Middlesbrough
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Legal and Governance

HEALTH SCRUTINY PANEL

Date: **Monday 19th June, 2023**
Time: **4.00 pm**
Venue: **Mandela Room, Town Hall, Middlesbrough**

AGENDA

1. Apologies for Absence

2. Declarations of Interest

3. Minutes - Health Scrutiny Panel - 21 March 2023 — 3 - 6

4. South Tees NHS Foundation Trust - Quality Account for 2022/2023 — 7 - 88

   Dr Hilary Lloyd, Chief Nurse and Dr Mithilesh Lal, Associate Medical Director will be in attendance to present South Tees NHS Foundation Trust's draft Quality Account for 2022/2023.

5. Any other urgent items which in the opinion of the Chair, may be considered.

Charlotte Benjamin
Director of Legal and Governance Services

Town Hall
Middlesbrough
Friday 9 June 2023

MEMBERSHIP

Councillors J Banks (Chair), M Storey (Vice-Chair), C Cooper, D Coupe, P Gavigan, D Jackson, D Jones, J Kabuye and J Rostron

Assistance in accessing information

Should you have any queries on accessing the Agenda and associated information please contact Georgina Moore, 01642 729711, georgina_moore@middlesbrough.gov.uk

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HEALTH SCRUTINY PANEL

A meeting of the Health Scrutiny Panel was held on Tuesday 21 March 2023.

PRESENT: Councillors D Jones (Chair), A Bell, T Mawston, D Rooney and M Storey

ALSO IN ATTENDANCE: D Smith (Chief Executive of Teesside Hospice)

OFFICERS: S Bonner

APOLOGIES FOR ABSENCE: Councillors C McIntyre, D Davison, A Hellaoui and P Storey

21/147 **DECLARATIONS OF INTEREST**

There were no declarations of interest received at this point in the meeting.

21/148 **MINUTES - HEALTH SCRUTINY PANEL - 17 JANUARY 2023**

The minutes of the Health Scrutiny Panel meeting held on 17 January 2023 were submitted and approved as a correct record.

21/149 **TEESSIDE HOSPICE - AN UPDATE**

The Chair welcomed the Chief Executive of Teesside Hospice to the meeting and invited him to make his presentation.

During the presentation it was explained the Chief Executive had been in post for four years and would have attended more Health Scrutiny Panel meetings, but Covid-19 had prevented that. The hospice had been set up approximately 44 years ago, with the intention of providing end of life care, something the NHS had not catered for at the time.

It was increasingly the case that, due to improvements to health care generally, people had complex illnesses requiring more specialist care. That was borne in mind when the hospice was created. It was seen as an ambitious project at the time.

Palliative medicine had become a speciality, but that was not well known. The hospice offered four core services and had 10 specialist beds, which were the only ones in the area. It was commented that James Cook University Hospital depended on the hospice with teams at both sites being fully integrated. That meant the In-Patient unit benefitted from a range of medical professionals.

The In-Patient Service had three general areas:

1. End of Life - for patients who chose to die at the hospice and could have multiple and complex illnesses. Patients on the unit took an unknown time to die.
2. Pain Management - delivered by specialists, as the drugs used had to be controlled.
3. Psychosocial and Spiritual Management - issues that could not be dealt with via generalist means.

It was the In-Patient Service that the hospice was best known for.

The hospice also had a Wellbeing Centre, which focussed on mental health needs and was often seen as a day service. The service provided techniques that could be administered to someone with other illnesses.

The hospice also offered a Lymphedema Unit, which provided pain management and treatments for those suffering from lymphedemas. The unit saw 594 referrals in 2022.

The final service was the Bereavement Counselling Service, which was described as much

more than a shoulder to cry on. Grief after death was not a mental illness and as such the service allowed people to deal with grief after the death of a loved one. Within the Bereavement Counselling Service there was a specialised counselling service for children. While that was a smaller service, it had a longer-term impact.

The hospice had 168 paid staff members which included back-office staff. The hospice was regulated by the CQC to the same standards as James Cook University Hospital, which was challenging. However, the hospice was capable of meeting that challenge.

The hospice also relied on volunteers particularly around retail and fundraisers.

The overall vision for the hospice was to not allow people to die scared and alone. Teesside Hospice was the only hospice in Middlesbrough.

The hospice was previously funded via grants, which were not reviewed in line with inflationary increases. The Covid-19 Pandemic showed there was a financial cliff-edge that had resulted in a transformation team being established, which had limited results.

The hospice was in a difficult position financially. The Health and Care Act, and its related statutory guidance, stated that palliative care should be a commissioned service as with other hospital services. It was commented there had been a change in service expectation by users. It was also recognised that an open conversation needed to take place between the hospice sector and Integrated Care Boards to ensure services received an appropriate level of funding.

The Chair thanked the Chief Executive of Teesside Hospice for their report and invited questions from Members.

A Member queried how many beds the hospice had, other than the 10 specialist beds. It was clarified that the hospice only had 10 beds. Without the hospice, those bed spaces would have needed to be in a hospital with the cost being between £900 and £1000 per day. It was also commented that the hospice was seen as a luxury but should be seen as an essential service.

A Member commented that the services offered by the hospice went beyond care, citing the example of a wedding being arranged for a patient. It was noted that despite the nature of the service the hospice could be a happy place.

A Member queried what funding was made available to the hospice. It was confirmed Teesside Hospice had access to approximately half of the funds it required. It was also queried if a lack of adequate funding would have an impact on other NHS services and if there was a noticeable trend in demand for services. It was confirmed that service demand was steady but there were more young people receiving care.

It was advised that the hospice was receiving an increase in patients requiring counselling, possibly owing to the Covid-19 pandemic. Grief counselling for young people was a unique service to Teesside Hospice and it was noted that mental health services struggled to recruit to specialist posts and the hospice complemented TEWV and CAHMs services.

It was confirmed the Government had not provided a definitive answer to how hospices would be funded. A discussion took place about the need for a full discussion to be held between the Integrated Care Boards and the hospice sector regarding financing.

It was commented that when the Integrated Care Boards were created, they covered a large geographic footprint which was raised as a concern at the time. It was queried whether that had impacted on the hospice sector. It was noted the Integrated Care Board system was complex and while the hospice sector sent representatives there had been no resolution about funding.

Members agreed that a full discussion was required between the Integrated Care Boards and the hospice sector.

The Chair thanked the Chief Executive of Teesside Hospice for their attendance.

ORDERED:

1. **That the Integrated Care Board be invited to a future meeting of Health Scrutiny Panel to provide input on funding for the hospice sector and;**
2. **That the information presented be noted.**

21/150 **STAKEHOLDER BRIEFING: NHS INTEGRATED URGENT CARE IN MIDDLESBROUGH AND REDCAR & CLEVELAND**

The Chair advised Members that a stakeholder briefing had been circulated, advising of an update regarding investment in urgent care services in Middlesbrough and Redcar and Cleveland.

The briefing pointed out that following a patient engagement survey, 83% of respondents were in favour of the introduction of the Integrated Urgent Care model at James Cook hospital as well as the extension of opening hours of the Redcar Primary Care Hospital's Urgent Treatment Centre.

Members were asked to note the briefing from the Integrated Care Board.

NOTED

21/151 **CHAIR'S OSB UPDATE**

The Chair advised that at the previous meeting of the Overview and Scrutiny Board, held on 22 February 2023, the Board had considered:

- the Executive Forward Work Programme;
- the Corporate Performance Update for Quarter Three 2022-2023;
- the Revenue and Capital Budget Projected Outturn Position for Quarter Three 2022/23;
- the Children's Finance Improvement Plan;
- the Statutory Finance Report;
- the Mayoral Budget Proposals 2023/24, Medium Term Financial Plan and Investment Strategy, including the outcome of the consultation;
- the Final Report of the Children and Young People's Learning Scrutiny Panel on Youth Offending and Partnership Working with Schools;
- the Final Report of the Culture and Communities Scrutiny Panel on Off Road Bikes; and
- updates from the Scrutiny Chairs.

NOTED

21/152 **ANY OTHER URGENT ITEMS WHICH IN THE OPINION OF THE CHAIR, MAY BE CONSIDERED.**

None.

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South Tees Hospitals
NHS Foundation Trust

Quality Account 2022/2023

June 2023

PART ONE - Statement on quality from the Chief Executive

PART TWO - Priorities for improvement, statements of assurance from the Board and reporting against core indicators

2.1 Priorities for improvement

a. **Review of progress with the quality priorities defined for improvement in 2022-23**

Patient safety quality priorities

1. Safety Culture
2. Pressure Damage
3. Clostridioides Difficile

Clinical effectiveness quality priorities

1. Clinical Audit
2. NICE

Patient experience quality priorities

1. Safe and Effective Discharge
2. Nutrition and Hydration
3. Patient Feedback

b. **Quality priorities defined for improvement in 2023-24**

2.2 Statements of assurance from the Board

Relevant health services
National clinical audits and national confidential enquiries
Local audits
Research
Use of the CQUIN Payment Framework
Care Quality Commission registration, reviews and investigations
Submission of records to the Secondary Uses Service
Information governance grading
Clinical coding audit
Data quality
Learning from deaths

2.3 Reporting against core indicators

Preventing people from dying prematurely
Summary Hospital Level Mortality Indicator
PROMS
Readmission within 28 days
National inpatient survey
Staff FFT
VTE
Clostridioides *difficile*
Patient safety incidents
Patient FFT

PART THREE – Overview of quality of care, and performance indicators

3.1 South Tees Accreditation for Quality of Care (STAQC)

3.2 Patient safety indicators

1. Safeguarding / Mental Capacity Act / LD
2. Falls
3. Duty of candour
4. Maternity

3.3 Clinical effectiveness indicators

1. Clinical Research
2. Consent
3. Getting It Right First Time and quality surveillance

3.4 Patient Experience Indicators

1. Patient involvement work on strategy and policy
2. Patient surveys – national/local
3. Accessible Information Standard and patient information work

3.5 Performance against key national priorities

Referral to Treatment
A&E 4 hour wait.
Cancer 62 day wait for first treatment.
Clostridioides *difficile* variance from plan (also included in section 2)
Summary Hospital Level Mortality Indicator (also included in section 2.3)
6-week wait for diagnostic tests
Venous thromboembolism risk assessment (also included in section 2.3)

3.6 Additional required information

Seven-day services
Freedom to speak up
Rota gaps for doctors in training

Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

Annex 2: Statement of directors' responsibilities for the quality report

Glossary

1. Statement on quality from the chief executive of the NHS foundation trust

I am pleased to introduce the 2022/23 Quality Report as Chief Executive of South Tees Hospitals NHS Foundation Trust.

