.01%**	**1.47%**

*Data from Trusts Friends and Family database - April 2016 to January 2017

FFT Breakdown by Area – Returns for April 2016 to January 2017

FFT Category	1 Extremely Likely	2 Likely	3 Neither	4 Unlikely	5 Extremely Unlikely	6 Don't Know	Total	Would recommend	Wouldn't recommend
In-patient	4,696	1,078	125	59	48	103	**6,109**	**94.52%**	**1.75%**
Emergency Care	2,106	470	64	49	51	52	**2,792**	**92.26%**	**3.58%**
Maternity	669	130	9	3	1	6	**818**	**97.68%**	**0.49%**
Day Case Unit	5,379	430	27	4	24	35	**5,899**	**98.47%**	**0.47%**
Outpatients	6,922	2,279	366	121	95	303	**10,086**	**91.23%**	**2.14%**
Radiology	4,669	2,019	204	45	14	223	**7,174**	**93.23%**	**0.82%**
Community Clinic	2,629	676	45	12	13	77	**3,452**	**95.74%**	**0.72%**
Community Dental	423	64	11	1	0	10	**509**	**95.68%**	**0.20%**
Paediatrics	358	90	18	4	4	10	**484**	**92.56%**	**1.65%**

*Data from Trusts Friends and Family database - April 2016 to January 2017

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.

To date through the Friends and Family Test (FFT), the Trust has received **49,909 positive** comments and **1,408 negative**, as detailed below (to note: it is possible to have more than one comment per FFT return).

Theme	POS
Staff (general)	8,950
Friendliness	6,872
Care/Compassion	4,440
Service/Customer Service/Management	4,267
Help/Support	4,256
Efficiency	3,182
Qs Answered/Info/Advice/Explanations	2,031
Miscellaneous	1,866
Professionalism	1,559
Reassured/Put at ease	1,272
Treatment	1,242
Politeness	1,223
Timeliness/Wait Times	1,144
Nursing/Care staff	792
Location Specific Comment	735
Attentiveness	557
Disposition of staff	555
Clinicians/Specialists etc.	463
Staff Named	453
Hygiene/Cleanliness	429
Neutral	377
Comfort	373
Convenience	293
Communication	201
NHS - general comment	194
Empathy/Understanding	182
Respect	173
Experience	154
Previous experience	154
Food	153
Facilities	146
Atmosphere	129
Environment	122
Admin and reception staff	115
Expertise/Proficiency	106
Child Friendly	95
FFT related comment	91
Aftercare	86
Dignity	66
Meeting and greeting	66

Theme	NEG
Timeliness/Wait Times	322
Communication	104
Staffing levels	100
Staff (general)	87
Parking	68
Service/Customer Service/Management	66
Efficiency	55
Location Specific Comment	44
Environment	38
Food	37
Facilities	33
Qs Answered/Info/Advice/Explanations	33
Clinicians/Specialists etc.	32
Noise	32
Treatment	26
Care/Compassion	25
Discharge	25
Admin and reception staff	21
Nursing/Care staff	21
Attentiveness	20
Medication	17
Hospital closure/new hospital etc.	13
Previous experience	13
Hygiene/Cleanliness	12
Comfort	11
Convenience	11
Privacy/Confidentiality	11
Equality and Diversity	10
Experience	9
Atmosphere	8
Help/Support	8
Politeness	8
Appointment Time	7
Empathy/Understanding	7
Equipment	7
Miscellaneous	6
Moving Wards	6
Aftercare	5
Disposition of staff	5
Expertise/Proficiency	5

Parking	66
Teamwork	57
Equality and Diversity	24
Hospital closure/new hospital etc.	23
Unreadable	21
Patience	20
Sedation/Pain Management	19
Appointment Time	18
Medication	18
Transport	18
Consistency	10
Staffing levels	10
Discharge	9
Ancillary staff	7
Privacy/Confidentiality	7
Appointment Length	6
Equipment	4
Infrastructure	2
Noise	2
Recommendation patient	2
H & S	1
Visiting	1
Total	**49,909**

NHS - general comment	5
Respect	5
Transport	5
Consistency	4
Professionalism	4
Dignity	3
Reassured/Put at ease	3
Appointment Length	2
Child Friendly	2
Friendliness	2
Meeting and greeting	2
Infrastructure	1
Sedation/Pain Management	1
Staff Named	1
Total	**1,408**

“My wife went on Facebook and told everybody how well I’ve been treated. The doctors/nurses, junior and senior, tea-lady and cleaners have been fabulous and very caring, thank you very much. [sic]”

“Although there is a 'no smoking' policy with large clear notices, nobody prevents people smoking close to the entrance. The unpleasant smell of smoke comes into the waiting area! [sic]”

“Every member of the staff were extremely caring and friendly. Best Hospital in the North. Very clean Hospital! Very, very well done! Nothing is too much to ask for. [sic]”

North Tees and Hartlepool NHS Foundation Friends and Family word bubble

The word bubble is displayed on each ward with the positive and negative comments for that specific ward, this allows the public to see what is being said about individual wards.

The Trust also produces a Trust version incorporating the negative and positive comments, please see the following word bubble for the Trust during April 2016 to March 2017.

What our patients have said about their hospital experience
(taken from the Trust's Friends and Family Test Comments April 16 – March 17)

"The staff on this ward always go the extra mile to help you in whatever needs doing. Even when they are short staffed they always do what needs doing in the call of duty. I have had a number of admissions on to this ward and all the staff have been brilliant. I would like to name them but I would need a lot of paper to fit in all the names. [sic]"

"I have never been so well looked after and cared for, mostly I have been so well looked after and cared for, and mostly I have been put at ease by your Staff. Without their patience and understanding I don't think I could have got through my ordeal. Thank-you all. [sic]"

Friends and Family – Staff

The Trust continues to ask Staff the Friends and Family Test, thus allowing staff feedback on NHS Services based on recent experience. Trust Staff are asked to respond to two questions.

Staff Friends and Family Test is conducted on a quarterly basis ***(*excluding Quarter 3 when the existing NHS Staff Survey takes place)***.

The following data refers to Quarters 1 to Quarter 3 of the 2016-17 financial year.

Breakdown of Responses – Care

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

How likely.... recommend?	Q1	Q2	*Q3	Q4
1 Extremely likely	54	16	139	
2 Likely	49	13	330	
3 Neither	20	9	188	
4 Unlikely	9	3	46	
5 Extremely unlikely	4	1	27	
6 Don't know	3	1	0	
Blank	0	0	15	
Would recommend	**74%**	**67%**	**56%**	
Wouldn't recommend	**9%**	**9%**	**12%**	

*Data from Trusts Friends and Family database - April 2016 to December 2016

Breakdown of Responses – Work

Work: **'How likely staff would be to recommend the NHS service they work in to friends and family as a place to work'**.

How likely.... recommend?	Q1	Q2	*Q3	Q4
1 Extremely likely	50	16	137	
2 Likely	46	12	328	
3 Neither	21	7	179	
4 Unlikely	15	3	55	
5 Extremely unlikely	6	4	31	
6 Don't know	1	1	0	
Blank	0	0	15	
Would recommend	**69%**	**65%**	**64%**	
Wouldn't recommend	**15%**	**16%**	**12%**	

*Data from Trusts Friends and Family database - April 2016 to December 2016

Part 2b: 2017-18 priorities for improvement

Introduction to 2017-18 Priorities

Key priorities for improvement for 2017-18 have been agreed through numerous consultation events with our patients, our staff, our governors, our Healthwatch colleagues, our commissioners, our local health scrutiny committees, our healthcare user group and our Board of Directors.

The Trust started the consultation period in September 2015 which allowed us to consult widely and provide stakeholders with a significant opportunity to consider and suggest the priorities that they would like to see us address.

Quality Accounts Marketplace

The Trust held the 3rd annual Quality Accounts Marketplace in December 2016. The aim of this event was to actively engage on a 1 to 1 level with our stakeholders, staff and patients.

Leads from key areas were at the event to describe the work that has been undertaken during the 2016-17 reporting year.

This event allowed the participants to discuss and actively engage with the leads for areas such as, dementia, adult safeguarding, complaints, compliments, Friends and Family Test and mortality.

Feedback and third party declarations have been invited from formal stakeholders. Full details of stakeholder feedback can be found in Annex A. Our Trust governors have also been actively involved in assisting us in setting our priorities.

The Trust continues to develop quality improvement capacity and capability to deliver our priorities as demonstrated throughout this Quality Account.

We would like to thank all of those involved in setting priorities for 2017-18 which are linked to patient safety, effectiveness of care and patient experience. We all agree that our priorities for improvement should continue to reflect three key principles, they are as follows.

Marketplace photo

Marketplace photo

Stakeholder priorities for 2017-18

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	Safety Thermometer	Palliative Care & Care For the Dying Patient
Dementia	Discharge Processes Medication	Is our care good? (Patient Experience Surveys)
Safeguarding Adults	Safety, Quality and Infections Dashboard (previously Nursing Dashboard)	Friends and Family recommendation
Infections		

Rationale for the selection of priorities for 2017-18

Through the Quality Accounts Marketplace and other engagement events we provided an opportunity for stakeholders, staff and patients to provide what they would like to see in the 2017-18 Quality accounts as the priorities.

We then chose three 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, how we will achieve it, measure it and report it.

Patient Safety

Priority 1 – Mortality

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

Overview of how we will do it

We will use 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 of how we will report it

- Report to Board of Directors meeting
- Report to Council of Governors meeting
- Report quarterly to the commissioners
- Report to Trust Outcome Performance Delivery Operational Group (TOPDOG)

Priority 2 – Improving care for people with dementia

There are currently approximately 14,000 people with a diagnosis of dementia across County Durham & Darlington and Tees. NHS Hartlepool/Stockton on Tees has the highest projected increase of dementia across the North East by 2025. All stakeholders identified dementia as a key priority.

All hospital patients admitted with dementia will have a named advocate and an individualised plan of care.

Overview of how it will be measured

We will use the Stirling Environmental Tool to adapt and audit the impact on our hospital environment.

We will ensure 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.

Overview of how will measure it

The Stirling Environmental audit assessment tool will be used to monitor the difference pre and post environmental adaptation.

The percentage of patients who receive the AMT and, where appropriate, further assessment will be reported monthly via UNIFY (national reporting system).

We will audit the number of patients over 65 admitted as an emergency that are reported as having a known diagnosis of dementia, or have been asked the (Prime Ministers) dementia case finding question.

We will continue to be involved in the National Audits and to review the outcomes.

Overview of how we will report it

- Dementia Strategy Group quarterly
- Monthly UNIFY

Priority 3 – Safeguarding Adults

The Trust and Commissioners believe that people with Learning Disability (LD) should not be in hospital unless absolutely necessary. When it is necessary to admit patients with LD, they must have an individualised plan of care and a named advocate.

Overview of how this will be achieved

All patients with LD will be referred on admission to the LD specialist nurse. The LD specialist nurse will act as the named advocate and will ensure that an individualised plan of care is in place and reasonable adjustments made and documented.

Overview of how we will measure it

Audits will be carried out and results reported and areas highlighted will be acted upon.

Overview of how we will report it

Audit results and action plans to be reported to Adult Safeguarding Group quarterly.

Priority 4 – Infection Prevention and Control

Rationale: Key stakeholders asked us to report on infections in 2017-18 due to the continued levels of infections during 2016-17.

Overview of how we will do it

- We will closely monitor testing regimes, antibiotic management and repeat cases and ensure we understand and manage the root cause wherever possible.

Overview of how we will would measure performance

- 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 reported; number of samples sent for testing and age profile of patients

Overview of how we said we would report it

- Board of Director meetings
- Council of Governor meetings (CoG)
- Infection Control Committee (ICC)
- Patient Safety and Quality Standards Committee (PS & QS)
- To frontline staff through Chief Executive brief
- Safety, Quality and Infections Dashboard
- Clinical Quality Review Group (CQRG)

Effectiveness of Care

Priority 5 – Safety Thermometer

NHS Safety Thermometer

The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. The Safety Thermometer has the following indicators to prevent avoidable harm, disability or death and to ensure that our care is effective with a focus on:

- Falls
- Pressure Ulcers
- Catheter related urinary tract infections (UTIs)
- Venous thromboembolism (VTE).

Overview of how we will do it

This indicator will continue to be audited on one day per month across the Trust and community services and the data submitted to NHS Digital.

Overview of how we will measure it

- Monthly data collection survey of the ward areas along with community bases.

Overview of how we will report it

- Report to PS & QS
- Report to Board of Directors meeting
- Report to Council of Governors meeting
- Safety, Quality and Infections Dashboard

Priority 6 – Discharge processes – Medication

The latest national patient experience survey identified that the Trust still has improvements to make with regards to medication discharge processes.

Overview of how we will do it

All patients will receive information about medication side-effects to watch out for at home.

Overview of how we will measure it

We will measure it via improvements in national and local patient surveys.

Overview of how we will report it

- Local audit reports reported to Drug and Therapeutic committee
- National inpatient survey report to Patient Safety and Quality (PS & QS) Committee
- Safety, Quality and Infections Dashboard

Priority 7 – Safety, Quality and Infections Dashboard

The Safety, Quality and Infections Dashboard will support close monitoring of nurse sensitive patient indicators on a day-to-day basis. It will support sharing of best practice and speedy review of any potential areas of concern.

Overview of how we will do it

Training will be undertaken and each department will evidence that their results have been disseminated and acted upon.

Ward matrons will present their analysis on a public area of the ward for patients and staff to see. The results will be discussed at ward meetings.

Overview of how we will measure it

The dashboard will be a standing agenda item on the Senior Clinical Matrons (SCMs) meeting. SCMs will monitor ward areas to ensure that data is up to date, accurate and displayed in a public areas.

Overview of how we will report it

- Monthly dashboard analysis to the Director of Nursing, Quality and Patient Safety
- Monthly to Senior Clinical Matron meeting and to the Nursing and Allied Health Professional Interprofessional Board (IPB)

Patient Experience

Priority 8 – Palliative Care and Care For the Dying Patient

The Trust has continued the use of Care For the Dying Patient (CFDP) and Family's Voice. Stakeholders and the Trust believe that this still needs to remain a priority in 2017-18 both in hospital and in the community.

Overview of how we will do it

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

Overview of how we will measure it

We will evaluate feedback in relation to pain, nausea, breathlessness restlessness, care for the patient and care for the family.

Overview of how we will report it

- Quarterly to IPB
- Annually to Patient Safety and Quality Standards (PS & QS)

Priority 9 – Patient 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 the question(s) to every patient interviewed in the Staff, Patient Experience and Quality Standards (SPEQS) reviews. We will also ask the question in all Trust patient experience surveys, along with monitoring patient feedback from national surveys.

Overview of how we will measure it

Analysis of feedback from SPEQS and patient experience/national surveys.

Overview of how we will report it

- Reports to Board of Directors
- Reported on the Safety, Quality and Infections Dashboard

Priority 10 – Friends and Family recommendation

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 and Maternity as well as Outpatients, Day Case Units, Community Clinics, Community Dental, Radiology and Paediatrics

Overview of how we will measure it

Analysis of feedback from patient surveys and discharge questionnaires.

Overview of how we will report it

- Reports to Board of Directors
- Reported on the Safety, Quality and Infections Dashboard

Part 2c: Statements of Assurance from the Board

Review of Services

During 2016-17 the North Tees and Hartlepool NHS Foundation Trust provided and/or subcontracted **64** relevant health services. The majority of our services were provided on a direct basis, with a small number under sub-contracting or joint arrangements with others.

The North Tees and Hartlepool NHS Foundation Trust has reviewed all the data available to them on the quality of care in **64** of these relevant health services.

The income generated by the relevant health services reviewed in 2016-17 represents 100% of the total income generated from the provision of relevant health services by North Tees and Hartlepool NHS Foundation Trust for 2016-17.

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 2016-17 and this can be found on the following link:

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

During 2016-17, **39** national clinical audits and **4** national confidential enquiries covered the relevant health services that North Tees and Hartlepool NHS Foundation Trust provides.

During 2016-17 North Tees and Hartlepool NHS Foundation Trust participated in **100%** 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 mandatory national clinical audits and national confidential enquiries that North Tees and Hartlepool NHS Foundation Trust was eligible to participate in during 2016-17 are as follows:

Mandatory National Clinical Audits
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)
Adult Asthma (BTS)
Asthma (paediatric and adult) care in emergency departments (RCEM)
Bowel Cancer (NBOCAP)
Case Mix Programme (CMP) (ICNARC)
Diabetes (Paediatric) (NPDA)
Elective Surgery (National PROMs Programme)
Endocrine and Thyroid National Audit – subject to confirmation
Falls and Fragility Fractures Audit programme (FFFAP) (inc. National Hip Fracture Database NHFD)
Inflammatory Bowel Disease (IBD) programme
Learning Disability Mortality Review Programme (LeDeR Programme)
Major Trauma Audit (TARN)
Maternal, Newborn and Infant Clinical Outcome Review Programme
National Audit of Dementia
National Cardiac Arrest Audit (NCAA)
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme (inc. Inpatient COPD Audit and Pulmonary Rehabilitation Audit)
National Comparative Audit of Blood Transfusion - Audit of Patient Blood Management in

Scheduled Surgery
National Diabetes Audit - Adults
National Emergency Laparotomy Audit (NELA)
National Heart Failure Audit (NICOR)
National Joint Registry (NJR)
National Lung Cancer Audit (NLCA)
National Prostate Cancer Audit
Neonatal Intensive and Special Care (NNAP)
Nephrectomy audit (BAUS)
Oesophago-gastric Cancer (NAOGC)
Paediatric Pneumonia (BTS)
Percutaneous Nephrolithotomy (PCNL) – subject to confirmation
Rheumatoid and Early Inflammatory Arthritis
Sentinel Stroke National Audit programme (SSNAP)
Severe Sepsis and Septic Shock – care in emergency departments (RCEM)
Stress Urinary Incontinence Audit (BAUS) – subject to confirmation

National Confidential Enquiries (NCEPOD)
NCEPOD Chronic Neurodisability Study
NCEPOD Non Invasive Ventilation (NIV) Study
NCEPOD Young People's Mental Health Study
NCEPOD Cancer in Children, Teens and Young Adults Study

The national clinical audits and national confidential enquiries that North Tees and Hartlepool NHS Foundation Trust participated in during 2016-17 are as follows:

Mandatory National Clinical Audits
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)
Adult Asthma (BTS)
Asthma (paediatric and adult) care in emergency departments (RCEM)
Bowel Cancer (NBOCAP)
Case Mix Programme (CMP) (ICNARC)
Diabetes (Paediatric) (NPDA)
Elective Surgery (National PROMs Programme)
Endocrine and Thyroid National Audit – subject to confirmation
Falls and Fragility Fractures Audit programme (FFFAP) (inc. National Hip Fracture Database NHFD)
Inflammatory Bowel Disease (IBD) programme
Learning Disability Mortality Review Programme (LeDeR Programme)
Major Trauma Audit (TARN)
Maternal, Newborn and Infant Clinical Outcome Review Programme
National Audit of Dementia
National Cardiac Arrest Audit (NCAA)
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme (inc. Inpatient COPD Audit and Pulmonary Rehabilitation Audit)
National Comparative Audit of Blood Transfusion - Audit of Patient Blood Management in

Scheduled Surgery
National Diabetes Audit - Adults
National Emergency Laparotomy Audit (NELA)
National Heart Failure Audit (NICOR)
National Joint Registry (NJR)
National Lung Cancer Audit (NLCA)
National Prostate Cancer Audit
Neonatal Intensive and Special Care (NNAP)
Nephrectomy audit (BAUS)
Oesophago-gastric Cancer (NAOGC)
Paediatric Pneumonia (BTS)
Percutaneous Nephrolithotomy (PCNL) – subject to confirmation
Rheumatoid and Early Inflammatory Arthritis
Sentinel Stroke National Audit programme (SSNAP)
Severe Sepsis and Septic Shock – care in emergency departments (RCEM)
Stress Urinary Incontinence Audit (BAUS) – subject to confirmation

National Confidential Enquiries (NCEPOD)
NCEPOD Chronic Neurodisability Study
NCEPOD Non Invasive Ventilation (NIV) Study
NCEPOD Young People's Mental Health Study
NCEPOD Cancer in Children, Teens and Young Adults Study

The national clinical audits and national confidential enquires that North Tees and Hartlepool NHS Foundation Trust participated in, and for which data collection was completed during 2016-17, 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.

National Clinical Audit	**Participation** **M=Mandatory** **N=Non-mandatory**	**% cases submitted**
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes (M)	Continuous monitoring
Adult Asthma (BTS)	Yes (M)	100%
Asthma (paediatric and adult) care in emergency departments (RCEM)	Yes (M)	100%
Bowel Cancer (NBOCAP)	Yes (M)	Continuous monitoring
Case Mix Programme (CMP) (ICNARC)	Yes (M)	Continuous monitoring
Diabetes (Paediatric) (NPDA)	Yes (M)	100%
Elective Surgery (National PROMs Programme)	Yes (M)	Hip replacement: 97% Knee replacement: 97% Groin hernia: 61%
Endocrine and Thyroid National Audit – subject to confirmation	Yes (M)	???
Falls and Fragility Fractures Audit programme (FFFAP)	Yes (M)	100%

(inc. National Hip Fracture Database NHFD)		
Inflammatory Bowel Disease (IBD) programme: Biologics Database	Yes (M)	0%
Learning Disability Mortality Review Programme (LeDeR Programme)	Yes (M)	On-going
Major Trauma Audit (TARN)	Yes (M)	Continuous monitoring
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes (M)	100%
National Audit of Dementia	Yes (M)	100%
National Cardiac Arrest Audit (NCAA)	Yes (M)	100%
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme (inc. Inpatient COPD Audit and Pulmonary Rehabilitation Audit)	Yes (M)	Continuous monitoring
National Comparative Audit of Blood Transfusion - Audit of Patient Blood Management in Scheduled Surgery	Yes (M)	100%
National Diabetes Audit - Adults	Yes (M)	100%
National Emergency Laparotomy Audit (NELA)	Yes (M)	Continuous monitoring
National Heart Failure Audit (NICOR)	Yes (M)	Continuous monitoring
National Joint Registry (NJR)	Yes (M)	Continuous monitoring
National Lung Cancer Audit (NLCA)	Yes (M)	Continuous monitoring
National Prostate Cancer Audit	Yes (M)	Continuous monitoring
Neonatal Intensive and Special Care (NNAP)	Yes (M)	Continuous monitoring
Nephrectomy audit (BAUS)	Yes (M)	Continuous monitoring
Oesophago-gastric Cancer (NAOGC)	Yes (M)	Continuous monitoring
Paediatric Pneumonia (BTS)	Yes (M)	100%
Percutaneous Nephrolithotomy (PCNL) – subject to confirmation	Yes (M)	???
Rheumatoid and Early Inflammatory Arthritis	Yes (M)	Continuous monitoring
Sentinel Stroke National Audit programme (SSNAP)	Yes (M)	Continuous monitoring
Severe Sepsis and Septic Shock – care in emergency departments (RCEM)	Yes (M)	100%
Stress Urinary Incontinence Audit (BAUS) – subject to confirmation	Yes (M)	???
National Audit of Diabetes Foot Care (NDFA)	Yes (N)	Continuous monitoring
National Diabetes Inpatient Audit (NaDIA)	Yes (N)	100%
7-day services national audit	Yes (N)	100%
Smoking Cessation Audit (BTS)	Yes (N)	100%
Safety Thermometer	Yes (N)	Continuous monitoring
Paediatric Orthopaedic Trauma Snapshot (POTS)	Yes (N)	100%
National Audit of Consultant Sign-off (RCEM)	Yes (N)	100%

National Clinical Audits

The reports of **8** national clinical audits were reviewed by the provider in 2016-17 and North Tees and Hartlepool NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Audit title	Actions taken/in progress
National Emergency Oxygen Audit (BTS)	One page guidance summary to be produced to act as reminder.
	Education in Grand Round meeting.
	Formal Nurse and Doctor training programme to be developed.
Venous Thrombo-embolism (RCEM)	Improved documentation of VTE risk assessment.
	Patient information leaflet to be drafted.
Procedural Sedation (RCEM)	Establish capnography monitoring within A&E in collaboration with Anaesthetist colleagues.
	Improved documentation for sedation monitoring.
Vital Signs in Children (RCEM)	Improved documentation of initial vital signs and timing of further monitoring.
Major Trauma Audit (TARN)	Improved use of trauma checklist.
	Collaborative work with James Cook University Hospital to develop severe head injury pathway.
National Audit of Dementia	Dementia Champions to raise awareness of the new document “All about me”.
	Improved discharge planning.
	Educational programme to support definitive diagnosis of delirium.
Smoking Cessation Audit (BTS)	Increased enforcement of smoking restrictions on trust ground.
	Improved documentation of non-cigarette smoking status.
	Increased awareness of need to offer nicotine replacement therapy to inpatients who are current smokers.
National End of Life Audit	Improved communication skills training.

Local Clinical Audits

The reports of **132** local clinical audits were reviewed by the provider in 2016-17 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
Adequacy of Documentation of Spinal Anaesthetic for Caesarean Sections	Improvement required in documentation of the processes in emergency caesarean sections.
Dental Decontamination Audit	Review of Tees Decontamination - Infection Control Policy and updating of protocols relating to infection control.
Management of Paediatric Sepsis	Sepsis tool being adapted for use jointly by Paediatrics and Emergency Medicine.
Management of Patients Presenting with Transient Loss of Consciousness (TLoC)	Teaching on TLoC to be included in teaching programmes.
Patient Information Leaflets in Surgery	Leaflet update to note that patients can contact Surgical Decisions Unit (SDU) for up to two weeks after discharge.
Shoulder Dystocia Management	The shoulder dystocia proforma to be covered in simulation sessions as part of mandatory training.
Elective Cost in Orthopaedics	All patients to be provided with a copy of the completed consent form.
Joint Revision Infection Rates Audit	A trust protocol is to be developed for suspected joint arthroplasty infection.
Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP)	Management team to continue to visualise notes on a daily basis and provide individual staff members with feedback.
Oral Bisphosphonate Prescribing	Night staff education session to ensure administration of oral bisphosphonate thirty minutes before breakfast.

All national audit reports are considered by the Audit and Clinical Effectiveness (ACE) Committee which reports to the Patient Safety and Quality Standards (PS & QS) committee, PS & QS reports directly to the Board of Directors.

The Trust participated in all seven national confidential enquiries (100%) that it was eligible to participate in, namely:

National Confidential Enquiries (NCEPOD):

NCEPOD study	Participation M=Mandatory N=Non-mandatory	% cases submitted
NCEPOD Chronic Neurodisability Study	Yes (M)	Data collection on-going
NCEPOD Non Invasive Ventilation (NIV) Study	Yes (M)	Data collection on-going
NCEPOD Young People's Mental Health Study	Yes (M)	Data collection on-going
NCEPOD Cancer in Children, Teens and Young Adults Study	Yes (M)	Data collection on-going

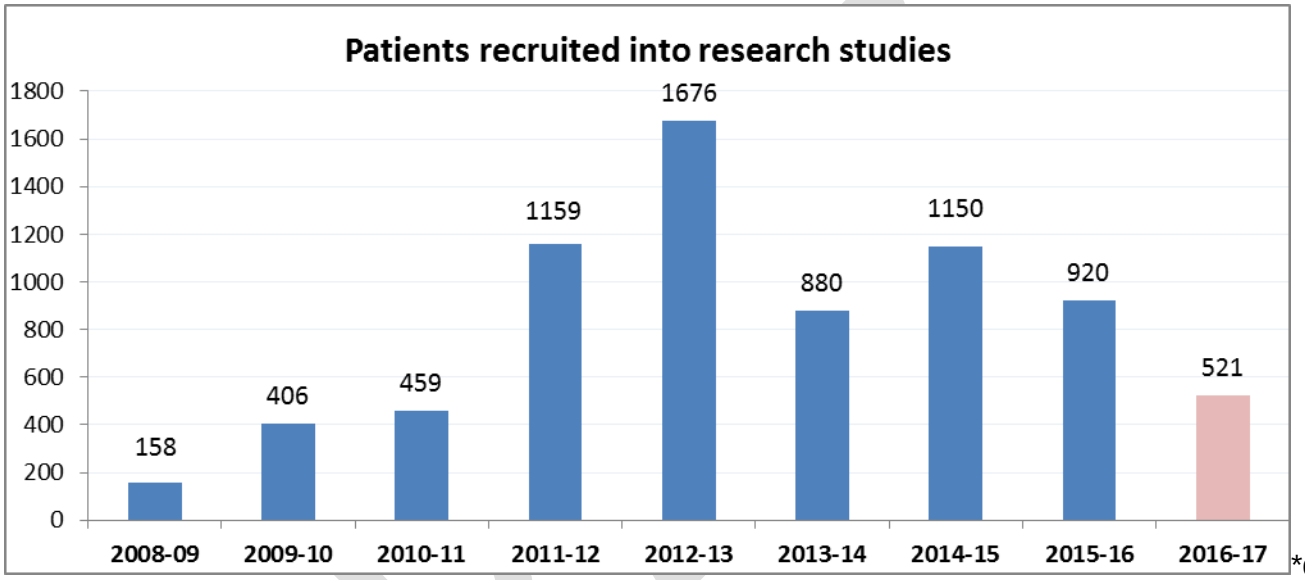
Patients recruited into research

The Government indicated in 2009 that it wanted to see a dramatic and sustained improvement in the performance of providers of NHS services in initiating and delivering clinical research. The aim was to increase the number of patients who have the opportunity to participate in research and to enhance the nation's attractiveness as a host for research by faster approvals and delivering to time and target.

Performance Data

The number of patients receiving relevant health services provided or subcontracted by North Tees and Hartlepool NHS Foundation Trust in 2016-17 that were recruited during that period to participate in research approved by a research ethics committee was 501*.

Total year on year recruitment into National Institute for Health Research (NIHR) portfolio research is shown below:



*data as at 06 February 2017

Regionally there has been a significant decrease in the total numbers of patients being recruited this year. The reasons are multifaceted and due to fewer large observational studies, increased participation in more complex interventional studies (with lower recruitment targets) and delays in anticipated study start up due to the new national Health Research Approval (HRA) process.

Within NTHFT, whilst our overall recruitment figures are lower, the trials we are participating in are more complex and we are accruing year on year additional follow-up burden for patients in existing trials.

2016-17 Study participation – number of studies

The National Institute of Health Research Clinical Research Network (NIHR CRN) portfolio is a database of clinical research studies that are supported by the NIHR CRN in England. Adoption on to the portfolio is dependent on a study meeting eligibility criteria. Research studies are reviewed for inclusion in the NIHR CRN Portfolio in parallel with the NHS Ethics review and R&D governance process. A non-portfolio study is a research study without the above support that has not been adopted onto the portfolio.

For 2016-17 of the patients recruited so far, 51% were recruited into interventional studies with 49% recruited into observational studies. Within the North East and North Cumbria, our trust has the highest proportion of interventional studies as a proportion of the total studies they participate in. Average for the region is 40% interventional studies.

Study participation – number of studies open

Study Type		Number of Studies	Actively recruiting patients	In follow-up
NIHR portfolio studies	Observational	66	122	44
	Interventional	100		
Non-portfolio studies	Observational	34	34	6
	Interventional	6		
Total	Observational	**100**		
	Interventional	**106**		

National position / ranking for number of studies conducted

Year	Overall national position	Ranking in "medium sized acute Trusts" category
2012-13	101st out of 394 organisations	7th out of 48 Trusts
2013-14	157th out of 454 organisations	25th out of 47 Trusts
2014-15	141st out of 445 organisations	26th out of 47 Trusts
2015-16	92nd out of 459 organisations	This information is no longer provided

Performance in Initiation and Delivery of research (PID data)

From 2013, government funding for research to the Trust has become conditional on meeting national benchmarks. We report quarterly to the Department of Health on the following performance measures.

- For non-commercial studies: meeting a 70-day benchmark to recruit first patients for trials

70 day benchmark met	No of Studies	Reason
Yes	9	
No	10	1 NHS delay 6 Sponsor delay 3 Neither – no eligible patients seen/consented

- For commercial studies: Recruitment to time and target stated in clinical trial agreement

Time and target met	No of Studies	Reason
Yes	6	
No	4	1 study - PI left the Trust – no replacement available for a long time 1 study - patients more likely to be seen in primary care 1 study – patient population rare, difficult to find 1 study – staffing issues

*Principal Investigator (PI)

Failure to provide acceptable explanation for poor performance over two consecutive quarters may result in financial penalties. We have provided extensive narrative to support why sometimes these metrics haven't been met; the Research & Development team meet monthly to review the data and work with teams to highlight when benchmarks are in danger of not being met and develop an action plan. Once submitted to the DH, we have to post this information in a publically accessible area of the Trust's website. A response to our submission is given to the Chief Executive so we ensure he receives a copy of our submission prior to upload so that any queries can be resolved prior to the receipt of the official response from DH.