As a clinically led organisation the safety and wellbeing of our patients, service users and colleagues - underpinned by our commitment to clinical research, innovation and training - is at the heart of our mission.

Our clinicians lead by the way they manage our limited resources and deliver safe, quality care across our hospitals and services – aided by the experience, professionalism and skills that exist across our clinical and support areas.

In May 2023, South Tees Hospitals NHS Foundation Trust became one of the first acute hospital trusts in England since the start of the COVID-19 pandemic in 2020, to achieve a rating improvement to 'Good' from the Care Quality Commission (CQC) for the care delivered to patients and service users.

In an endorsement of the trust's improvement journey since its last full inspection in 2019, inspectors also upgraded our rating for leadership at the organisation to 'Good'. When the CQC inspects hospital trusts, the care regulator also reviews whether they are safe, caring, effective and responsive to people's needs, and the trust achieved an overall 'Good' rating in each area.

Over the last three years, our experienced clinicians have laid the foundations of a trust where safety and quality are put first, where colleagues feel empowered to make improvements for their patients and service users, where limited funding is used to invest in the things that experienced clinicians agree will make the biggest difference for the people we serve, and where influence to make positive changes beyond hospital walls is being exercised.

But these are only the foundations of larger change. Our commitment to leading-edge clinical research, education, training and innovation – with the needs of our patients, service users and colleagues at the centre – is at the heart of this next phase of our clinically-led journey.

In parallel, our decision in 2023 to come together with North Tees and Hartlepool NHS Foundation Trust to form a hospital group will support both organisations' shared goals for our patients, service users and colleagues by formalising the way we already work together in the interests of the people and communities we have the privilege to serve.

To the best of my knowledge, the information contained in this Quality Account is accurate.

Sue Page CBE
Chief Executive

2. Priorities for improvement and statements of assurance from the Board

2.1 Priorities for improvement

a. Review of progress with the quality priorities defined for improvement in 2022-23

The quality account provides an opportunity for the Trust to reflect on its achievements over the last 12 months. This includes a look back at the progress made against the quality priorities for 2022/23 that were defined in the 2021/22 Quality Account and summarised in the table below.

Quality priorities for improvement in 2022/23		
Patient Safety	**Clinical Effectiveness**	**Patient Experience**
1. To ensure there is a positive safety culture within the organisation in which openness, fairness, accountability and learning from high levels of incident reporting is embedded.	1. To review and revise our processes for Clinical Audit to facilitate effective and evidence based clinical care for our patients.	1. To ensure that patients, their relatives, and carers will have the best experience possible in relation to a planned, safe and effective discharge from our hospitals.
2. To ensure the care that we provide to our patients is safe, and of the highest possible standard by reducing pressure damage.	2. To review and revise our processes for NICE (National Institute for Health and Care Excellence) in order to facilitate effective and evidence based clinical care for our patients.	2. To ensure all patients have their nutrition and hydration needs met.
3. To reduce the risk of Clostridioides *difficile* infection for inpatients.		3. To ensure that we have effective ways of receiving feedback from our patients, their relatives and carers which will lead to demonstrable improvements in practice.

Our ambition for improvement, agreed actions, aims and progress at the end of 2022/23 for each quality priority are detailed below.

Patient safety quality priorities

1. Positive safety culture

We planned to implement and embed all elements of the action plan developed from the thematic review undertaken in 2021 of 'never events' (incidents that should be avoidable if preventative measures have been implemented). This will ensure that there are effective and proactive processes and systems in place to facilitate effective system-based learning and improvements across the organisation.

We agreed to:

- Work with our Patient Safety Ambassadors and Patient Safety Specialists to understand current skills, capability and capacity within the organisation.

- Convene a Working Group by the end of quarter 1 to ensure that all relevant areas of the Trust are involved in the implementation of the action plan.
- Ensure the safety sections of our recently published NHS Staff Survey results are reviewed and discussed, and agree actions needed to improve the patient safety culture.

We aimed to:

1. Achieve a continued reduction in the number of never events occurring within the Trust.
2. Monitor staff survey results and other safety culture assessment tools, and specifically to achieve an improvement in the following staff survey questions:
    - ‘I would feel secure raising concerns about unsafe clinical practice’ (Q17a) from 76.9% in 2021 to above 80% in 2022/23.
    - ‘I am confident that my organisation would address my concern’ (Q17b) from 60.7% in 2021, to above 65% in in 2022/23.

<u>End of year progress</u>

During 2022/23, progress has been made against the recommendations identified within the thematic review of never events. The NHS published the national Patient Safety Incident Response Framework (PSIRF) documents in August 2022, which inform the infrastructure of how future patient safety incidents are identified for investigation, learning and improvement. A task and finish group was convened at South Tees to begin the preparations for implementation of the new framework, and the transition away from the previous Serious Incident Framework (2015). The Trust has 12 months to implement the PSIRF and is now in the third ‘Governance and quality monitoring’’ phase of the implementation journey, where sound processes will be developed to determine how the Trust will respond to patient safety incidents as they arise.

A Patient Safety/Patient Experience Workstream Group is meeting regularly to identify and deliver the activities and practices required to implement a restorative, just and learning culture across the Trust. This approach supports consistent, fair and restorative responses to our staff, patients, their families and carers following their involvement in patient safety, patient experience or safeguarding incidents.

The Trust has been successful in its bid for funding from the Academic Health Sciences Network in relation to developing restorative and compassionate responses to harmed patients, their relatives and staff involved in patient safety incidents. This is to enable the Trust to provide effective and tailored support to meet individual needs. With the funding, the Trust has commissioned two cohorts of accredited Restorative Practice Facilitator training for April and June 2023 which will help to shape the organisation’s responses to patient safety incidents and complaints.

A task and finish group has continued to meet to plan the implementation of a Peer Support Programme for staff involved in adverse or traumatic incidents. A framework has been developed and part of the funding described above was planned to fund an administrative post for this service.

A further cohort of Family Liaison Officer (FLO) training was completed in March 2023, with another planned in June 2023, to ensure the Trust can continue to provide compassionate engagement to patients and their families. Patients and relatives are now routinely involved in patient safety incident investigations and review draft investigation reports until they are satisfied that the report reflects all perspectives and that it is written with the patient and/or family as the primary audience.

Work has progressed within the Trust in relation to locally derived safety standards which apply to invasive procedures (LocSSIP). The Medical Director is the Executive Sponsor for LocSSIP compliance, and the LocSSIP project team is resourced to ensure the effective implementation and ongoing audit programme of LocSSIPs is supported and standards of practice are sustained. An electronic share point on the Trust intranet has been created for staff to access patient safety learning from incidents, which over the coming year will be extended to include learning from inquests, claims, safeguarding and complaints.

The Staff Survey 2022 showed that the Trust ranked third highest (74%) in the region in terms of responses to Q17a 'I would feel secure raising concerns about unsafe clinical practice'. All Trusts in the region experienced a reduction in the number of their staff who agreed with this question during the most recent survey, however the Trust's reduction was the smallest and number of staff agreeing remained well above regional and national average. Similarly, the responses to Q17b 'I am confident that my organisation would address my concern' also saw a region-wide reduction.

Summary

There has been much progress made in relation to facilitating effective system-based learning and improvements across the organisation. However, we have not achieved the outcomes we had hoped for and therefore this quality priority will be revised and carried over; work will continue during 2023/24 to complete the remaining recommendations in order to achieve demonstrable improvement in safety measurements.

2. Skin care and reducing pressure damage.

It is important that all pressure ulcers are recognised as patient safety incidents and reported accordingly. Any pressure ulcer that meets, or potentially meets, the threshold of a serious incident should be thoroughly investigated to ensure any issues in care are identified, understood and resolved to prevent the likelihood of future recurrence. This requires an assessment of whether any acts of omission may have led to the pressure ulcer developing.

It is essential to maintain this level of scrutiny as the investigation process transitions to the national Patient Safety Incident Response Framework (PSIRF). This will bring significant changes to how patient safety processes will look and feel in future and the approach that is taken for pressure ulcer investigations. The focus will be on reviewing themes that emerge to focus organisational learning and subsequent improvement. The Pressure Ulcer Improvement Group will continue to learn and reduce the incidence of avoidable category 3 and 4 pressure ulcers in order to have a positive impact on patients who are most at risk.

We agreed to:

- Ensure staff are appropriately knowledgeable in pressure ulcer prevention.
- Continue the Pressure Ulcer Improvement Group to ensure a strategic approach is taken to pressure damage prevention.
- Implement 'PURPOSE-T' as a pressure ulcer risk assessment framework and audit the impact of this.

We aimed to:

- Monitor the frequency of staff training relating to pressure ulcer prevention and increase if necessary.
- Reduce category 3 and 4 pressure ulcers, and serious incidents, complaints, inquests and claims relating to pressure ulcers.

- Gather category 3 and 4 pressure ulcer data by acute and community setting and identify those which are new and avoidable and attributed to the Trust.
- Identify learning through themed analysis of pressure ulcer investigations.
- Submit an overarching Pressure Ulcer Improvement Plan to Tees Valley Clinical Commissioning Group (TVCCG) rather than individual action plans.

End of year progress

A tissue viability action plan was developed to define and monitor improvements in pressure ulcer prevention and management within the organisation. Members of the Pressure Ulcer Improvement Group continue to meet monthly to track delivery and progress of actions. This has been further developed following an agreement to submit to TVCCG to highlight any organisational learning.

PURPOSE-T is a pressure ulcer risk assessment that consists of three steps: screening, full assessment, and assessment stratification. It has been introduced at South Tees to the acute hospitals, launched via our digital clinical data platform Patientrack, and is being embedded within community services.

An assessment is scheduled for all patients on admission and the tool supports decision making through a standardised list of preventative actions. Patients at risk, or who already have a pressure ulcer, are highlighted and this information is visible at patient, ward and organisation level. The functionality also allows visibility of any outstanding assessments and interventions.

Over the last quarter of 2022/23, training and education took place in both our community hospitals, on Tocketts and Zetland wards. Tocketts ward introduced PURPOSE-T with success in March 2023 and have subsequently gone digital, completing the risk assessments on Patientrack. A planned go-live date has been identified for Zetland ward.