Achievements

The research and development department (R&D) continue to work with departments across the Trust to promote the importance of healthcare professionals being involved in research. Through the Trust's provision of an R&D Incentive fund we have been able to help to develop staff knowledge and skills to enable them to lead and/or be involved in research studies. The fund has provided the following support in this year:

Purpose of application	Funding amount (£)
Part-funding of course fees for PhD at Durham University	2,026
Course fees for Stage 1 of Doctor of Health & Social Care Professional Programme, Teesside University	2,250
1 year clinical backfill to support the preparation of NIHR Programme Grant	11,500
Three allocations of 0.5PA for "Green Shoot" awards (£5,500 each)	16,500

We currently have **138 members of staff with valid Good Clinical Practice (GCP) training.** Most specialisms and all directorates are now participating in research to a greater or lesser degree. The few exceptional areas where activity is non-existent are in active discussion with the R&D department, specifically to identify potential studies that might be relevant.

There are **93 members of staff acting as principal investigators/local collaborators** in research approved by a research ethics committee within the Trust, some of whom have up to ten studies in their research portfolio. We have 2**6 clinical research network funded research staff** within the Trust (nurses, midwifves, data assistants, team leader and Pharmacy technician) two of whom are funded from commercial income.

Our bi-monthly research nurses working group continues to be well attended and provides professional support and mentorship as well as assisting us with national research initiatives such as raising the profile of research with patients, involving patients in meaningful PPI (patient and public involvement), developing training packages for research nurses and training nurses for commercial studies.70 day benchmark

Commercially Sponsored Studies

We continue to increase our participation in commercially sponsored studies. We now have **20 commercially sponsored studies** active within the Trust in this year (16 last year) within Respiratory Medicine, Paediatrics, Neonates, Cardiology and more recently Gastroenterology, Obstetrics &Gynaecology and Cancer.

Our respiratory and cardiology research teams continue to develop their reputation as a "preferred site" for commercially sponsored research studies.

Awards and accolades

Certificates of Excellence were awarded from Teesside University to the following staff for their support to student nurses whilst on their service improvement placement within R&D:
Wendy Cheadle Research Nurse, **Jane Greenaway** R&D Manager, **Helen Talbot** R&D Facilitator, **Pauline Shepherd** R&D Administrator

Two of our teams received "performance flow-through funding" from the Clinical Research network as determined by performance against their "Recruitment to Time and Target". The **Respiratory Team** were awarded 2 sets of performance flow-through funding as they recruited to time and target for the SIROCCO and FLAME commercial studies. The **Surgical Research** team received a payment for their successful recruitment to the REGENERYS study.

We held a joint Conference with Education and Organisational Development "Improving Patient Care through Research and Education" which was a great success. Using the newly refurbished lecture

theatre we were able to highlight some of the recent Trust developments and innovations in both departments as well as identify opportunities for future working. Delegates felt the day was useful to their role and enjoyed the workshop sessions in the afternoon. Professor Pali Hungin's key note address on how we can develop collaborations with local Universities was well received and sparked a renewed vigour for cross-organisation developments.

Commissioning for quality and innovation (CQUIN)

A proportion of North Tees and Hartlepool NHS Foundation Trust income in 2016-17 was conditional on achieving quality improvement and innovation goals agreed between North Tees and Hartlepool NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

2015-16 income

The total income received through achievement of CQUIN goals in 2015-16 was **£3,697,653** from the total amount available of **£5,141,601.**

Further details of agreed goals for 2015-16 and the following 12 month period are available electronically at:

http://www.england.nhs.uk/wp-content/uploads/2014/02/sc-cquin-guid.pdf

2016-17 income

The total income received through achievement of CQUIN goals in 2016-17 is **£1,143,341** from **£1,302,531** available; **Data for Q1 and Q2 only and provided by the Trusts finance department.**

This value was conditional upon achieving quality improvement and innovation goals.

	Achievement (%)			
Indicator name	**Q1**	**Q2**	**Q3**	**Q4**
Introduction of staff health & wellbeing initiatives	100%	100%		
Healthy food for NHS staff, visitors and patients	100%	100%		
Improving the uptake of flu vaccinations for frontline clinical staff	100%	100%		
Timely identification and treatment for sepsis in emergency department	100%	100%		
Timely identification and treatment for sepsis in inpatient settings	100%	100%		
Reduction in antibiotic consumption per 1,000 admissions	100%	100%		
Empiric review of antibiotic prescriptions	100%	100%		
Undertake a root-cause analysis on all long waiters and a clinical harm review where there is a positive diagnosis.	100%	100%		
Reducing inappropriate hospital utilisation through the installation and implementation of a Clinical Utilisation Review (CUR) system over two years.	90%	90%		
Increase awareness and capability of workforce in CHC (Continuing Healthcare) pathways to improve effectiveness of CHC Checklist completion and CHC process efficiency	100%	100%		
Intervention Planning for People who Frequently Attend A&E (Supporting Regular Attenders to Receive Appropriate Care and Treatment)	100%	100%		
Diabetes transformation	100%	100%		
Increase update of diabetic eye screening for young people	100%	100%		
Critical care	100%	100%		
Dose banding	100%	100%		

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**.

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 Care Quality Commission (CQC) has not taken enforcement action against North Tees and Hartlepool NHS Foundation Trust during 2016-17.

The CQC inspection team visited the Trust in July 2015 to undertake the mandated inspection that all Trusts must have.

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.

Overall ratings for the Trust

Overall rating for this trust	Requires improvement
Are services at this trust safe?	Good
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**

The following tables demonstrate the ratings for the North Tees and Hartlepool sites, Minor injuries unit/One Life Centre and community health services.

University Hospital of North Tees

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Medical care	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
maternity and gynaecology	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Good	Good	Good	Good	Requires improvement	Good
End-of-life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Good	Good	Good	Requires improvement	Good
Overall	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

University Hospital Hartlepool

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Inadequate	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
maternity and gynaecology	Good	Requires improvement	Not rated	Good	Requires improvement	Requires improvement
Services for children and young people	Good	Good	Good	Good	Requires improvement	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Requires improvement	Good
Overall	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement

Minor Injuries Unit, One Life Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Not rated	Good	Good	Good
Overall	Good	Good	N/A	Good	Good	Good

Community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good	Good	Good	Good	Requires improvement	Good
Community health services for children	Good	Requires improvement	Good	Good	Good	Good
End-of-life care	Good	Good	Good	Good	Good	Good
Community dental services	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Following the announced inspection in July 2015, where an overall 'Requires Improvement' rating was received, the Trust has **fully addressed** the **14** areas stated to be 'must do' actions. In addition, **all 50** 'should do' actions **have been reviewed**, with much work having been completed.

A key element of making changes and developing services is on-going monitoring and assurance; each clinical area has a programme of audit and assurance work which enables demonstration of achievement of expected outcomes. A quantity of this work is undertaken by the clinical areas themselves, but additional assurance is achieved by some external audit from other specialities. A central electronic area is currently being prepared for launch to enable evidence from the programme of audit and assurance work to be stored and readily available for access to internal stakeholders; access can be arranged for designated external stakeholders such as commissioners and inspectors.

There are some areas of development work which remain in progress, including completing recruitment to safeguard delivery of the critical care outreach service, completion of scoping 7 day service-delivery of Specialist Palliative Care and development of television screens around the Trust to enable delivery of health-related messages and waiting time information.

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 among others, 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 http://www.nth.nhs.uk/patients-visitors/cqc/news-bulletin/ are being published and again are available to the public on the Trust's website.

The Trust has not been informed of a date for a re-inspection. When this is given, there will be notice given to the Trust that this is due. Until the re-inspection and issuing of the report from this has taken place, the Trust will remain rated 'Requires Improvement'

Duty of Candour

Duty of Candour is the process of being open and transparent with people who use the Trusts services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. Trusts are set specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

From the time of the final consultation in relation to the regulations, the Trust reviewed its processes already in place for Being Open (NPSA). Once the regulations were approved through Parliament the trusts policy was in place and in use. The Trust policy details how application of the regulations should be recorded; this is supported by the provision of a healthcare document to be completed and stored in the patients records, full completion of this records sheet will ensure all of the necessary regulatory points are recorded.

On a weekly basis the Trusts Safety Panel reviews all incidents where harm has been reported as moderate harm or above. This highlights cases to the panel members and provides details of the application of the regulations within clinical areas; where necessary challenges may be made around these decisions.

Monitoring of compliance is reported to the Trust Board and also to the Trusts Commissioners; there have been two cases where the Trust could not evidence that the regulations had been applied in full. The evidence required is very specific and the Trust is confident that although this written evidence was not available there was the required level of discussions with the patients involved at the time. The Trust prides itself in its approach to being open and honest, and as a result of the lack of evidence in these cases the policy is being reviewed in order to ascertain if any changes need to be made to the processes to support full compliance. There are continuing training and update sessions available to all staff in relation to Duty of Candour and details of any external seminars are shared to enhance our wider knowledge of the regulations.

The Trust policy and the application of this was reviewed by the Trusts internal auditors at the end of 2015-16; the report was published in quarter 1 and this recognised there was a significant level of assurance in relation to compliance with this policy and the legal requirements. Currently, there have been no concerns raised through the Care Quality Commission in relation to the application of these regulations within the Trust.

Sign Up to Safety

The Trusts Sign up to Safety campaign aims to reduce the incidence of avoidable harm that occurs to service users within the organisation by 50% over the next 3 years, with a specific focus on:

- Reducing pressure ulcers
- Reducing falls with fracture
- Reducing Obstetric Birth Injuries
- Reducing surgical complications
- And Reducing Pressure damage

Whilst this is an overall aim, there will be focussed areas of work undertaken to examine specific areas of high risk. These have been identified through analysis of data available from current and past harm reporting from complaints, incidents and claims. In the lifetime of this strategy on-going monitoring of trends associated with harm will be used to identify areas for action as the data analysis evolves.

During September 2016, the Trust held a Patient Safety week to recognise service improvements made as a result of safety issues identified through incident reporting and analysis. The displays were visited by a wide range of colleagues including the Chief Executive, The Director of Nursing, Quality and Patient Safety, governors, staff and also a representative for the NHSLA's Safety and Learning team.

Commissioners Assurance

Currently during this year the Trust had 5 unannounced Commissioner Assurance visits during 2016-17.

These unannounced visits took place on Ward 26 in April, the Holdforth Unit in June 2016, Ward 40 in September 2016, Ward 27 in November 2016, Ward 40 in January 2017 and Paediatric Day Unit Hartlepool and Out-patients Hartlepool in March 2017.

An action plan has been developed for any issues identified at each of these visits and these have been shared with the commissioners.

Quality of Data

Good quality information underpins the effective delivery of patient care and helps staff to understand what they do well and where they might improve.

The members of the Council of Governors are encouraged to test the data reports they receive through participation in the SPEQS reviews. This enables governors to speak directly to patients and staff and provides assurance that standards are aligned with information reported.

Training staff in critical appraisal is a vital part of ensuring that evidence is considered in an objective and balanced way. We develop clinical staff so that they have the skills and knowledge to use evidence in a way that supports them to make the best clinical decisions.

Additional assurance in relation to data quality is provided independently by Audit One. This provides rigorous and objective testing of data collection and reporting standards. Results of these independent audits are reported to the audit committee and provide the Trust with independent appraisal of clinical, financial and business governance standards. This process of internal audit enables the Trust to test quality assumptions and pursue its philosophy of continual improvement. In order to test and improve quality of data the Trust will continue to commission independent audits of its key business.

NHS number and general medical practice validity

North Tees and Hartlepool NHS Foundation Trust submitted records during 2016-17 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 is shown in the following table:

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	**98.90**	Percentage for admitted patient care	**100**
Percentage for outpatient care	**99.90**	Percentage for outpatient care	**100**
Percentage for accident and emergency care	**99.10**	Percentage for accident and emergency care	**100**

*Data for April 2016 to December 2017

Information governance (IG)

Information governance means keeping information safe. This relies on good systems, processes and monitoring. Every year we audit the quality of specific aspects of information governance through the national information governance toolkit. Staff training and awareness of Information Governance is a key indicator, in 2016-17 we again had to ensure that 95% of all of our staff had received information governance training. This target was challenging, however we have continued to make significant progress and for the fifth year running we have met the target with a total of 95% of all staff trained during the year.

We continue to provide assurance to the Board of Directors that we are constantly assessing and improving our systems and processes to ensure that information is safe The Trusts Information Governance Toolkit Assessment* compliance score of 77% for 2015-16 was graded as "Satisfactory" Green and gives assurance that quality standards are being maintained.

North Tees and Hartlepool NHS Foundation Trust Information Governance Assessment Report overall score for 2016-2017 was **xx%** and was graded as GREEN.

Requirement	2012-13	2013-14	2014-15	2015-16	2016-17
Information governance management	93%	100%	100%	93%	
Corporate Information Assurance	66%	77%	77%	77%	
Confidentiality and Data Protection assurance	79%	87%	91%	70%	
Clinical information assurance	93%	93%	86%	73%	
Secondary use assurance	83%	83%	79%	79%	
Information security assurance	75%	75%	84%	75%	
Overall Assessment	81%	84%	86%	77%	

A "Satisfactory" green rating is achieved where Trusts achieve level 2 or above on all requirements; a "Not Satisfactory" red rating is achieved where Level 2 or above is not evidenced for all requirements.

*The IG toolkit is available on connecting for health website. www.igt.connectingforhealth.nhs.uk

We receive a number of Freedom of Information (FOI) requests every year. In order to be transparent about information we have been asked to provide, we have developed a virtual reading room on our Trust internet site. Since 1st January 2012, we have been posting responses to Freedom of Information requests on the site and these can be viewed by the public on: www.nth.nhs.uk/foirr

Clinical coding error rate

Clinical coding translates medical terms written by clinicians about patient diagnosis and treatment into codes that are recognised nationally.

North Tees and Hartlepool Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

The Audit Commission no longer audits every Trust every year where they see no issues. The in-house clinical coding audit manager conducts a 200 episode audit every year as part of the IG Toolkit and also as part of continuous assessment of the auditor.

	2015-16	2016-17
Primary diagnoses correct	91.50%	**91.00%**
Secondary diagnoses correct	89.94%	**87.65%**
Primary procedures correct	91.43%	**92.74%**
Secondary procedures correct	83.41%	**87.50%**

The services reviewed within the sample were 200 finished consultant episodes (FCEs) in consultant episodes taken from a random sample of all specialties. The results should not be extrapolated further than the actual sample audited.

The errors include both coder and documentation errors of which the coding errors will be fed back to the coders as a group and individually. The documentation errors will be taken to directorate meetings.

Depth of coding and key metrics is monitored by the Trust in conjunction with mortality data. External 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 also attend the mortality review meetings to ensure the correct coding of deceased patients.

Our coders organise their work so that they are closer to the clinical teams. This results in sustained improvements to clinical documentation. This supports accurate clinical coding and a reduction in the number of Healthcare Resource Group changes made. This is the methodology which establishes how much we should get paid for the care we deliver. We will continue to work hard to improve quality of information because it will ensure that NHS resources are spent effectively.

Specific issues highlighted within the audit have been fed back to individual coders and appropriate training planned where required. North Tees and Hartlepool NHS Foundation Trust will be taking the following actions to improve data quality. The Trust has recruited and trained 6 additional coders to start coding all inpatient activity from notes. This started in January with the Emergency Assessment Unit and is to be rolled out over the remaining wards during 2016. This will improve the capture of additional co-morbidities that are used to calculate HSMR and SHMI.