The related SSKIN care plan for pressure ulcer prevention has also been digitalised. This requires a full holistic assessment, including of the patient's skin by a registered nurse at prescribed intervals. The prescribed care can then be delivered by non-registered staff.

At the time of reporting 91% of all registered nurses have received ward-based education on PURPOSE-T and 89% on the SSKIN care plan. Compliance in training for non-registered nurses has increased to 87%. Multiple videos have been created to support the delivery of education with a high uptake from clinical staff. It has also been agreed for tissue viability training to become mandatory for some staff roles and this will be enacted during 2023/24.

During 2022/23 there has been a reduction in reported serious incidents related to pressure ulcers. There is focused work related to pressure ulcer reporting within community services. Currently pressure ulcers are reported in terms of 'count' which is not contextualised in relation to patient population. It is the intention to capture reported pressure ulcers in relation to local case load so that pressure ulcer prevalence is monitored proportionality and reflective of increase in case load.

As the Trust transitions to PSIRF the Pressure Ulcer Review Panel will take place once a week. Each patient with a category 3 or 4 pressure ulcer, deep tissue or unstageable skin damage will be discussed, and any themes identified. The aim is to ensure a system-based approach to learning from patient safety incidents, with a considered and proportionate response, supportive oversight, and improvement.

In addition to this, the tissue viability (TVN) team now offer weekly clinical supervision to staff in the community collaborative. Further work is required to support engagement with acute colleagues and a flexible approach is required.

The Pressure Ulcer Safety Huddle (PUSH) tool is now incorporated within our incident reporting system DATIX so that a review of care, interventions and management plan can be easily examined. When completed, this allows early identification of any gaps in care by triggering a rapid review safety huddle within the shift that pressure damage is observed on a ward, or within 24 hours in the community.

The TVN team have updated the Web ICE requesting and reporting system to improve the reporting of any new or deteriorating pressure ulcer referrals. This includes the addition of staff prompts which direct them to pressure ulcer prevention and dressings guide, facilitating preventative advice in advance of the TVN assessment.

The Fundamentals of Practice monthly meetings review the pressure ulcer incidence in each collaborative, discussing data for each ward area within the meeting. If a clinical area has had a recent serious incident or themes have been identified, then these are discussed at the meeting. The action plan is reviewed to monitor progress and signed off if actions are completed.

Capacity and demand modelling has been completed which has identified a gap in service provision due to historical commissioning agreements. It was agreed to extend the Band 4 provision to full time hours and to advertise for a Band 8a Tissue Viability Lead. The Tissue Viability Lead is now in post.

Summary

Considerable work has been done during 2022/23 to introduce the PURPOSE-T risk assessment, to digitise the SSKIN care plan, and to embed the PUSH tool within our incident reporting system. Together with staff training, and improvements in the resources available to staff when referring to the TVN team we are confident that the understanding and skills of our staff, and skin care for our patients is improved. The governance processes and the work of the Pressure Ulcer Review Panel and Fundamentals of Practice group are ensuring appropriate review with thematic analysis and actions to ensure learning.

This work will continue in 2023/24 with a focus on pressure ulcer reporting contextualised to patient population, the introduction of tissue viability role specific training, ward level dashboards showing real time data for pressure ulcer risk assessments and replicating clinical supervision forums for acute services that have proven to be effective for the community.

3. Reducing the risk of Clostridioides *difficile* infection for inpatients.

Clostridioides *difficile* infection (CDI) is caused by a type of bacteria and is an important cause of infectious diarrhoea in healthcare settings and in communities. The CDI objective for 2022/23 for South Tees was to have no more than a combined total of 111 community-onset healthcare-associated (COHA) and/or healthcare-onset healthcare-associated (HOHA) cases among patients aged over two years.

The 2021/22 *C. difficile* definitions are as follows:

a. Hospital onset healthcare associated (HOHA): cases detected in the hospital ≥2 days after admission.
b. Community onset healthcare associated (COHA): cases that occur in the community (or within <2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks.

c. Community onset indeterminate association (COIA): cases that occur in the community (or within <2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent 4 weeks.

d. Community onset community associated (COCA): cases that occur in the community (or within <2 days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks.

We aimed for a reduction in the level of CDI in line with national trajectory and agreed to:

- Review, implement and embed all elements of the CDI recovery and action plan learning from the review of 2021/22 in order to improve patient safety and experience.
- Implement and establish the structured review process for all cases of trust assigned CDI.
- Embed the role of dedicated CDI Infection Prevention and Control Nurse (IPCN) and review the impact of the role.
- Update and implement the CDI toolbox training programme with an initial focus on completion in four key priority areas with a full programme offered by the end of 2022/23.
- Implement new assurance audits in relation to the 'focus on five' for CDI in addition to current processes.
- Complete the action plans and CDI recovery plan by the end of 2022/23, ensuring the required standards and good practice are embedded across all clinical areas.

<u>End of year progress</u>

The actions taken during 2022/23 include:

- CDI action plan reviewed for 2022/23 regarding CDI reduction strategy.
- Implementation of the structured review process. This has been strengthened with improved medical and multidisciplinary team (MDT) input.
- Implementation and embedding of the role of the CDI IPCN with a lead IPCN and a deputy to support in their absence.
- A meeting with North Tees and Hartlepool NHS Foundation Trust regarding collaborative working in relation to cleaning and decontamination.
- CDI toolbox teaching which has been reviewed and updated across the year with varying elements and additional changes reflective of current practice. The infection prevention and control (IPC) team and the IPC link practitioners focused this on specific areas initially but have covered all areas of the Trust across the year.
- Increased audit and surveillance in 'hot spots.' This included areas that had any CDI cases, low environmental audit or hand hygiene scores, or increased cases of other infections.
- Implementation of a dedicated cleaning programme. The impact of this was evident at the Friarage Hospital, however due to operational pressures and lifecycle works the implementation of this at JCUH has been disrupted since December. Plans are underway to reintroduce this in 2023/24.
- A 'Focus on Five' campaign in relation to CDI which encompasses the following:

Figure 2: 'Focus on Five' communication campaign information

Summary

Through our robust structured review process, we have identified themes relevant to CDI cases including antimicrobial prescribing, complex patient history and environment.

There will be an ongoing focus on C. *difficile* in 2023/24 to ensure we deliver safe patient care in a suitable environment. We continue to have a clear and detailed CDI plan and will work closely across the ICB and nationally in 2023/24 to review our position and learn from others.

Clinical effectiveness quality priorities

1. Review and revision of clinical audit processes.

We planned to review and implement a Trust-wide approach to clinical audit which is embedded in practice and demonstrates improvement and best practice for our staff and our patients.

We agreed to:

- Have effective systems in place for all elements of the clinical audit and action planning cycle.
- Deliver patient care based on the most up to date evidence and best practice standards.
- Review all level 1, 2, 3 and 4 clinical audits and agree these in the forward plan.
- Have an effective system in place for the reporting and tracking of all clinical audit activity.

We aimed for:

- 100% of relevant clinical audits completed at levels 1.
- 80% of relevant clinical audits completed at levels 2.
- An increase in clinical audits completed at level 3 and 4 against 2021/22 levels.
- 100% of clinical audit action plans completed at levels 1.
- 80% of clinical audit action plans completed at levels 2.
- An increase in clinical audit action plans competed at levels 3 and 4 against 2021/22 levels.

End of year progress

There has been good progress with developing effective systems for the clinical audit and action planning cycle. A Clinical Audit and NICE Operational Group has been established to provide assurance to the Clinical Effectiveness Steering Group (CESG) that there are robust and effective processes in place for national and local clinical audits, NICE guidance and service evaluation. In particular it will ensure:

- The planned participation in national and local audits is effectively prioritised and planned to meet the Trust's objectives and statutory requirements.
- Escalation of non-compliance, delays and risks to CESG and appropriate recording on the Trust's risk register as required.
- Progress updates on national audits, and implementation of action plans for national clinical audits.
- Clinical audits which demonstrate significant risks to the quality of clinical care, and level 1 and 2 clinical audits at risk of non or reduced participation are escalated.
- Horizon scanning for attendance and presenting at local, national and regional events and conferences.

The clinical audit team are in the process of implementing a new digital platform called InPhase. When established, InPhase will integrate audit, incident, patient feedback and performance data and will provide significantly increased quality assurance.

Level 1 clinical audits

The level 1 audits are the national audits, and detailed information regarding participation is included in section 2.2 of this report. In summary, the Trust participated in 92% of national audits it was eligible for, and actions are being taken to resolve any the issues that resulted in non-participation. Once implemented, InPhase will provide visibility of action plans and an improved ability to monitor progress and completion.

Level 2 clinical audits

The level 2 audits include those required to measure compliance with the national Commissioning for Quality and Innovation (CQUIN) scheme, and our locally derived safety standards which apply to invasive procedures (LocSSIP). There are 97 audits in total.

The trust currently has 82 active LocSSIP, 60 of which have been audited. The most recently published will enter a cycle of audit in the coming months.

To facilitate learning within the clinical collaboratives, the results of LocSSIP compliance are included in all Clinical Collaborative Board data packs. The clinical audit team are seeking

evidence of the sharing and discussion of LocSSIP audit results at directorate meetings to ensure learning and improvement where this is required. However, as above we are currently unable to monitor completion of associated action plans.

Level 2 audits	Completion of audits during 2022/23
CQUIN	100%
LocSSIP	73%
Total	77%

Table 1: Percentage of level 2 audits completed during 2022/23

Level 3 and 4 clinical audits

Other clinical audits are reviewed throughout the financial year to provide continued compliance and assurance and there are currently no outstanding risks relating to these. Further work will take place around data and monitoring of level 3 and 4 clinical audits completion and action plans.

Summary

There have been improvements in our processes for clinical audit and action planning cycle, and we achieved 92% participation in level 1 audits (target of 100%), and 77% completion of level 2 audits (target of 80%). These results provide assurance that a significant proportion of patient care is based on the most up to date evidence and best practice standards.

There will be an ongoing focus on improvement work in clinical audit during 2023/24 to ensure we deliver patient care based on the most up to date evidence and best practice standards. A detailed forward plan for clinical audit has been approved, and implementation of InPhase is being prioritised which will improve the visibility and triangulation of data and provide greater assurance.

2. Review and revision of processes for NICE

The National Institute for Health and Care Excellence (NICE) make evidence based, best practice recommendations, publishing quality standards, and guidance that includes NICE guidelines (clinical, social care, public health, medicines practice), technology appraisals, interventional procedures, medical technologies, diagnostics and highly specialised technologies. Implementing these helps to improve patient safety and reduce the risk of harm across the health system.