Diagnosis Coding Depth – North East Trusts (January 2016 to December 2016)

Trust	Total Activity	Diagnosis Coding Depth	Average Diagnosis Coding Depth
Trust 1	138,763	748,455	5.39
Trust 2	111,607	593,003	5.31
NTHFT	**111,923**	**579,339**	**5.18**
Trust 4	46,297	238,439	5.15
Trust 5	183,717	912,352	4.97
Trust 6	83,014	398,911	4.81
Trust 7	246,258	1,092,658	4.44
Trust 8	136,597	592,058	4.33
Trust 9	169,693	706,887	4.17

*Data taken from Data Quality Clinical Coding in HED

Part 2d: Core set of Quality Indicators

Measure	Measure Description	Data Source
1a	The value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust	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, **October 2015 – September 2016**

Time period	OD banding	Trust Score	National Average	Highest – SHMI Trust Value in the country	Lowest – SHMI Trust Value in the country
Jul 2014 – Jun 2015	Band 1 (Higher than Expected)	1.209	1.00	1.209	0.661
Oct 2014 – Sept 2015	Band 1 (Higher than Expected)	1.177	1.00	1.177	0.651
Jan 2015 – Dec 2015	Band 1 (Higher than Expected)	1.173	1.00	1.173	0.669
Apr 2015 – Mar 2016	Band 1 (Higher than Expected)	1.132	1.00	1.178	0.678
Jul 2015 – Jun 2016	Band 2 (As Expected)	1.118	1.00	1.171	0.694
Oct 2015 – Sep 2016	Band 2 (As Expected)	**1.119**	**1.00**	**1.1638**	**0.6897**

SHMI Regional - October 2015 – September 2016

Trust	Trust Score	OD banding
SOUTH TYNESIDE NHS FOUNDATION TRUST	1.1597	1
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	**1.1195**	**2**
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	1.0667	2
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	1.0438	2
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	1.0337	2
CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST	0.9988	2
GATESHEAD HEALTH NHS FOUNDATION TRUST	0.9934	2
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	0.9720	2

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 measure. The Secretary of State for health has introduced a requirement for all Trusts to undertake mortality reviews; this has been supported by the CQC and a national system for recording mortality reviews is to be introduced over 2017-18. The Trust introduced mortality reviews in 2014 and continues to undertake these over two sessions each week, this has been supported by the inclusion of the mortality reviews in the quality work undertaken by all consultants staff as part of their annual appraisal.

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 Trusts 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 the 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.

Over the last year the Trust continues to review the process for recording patients who are receiving Specialist Palliative Care or End of Life Care, to ensure that this activity is included in the data collection from clinical coding. The Specialist team have been involved in the care of an increasing number of patients over this last year. The Trust has also been running update sessions for consultant staff who are not part of the Specialist Palliative Care team in order to ensure the care given to all of our patients, who are reaching the end of their lives, is of the highest standard regardless of whether they are seen be the specialist team.

The Trust continues to take a key role in regional Community Acquired Pneumonia Project which is running in conjunction with other North East Trusts; the Trust has also joined the Serious Infections – SEPSIS Project with informatics performed by Clarity in both instances. The results from the data collection demonstrate continued improvement over this year, the projects are continuing currently.

Finally, the Trust has closed the Keogh Delivery Group and replaced it with a streamlined Trust Outcome Performance Delivery Operational Group (TOPDOG); this group looks at mini projects that can be undertaken throughout the year, as well as providing the support and guidance to areas that want to improve services and processes within the Trust. The multiple work streams that have been delivered during 2016-17 have continued 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 this is an excellent reduction the actions already initiated are being followed to completion and there are further areas being identified for review, and potential improvement work, from the analysis of a wide variety of data and information sources on a regular basis.

Measure	Measure Description	Data Source
1b	The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust	NHS DIGITAL

Percentage of deaths with palliative care coding, October 2015 – September 2016

Time period	Diagnosis Rate	Diagnosis Rate National Average	Highest – Diagnosis Rate	Lowest – Diagnosis Rate	Combined Rate	Combined Rate National Average	Highest – Combined Rate	Lowest – Combined Rate
Oct 2014–Sep 2015	18.40	25.74	48.30	0.00	18.40	25.89	48.30	0.00
Jan 2015 – Dec 2015	30.84	27.57	54.75	0.19	30.84	27.70	54.75	0.19
Apr 2015 – Mar 2016	35.06	28.67	54.60	0.58	35.06	28.82	54.60	0.58
Jul 2015 – Jun 2016	35.88	29.39	54.83	0.57	35.88	29.55	54.83	0.57
Oct 2015–Sep 2016	**36.42**	**29.60**	**56.27**	**0.39**	**36.42**	**29.70**	**56.27**	**0.39**

Latest Time Period benchmarking position – October 2015 – September 2016

Provider	Diagnosis Rate	Combined Rate
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	36.93	38.04
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	**36.42**	**36.42**
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	31.22	31.22
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	28.19	28.19
SOUTH TYNESIDE NHS FOUNDATION TRUST	25.19	25.19
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	22.63	22.63
CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST	17.30	17.30
GATESHEAD HEALTH NHS FOUNDATION TRUST	14.27	14.95
National Average	**29.60**	**69.70**

The **North Tees and Hartlepool NHS Foundation Trust** considers that this data is as described for the following reason. The use of palliative care codes in the Trust had remained static over a number of years, processes and procedures were reviewed in 2015-16 and improved again in 2016-17.

The **North Tees and Hartlepool NHS Foundation Trust** has taken the following actions to improve this number, and so the quality of its service. The review of case notes continues to demonstrate that there are a high number of patients who have been discharged home to die in accordance with their wishes and this has affected the hospital HSMR and SHMI value.

In an effort to visibly support clinical teams, the Specialist Palliative Care Team are promoting a more proactive approach to identification and support of those patients who may be dying. There is a holistic approach taken to their care, with the host team remaining key workers with the support of Specialist Palliative Care Clinicians, Clinical Nurse Specialists, End of Life Co-ordinator and Chaplaincy in advisory and supportive roles. All patients who may be dying or have an uncertainty to their recovery can be identified through TRAKCARE via the Palliative Care Alert, or the End of Life Care Alert, or can be referred to the service directly by any staff member. Over the last year the Trust continues to review the process for recording patients who are receiving Specialist Palliative Care or End of Life Care, to ensure that this activity is included in the data collection from clinical coding. To promote appropriate and timely referral, the trust has provided a detailed training course facilitated by the Specialist Palliative Care team to increase education for senior clinical staff, this along with the changes made to documentation will improve the quality of documentation and in turn the quality of the Trusts clinical coding. The Specialist Palliative Care Team follow up on all patients who are referred through the various methods and advise, support and signpost accordingly.

The Trust continues to work with commissioners to review pathways of care and support patient choice of residence at end of life wherever possible, further work is on-going with GPs to try and reduce inappropriate admissions to the Trust.

Specialist palliative care processes have been reviewed, with amendments made to both practice and procedures. With an improvement in specialist palliative care being documented, this allows for the information to be coded more accurately, thus in turn help reduce the HSMR value.

Measure	Measure Description	Data Source	Value
2	The Trust's patient reported outcome measure scores (PROMS) for- 1. Groin hernia surgery 2. Varicose vein surgery 3. Hip replacement surgery 4. Knee replacement surgery	NHS DIGITAL	Adjusted average health gain EQ-5D Index

The data for hips and knee replacements is now split between primary and revisions.

April 15 to March 16	Groin hernia	Varicose vein	Hip replacement – Primary	Hip replacement – Revisions	Knee replacement – Primary	Knee replacement – Revisions
Trust Score	0.022	**No data**	0.438	**No data**	0.334	**No data**
National Average	0.088	0.094	0.439	0.284	0.321	0.260
Highest National	0.135	0.130	0.520	**No data**	0.412	**No data**
Lowest National	0.010	0.037	0.359	**No data**	0.207	**No data**

April 16 to September 16	Groin hernia	Varicose vein	Hip replacement – Primary	Hip replacement – Revisions	Knee replacement – Primary	Knee replacement – Revisions
Trust Score	0.80	**No data**	**No data**	**No data**	0.368	**No data**
National Average	0.89	0.099	0.449	0.285	0.337	0.289
Highest National	0.162	0.152	0.525	**No data**	0.430	**No data**
Lowest National	0.30	0.016	0.330	**No data**	0.286	**No data**

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 Trusts position continues to demonstrate good results.

The **North Tees and Hartlepool Foundation Trust** has taken the following actions to improve this score. 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 percentage of patients 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; aged: (i) 0 to 15; and (ii) 16 or over.	NHS DIGITAL

Age Group	Value	Data for 2012-13 standardised to persons 20xx-xx	Data for 2011-12 standardised to persons 2007-08	Data for 2010-11 standardised to persons 2007-08	Data for 2009-10 standardised to persons 2007-08	Data for 2008-09 standardised to persons 2007-08
0 to 15	Trust Score	Not Available	8.79	11.39	12.05	11.73
	National Average	Not Available	10.01	10.15	10.18	10.09
	Band	Not Available	B5	A1	A1	A1
	Highest National	Not Available	14.94	25.80	22.53	22.73
	Lowest National	Not Available	0.00	0.00	0.00	0.00
16 or over	Trust Score	Not Available	10.72	10.26	10.07	9.82
	National Average	Not Available	11.45	11.42	11.16	10.90
	Band	Not Available	A5	W	W	A5
	Highest National	Not Available	17.72	23.99	16.82	24.43
	Lowest National	Not Available	0.00	0.00	0.00	0.00

To Note: *Please note that this indicator was last updated in December 2013 and future releases have been temporarily suspended pending a methodology review.*

The **North Tees and Hartlepool 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 November 2016 position (latest available data) indicates the Trust has an overall readmission rate of 8.33% against the internal stretch target of 7.70%, indicating the Trusts readmission rates have increased by 1.15% compared to the same period in 2015. Audits are being undertaken at specialty level to identify areas for improvement and gaps in services to address across the system.

The North Tees and Hartlepool Foundation Trust has taken the following actions to improve performance in preventing avoidable readmissions within 30 days of discharge. This continues to present a considerable challenge for the Trust and is being addressed by several means including the reinvestment of readmission penalty money and other non-recurrent funding sources. With the required focused clinical leadership and strategic approach there has been a continued improvement to the elective and emergency readmission position.

Patient pathways continue to be redesigned to incorporate an integrated approach to collaboration with primary and social care services, providing care closer to home and reducing hospital admissions and readmissions. There have been a number of initiatives introduced including: a discharge liaison team of therapy staff to actively support timely discharge, working closely with the patient flow managers; inclusion of social workers within the hospital teams to facilitate discharge with appropriate packages of care to prevent readmission; the redesign of integrated care pathways for long term conditions by direction and delivery through an executive director led programme; utilisation of ambulatory care 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.

Measure	Measure Description	Data Source
4	The Trusts responsiveness to the personal needs of its patients	NHS DIGITAL

Period of Coverage	National Average	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST (out of 100)
2016-17	**Not available**	**Not available**
2015-16	69.60	67.70
2014-15	68.90	68.10
2013-14	68.70	69.00
2012-13	68.10	68.70

Benchmarked against over North East Trusts for 2016-17;

Trust	Overall Score (out of 100)
Northumbria Healthcare NHS Foundation Trust The	Not available
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	Not available
South Tees Hospitals NHS Trust	Not available
Gateshead Health NHS Foundation Trust	Not available
South Tyneside NHS Foundation Trust	Not available
County Durham and Darlington NHS Foundation Trust	Not available
City Hospitals Sunderland NHS Foundation Trust	Not available
North Tees & Hartlepool NHS Foundation Trust	**Not available**

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, 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 so the quality of its services, by delivering accredited programmes that focus on responsiveness of patient and carers for both registered and unregistered nurses on. We use human factors training to raise awareness of the impact 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 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	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
Trust 1	59	63	59	65	70	70
Trust 2	49	50	57	53	61	59
Trust 3	73	69	70	75	76	81
NTHFT	63	61	57	54	62	**64**
Trust 4	70	69	77	70	85	82
Trust 5	69	74	76	80	72	73
Trust 6	63	68	64	53	62	59
Trust 7	79	86	87	84	89	91
North East	66	67	68	67	72	72
England	62	65	67	67	70	70
National High	**-**		**94**	**93**	**93**	**92**
National Low	**-**		**38**	**36**	**37**	**56**

Friends and Family Test – Staff

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

	*Q1	*Q2	**Q3	*Q4
Percentage Recommended – Care	74%	67%	56%	
Percentage Not Recommended – Care	9%	9%	12%	

*Q1, Q2 and Q4 data obtain from the Friends and Family Test for Staff
**Q3 information taken from the NHS National Staff Survey

Work: 'How likely staff would be to recommend the NHS service they work in to friends and family as a place to work'.

	*Q1	*Q2	**Q3	*Q4
Percentage Recommended – Work	69%	65%	64%	
Percentage Not Recommended – Work	15%	16%	12	

*Q1, Q2 and Q4 data obtain from the Friends and Family Test for Staff
**Q3 information taken from the NHS National Staff Survey

More detail can be found for the Friends and Family Test in Part 3: Review of Quality Performance 2014-15, under Priority 3: Patient Experience – Friends and Family recommendation, point 3.

The **North Tees and Hartlepool NHS Foundation Trust** considers that this data is as described for the following reasons. The Trust continue to actively engage with and encourage staff to complete and return the Staff Survey along with the quarterly Staff Friends and Family Test, so that areas of improvement(s) can be identified and acted upon in future. This year marked a significant improvement in the response rate for the Staff Survey at 61% compared to 45% the previous year.

The **North Tees and Hartlepool Foundation Trust** has taken the following actions to further improve this percentage, and so the quality of its services, by involving the views of the staff in developing a strategy for care. Understanding the views of staff is an important indicator of the culture of care within the organisation, and as such all departments are monitored in relation to the Staff Friends and Family test, ensuring that all anonymous negative comments made on the returns are reviewed and plans put in place to improve the level of care provided by the Trust.

National Staff Survey

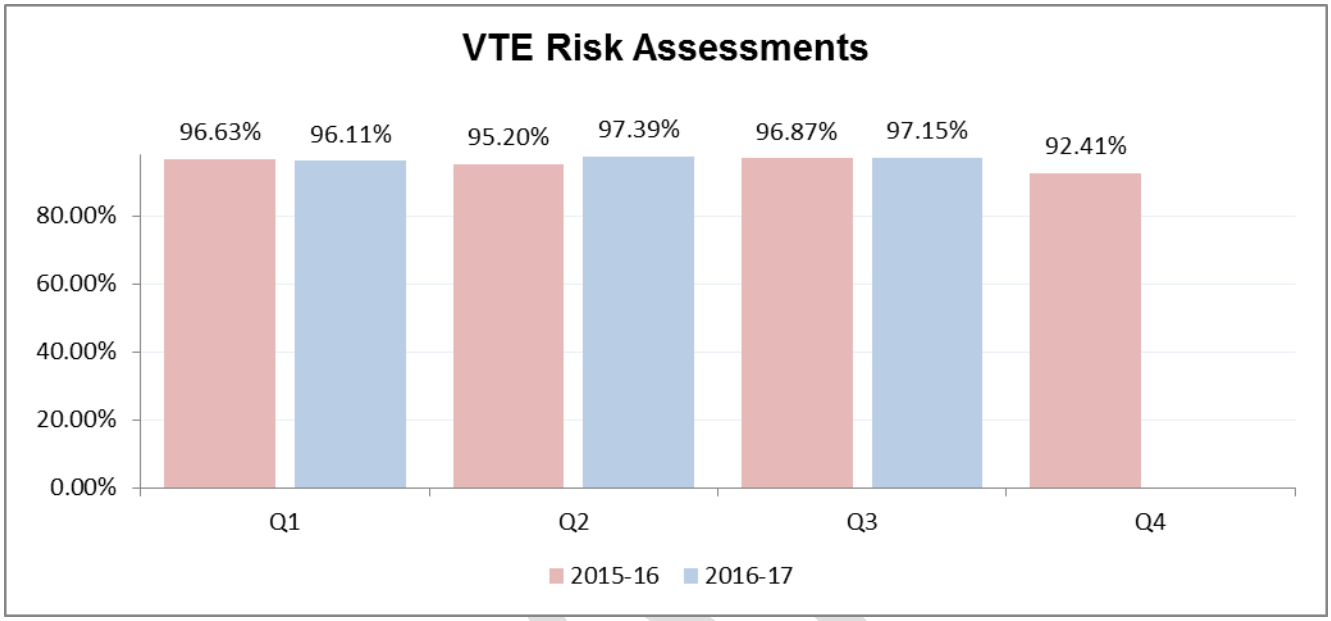
Percentage of *staff experiencing harassment, bullying or abuse from staff* in the last 12 months

2014	2015	2016	2016 National Average
21%	26%	**20%**	**23%**

Percentage believing that *Trust provides equal opportunities for career progression or promotion*

2014	2015	2016	2016 National Average
90%	90%	**90%**	**87%**

Measure	Measure Description	Data Source
6	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE)	NHS DIGITAL



Two year reporting trend

Measure	Reporting Year	2015-16				2016-17			
Venous Thromboembolism	Quarter	Q1	Q2	Q3	Q4	Q1	Q2	Q3	*Q4
	Value	96.63%	95.20%	96.87%	92.41%	96.11%	97.39%	97.15%	
	National Average	96.05%	95.86%	95.61%	95.53%	95.73%	95.51%	94.23%	
	Highest National	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	
	Lowest National	86.08%	75.04%	78.50%	78.06%	80.61%	72.14%	76.48%	

*Q4 data no available at time of print

North East Trust benchmarking 2016-17

	2015-16			
Trust	Q1	Q2	Q3	*Q4
North Tees & Hartlepool NHS Foundation Trust	**96.11%**	**97.39%**	**97.15%**	
City Hospitals Sunderland NHS Foundation Trust	98.33%	98.43%	98.68%	
South Tees Hospitals NHS Trust	96.04%	95.50%	95.26%	
South Tyneside NHS Foundation Trust	96.29%	96.37%	95.75%	
County Durham and Darlington NHS Foundation Trust	96.56%	96.92%	97.01%	
Gateshead Health NHS Foundation Trust	97.83%	97.88%	98.55%	
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	91.70%	95.83%	96.85%	
Northumbria Healthcare NHS Foundation Trust	93.63%	94.56%	94.29%	

*Q4 data no available at time of print

The Trust has promoted the importance of doctors undertaking assessment of risk of VTE for all appropriate patients in line with best practice.