We planned to review and revise our processes for responding to NICE guidelines and quality standards in order to facilitate effective and evidence based clinical care for our patients.

We agreed to:

- Have an effective system for dissemination, reporting and tracking all NICE activity.
- Review all NICE quality standards to agree relevance and report on levels of compliance.
- Review all NICE guidelines to agree relevance and report on levels of compliance.

We aimed for a 10% increase from 2021/22 compliance with NICE guidelines and quality standards assessed as relevant to the Trust and with good assurance of compliance provided by supporting evidence.

End of year progress

We have had processes in place for disseminating, reporting, and monitoring NICE activity during 2022/23 and the implementation of the Clinical Audit and NICE Operational Group as described above regarding clinical audit has strengthened this. All new guidance is monitored on a weekly basis and any technology appraisals and highly specialist technologies are disseminated at that time. All other new guidance is disseminated at the first opportunity.

We have evidence of compliance in 2022/23 for:

- Technology appraisals (TA) with evidence of full implementation - 85%
- NICE guidelines with evidence of compliance – 43%
- NICE quality standards with evidence of compliance – 78%

We now have NICE guidance available within the InPhase platform. Our NICE Facilitator is responsible for assessing the implementation of NICE guidance and assurance of compliance, working alongside the Clinical Audit Facilitators to ensure alignment of activity in both areas of work and to define robust processes for reporting NICE compliance.

Summary

We have had processes in place for disseminating, reporting, and monitoring NICE activity during 2022/23 and have evidence of compliance with 85% of technology appraisals, 43% of NICE guidelines and 78% of NICE quality standards. The InPhase platform will enable the Trust to monitor and report compliance with NICE evidence-based practice much more effectively in the future and use our existing systems and processes to drive increases in compliance.

Patient experience quality priorities

1. Planned, safe and effective discharge from our hospitals.

Safe and effective discharge from hospital is a complex process that needs to ensure people are discharged to the most appropriate place and continue to receive the care and support they need after they leave hospital. We were aware from the feedback from patients, relatives, carers and community colleagues that we did not always get discharge from hospital right. Using various methods, we planned to undertake improvement work in relation to discharge on a selection of pilot wards across Trust sites, to facilitate an effective, co-designed and patient centred process.

We agreed to:

- Establish a training programme with at least 20 members of discharge staff trained.
- Identify wards or departments to implement new ways of working, as identified in the discharge action plan.
- Work with patients, relatives and carers to understand what matters to them in relation to planning a safe and effective discharge and develop an action plan around these standards.
- Complete the actions by the end of 2022/23 and ensure the standards and good practice were fully embedded and disseminated to other clinical areas.
- Enable patients, relatives and carers to expect consistently high standards of care in relation to their discharge, based on co-designed pathways and initiatives, as set out in the Trust's improvement plan.
- Monitor progress with the quality priority at the Discharge Board.

We aimed for:

- Evidence of learning and/or change in practice from patient feedback and incidents.
- Feedback from the patient experience discharge survey.
- At least 95% of patients over the age of 65 leaving hospital and going straight home or to their usual place of residence either on discharge pathway 0 or pathway 1.
- 70% of patients not meeting the criteria to reside in hospital to be discharged by 5pm.
- A reduction in patients re-admitted as an emergency admission within 30 days of a discharge.

<u>End of year progress</u>

- Preceptorship programme for newly qualified staff, promoting good, safe and effective discharge with the patient at the centre of all we do.
- Discharge educator role created for ward-based learning.
- Series of discharge-related workshops held across the Trust and wider system.
- Implementing 'model ward' approaches, including timely ward rounds, improved discharge letters and processes and focus on priority discharges to enable early and good patient flow.
- Opened purpose-built discharge suite to facilitate safe and timely discharge.
- Involvement with patients, carers and families on admission to establish date of discharge and requirements to return home safely.
- Transfer of care hub created in collaboration with local authorities to support ward colleagues and social workers to return people safety home after their hospital treatment and help to ensure social care support is available in the community.
- Patient and carer feedback used to increasingly inform and design discharge pathways and arrangements.
- Single point of access integrated across health and social care in Teesside and North Yorkshire
- Posters and letters sent to all Care Home Managers across Redcar & Cleveland, Middlesbrough and North Yorkshire local authority areas to advise that the transfer of care hub is the main point of contact in relation to hospital discharges.
- To address the national and local challenges in social care, proportionate care implementation used to maximise the care resource and support people at home.
- Rapid improvement methodologies used to achieve a significant 66 per cent reduction in delay for patients moving to primary care hospitals and a 32 per cent increase in the suitability of patients utilising these beds.
- A renewed focus around pathway 0 has been put in place following winter pressures.
- Progress continues to be made against ambitious discharge targets.

Summary

Timely and safe discharge is a quality priority for the Trust, and significant progress has been made during 2022/23. Challenges within social care persist and joint working will continue to focus on addressing these in partnership. In addition, the Trust continues to make improvements in the patient journey through the development of a number of schemes and initiatives. National and local targets are monitored through the discharge board and quality assurance committee.

Figure 3: Discharge related information resources

2. Meeting the nutrition and hydration needs of patients.

Adequate nutrition and hydration are a fundamental standard and a basic human right for all patients in receipt of NHS care. All patients should have their nutrition and hydration needs met, in line with their assessed needs and best practice. To achieve this the trust must have effective systems in place in order to demonstrate this fundamental standard is being achieved.

We agreed to:

- Ensure that patients' nutrition and hydration needs are assessed on admission, reassessed weekly if they stay in hospital longer than 7 days, and that a care plan is in place.
- Ensure that clear processes and systems are in place to ensure that patients receive the best mealtime experience.
- Ensure that we can capture patient experience in relation to nutrition and hydration and be responsive to feedback.
- Implement the Malnutrition Universal Screening Tool (MUST) on our digital clinical data platform Patientrack.
- Establish a Nutrition Link Nurse network across the Trust and a programme of education.
- Conduct a quality improvement review of the mealtime process.
- Develop mechanisms to obtain feedback regarding nutrition and hydration, specifically in relation to vulnerable groups of patients.
- Develop a Nutrition and Hydration Strategy
- Ensure patients, relatives and carers can expect consistently high standards of care in relation to nutrition and hydration, based on co-designed pathways and initiatives.

- Ensure timely visibility of data, with appropriate action taken relating to nutrition and hydration.

End of year progress

The Trust is immensely proud of the work it has done over the last 12 months on nutrition and hydration, as part of its recovery from COVID-19.

- Following staff training, implementation of the digital MUST screening programme has now been rolled out to all inpatients including the primary care hospital wards, enabling daily reports of compliance with MUST screening Trust-wide to review at daily huddles.
- Data for quarter 4 2022-23 shows Trust MUST compliance at 95% overall.
- The Trust nutrition dashboard is under development. This will integrate nutrition metrics regarding compliance, care plans, incidents and complaints to enable staff to react more rapidly to the data.
- We have a programme of learning and professional development for all nutrition link nurses and healthcare assistants to support ongoing patient care. 91 registered nurses and 20 healthcare assistants (HCA) attended training in February 2023.
- Across the Trust, clinical teams demonstrated their focus on improving nutrition and hydration for patients during the March 2023 Nutrition and Hydration Week. See additional detail below.
- Seven wards now have a Ward Nutrition Assistant in post, with a further 4 wards currently recruiting. Part of this role is to support assisted feeding of patients who need support with eating and drinking. In addition to this, we continue to welcome daily support from staff volunteers across the Trust for wards with higher numbers of patients requiring assisted feeding when this is needed. The education team coordinates this using data from the Patientrack reports to identify areas that may require help.
- The Trust-wide catering survey is now providing more detailed information about patients' mealtime experience. Data from quarter 4 reports an overall experience rating of 81%. Key learning points to note from this include:
    - 55.43% of patients report receiving a menu prior to mealtimes; this is a current point of focus for the Nutrition and Hydration Council who are working closely with catering providers to ensure improvement in this area.
    - 94.4% of patients reported they were offered meals that met their specific dietary requirements.
- From April 2023 the newly appointed Trust Food Services Lead Dietitian will take up post, working alongside catering and ward teams, multidisciplinary team members, and the nutrition co-ordinators to address key projects identified from patient experience feedback.
- The Nutrition and Hydration Strategy was developed and implementation over the next two years will be led by the Nutrition and Hydration Steering Group.

Nutrition and Hydration week

Nutrition and Hydration Week aims to highlight, promote and celebrate improvements in the provision of nutrition and hydration locally, nationally and globally. A highlight is the Global Tea Party. It is always an opportunity to learn a bit more about nutrition and hydration for both our colleagues and patients. As part of our improvement plan for nutrition and hydration, there were a lot of initiatives and additional activities planned to start during Nutrition and Hydration Week.
One of these was the 'Thirsty Thursday' focus days when our hydration champions raised awareness of trust's traffic light jug scheme.

The coloured water jug lids are a simple visual way of monitoring how much patients are drinking to help minimise their risk of dehydration and acute kidney injury (AKI). Patients are given a water jug with a red lid first thing in the morning and once they have drunk it all (or the equivalent volume of other fluids), the jug is refilled or the water in the jug is refreshed, and the lid is switched to an amber colour, and then green.

Figure 4: Traffic light jug scheme - coloured water jug lids

Colleagues celebrated and shared all the great activities on social media, alongside the Trusts 'understanding complex nutrition' which is simulation-based training that supports staff to:

- Understand complex nutrition.
- Recognise complications in relation to nutrition.
- Demonstrate A-E assessment.
- Understand mental capacity and decision making around nutrition.
- Make appropriate referrals to the wider multidisciplinary team.
- Build confidence in patient assessment and multidisciplinary team working.

This is just a snapshot of the work that went on across the Trust wards to celebrate Nutrition and Hydration Week 2023. The ideas and enthusiasm were overwhelming, and some fantastic themes observed and shared with colleagues trust wide.

Figure 5: Photographs for staff initiatives to celebrate Nutrition and Hydration Week 2023

Summary

There has been a significant focus on nutrition and hydration across the Trust during 2022/23 and we are confident that staff are engaged in ensuring that planned improvements have been made, and good practice is being embedded and effectively monitored.

Whilst the Trust wide catering survey has been developed further and increasing numbers of patients are contributing to this, there is further work to do during 2023/24 to ensure our more vulnerable patients can provide their feedback more easily.