The **North Tees and Hartlepool Foundation Trust** considers that this data is as described for the following reasons. By understanding the percentage of patients who were admitted to hospital who were risk assessed for VTE helps the Trust to reduce cases of avoidable harm. The Trust has ensured that a robust reporting system is in place and adopts a systematic approach to data quality improvement.

The **North Tees and Hartlepool Foundation Trust** has taken the following actions to continue to improve this percentage, and so the quality of its services, by updating the training booklets to keep them relevant, ensuring that it is part of the mandatory training and providing guidance on the importance of VTE risk assessment at induction of clinical staff. Consultants continue to monitor performance in relation to VTE risk assessment on a daily basis.

The Trust ensures that each Directorate clinical leads are responsible for monitoring and audit of compliance of NICE VTE guidelines and this will be presented yearly to the Audit and Clinical Effectiveness (ACE) committee.

The following table demonstrates the venous thromboembolism (VTE) mandatory training for the whole Trust:

Requiring Training	Trained	% Compliance
1,292	**1,215**	**94%**

*data as of 14 February 2017

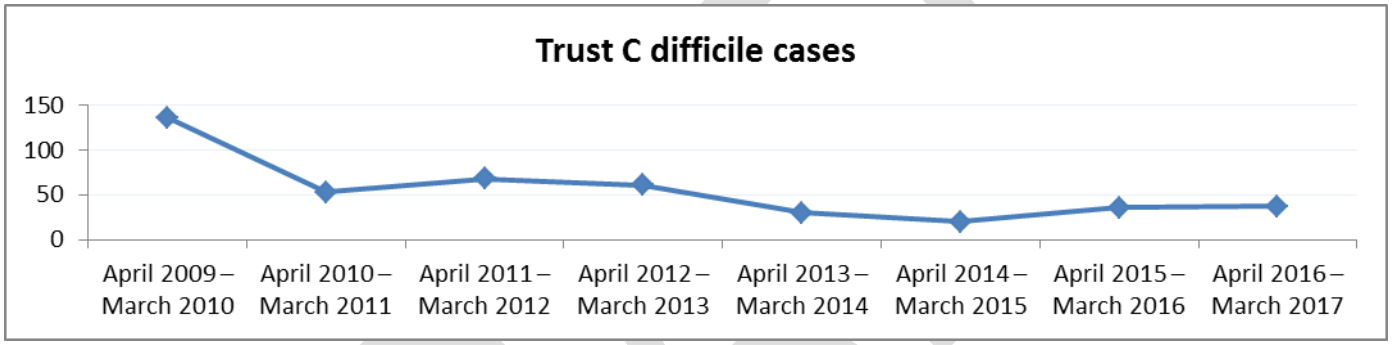
Patient Pic

Patient Pic

Measure	Measure Description	Data Source
7	The rate per 100,000 bed days of cases of C difficile infection that have occurred 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
April 2016 – March 2017	**37**	**Not Available**	**Not Available**	**Not Available**	**Not Available**
April 2015 – March 2016	36	17.70	14.90	66.00	0.00
April 2014 – March 2015	20	10.40	15.10	62.20	0.00
April 2013 – March 2014	30	15.70	13.60	37.10	0.00
April 2012 – March 2013	61	30.80	17.40	31.20	0.00

* 2016-17 data not available at the time of print



The **North Tees and Hartlepool 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 Foundation Trust** has taken the following actions to improve this, 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. A project with NHS Improvement looking at a specific role to clean patient equipment was completed and rollout across all wards is now being explored
- 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 participated in European Antibiotic Awareness day and also submitted date to the Public Health England point prevalence survey which included antibiotic prescribing
- a Continued emphasis on high standards of hand hygiene for staff and patients, utilising hand hygiene champions and a monthly RAG report
- Daily monitoring of affected patients to ensure good clinical management and the reduction in risk of cross infection.
- The reintroduction of regular infection prevention and control training for all staff and the development of an e-learning package on C difficile

The trust intends to continue with these measures and will explore every opportunity for further improvement in 2017-18.

Measure	Measure Description	Data Source
8	The number and, where available, rate of patient safety incidents that occurred within the trust during the reporting period, and the 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 2015 – March 2016**

	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 15 – Mar 16	**2,916**	**26.50**	**0.16**	**0.97**	**0.00**	**3**	**0.10**
Apr 15 – Sep 15	3,117	32.30	0.43	2.92	0.07	7	0.22
Oct 14 – Mar 15	3,074	30.40	0.50	5.19	0.05	7	0.23
Apr 14 – Sep 14	3,068	32.40	0.49	82.86	0.00	8	0.26

Regional Benchmarking

	October 2015 – March 2016	
Trust	**Degree of Harm (All) – Rate per 1000 bed days**	**Degree of Harm (Severe or Death) %**
Gateshead Health NHS Foundation Trust	30.90	0.61%
South Tees Hospitals NHS Trust	32.80	0.46%
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	28.90	0.44%
County Durham and Darlington NHS Foundation Trust	38.90	0.42%
South Tyneside NHS Foundation Trust	33.90	0.37%
Northumbria Healthcare NHS Foundation Trust	43.90	0.32%
North Tees & Hartlepool NHS Foundation Trust	**26.50**	**0.10%**
City Hospitals Sunderland NHS Foundation Trust	63.50	0.09%

*Data for Oct 15 – Mar 16

The **North Tees and Hartlepool Foundation Trust** considers that this data is as described for the following reasons. The Trust endeavours to foster and promote a positive culture of reporting across all teams and services. This is enhanced by encouraging timely reporting of incidents, regardless of level of harm and reinforcing that the purpose of reporting is to learn from investigation of incidents and to promote a culture of openness and honesty across the organisation. The investigations undertaken support the development of systems and processes to prevent future patient harm. The quality of the incident reporting is checked at various stages of the reporting and investigation process.

The **North Tees and Hartlepool 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, pressure damage and discharge problems; there are also additional processes in place for reviewing the root causes of incidents, developing improvements and to evaluation of the impact on these.

All reported incidents are reviewed internally within the local departments for accuracy in regards the level of harm, and there are various processes in place in the organisation to provide assurance that the recorded level of harm reflects the nature of the incident.

The weekly multidisciplinary Safety Panel reviews all incidents of moderate harm or above, the panel agrees the level of investigation and reviews the application of Duty of Candour regulations by the clinical directorates. Where there is any discrepancy, the investigating team are asked to provide further details for review and discussion. In complex cases, where the identification of the required level of investigation is unclear, the incident, and all evidence collated through the investigation to date, is reviewed by the Medical Director and / or Director of Nursing for a decision. Incidents of significant harm are managed within the National Framework for Serious Incidents and the current requirements for both the national NHS contract and the local Clinical Commissioning Groups (CCGs).

On conclusion of a Serious Incident investigation, the weekly Safety Panel reviews and approves the Comprehensive Investigation report which is developed from the internal investigation, and reviews the actions that have been initiated to seek assurance that these will reduce the risk of future recurrence. Once agreed by the panel, the reports and action plans are forwarded to the CCG for external review and approval prior to closure. Information in relation to the root cause of an incident, the recommendations made following investigation and actions initiated are recorded on the national STrategic Executive Information System (STEIS). This allows NHS Improvement and the Care Quality Commission (CQC) to review overall learning and identify any trends that may require inclusion in national action.

The Trust works in close collaboration with the local CQC inspectors in relation to incident reporting and regularly communicates in relation to serious incident investigations and also overall trend in incident reporting.

Where an incident does not meet the criteria within the national framework for serious incidents, but the Trust identifies that lessons can be learnt locally within a team or wider across the organisation, an internal process of investigation is initiated which mirrors the national framework. This proactive approach to safety and quality allows the Trust to internally consider areas of service provision with recourse to escalate more serious concerns if they become apparent through the investigation.
The Trust reports all patient related reported incidents into the National Learning and Reporting System (NRLS), this allows a national view to be obtained in relation to all patient safety incidents reported, regardless of harm level. The national analysis of this information provides information for NHS Improvement to review and consider where actions need to be taken in relation to national trends in lower level incidents. This analysis can lead to a national safety alert being published; the Trust is fully compliant with all of the National Patient Safety Alerts that have been published in relation to this analysis. Processes are in place to ensure there is continual review of processes in order to provide on-going assurances.

To support the Trusts drive to increase reporting and create a positive safety culture across all departments, there is on-going education and updating of relevant staff groups including students, new starters, and managers. The emphasis is on proactive reporting of all types of safety incidents, those with harm or the potential for harm to one or more patient, with the emphasis within the investigation to be on the learning for the individual, the team and the organisation as a whole.

Part 3a: Additional Quality Performance measures during 2016-17

This section is an overview of the quality of care based on performance in 2015-16 against indicators

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 2015-16 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 2015-16. 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

Why / How we chose this measure.

Following consultation with key stakeholders it was evident that falls continue to be one of the Trusts key harm measures to monitor and improve on.

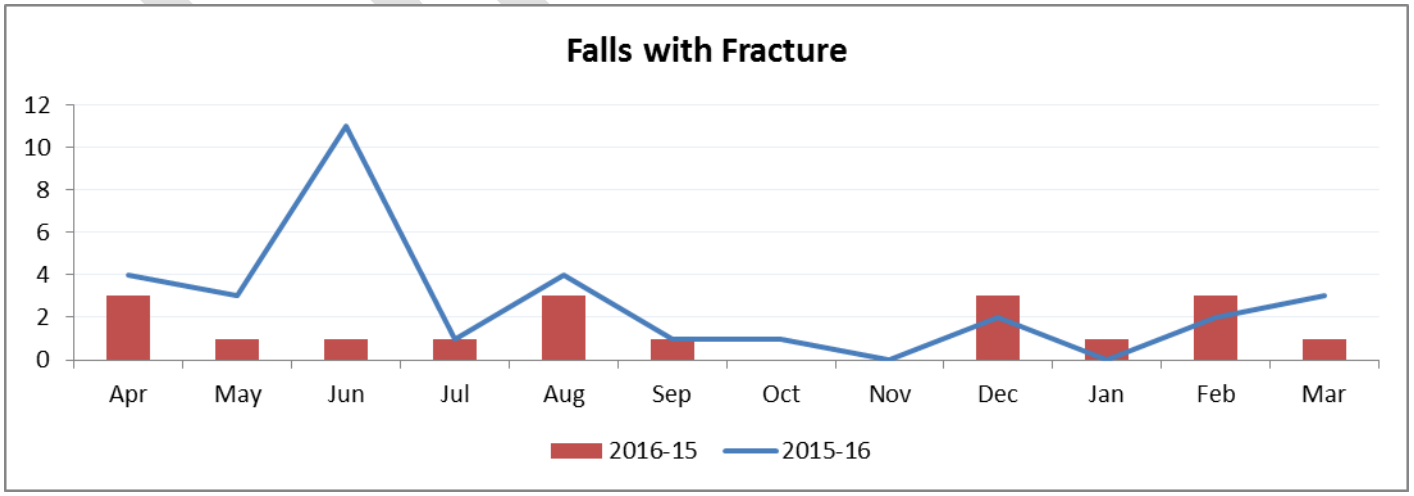
Patients aged 65 years and over are at highest risk of falling and patients aged 85 and over are at highest risk of injury from a fall.

Falls with Fracture

During **2016-17** the Trust has experienced **18** falls resulting in fracture; this has *decreased* from **32** in the 2015-16 reporting period.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2013-14	1	2	1	1	4	4	4	1	1	0	1	1	**21**
2014-15	1	4	2	9	1	4	3	5	3	3	3	4	**42**
2015-16	4	3	11	1	4	1	1	0	2	0	2	3	**32**
2016-15	**3**	**1**	**1**	**1**	**3**	**1**	**0**	**0**	**3**	**1**	**3**	**1**	**18**

*Data obtained via the Trusts Incident Reporting database (Datix) as of 28 March 2017.



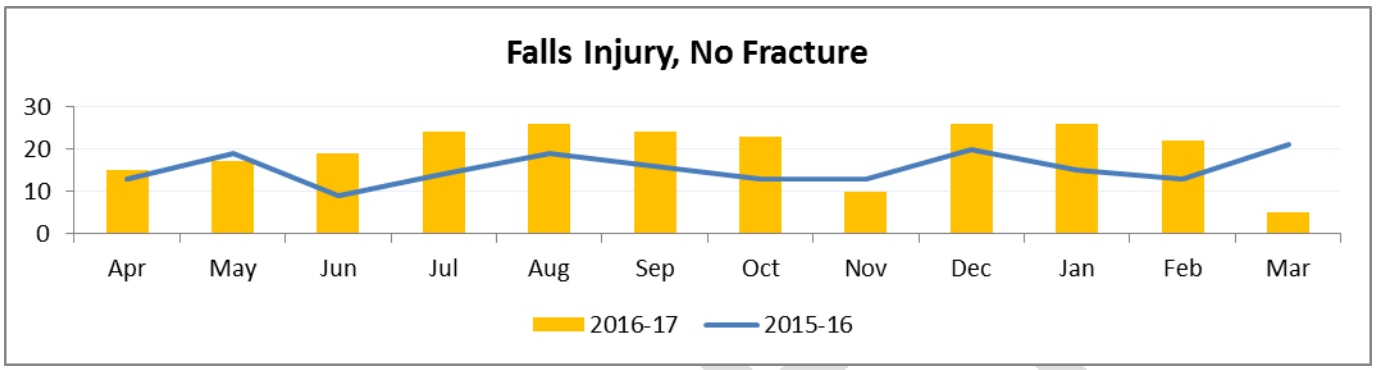
The trust has a robust system in place to understand the background to all falls that result in significant injury; these incidents are shared with staff for future learning.

Falls Injury, No Fracture

During **2016-17** the Trust has experienced **237** falls resulting in an injury and no fracture; this has *increased* from 185 in the 2015-16 reporting period.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2013-14	28	21	27	35	22	37	23	26	31	30	24	26	**330**
2014-15	25	27	19	29	33	29	27	31	33	37	40	25	**355**
2015-16	13	19	9	14	19	16	13	13	20	15	13	21	**185**
2016-17	**15**	**17**	**19**	**24**	**26**	**24**	**23**	**10**	**26**	**26**	**22**	**5**	**237**

*Data obtained via the Trusts Incident Reporting database (Datix) as of 28 March 2017.