3. Using feedback from our patients, their relatives and carers to improve practice.

The Trust wanted to create opportunities for increased engagement and involvement with our patients and their relatives and carers in order to develop responsive and receptive patient centred services. We will increase the number of patient experience contacts with patients, their relatives, and carers, particularly face to face by ensuring there are fit for purpose facilities within the organisation.

We agreed to:

- Establish a Patient Participation Group.
- Recruit patients to initiatives across the organisation.
- Maintain or increase annual patient-led assessments of the care environment (PLACE) scores and benchmark to other local and national Trusts.
- Carry out monthly PLACE-Lite assessments focusing on different areas every month and benchmark to other local and national Trusts. PLACE-Lite is recommended good practice to complement the annual PLACE collection and it is an effective way of assessing and monitoring progress in areas identified as requiring improvement and for preparation in advance of the main collection.
- Review the current estate provision for patients, relatives and carers.
- Use quality improvement activity to inform what matters to patients, relatives and carers.

We aimed for:

- An increase in patient experience contacts by at least 10% on the previous year.
- Examples of improvements in practice informed by patient/relative/carer feedback and participation.
- Demonstrable improvement in the environment for the provision of patient experience activity.
- PLACE-Lite benchmarking data and local action plans.

End of year progress

The Patient Experience Steering Group (PESG) includes Trust staff, external partners and governors meeting on a monthly basis to discuss the patient experience at the trust, including hearing patient stories, the monthly and annual patient experience reports, reviewing policies, standard operating procedures and other key documents aligned to assuring the improvement of the patient experience. The group also reviews the national patient experience surveys for adult inpatients and maternity services and oversees the associated action plans.

The group has monitored progress with the quality priority ambitions and has commissioned several pieces of work during 2022/23 based on the feedback received by patients.

Patient involvement and participation

We are recruiting to the patient involvement bank which will include patients, carers, community groups and charities supporting patients and carers. This allows patients and carers the choice and opportunity to be involved in work as and when they are able. The work we will invite them to be involved in currently include the review of written and digital patient information, and the review and development of new pathways of care. Future developments include patient or carer presence at meetings held in the organisation, recruitment panels, and patient participation groups in areas such as cancer services, in collaboration with other NHS trusts.

The Patient Experience Team are also working with community charities, and groups representing deaf and blind people, people living with dementia, BAME people, and young carers to increase engagement and input from all people within our communities.

Patient Experience and Involvement Strategy

In collaboration with Healthwatch South Tees, and patients and carers we ran an engagement event in February 2023 to create a Patient Experience and Involvement Strategy. The event ran over three consecutive workshops and involved patients from different communities in the South Tees, Redcar and Cleveland and North Yorkshire areas.

The workshops were well attended, and the contribution from patients and carers were invaluable to creating the strategy. Feedback from those who attended the workshops included:

"It was great to be involved, I enjoyed capturing the event and obtaining feedback from the delegates. I learned that there are plenty of people who are passionate about improving the NHS and by sharing their knowledge and experiences we have a great opportunity to implement change".

Figure 6: Photographs of collaborative working at the Patient Experience and Involvement Strategy engagement event

The graphic below shows the outcome of this fantastic work. The strategy will be published during quarter 1 of 2023-24. Work is planned to ensure the strategy is embedded in the organisation in partnership with patients and carers and the support of Healthwatch.

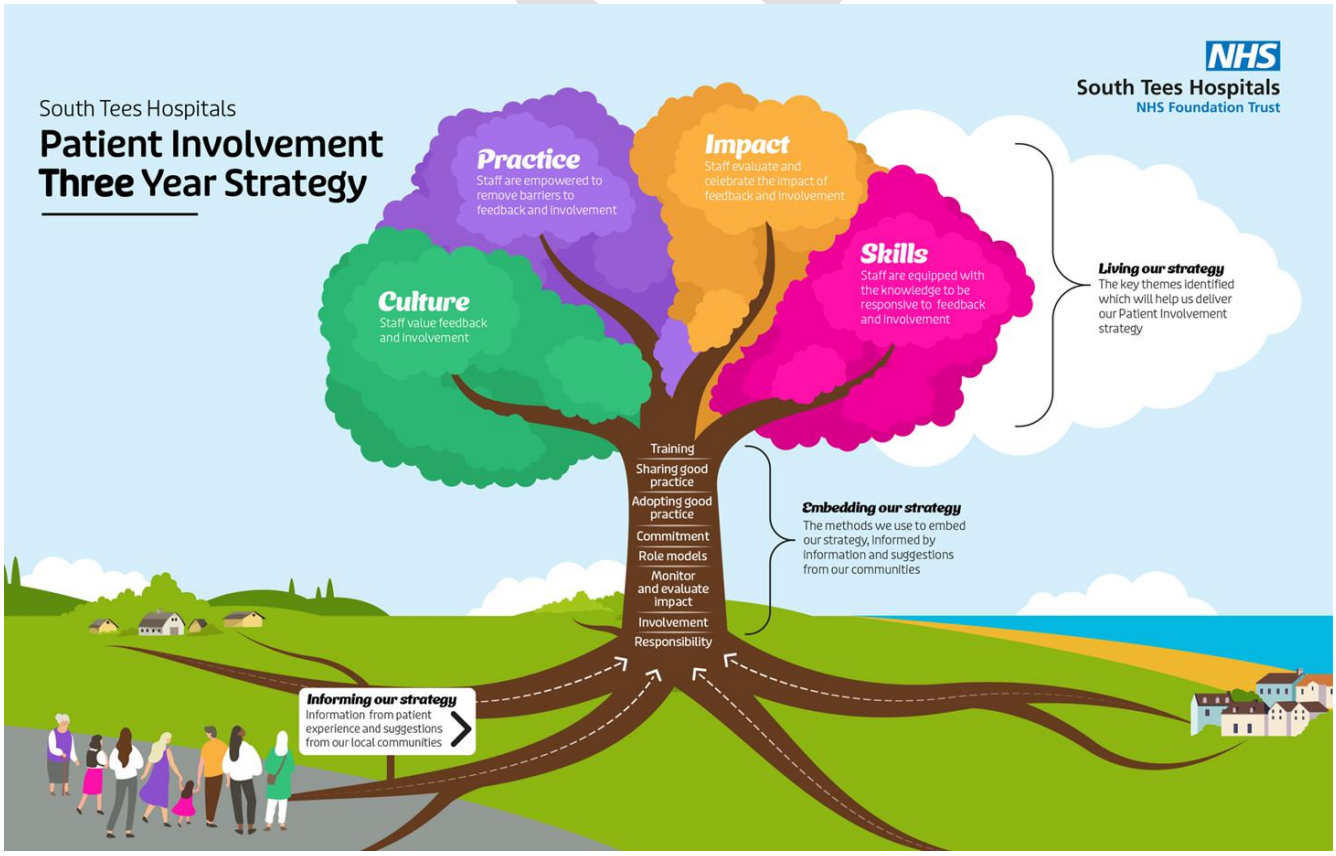


Figure 7: Our Patient Involvement Strategy

Patient-led assessments of the care environment (PLACE)

The annual PLACE assessments of all inpatient sites took place during September to November 2022 following a break due to COVID-19. The results were published on 23 March 2023 and the performance of South Tees NHS Foundation Trust compared against the national average PLACE scores is indicated in the table below.

The overall organisational scores for the Trust are above the national average on all eight domains which represents excellent performance against standards, particularly as the criteria are now stricter.

The results also indicate improvement in all domains and sites except for condition, appearance and maintenance at East Cleveland Primary Care Hospital which reduced from a score of 95.19% in 2019 due to damage to door frames, walls and ceiling tiles noted at the time of the visit. This is being rectified by NHS Property Services. Corrective action plans have been developed to address any other areas of weakness identified during the assessment and these will be monitored until the actions are completed.

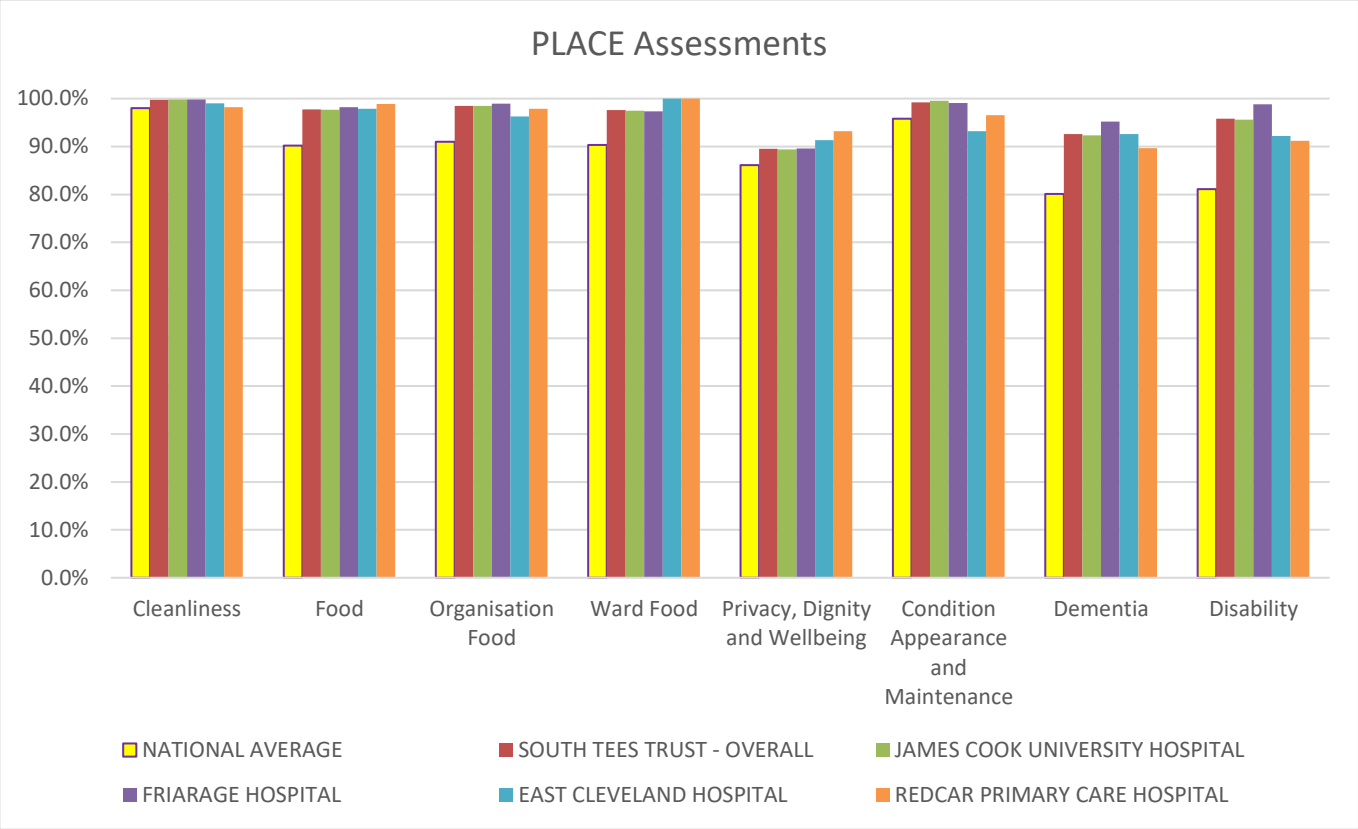


Table 2: Site specific PLACE results for South Tees Trust compared to national average 2023

Place Lite continues monthly across the James Cook Hospital site and we are now expanding to include our community hospitals and the Friarage Hospital in Northallerton. Our patient assessors are fully involved in all assessments and the aim is to visit two wards and two departments each month. Actions to address any areas that require improvement are developed, shared with the relevant parties and followed up to ensure completion.

Improvements in practice informed by feedback.

Based on patient and staff feedback, work was commissioned to understand the translation and interpreting services provided to the Trust and a full review of the service specifications and requirements was completed. Interim actions were taken to improve patient experience including a demonstration of an upgraded portal, use of the telephone interpreter service where appropriate, ensuring processes for access and escalation of complaints, and monthly operational meetings to monitor key performance indicators.

It was identified from patient feedback that carers needed to be recognised in their role and allowed the additional support time required for visiting out of hours, assisting with meals and drinking, and involvement in the patient's care including meetings and discharge plans. The Carers Passport has been developed to provide relevant information and support, including free or discounted car parking tickets and regular drinks.

We also collaborated with Carers Together - South Tees to develop a discharge leaflet to enable carers to understand what to expect at discharge, things to consider and a list of useful contacts. Consent was also gained to share information with the charities, Carers Together - South Tees and Carers Plus – North Yorkshire ensuring that carers were able to access support following discharge.

We have ongoing work being undertaken by the Head of Healthcare Records and Central Appointments on unanswered telephones, with the intention of improving the patient experience by increasing the number of calls answered and reducing the volume of complaints received. A review of all calls received by the trust was carried out looking at total volumes of calls by call centre and those calls received, answered, abandoned and the average wait to answer and duration of the call. This provides a sound basis upon which to commence deep dive analysis to allow targeted reviews and implement actions for improvement.

Other improvements made as a direct result of patient, relative or carer feedback include:

- Creating a more comfortable seating area and hydration station in the Infectious Diseases Clinic
- Introducing a process for ensuring information about delays within the operating theatres is communicated to patients awaiting surgery on the wards. This is being audited to ensure it is effective and embedded in practice.
- The anaesthetic team are reviewing our guidelines regarding the length of pre-operative fasting and ensuring this is in line with best practice and Royal College of Anaesthetists advice.
- Enabling email contact to the Endoscopy Department for patients, relatives and carers who are unable to use telephones.

There is additional information in section 3.4 of this report regarding other patient experience work and progress with other initiatives started during 2022/23.

<u>Summary</u>

There has been some significant progress with work to create opportunities for increased engagement and involvement with our patients and their relatives and carers to develop responsive and receptive patient centred services. And the contribution of the patient-led assessments of the care environment continues to provide important information for improvement and assurance. Unfortunately, our ambition to record and increase patient experience contacts with patients, their relatives, and carers, and to develop improved patient experience facilities within the organisation has not been possible to progress due to limited staff resource.

There are many good examples of the value we place on patient, relative and carer feedback and how we have used this to improve the services and care we provide, and the environment in which we do this. The work with our local Healthwatch and patients to develop our Patient Involvement Strategy is a very significant step forward in collaborative working with our stakeholders and the strategy will be embedded in the organisation in partnership with patients and carers and with the support of Healthwatch.

Quality priorities defined for improvement in 2023-24

The Trust has agreed the following priorities for 2023/24 following a consultation process with clinical colleagues and the Council of Governors.

Quality Priorities 2023/24		
Safety	**Clinical Effectiveness**	**Patient Experience**
We will continue to develop a positive safety culture, in which openness, fairness and accountability is the norm.	We will ensure continuous learning and improved patient care from GIRFT and clinical audits	We will implement the Patient Experience Strategy that has been developed in collaboration with our patients, careers and Healthwatch
We will continue to optimise the Trust's ability to learn from incidents, claims and inquests to improve outcomes for our patients	We will strengthen the mortality review processes, ensuring learning from deaths is triangulated and shared	We will develop and implement a Mental Health Strategy to improve care and share learning for our patients who have mental ill health
We will increase medication safety and optimise the benefits of ePMA		We will develop and implement shared decision making and goals of care

The agreed priorities are areas of importance that will make a difference to our patients. Some of our priorities are new, whilst others have been revised and carried over from last year. Agreed actions will be delivered and monitored during a 12-month period from the 1 April 2023 to 31 March 2024, with regular updates provided through the year via our quality governance structure.

2.2 Statements of assurance from the Board

Relevant health services

During 2022/23, South Tees Hospitals NHS Foundation Trust provided and/or sub-contracted 91 relevant health services. South Tees Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 91 of these relevant health services. The income generated by the relevant health services reviewed in 2022/23 represents 93.4**%** of the total income generated from the provision of relevant health services by the South Tees Hospitals NHS Foundation Trust for 2022/23.

National clinical audits and national confidential enquiries

South Tees Hospitals NHS Foundation Trust is committed to undertaking effective clinical audit across our clinical services and recognises that this is a key element for providing high quality care. Clinical audit enhances patient care and safety, provides assurance of continuous quality improvement and developing and maintaining high quality patient-centred services.

The Trust has a well-structured clinical audit programme which is regularly reviewed to ensure it reflects the needs of our acute and community services. During 2022/23, 60 national clinical audits and 3 national confidential enquiries covered relevant health services that South Tees Hospitals NHS Foundation Trust provides.

During 2022/23, South Tees Hospitals NHS Foundation Trust participated in 92% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in. Eligibility, for the purpose of this report, is defined as those national audits that the Trust could participate in that were not suspended due to the COVID-19 pandemic.

The national clinical audits and national confidential enquiries that the South Tees Hospitals NHS Foundation Trust was eligible to participate in, and for which data collection was completed during 2022/23 are listed below in Table 3, alongside the number of cases submitted to each audit or enquiry as a number or percentage of the number of registered cases required by the terms of that audit or enquiry:

Title	Eligible	Participated	% Cases
Breast and Cosmetic Implant Registry			0%
Case Mix Programme (CMP) Also includes Cardiac Intensive Care (Intensive Care National Audit & Research Centre (ICNARC) data)			100%
Child Health Clinical Outcome Review Programme - National Confidential Enquiries into Patient Outcome and Deaths (NCEPOD) Transition from child to adult health services			33% (3/9)
Elective Surgery - National PROMs Programme (Patient Reported Outcomes Measure)			73%
Emergency Medicine QIP - Pain in Children (care in Emergency Departments)			100%
Emergency Medicine QIP – Assessing for cognitive impairment in older people (care in Emergency Departments)			100%

Title	Eligible	Participated	% Cases
Emergency Medicine QIP – Mental Health – Self Harm (care in Emergency Departments)			Paused July 2021 by RCM, reopened October 2022. Awaiting publication of paper
The Falls and Fragility Fracture Audit Programme (FFFAP) The Fracture Liaison Service Audit (FLS-DB)			60.1%
Falls and Fragility Fractures Audit programme (FFFAP): National Audit Inpatient Falls			100%
Falls and Fragility Fractures Audit programme (FFFAP): National Hip Fracture Database			94.6% (N=457)
Inflammatory Bowel Disease Audit			0%
Learning Disabilities Mortality Review Programme (LeDeR)			100%
Maternal, New-born and Infant Clinical Outcome Review Programme			100%
Medical and Surgical Clinical Outcome Review Programme (National Confidential Enquiry into Patient Outcome and Death, NCEPOD) Community Acquired Pneumonia (CAP)			100% N=3
Medical and Surgical Clinical Outcome Review Programme (National Confidential Enquiry into Patient Outcome and Death, NCEPOD) Testicular Torsion			Ongoing
Muscle Invasive Bladder Cancer Audit			100% N=8
National Acute Kidney Injury Audit			Awaiting publication of paper
National Adult Diabetes Audit – National Diabetes Core Audit			0%
National Adult Diabetes Audit – National Pregnancy in Diabetes Audit			100% N=37
National Adult Diabetes Audit – National Diabetes Foot Care Audit			50% Awaiting publication of paper
National Diabetes Audit – Adults: NaDIA - Safety Audit			0%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Adult Asthma Secondary Care			N=46
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Chronic Obstructive Pulmonary Disease (COPD) Secondary Care			N=196
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Paediatric Asthma Secondary Care			100%

Title	Eligible	Participated	% Cases
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Pulmonary Rehabilitation-Organisational and Clinical Audit			86.6%
National Audit of Breast Cancer in Older People (NABCOP)			100%
National Audit of Cardiac Rehabilitation (NACR)			100% n=2900
National Audit of Care at the End of Life (NACEL)			100%
National Audit of Dementia			100%
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)			100% Cohort 3
National Bariatric Surgery Registry			100%
National Cardiac Arrest Audit (NCAA)			100%
National Cardiac Audit Programme (NCAP) – Cardiac Rhythm Management			100% n=790
National Cardiac Audit Programme (NCAP) - Myocardial Ischaemia National Audit Project MINAP			100% n=1640
National Cardiac Audit Programme (NCAP) - National Adult Cardiac Surgery Audit			100% n=850
National Cardiac Audit Programme (NCAP) - National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)			100% n= 1600
National Cardiac Audit Programme (NCAP) - National Heart Failure Audit			100% n=330
National Comparative Audit of Blood Transfusion programme - 2022 Audit of Patient Blood Management & NICE Guidelines			76% (114/149)
National Early Inflammatory Arthritis Audit (NEIAA)			Ongoing
National Emergency Laparotomy Audit (NELA)			100%
National Gastro-intestinal Cancer Programme: National Oesophago-gastric Cancer (NOGCA)			100%
National Gastro-intestinal Cancer Programme: National Bowel Cancer Audit (NBOCA)			100%
National Joint Registry (NJR)			65.4%
National Lung Cancer Audit (NLCA)			100%
National Maternity and Perinatal Audit (NMPA)			100%
National Neonatal Audit Programme			100%
National Obesity Audit			0%
National Ophthalmology Database Audit			70.9%
National Paediatric Diabetes Audit (NPDA)			100%
National Perinatal Mortality Review Tool			100%
National Prostate Cancer Audit			100%