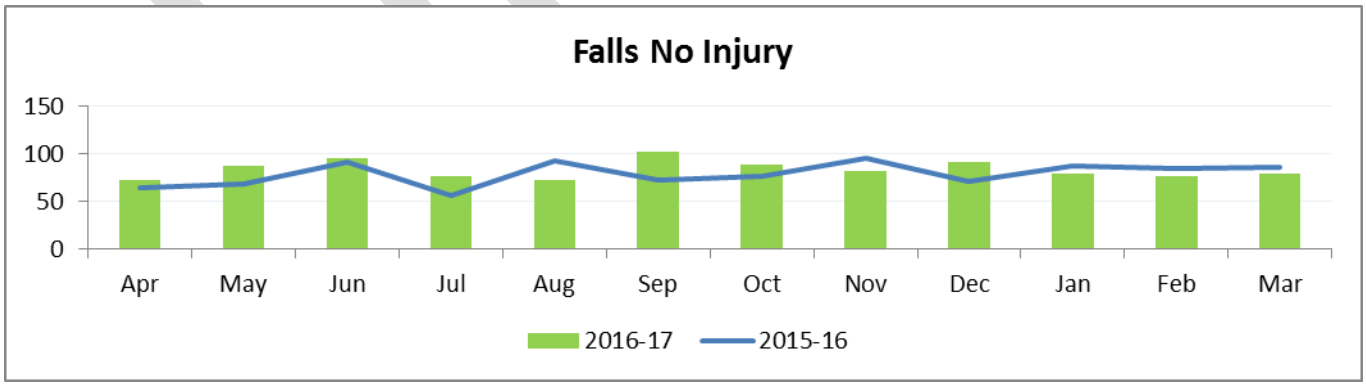


Falls with No Injury

During **2016-17** the Trust has experienced **1,004** falls resulting in no injury; this has *increased* from 947 in the 2015-16 reporting period.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2013-14	100	110	67	98	71	80	84	96	88	101	78	70	**1,043**
2014-15	120	87	66	84	108	93	97	84	88	85	100	82	**1,012**
2015-16	65	69	91	56	93	72	76	95	71	88	85	86	**947**
2016-17	**73**	**88**	**95**	**76**	**72**	**102**	**89**	**82**	**92**	**79**	**77**	**79**	**1,004**

*Data obtained via the Trusts Incident Reporting database (Datix) as of 28 March 2017.



The Trust is reporting more falls with injury, but these injuries do not include any significant harm which would increase the patient's hospital stay or require the patient to receive any on-going treatment.

The number of falls that have resulted in no harm has reduced, this reflects the positive work undertaken by all areas to assess and manage those patients at high risk of falls. This includes assessment of risk within 6 hours of admission and continued assessment throughout the patients'

journey. Interventions such as one to one care for patients identified as high risk of falls, medication review and mobility assessment has improved the trusts performance.

The Trust is taking part in a National audit of Falls in May 2017. Also, the Trust is planning a comprehensive review of the Trust Falls policy to reflect the new national guidelines and evidence base regarding care of fallers. For 2017-18 the Trust aims to introduce a post falls checklist to ensure all patients receive excellent care following a fall and further work will be undertaken to share any learning from incidents related to falls.

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 2013 the Trust has had **5** Never Events and they are broken down as follows:

Reporting Year	Number of Never Events
2013-14	1
2014-15	1
2015-16	2
2016-17	**1**
Totals:	**5**

There has been one Never Event reported in the period of 2016-17; this incident related to wrong site surgery, the patient involved is fully aware of the incident and has been involved in and has been given feedback in relation to the investigation findings. As a result of this incident there has been a continued focus on the Trusts use of the WHO Surgical checklist in order to reduce the risk of any further never events occurring to a minimum. The incident has been reported to NHS England and the Trusts Commissioners on the Strategic Executive Information System (STEIS), the CQC and Monitor as required.

The NHS England report can be accessed via:

http://www.england.nhs.uk/ourwork/patientsafety/never-events/ne-data/

Effectiveness of Care

Discharge processes

Rationale: Although quality of discharge information has improved considerably over the years, this remains a priority with further improvements recommended by stakeholders.

Overview of how we said we would do it

- All concerns and/or incidents raised onto Trusts Datix system

Overview of how we said we would measure it

- Quarterly analysis of discharge incidents on Datix

Overview of how we said we would report it

- To the Discharge Steering Group

Completed and reported?

- Reported to the Discharge Steering Group✓

Patient Discharge Incidents
The number of discharge incidents is down in Q3 which is reflective of the hard work and efforts in improving safe discharging for our patients. Of those patients discharged in Q3 only 0.2% of patients had an issue with discharge identified and reported on Datix. The trust continues to develop relationships with providers to build confidence and communication between teams and to ensure any issues that do arise be dealt with swiftly to minimise the risk of reoccurrence. A number of initiatives in the trust work towards improving discharge planning further and ensure the patient experience is seamless.

Patient Flow Reforms
There are a number of discrete teams with a key remit of facilitating patient flow and timely discharge. These include the Discharge Liaison Team (DLT), the Patient Flow Team, the Discharge Lounge, the Clinical Site Managers and the Emergency Care Therapy Team (ECTT). Work is now underway to consider how these teams can work together as a more coordinated unit. The trust has identified an area to co locate teams to promote timely engagement and action teams are now co-located. The Patient Flow Team is also currently exploring the opportunities that Trakcare affords in relation to monitoring patient flow, on-going work with Trak team to provide a system where the principles of the SAFER bundle can be utilised to assist patient flow i.e. those most sick, those for discharge etc. Ward huddles are well embedded and key in driving forward the SAFER bundle. The teams continue to promote earlier in the discharge.

NESTA 100 day challenge
There is a new initiative in Stockton called the NESTA 100 day challenge which began on 23 January 2017 – this involves a mix of acute, community, social care and local authority and governor colleagues keen to improve processes and challenges in the system. There are 3 groups (2 out of hospital and 1 acute) each with specific goals to either improve discharge from hospital or prevent unnecessary hospital admissions.

Integrated Discharge team
The Trust are in the process of establishing the Integrated Discharge Team made up of health and social care professionals. This will ensure that teams are working closely together to discharge patients safely and efficiently. Hartlepool Borough Council social care workers have moved into the

hospital in January and we are working with Stockton as part of the 100 day challenge to look at new ways of working.

Volunteers in Discharge Lounge
The Trust is due to introduce two volunteers who will work in the discharge lounge to provide support and friendly dialogue to patients before they leave the Hospital. It is hoping that the patients will feel comfortable talking to our volunteers and we might be able to signpost them to appropriate voluntary and third sector Organisations in the Community.

Patient Choice Policy
The Policy has been revised and agreed with our key external stakeholders. The policy now gives clear guidance as to what should occur when the patient's first choice of nursing or residential home is unavailable and also covers the process to follow in those circumstances when a patient, or their family or carers, do not work with the Trust to facilitate discharge from hospital.

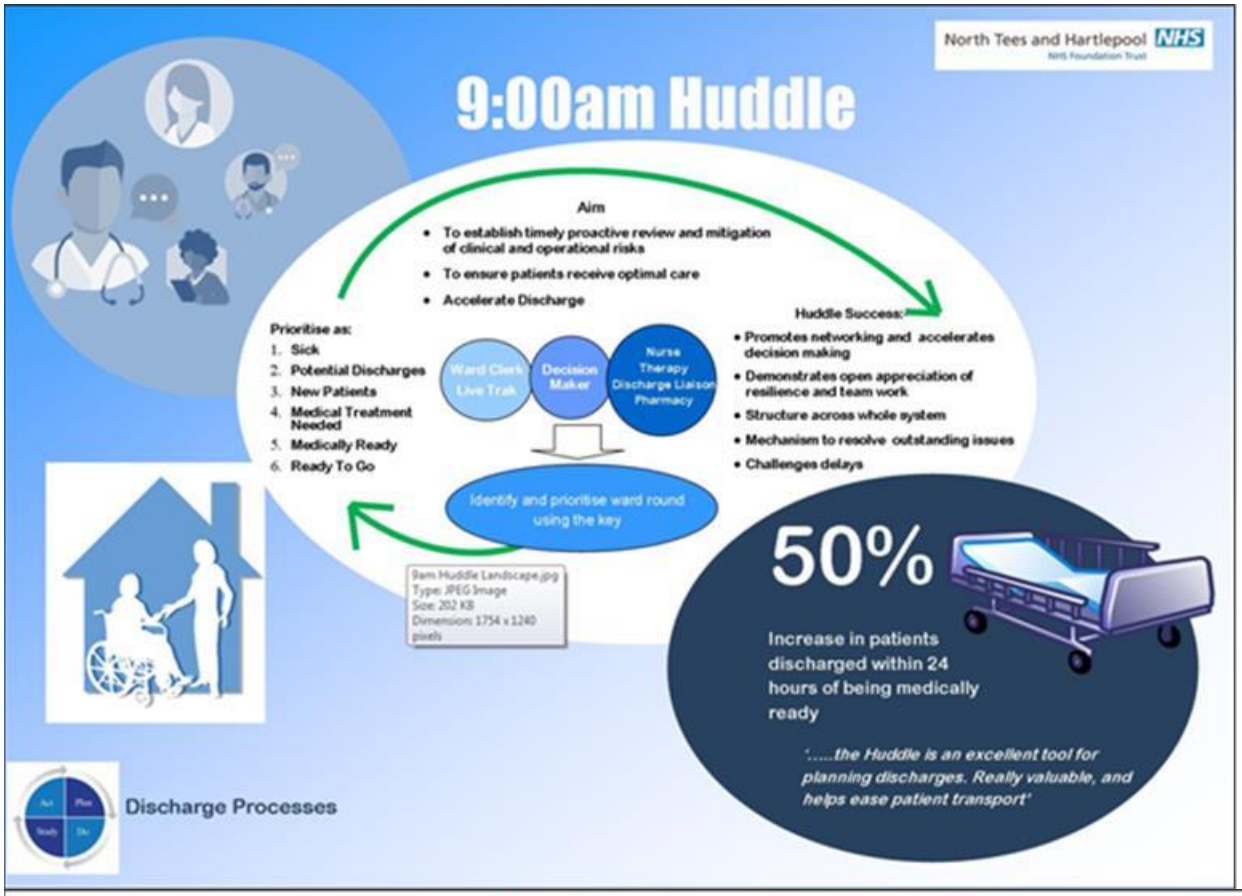
Patient information to support the new policy has also been approved and ward staff are involved in implementing the policy with the support from their senior clinical matron and discharge liaison team, especially in relation to the family meetings. It is embedded with clinical teams and feedback and monitoring is through the Discharge Steering Group. This policy continues to be managed by staff to support discharge from hospital to care homes.

Delays Database
The DLT are now utilising and populating, on a daily basis, a database that tracks all delayed discharges. The DLT are now able to capture and categorise all delays in discharge, including those that are internal to the Trust. This will allow us to track patients and target our intervention more appropriately. The recent introduction of an expected date of discharge for all patients will support this. The database will also allow us to more effectively measure and audit the efficacy of any new initiatives introduced to reduce delays in discharge.

Out of Hospital Care Clinical Strategy
The strategy incorporates plans to provide some nursing interventions in the community that until now have only been provided in the acute setting. These plans include the administration of long line IV antibiotics, IV diuretics and subcutaneous fluids. These proposals are at the developmental stage, but have been well received by commissioning colleagues; once implemented there will be a cohort of the current inpatient caseload who could be safely managed in the community, thereby enabling earlier discharge and reducing demand for inpatient beds.

Respiratory "Hospital at Home" Service (HAH)
The service accepts GP referrals for a cohort of patients with COPD who would previously have been admitted to hospital. These patients will be managed in the community by the new multidisciplinary team. This initiative will not only prevent admissions, but will also facilitate earlier supported discharge for some patients. This service is available across both localities 7 days per week. The team can support early discharge from hospital, taking referrals up to 6pm every evening. This continues to be a valuable team to safely support early discharge from hospital. This continues to be a successful service and has received very positive praise from peer, patients and relatives.

Seven day working
Work is on-going to progress to a position where the Trust and our partner organisations manage the discharge of patients as effectively on a weekend, as happens during the working week.



THINK 'HOME IS BEST'

for FRAIL patients

H = Hotline

- Have you discussed with **SPA Clinical Triage?** Able to offer support from other services in the community
- Tel number 01429 522277 (8am – 10pm)

O = OT/Physio

- Have you discussed with **ECTT**? Able to offer guidance on management plans
- Bleep #6920 (08:30-19:00)

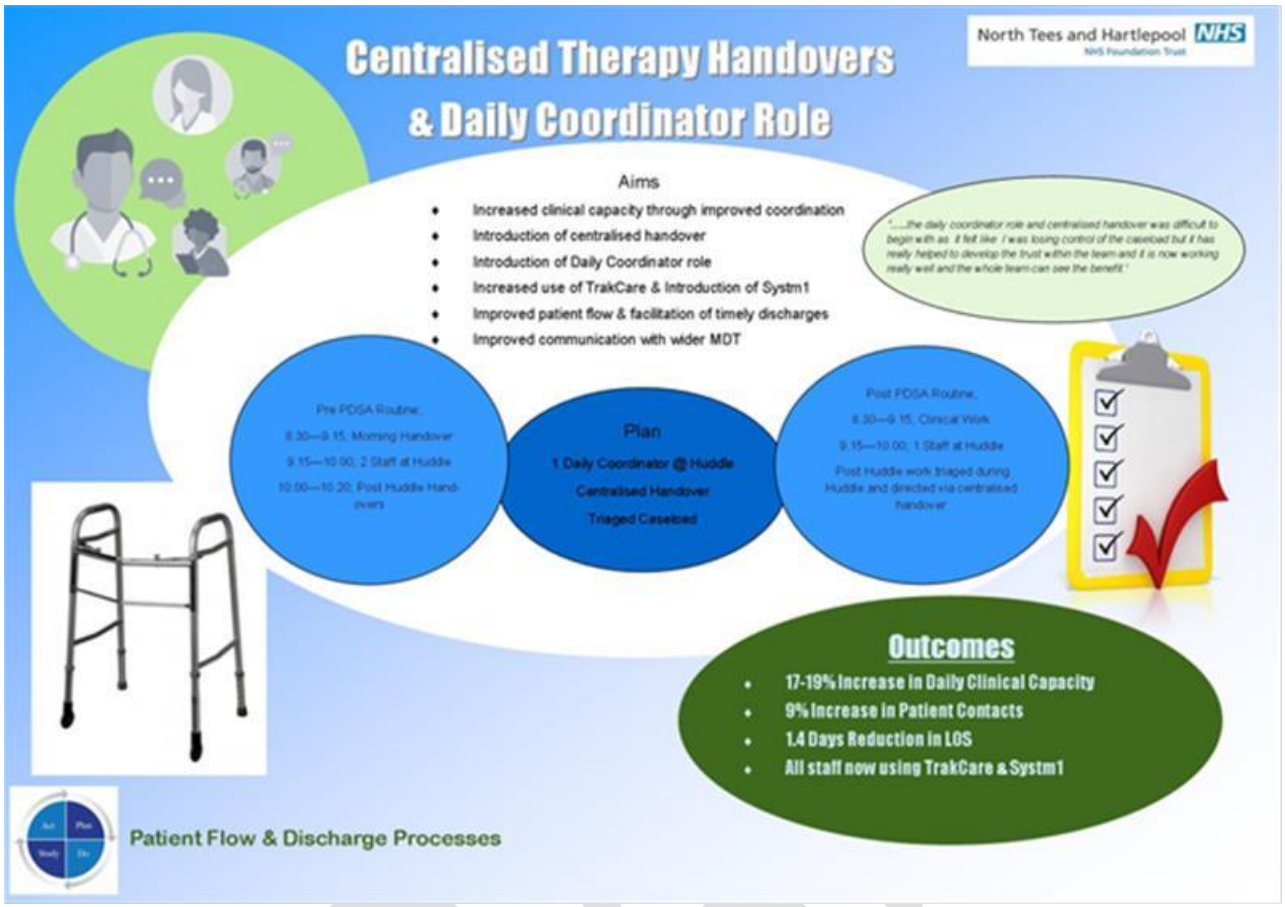
M = Mental health

- Have you discussed with **Psychiatry Liaison**? Able to check any known management plan or offer support (Frailty Nurse assessment 'in hours' and information sharing 'out of hours'). Contact 01642 624318 - this number is active 24/7

E = Elderly care

- Have you considered a **Rapid Access Clinic referral?** Mon to Fri clinics for assessment by an Elderly Care Physician. Forms in A&E.

"E.D. phone HOME"


North Tees and Hartlepool NHS
NHS Foundation Trust
Centralised Therapy Handovers
& Daily Coordinator Role
Aims
Increased clinical capacity through improved coordination
Introduction of centralised handover
Introduction of Daily Coordinator role
Increased use of TrakCare & Introduction of Systm1
Improved patient flow & facilitation of timely discharges
Improved communication with wider MDT
'.....the daily coordinator role and centralised handover was difficult to begin with as it felt like I was losing control of the caseload but it has really helped to develop the trust within the team and it is now working really well and the whole team can see the benefit.'
Pre PDSA Routine:
8.30—9.15: Morning Handover
9.15—10.00: 2 Staff at Huddle
10.00—10.20: Post Huddle Hand-overs
Plan
1 Daily Coordinator @ Huddle
Centralised Handover
Triaged Caseload
Post PDSA Routine:
8.30—9.15: Clinical Work
9.15—10.00: 1 Staff at Huddle
Post Huddle work triaged during Huddle and directed via centralised handover
Outcomes
17-19% Increase in Daily Clinical Capacity
9% Increase in Patient Contacts
1.4 Days Reduction in LOS
All staff now using TrakCare & Systm1
Patient Flow & Discharge Processes

Staff, Patient Experience and Quality Standards (SPEQS)

Staff and patient experiences are what drive the Trust in ensuring that the standard of care being provided is of a high standard. The following data for Staff, Patient Experience and Quality Standards (SPEQS) is an internal reporting tool used when visits have taken place.