Title	Eligible	Participated	% Cases
National Vascular Registry			>85% Compliant
Neurosurgical National Audit Programme			100%
Paediatric Intensive Care Audit Network (PICANet)			100%
Respiratory Audits - National Outpatient Management of Pulmonary Embolism			100%
Respiratory Audits - National Smoking Cessation 2021 Audit			100%
Sentinel Stroke National Audit Programme (SSNAP)			Ongoing
Serious Hazards of Transfusion Scheme (SHOT)			100%
Society for Acute Medicine Benchmarking Audit			100%
The Trauma Audit & Research Network (TARN)			100%
UK Cystic Fibrosis Registry			100% N=51
UK Parkinsons Audit			100%
UK Renal Registry Chronic Kidney Disease Audit			100%

Table 3: National Clinical Audits 2022-23 – eligibility and participation

The reports of three national clinical audits were reviewed by the provider in 2022/23 and South Tees Hospitals Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

National Hip Fracture Database

- The hip fracture team have implemented several governance meetings ranging from bi-weekly to quarterly. Meetings of surgical, orthogeriatric, anaesthetic, nursing, therapy, and management leads take place at least monthly. A formal discussion takes place at each meeting to identify possible reasons for any performance that is significantly below average and to plan a quality improvement project to address it. There are processes in place to review policies and protocols and to compare these with those in other units as described in the Facilities Survey.
- Monthly governance meetings are used to plan appropriate quality improvement interventions, and to monitor the impact of these using the real-time data reported in the National Hip Fracture Database (NHFD) run charts. A new quarterly governance tool is designed to help us do this.
- Key performance indicator (KPI) caterpillar plots are used to identify better-performing neighbouring units, share best practice, and collaborate in designing quality improvement work. For example, the KPIs have been used to monitored initial care, to improve the provision of local anaesthetic nerve blocks and to improve fast-tracking patients to an appropriate ward.
- The hip fracture teams are in the process of minimising inequalities in health care, by reviewing whether support and information is provided in formats and languages appropriate to their patients. They are also signposting patients, their families and carers to the NHFD website resources which are designed to help them understand their care and recovery following a hip fracture.

National Neonatal Audit Programme

- Education of all staff on the Neonatal Intensive Care Unit (NICU) regarding data input has started with training of band 6 staff to ensure each baby has a date of birth entered on admission so that their review date can be captured accurately.
- We have employed an administrator to support data entry and data cleansing.
- There has been productive liaison between the neonatal team and ophthalmologists to ensure relevant examinations are undertaken at the optimal time.
- We have agreed a process with NICU and ophthalmology consultants for robust data entry of results regarding babies who are subsequently seen as an outpatient.

National Paediatric Diabetes Audit

- Additional administrative support is in place to provide quality control of data entry.
- A process has been introduced to ensure data capture of flu vaccinations, sick day rules and ketone measurements is assessed monthly, and the data is entered correctly.
- Quality improvement project is in place to increase the percentage of patients downloading their devices (blood glucose monitoring devices and insulin pumps) at home so their data can be reviewed by the diabetes team. The team will support managing HbA1c within the target range and aim to equip patients with the knowledge and confidence to self-adjust insulin doses through a patient empowerment tool.
- Quality improvement pathway for first year after diagnosis is in place.

Local audit

The reports of three local clinical audits were reviewed by the provider in 2022/23 and South Tees NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Completion of MUST in Critical Care Stepdown Patients

- Findings will be fed back to nursing teams and Patientrack team for system level amendments to be implemented.
- Audit will be repeated to identify if changes to the system have addressed the issues identified in cycle 1.

Clinical Audit of Partial Breast Radiotherapy

- Increased number of reviewers outlining and look at clinical implications of variations in outlining.
- To re-audit the same parameters in six months.

Post-operative wound care understanding in patients sustaining open fractures of the upper and/or lower limb

- Increase departmental awareness that patient understanding of wound care can improve and should involve discussion with the patient prior to discharge.

- Increase patient understanding of wound care both by discussion with patients while in the hospital and by providing information to take home with them.

Clinical Research

The number of patients receiving relevant health services provided or subcontracted by South Tees NHS Foundation Trust (STH) in 2022/23 that were recruited during that period to participate in research approved by a research ethics committee was 5588 (across 157 studies). This compares favourably with the 3797 patients recruited last year across 145 studies and represents a 47% increase in patient recruitment and is our highest ever recruitment to date.

There is detailed information about our clinical research work in Part 3 of this report.

Use of the Commissioning for Quality and Innovation (CQUIN) payment framework

A proportion of the South Tees Hospitals NHS Foundation Trust's income in 2022/23 is conditional on achieving quality improvement and innovation goals agreed between South Tees Hospitals 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 (CQUIN) payment framework.

Further details of the agreed goals for 2022/23 are available on request from the Quality Assurance Team, South Tees Hospitals NHS Foundation Trust, The James Cook University Hospital, Marton Road Middlesbrough TS4 3BW or via email stees.qualityassurance@nhs.net

CQC registration, reviews and investigations

South Tees Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is unconditional. The Care Quality Commission took enforcement action against South Tees Hospitals NHS Foundation Trust during 2022/23. South Tees Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during 2022/2023.

The CQC completed a focused unannounced inspection of the core services for medicine and surgery at James Cook University Hospital and the Friarage Hospital in February 2022 with a report published in May 2022. This was not a full inspection, therefore the significant changes and improvements the Trust had made since 2019 full inspection were not reviewed. During their visit, the CQC recognised the enormous efforts of colleagues in the face of the unprecedented Omicron winter pressure on services at the time of their inspection.

The overall rating remained at requires improvement, with the Trust being served warning notices under Section 29A of the Health and Social Care Act 2008 in relation to regulated activities at James Cook University Hospital. The Trust was required to make significant improvements in the assessment and management of patients' nutrition and hydration needs; assessment and management of patient's individual needs; discharge processes; and adherence to the Mental Capacity Act.

The trust was already acting on these areas as part of its clinically led recovery from the the winter Omicron surge, which at its peak saw more than 500 COVID-related staff absences. However further work was planned and prioritised to ensure significant improvements were made to patient care in all these areas. Much of that work is reflected in this report. The Trust completed all the detailed action plans by September 2022 and presented the work done and outcomes during a

subsequent planned visit, when the CQC also re-visited some of the wards inspected in February and talked to staff and patients.

The CQC subsequently inspected urgent and emergency care and critical care services at The James Cook University Hospital, and medical wards (including services for older people) and surgery at both The James Cook University Hospital and Friarage Hospital. They also inspected the well-led key question for the trust overall. The inspection occurred between November 2022 to January 2023.

The CQC found significant improvements in the quality of care at South Tees Hospitals NHS Foundation Trust, and our overall rating moved up from requires improvement to good. The full report is available at https://www.cqc.org.uk/provider/RTR/inspection-summary

Overall trust quality rating	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Figure 8: South Tees Hospitals NHS Foundation Trust overall CQC rating

All well as the overall trust rating improving, the overall rating for Friarage Hospital and The James Cook University Hospital improved from requires improvement to good overall. Both hospitals are now rated as good in all five key questions of safe, effective, caring, responsive and well-led.

"When we returned to South Tees, we found an effective leadership team who had made significant and widespread improvements since our last inspection. This is reflected in their overall rating change from requires improvement to good, of which all their staff should feel very proud. Our inspectors saw much more effective processes, and management of services which was having a direct positive impact on the quality of care people were receiving. For example, these systems were used to identify risks to people and implement actions to reduce the impact of them, meaning they were much safer, and receiving more effective care.

"This was most evident in critical care which was unrecognisable from our last inspection. It was most impressive they were able to do this during the COVID-19 pandemic.

"Staff across all the services we visited were well engaged and committed to continually learning and improving people's care. It was also very impressive that leaders engaged staff to contribute to decision-making, for example to help avoid financial pressures compromising the quality of care."

Sarah Dronsfield, CQC Deputy Director of Operations in the North

The areas noted for improvement in the inspection and in the report are included in an action plan which is being monitored to ensure actions are progressed to completion and that ongoing assurance of compliance and high-quality care is embedded within the governance systems and processes.

Submission of records to the Secondary Uses Service

South Tees Hospitals NHS Foundation Trust submitted records during 2022/23 to the Secondary Uses Service for inclusion in The Data Quality Maturity Index (DQMI). This is a monthly publication intended to highlight the importance of data quality.

The percentage of records in the latest published data for November 2022 which included the patient's valid NHS number was:

- 100% for admitted patient care
- 100% for outpatient care, and
- 99.5% for emergency department care.

The percentage of records in the latest published data for November 2022 which included the patient's valid General Medical Practice Code was:

- 99.8% for admitted patient care
- 99.8% for outpatient care, and
- 99.1% for emergency department care.

Information Governance grading

Information governance is assessed as part of the mandatory annual national process of submitting compliance with the NHS Data Security and Protection Toolkit (DSPT), which is currently based upon the National Data Guardian's 10 Data Security Standards. The content of the DSPT is aimed at providing assurance around technical aspects of cyber security, information security and data protection compliance.

The 2021/22 DSPT submission was assessed against compliance with 38 assertion areas which are comprised of over 149 pieces of evidence, 110 of these are mandatory. South Tees Hospitals NHS Foundation Trust DSPT status for 2021/22 was 'Approaching Standards' with an action plan in place. The Trust was non-compliant with five standards at the time of submission in June 2022; two of those standards have since been completed.

The three areas which continue to be non-compliant are:

- 95% of staff compliant with the Data Security Awareness training at the date of final submission (3.2.1).
- Devices that are running out-of-date unsupported software and no longer receive security updates (patches) are removed from the network, or the software in question is uninstalled. Where this is not possible, the device should be isolated and have limited connectivity to the network, and the risk assessed, documented, accepted and signed off by the SIRO (8.1.3).
- All infrastructure is running operating systems and software packages that are patched regularly, and as a minimum in vendor support (8.4.2).