The Trust has commenced the newly revised (from August 2016) SPEQS process utilising the five CQC domains of:

Due to the increase in the number of metrics being measured, the scoring system has changed; therefore the ability to achieve a score of 100% is more challenging.

The current data is for in-patients areas with; further SPEQS assessment frameworks being developed from April 2017 for day case / outpatient Emergency Care, Maternity and Community.

The SPEQS led by the *Director of Nursing, Quality and Patient Safety and Quality* or by the *Associate Director of Nursing, Quality and Patient Experience* is undertaken by Senior Clinical Matrons, members of the Board, Assistant Directors and our Governors.

SPEQS is an additional avenue to provide valuable feedback on patient's standard of care. Each visit of the ward/area is documented on a standard SPEQS template and is input into the SPEQS database when reporting back the results.

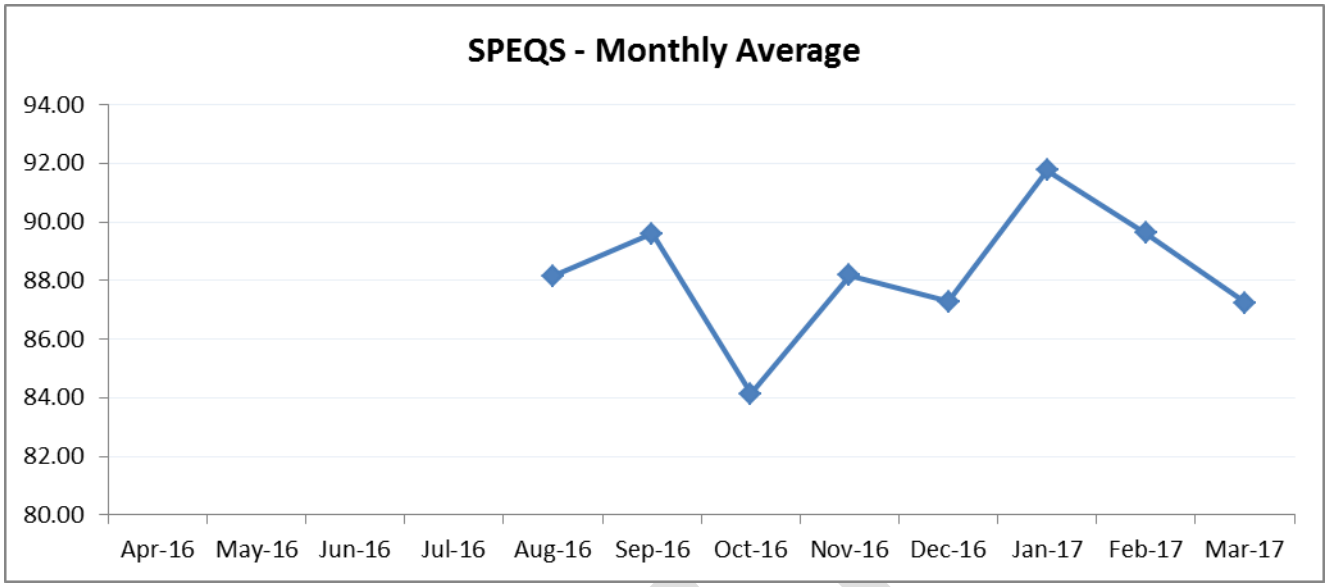
Reports from the SPEQS reviews are provided to the Board of Directors and to the Council of Governors periodically.

The following table provides data (**in-patients only**) relating to the 2016-17 visits:

SPEQS CQC Domains	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total
Safe (%)	**Not In Use During This Period**				89.01	87.29	86.52	90.59	86.53	93.39	91.82	90.34	**89.44**
Effective (%)					87.69	91.19	84.87	89.18	84.20	94.48	86.40	85.20	**87.90**
Caring (%)					90.99	85.48	91.77	90.37	96.42	90.71	95.37	92.88	**91.75**
Responsive (%)					92.66	84.57	70.36	81.76	88.79	83.35	88.79	86.90	**84.65**
Well-Led (%)					79.65	84.27	75.79	81.30	77.98	87.85	88.15	76.98	**81.50**
Monthly Average (%)					**88.16**	**89.59**	**84.13**	**88.18**	**87.27**	**91.77**	**89.61**	**87.24**	**88.24**

Commodes Clean %	**Not In Use During This Period**	90.00	88.89	80.00	82.50	58.33	97.30	90.00	95.45	**86.05**
Toilet Clean %		92.31	92.86	100.00	96.08	100.00	100.00	97.78	100.00	**97.31**

*Data obtained from the Trusts internal SPEQS visits database and is up to 28 March 2017



Clinical Effectiveness Indicators

Why / How we chose this as a priority.

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 TIAs and Stroke indicators.

The following table demonstrates the quarter on quarter performance with a benchmark position against 2014-15 data and against the 2015-16 performance target.

	2015-16 Performance	2016-17 Target	Q1	Q2	Q3	*Q4	2016-17 Performance
Stroke – 80% of people with stroke to spend at least 90% of their time on a stroke unit	80%	%	88.20%	92.50%	91.50%		
Percentage high risk TIA cases treated within 24 hours	75%	%	85.70%	92.60%	89.70%		

Patient Experience

Why / How we chose this as a priority.

The Trust continues to work hard to improve customer satisfaction through patient experience.

*We do recognise that we don't always get things right and this is why we have a dedicated **patient experience team** to listen to and investigate any concerns or complaints.*

Complaints

Complaints process

The Trust continues to use three complaints streams:

- **Stage 1** – Informal; to be dealt with by the Patient Experience Team (PET) or at the time of complaint at ward level
- **Stage 2** – Formal; for a meeting to be arranged with the complainant to discuss the complaint with the Senior Clinical Matron, consultant and relevant personnel involved in the complaint with hopefully a resolution at this stage
- **Stage 3** – Formal; if Stage 1 or stage 2 did not resolve the issue or the complainant did not want to go through those routes, a formal stage 3 is then raised

Stage	Number of Complaints
Stage 1 (Informal)	858
Stage 2 (Formal Meeting)	70
Stage 3 (Formal Chief Exec Letter)	270
Total	**1,198**

2016-17 Complaints by complaint type:

From the **1,198** complaints received in 2016-17 there are **930** with a sub-subject description.

Please see the following breakdown of the ***top 10 complaint types***.

Sub-subject Description	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Communication - Insufficient	11	17	14	10	24	18	19	21	22	24	28	11	**219**
Attitude - unprofessional	8	14	7	6	6	10	9	11	3	10	14	4	**102**
Treatment and procedure delays	6	8	3	10	16	14	12	8	8	5	4	8	**102**
Outpatient delay	6	3	5	11	16	18	10	6	2	4	5	4	**90**
Outpatient cancellation	10	2	3	2	8	10	4	3	3	5	4	1	**55**
Competence of staff member	5	1	3	5	3	6	6	2	2	5	8	3	**49**
Delay to diagnosis	5	1		4	2	2		4	3	3	7	4	**35**
Receptionist/administration staff incl attitude and communiation	2	2	3	7	2	1	3	4		4	5		**33**
Discharge arrangements	1	2	4	2		3	4	2	5	1		2	**26**
Pain Management	5		1	3	1	4	3	1		2	1		**21**

*Data for 2016-17 obtained via the Safety, Quality and Infections Dashboard – via Datix up to 28 Mar 2017

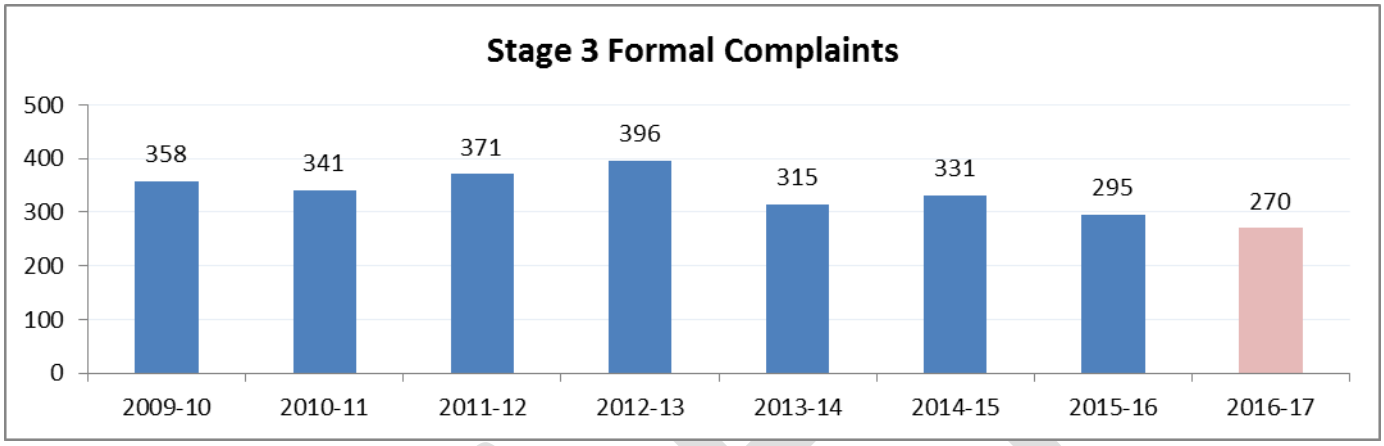
Since the 1st April 2016, the Trust has received **1,198** complaints of which **270** have gone onto the formal complaint process, this only equates to **22.54%** of the complaints.

Stage 3 – Formal Complaints

The number of formal complaints received over the last 7-years is shown in the following table:

	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Stage 3 Formal Complaints	358	341	371	396	315	331	295	**270**

*Data obtained via the Trusts Incident Reporting via Datix up to 21 Mar 2017



The following table trends the 2016-17 formal complaints by quarter.

	2016-17 Q1	2016-17 Q2	2016-17 Q3	2016-17 Q4	Total
Totals	74	74	53	69	**270**

*Data obtained via the Trusts Incident Reporting via Datix up to 28 Mar 2017

All lessons learned from complaints are taken back into the clinical teams and managed proactively.

The themes are collated and aggregated analysis is considered in the Trust's quarterly Complaints, Litigation, Incidents and Performance (CLIP) report. The Directorates identify the top themes within their area and provide actions for improvement which is then followed up in the subsequent quarterly CLIP report.

Formal Complaints Compliance with 25 day target

We continually monitor the percentage of formal complaints that the Trust responds to in the required 25 day turn-around period.

Month	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Compliance Rate	82%	76%	100%	93%	96%	92%	100%	95%	92%	92%		

*Data obtained from Trust complaints dept.

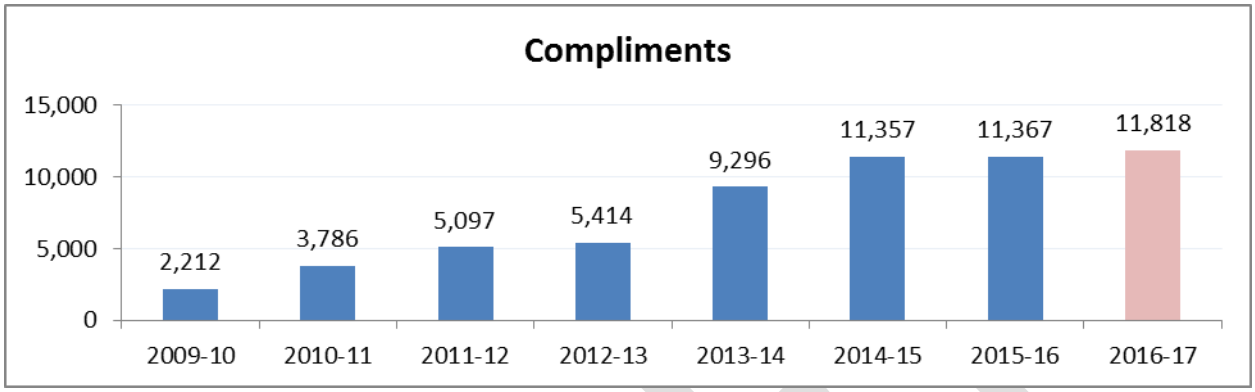
The Trust Complaints dashboard produces a weekly report; this data details the number of open complaints and which stage they fall under, the report also details the number of days open. The report is circulated to the Patient Safety Co-ordinators in each directorate to review the cases to see if they can be closed.

Compliments

In 2009-10 we started to record the number of **compliments** received. The number of thank you and complimentary comments has increased year on year.

Trends in compliments can be seen in the following table and chart.

Year	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Compliments	2,212	3,786	5,097	5,414	9,296	11,357	11,367	**11,818**



Pressure ulcers (also known as decubitus ulcer or pressure sores)

Why / How we chose this as a priority.

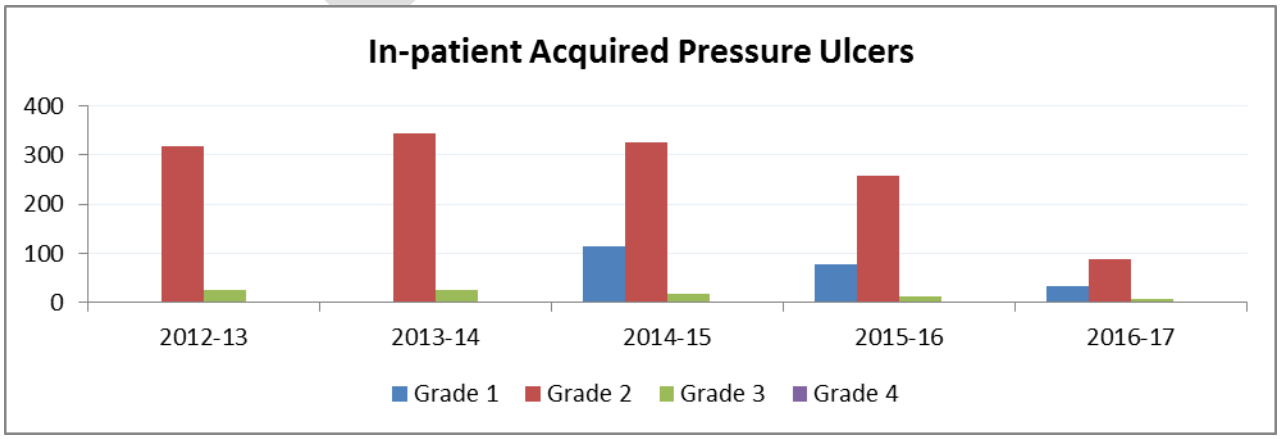
Following consultation with key stakeholders it was evident that pressure ulcers continue to be one of the Trusts key measures for improvement, therefore it was agreed to retain this indicator as rolling priority for our patients.

To note: prior to 2014-15 reporting year, Pressure ulcers were classified as **Grade 2 and below** and **Grade 3 and above**, this explains the N/A values in the above table for 2012 to 2014.

Year on Year Comparison – In-*Hospital Acquired*

Reporting Period	2012-13	2013-14	2014-15	2015-16	2016-17
Grade 1	N/A	N/A	114	78	**33**
Grade 2	317	343	326	258	**88**
Grade 3	25	25	18	12	**6**
Grade 4	N/A	N/A	2	1	**1**
Total	**342**	**368**	**460**	**349**	**128**

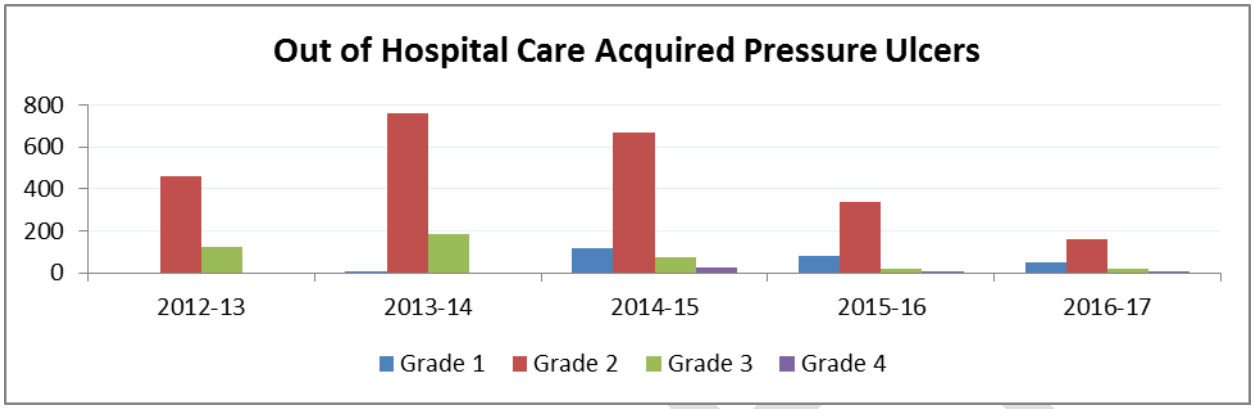
*Data obtained via the Trusts Incident Reporting database (Datix) data as of end of January 2017



Year on Year Comparison – Out of Hospital *Acquired*

Reporting Period	2012-13	2013-14	2014-15	2015-16	2016-17
Grade 1	N/A	3	118	83	**57**
Grade 2	458	759	667	337	**204**
Grade 3	124	187	74	21	**27**
Grade 4	N/A	N/A	25	8	**5**
Total	**582**	**949**	**884**	**449**	**293**

*Data obtained via the Trusts Incident Reporting database (Datix) data as of end of January 2017



Actions taken by the Trust:

In 2016 the Trust participated in a regional collaborative pressure ulcer improvement project, with two wards participating; the aim being to rollout improvement actions to all areas. Part of the project involved using the hand symbol from the SSKIN (surface inspection, skin inspection, keep moving, incontinence and nutrition) bundle as a visual reminder of patients who are at risk and require appropriate position changes and assessment. This collaborative project is planned to roll over to a second year and is being led by the Academic Health Sciences Network. The aim of the project is to reduce avoidable pressure ulcers to zero.

Communication between services continues to be promoted in order that seamless holistic care can be achieved when patients move between hospital and community. A key element of this is ensuring wound care information is passed onto the next care provider.

A weekly review panel discusses all incidents of skin damage and agrees which of them require reporting through the Serious Incident Framework. Reports on these cases are presented to the Serious Untoward Incident panel prior to submission to commissioners. Learning from incidents is shared via directorate meetings and newsletters.

The Integrated Professional Board continue to oversee the Tissue Viability Operational Group which has the remit of reviewing the Trust action plan and Trust policies and guidelines to pursue continuous improvement in performance. The Tissue Viability Operational group has been renamed from the Pressure Ulcer Operational Group to correctly reflect that all skin damage is considered by the Trust, not just that caused by pressure.

Monthly pressure ulcer prevalence reports are compiled via the NHS Safety Thermometer, along with larger scale pressure ulcer prevalence audits which are conducted across all areas, as a minimum, on an annual basis.

After a successful pilot of an updated pressure ulcer prevention care bundle, the updated care bundle will be rolled out from April 2017. The care bundle has been extensively trialled with valuable feedback obtained from the pilot areas. Use of this care bundle in this Trust and others has proven to reduce the numbers of pressure ulcers occurring. The updated version reinforces the Registered Nurses responsibility for setting the frequency of care delivery for that patient.

The Tissue Viability team continue to deliver the Trust's "Shining the light on skin integrity" training. This is an intensive training afternoon presented by internal and external speakers. The training is very clinically focused and the feedback from the attendees is always very good indeed. The Trust continue to offer this training to local care and nursing home staff to help prevent pressure ulcers in the wider health community.

The Tissue Viability team, with the help of departmental staff and managers, maintain a network of link workers – Tissue Viability Champions. The Champions meet bi-monthly for updates on wound care and all matters related to tissue viability. This meeting is well attended and the training topics at the meetings are chosen by the Champions themselves and delivered by either the Tissue Viability team or colleagues from the wound care industry.

The Trust is involved in a regional, NHS England led, project on leading change, adding value, improving wound care. There are 2 main work streams in this project which focus on improving leg ulcer treatment and educational competencies in wound care assessment. This project aims to contribute towards achievement of CQUIN targets related to wound assessment.

A new carers and relatives patient information leaflet has been developed to give information on skin damage and care of skin. Delivering information to carers and relatives is vital to promote skin health.

The Trust once again this year participated in the regional "Stop the pressure" conference. A regional event was held at Sunderland Football Stadium and staff from the Trust attended to partake the conference which related to pressure ulcers and their prevention. To support the regional study day local information stands were set up throughout the trust on Stop the Pressure week. The pledge board was once again very popular with staff from across the Trust giving their pledges on what they will do throughout the year to continue to reduce avoidable pressure ulcers.

Section 3c: 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.

Monitor Compliance Framework Indicators	2016-17 Target	2016-17 Performance	2015-16 Performance	Achieved (cumulative)
Clostridium Difficile – meeting the C.Diff objective	13	35	36	✘
MRSA - meeting the MRSA objective	0	1	2	✘
Cancer 31 day wait for second or subsequent treatment – surgery (Apr 16 to Feb 17)	94%	98.20%	100.00%	✔
Cancer 31 day wait for second or subsequent treatment – anti cancer drug treatments (Apr 16 to Feb 17)	98%	99.80%	100%	✔
Cancer 31 day wait for second or subsequent treatment – radiotherapy	94%	N/A	N/A	N/A
Cancer 62 Day Waits for first treatment (urgent GP referral for suspected cancer) (Apr 16 to Feb 17)	85%	85.40%	82.19%	✔
Cancer 62 Day Waits for first treatment (from NHS cancer screening service referral) (Apr 16 to Feb 17)	90%	97.60%	96.43%	✔
Cancer 31 day wait from diagnosis to first treatment (Apr 16 to Feb 17)	96%	99.70%	99.04%	✔
Cancer 2 week wait from referral to date first seen, all urgent referrals (cancer suspected) (Apr 16 to Feb 17)	93%	94.30%	93.03%	✔
Cancer 2 week wait from referral to date first seen, symptomatic breast patients (cancer not initially suspected) (Apr 16 to Feb 17)	93%	97.00%	93.61%	✔
Maximum time of 18 weeks from point of referral to treatment in aggregate, admitted patients (April 16 to Feb 17)		85.15%	79.25%	
Maximum time of 18 weeks from point of referral to treatment in aggregate, non-admitted patients (April 16 to Feb 17)		96.28%	97.19%	

Maximum time of 18 weeks from point of referral to treatment in aggregate, patients on incomplete pathways (April 16 to Feb 17)	92%	92.68%	92.21%	✔
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge (April 16 to Feb 17)	95%	94.01%	94.60%	✘
Community care data completeness - referral to treatment information completeness (Feb 17)	50%	97.44%	95.38%	✔
Community care data completeness - referral information completeness (Jan 17)	50%	97.44%	93.40%	✔
Community care data completeness - activity information completeness (Jan 17)	50%	94.70%	93.66%	✔
Community care data completeness - patient identifier information completeness (Shadow Monitoring) (Jan 17)	50%	94.74%	93.66%	✔
Community care data completeness - End of life patients deaths at home information completeness (Shadow Monitoring) (Jan 17)	50%	89.81%	88.64%	✔
Compliance with access to healthcare for patients with learning disabilities	100%	Full compliance	Full compliance	✔
Other National and Contract Indicators		**2016-17 Performance**	**2015-16 Performance**	**Achieved**
Cancelled Procedures for non-medical reasons on the day of op (April 16 to Feb 17)	0.80%	0.57%	0.44%	✔
Cancelled Procedures reappointed within 28 days (Apr 16 – Feb 17)	100%	99.05%	96.91%	✘
Eliminating Mixed Sex Accommodation (Apr 16 – Feb 17)	Zero cases	0	0	✔
A&E Trolley waits > 12 hours (Apr 16 – Feb 17)	Zero cases	0	0	✔
Choose and Book slot issues (Dec 15)	<4%	2.30%	No data	✔
Stroke - 90% of time on dedicated Stroke unit (Apr 16 – Jan 17)	80%	90.72%	87%	✔
Stroke - TIA assessment within 24 hours (Apr 16 – Jan 17)	75%	85.39%	82%	✔
Delayed transfers of care (Apr 16 – Feb 17)	<3.5%	4.17%	1.63%	✘
Breast Feeding at Delivery (Apr – Feb 17)	>=50%	48.48%	49.36%	✘
Number of Diagnostic waiters over 6 weeks (Apr 16 – Feb 17)	99%	99.36%	99.65%	✔
Retinal Screening - offered an appointment within 48 hours (Feb 17)	95%	99.50%	92.91%	✔
VTE Risk Assessment (Apr 16 - Feb 17)	95%	97.04%	95.57%	✔
Health Visitor Numbers (Feb 17)	73.49	66.17	68.49	✘

* Retinal Screening can have more than 1 offer per patient; therefore can be greater than 100%

Additional Assurance:

The following indicators have been subject to assurance by the independent auditors PricewaterhouseCoopers:

Further assurance indicators	Definition
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period ("incomplete pathways indicator"	The Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report: • The indicator is expressed as a percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period; • The indicator is calculated as the arithmetic average for the monthly reported performance indicators for April 2016 to March 2017; • The clock start date is defined as the date that the referral is received by the Foundation Trust, meeting the criteria set out by the Department of Health guidance; and The indicator includes only referrals for consultant-led service, and meeting the definition of the service whereby a consultant retains overall clinical responsibility for the service, team or treatment.
Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge ("4 hour A&E waiting times indicator	The Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report: • The indicator is defined within the technical definitions that accompany *Everyone counts: planning for patients 2014-15 – 2018*-19 and can be found at www.england.nhs.uk/wp-content/uploads/2014/01/ec-tech-def-1415-1819.pdf • Detailed rules and guidance for measuring A&E attendances and emergency admissions can be found at https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/03/AE-Attendances-Emergency-Definitions-v2.0-Final.pdf

Annex A: Third party declarations

We have invited comments from our key stakeholders. Third party declarations from key groups are outlined below:

Statement from NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group (HAST) and Durham, Dales, Easington and Sedgefield (DDES) Clinical Commissioning Group, for North Tees and Hartlepool Hospital NHS Foundation Trust (NTHFT) Quality Account

Hartlepool Healthwatch –

Stockton Healthwatch –

Statement from Adult Services and Health Select Committee, Stockton-on-Tees –

The Trusts Council of Governors –

Hartlepool Borough Council - Audit and Governance Committee –

Healthcare User Group (HUG) –

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.

Monitor 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 2015-16* 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 2016 to April 2017
  - papers relating to Quality reported to the Board over the period April 2016 to May 2017
  - feedback from commissioners dated *xxxxx*
  - feedback from governors dated xxxxx
  - feedback from local Healthwatch organisations dated *xxxx*
  - feedback from Overview and Scrutiny Committee dated *xxxxx*
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated *Q3 2016-17*
  - the latest national patient survey *2016*
  - the latest national staff survey *2017*
  - the Head of Internal Audit's annual opinion over the trust's control environment dated *April 2017*
  - CQC Quality Report – Inspection Report 03/02/2016

  - 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 Monitor's annual reporting guidance (which incorporates the Quality Accounts Regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the quality report (available at www.monitor.gov.uk/annualreportingmanual).

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
NB: sign and date in any colour ink except black

Date..... Date.....

Chief Executive..... Chairman.....

Annex C

Independent Auditors' Limited Assurance Report to the Council of Governors of North Tees and Hartlepool NHS Foundation Trust on the Annual Quality Report

[awaiting report]

Annex D

We would like to hear your views on our Quality Accounts.

North Tees & Hartlepool NHS Foundation Trust value your feedback on the content of this year's Quality Account.

Please fill in the feedback form below, tear it off and return to us at the following address:

Patient Experience Team
North Tees & Hartlepool NHS Foundation Trust
Hardwick Road
Stockton-on-Tees
Cleveland
TS19 8PE

.....

Thank you for your time.

Feedback Form (please circle all answers that are applicable to you)

What best describes you: Patient Carer Member of public Staff Other

Did you find the Quality Account easy to read?	Yes	No	
Did you find the content easy to understand?	Yes all of it	Most of it	None of it
Did the content make sense to you?	Yes all of it	Most of it	None of it
Did you feel the content was relevant to you?	Yes all of it	Most of it	None of it
Would the content encourage you to use our hospital?	Yes all of it	Most of it	None of it
Did the content increase your confidence in the services we provide?	Yes all of it	Most of it	None of it

Are there any subjects/topics that you would like to see included in next year's Quality Account?
.....
.....
.....
.....
.....
.....
.....

In your Opinion, how could we improve Our Quality Account?
.....
.....
.....
.....
.....
.....
.....
.....

Alternatively you can email us at: **Patientexperience@nth.nhs.uk** With the Subject **Quality Accounts**

Glossary

A&E	Accident and Emergency
ACE Committee	Audit and Clinical Effectiveness Committee – the committee that oversees both clinical audit (i.e. monitoring compliance with agreed standards of care) and clinical effectiveness (i.e. ensuring clinical services implement the most up-to-date clinical guidelines)
ACL	Anterior Cruciate Ligament – one of the four major ligaments of the knee
AMT	Abbreviated Mental Test
AquA	Advancing Quality Alliance
CABG	Coronary Artery Bypass Graft (or "heart bypass")
CFDP	Care For the Dying Patient
CCG	Clinical Commissioning Group
CDI	Clostridium difficile Infection
CHKS	Comparative Health Knowledge System
Clostridium Difficile (infection)	An infection sometimes caused as a result of taking certain antibiotics for other health conditions. It is easily spread and can be acquired in the community and in hospital
CLRN	Comprehensive Local Research Network
COPD	Chronic Obstructive Pulmonary Disease
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
DLT	Discharge Liaison Team
DoLS	Deprivation of Liberty Safeguards
DVLA	Driver and Vehicle Licensing Agency
EAU	Emergency Assessment Unit
E coli (infection)	Escherichia coli – An infection sometimes caused as a result of poor hygiene or hand-washing
EMSA	Eliminating mixed sex accommodation
EOL	End of Life

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
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
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
HES	Hospital Episode Statistics
HMB	Heavy Menstrual Bleeding
HQIP	Healthcare Quality Improvement Partnership
HRG	Healthcare Resource Group – a group of clinically similar treatments and care that require similar levels of healthcare resource
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
HUG	Healthcare User Group
IBD	Inflammatory Bowel Disease
ICNARC	Intensive Care National Audit and Research Centre
ICS	Intensive Care Society
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
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

Kardex (prescribing kardex)	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
LAC	Looked After Children
LD	Learning disabilities
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
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK
MCA	Mental Capacity Act
MHA	Mental Health Act
MHRA	Medicines and Healthcare products Regulatory Agency
MIU	Minor Injuries Unit
MINAP	The Myocardial Ischaemia National Audit Project
Monitor	The independent regulator of NHS foundation trusts
MRSA	Methicillin-Resistant Staphylococcus Aureus - a type of bacterial infection that is resistant to a number of widely used antibiotics
MUST	Malnutrition Universal Screening Tool
NCEPOD	The National Confidential Enquiry into Patient Outcome and Death
NCRN	National Cancer Research Network
NEEP	North East Escalation Plan
NEPHO	North East Public Health Observatory
NEQOS	North East Quality Observatory System
NEWS	National Early Warning Score
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
NTHFT	North Tees and Hartlepool Foundation Trust
OFSTED	The Office for Standards in Education
PALS	Patient Advice and Liaison Service
PAS	Patient Administration System
Patient Safety and Quality Standards (Ps&Qs) Committee	The committee responsible for ensuring provision of high quality care and identifying areas of risk requiring corrective action
PICANet	Paediatric Intensive Care Audit Network
PREVENT	the government's counter-terrorism strategy
PROMs	Patient Reported Outcome Measures
Pseudonymisation	A process where patient identifiable information is removed from data held by the Trust

R&D	Research and Development
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
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
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
SPEQS	Staff, Patient Experience and Quality Standards
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
TRAKCARE	Electronic Patient Record System
Tough-books	Piloted in 2010, these 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
UHH	University Hospital of Hartlepool
UNIFY	Unify2 is an online collection system used for collating, sharing and reporting NHS and social care data.

UHNT	University Hospital of North Tees
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