The Trust maintains an action plan regarding compliance which is monitored at the bi-monthly Information Governance Steering Group and reported to the Trust Senior Information Risk Owner (SIRO), as well as being reviewed by the annual DSPT Internal Audit review.

The 2021/22 DSPT review has been performed by PwC (PricewaterhouseCoopers) as part of a national standardisation exercise, the findings of which are monitored and discussed at the Trust Audit and Risk Committee.

At the time of writing, the status of the 2022/23 DSPT is that the Trust has provided 96 of the 113 mandatory evidence items required, and 20 of the 36 assertions in this year's toolkit have been completed. The final submission date is 30 June 2023.

Clinical coding audit

South Tees Hospitals NHS Foundation Trust was not subject to a Payment by Results clinical coding audit during 2022/23 by the Audit Commission.

Data quality

South Tees Hospital Foundation Trust will be taking the following actions to improve data quality:

- Data that is collected, recorded, and reported within the trust complies with national data standards outlined in the NHS Data Dictionary and is clinically coded in compliance with data classifications set out by World Health Organisation and NHS Digital ICD10 and OPCS 4.9
- To help and support the clinical collaboratives the Business Intelligence Unit and the Data Quality Team develop analytical tools and reports to help identify operational and clinical efficiencies and to help improve their data quality.
- To maintain compliance with legal and regulatory requirements, the Trust routinely monitors the completeness and quality of data. Monitoring reports and audits are used to improve processes, training documentation and use of computer systems. Examples of monitoring include:

Type of Monitoring	Frequency	Responsibility
External and internal audit of data quality of differing aspects of the Trust's data	Annual (external) Weekly and ad-hoc (internal)	Clinical Coding Team
Check of completeness and validity of data submitted to SUS and other mandatory returns	Weekly	Finance and Business Analysts
Validation of blank or invalid patient demographic details	Weekly	Data Quality Team
Validation of inpatient and outpatient activity	Weekly	Data Quality Team
Investigation of queries, issues, errors as they arise	Ad-hoc	Data Quality Team
Benchmarking of audit inputs and outputs to identify discrepancies that may indicate data quality improvements required	Annual cycle	Clinical Effectiveness

All members of staff involved in recording patient data have the responsibility to ensure they keep up to date with NHS data standards and recording guidance relevant to their role. Online data quality awareness sessions are available via the data quality intranet. These sessions are easily accessible and cover key data recording standards along with a range of guidance documents which keep members of staff updated on any new changes to data recording.

The guidelines and procedures contain guidance and advice relating to the collection of data along the patient pathway ensuring as a Trust we are following national guidance. Staff are recommended to carry out these sessions on a yearly basis.

Learning from deaths

During 2022/23, 2,083 patients of South Tees Hospitals NHS Foundation Trust died. This comprised the number of deaths which occurred in each quarter of that reporting period:

- 462 in the first quarter;
- 475 in the second quarter;
- 563 in the third quarter;
- 583 in the fourth quarter.

By 31st March 2023, 2,074 case record reviews and 17 investigations have been carried out in relation to 2,083 deaths above. In nine cases, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 5 in the first quarter;
- 2 in the second quarter;
- 2 in the third quarter;
- 0 in the fourth quarter.

During the reporting period 0.1% were judged to be due more likely than not to problems in care. The Trust established a Medical Examiner Service in May 2018. Approximately 98% of deaths are scrutinised by Medical Examiners. Any death where there may be a problem in care (or that meets specific criteria) is reviewed by a central team of four consultants with expertise across many specialties. Each review results in two grades, one for quality of care and one for preventability of the death. Particularly complex cases are further reviewed by a cross-specialty panel of senior medical and nursing staff.

Learning and actions resulting from death reviews include:

- End-of-Life Care. Actions are coordinated through the End-of-Life Group, which receives information on themes and cases from Medical Examiner scrutiny and mortality reviewers. Documentation of Do Not Attempt Cardiopulmonary Resuscitation and other end of life documentation audit work is conducted as part of health care records audits.
- Documentation in the medical records. This i is addressed through the South Tees Accreditation for Quality of Care (STACQ) and health care records audits, although the longer-term solution is implementation of electronic patient records. Progress on this work is reported to the Miya Programme Board through Trust Committees to Board level. The trust developed a communications campaign called “Documenting for great CARE” highlighting the issue with hints, tips, advice, and guidance to help clinicians ‘keep the chain going’. The campaign is shared through the Trust’s usual channels. This includes what good documentation looks like and how clinicians can support improvement in the clinical coding of the care they have delivered.
- Coordination of care between specialities. Internal coordination of care is recorded in hospital records by referring and receiving clinicians. Coordination of care will improve with implementation of electronic records.

- Transfer of patients from other hospitals. This is less common but a known problem. Information about patients prior to, and at the time of, referral is currently in the medical record, usually in a summary form (it currently relies on the doctor accepting referral to make this summary) and there is a process currently on-going around procurement of a digital system across the region (led by Newcastle upon Tyne Hospitals NHS FT). The intention is to procure a single system for all Trusts in the North East and North Cumbria and procurement is nearing completion with an announcement expected in early 2023-24 followed by an implementation plan for cardiac, renal, vascular, orthopaedic and other specialty services.

Four hundred and thirty-five (435) case record reviews and three investigations were completed after 31/03/2022 which related to deaths which took place before the start of this reporting period. Before the reposting period 0.05% are judged to be due more likely than not to problems in care. This number has been estimated using the adapted version of the Preventable Incident, Survival and Mortality Study (PRISM) methodology. During 2021/22, 0.2% are judged to be more likely than not to have been due to problems in care.

2.3 Reporting against core indicators

Summary Hospital-level Mortality Indicator (SHMI)

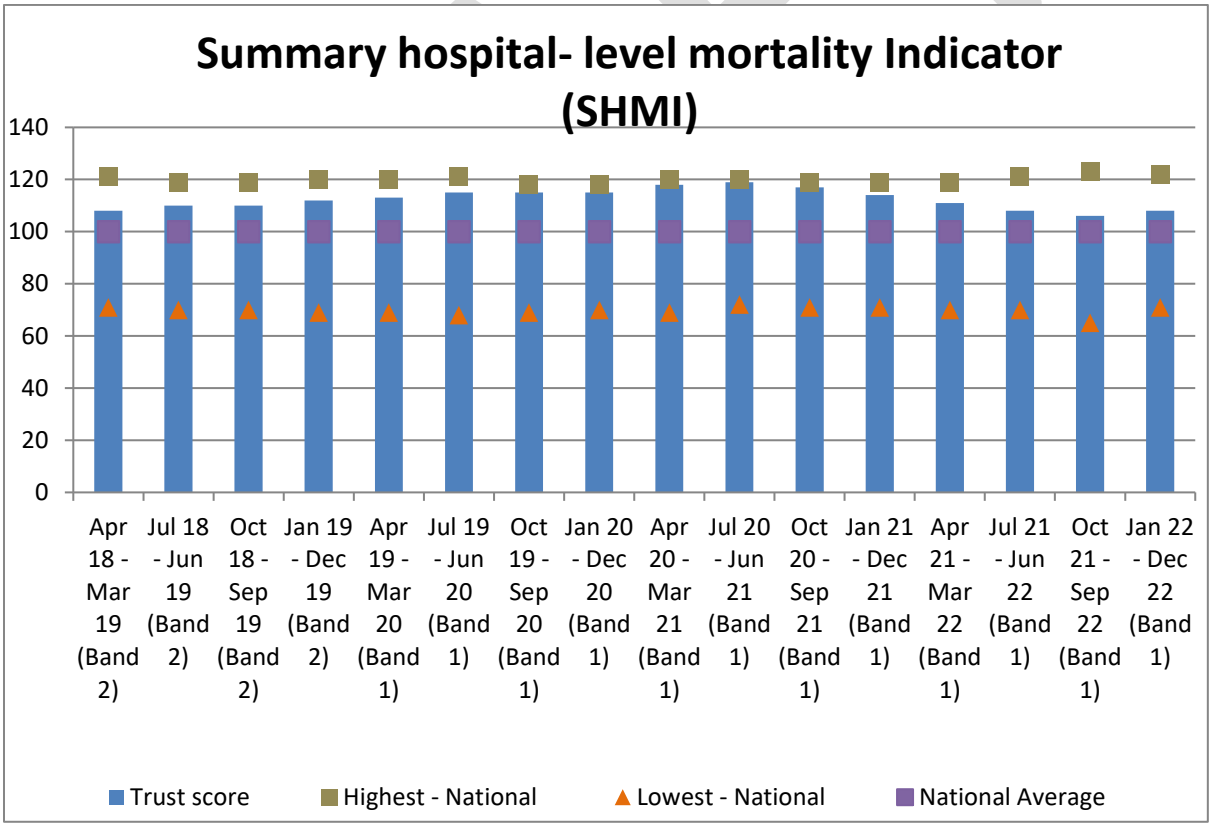


Figure 9: Summary Hospital Level Mortality Indicator (SHMI) (Data source: NHS Digital)

South Tees Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

1. The SHMI is not designed to account for the COVID-19 pandemic and although spells coded for COVID-19 have been removed by NHS Digital from the indicator calculation, the large reduction in the number of admissions to hospital, particularly during wave 1, has had a substantial impact on the expected number of deaths. For the 12 months Jan – Dec 2022 the number of spells included in SHMI is 87% of pre-pandemic levels, partly because 4.6% of spells have been removed by NHS Digital because they contain a spell code for COVID-19. However, SHMI has fallen compared to the pandemic period and is 'as expected' meaning that the number of observed deaths is within the statistical limits, compared to the estimated number of hospital deaths expected given the population of patients cared for in the Trust. The fall in the number of admissions has not been experienced evenly across the country, with areas that had high levels of COVID-19, such as the North-East, experiencing a greater impact.
2. Despite the high level of need in the population the Trust serves, the organisation has historically fallen behind other Trusts in recording the number of other medical conditions patients have, alongside the main illnesses being treated. The Trust is in the process of implementing electronic records systems which are expected to address this comorbidity recording anomaly and an improvement has occurred in the 12 months to December 2022, with further improvements planned as electronic records continue to develop.

   Patients who are treated within a single day for unplanned care without the need for admission are currently removed from the dataset which is used to calculate SHMI to another emergency care dataset and this therefore removes low-risk patients from the datasets calculation. This change in the way patients who are treated within a single day for unplanned care without the need for admission are recorded, has taken place earlier than in other Trusts.

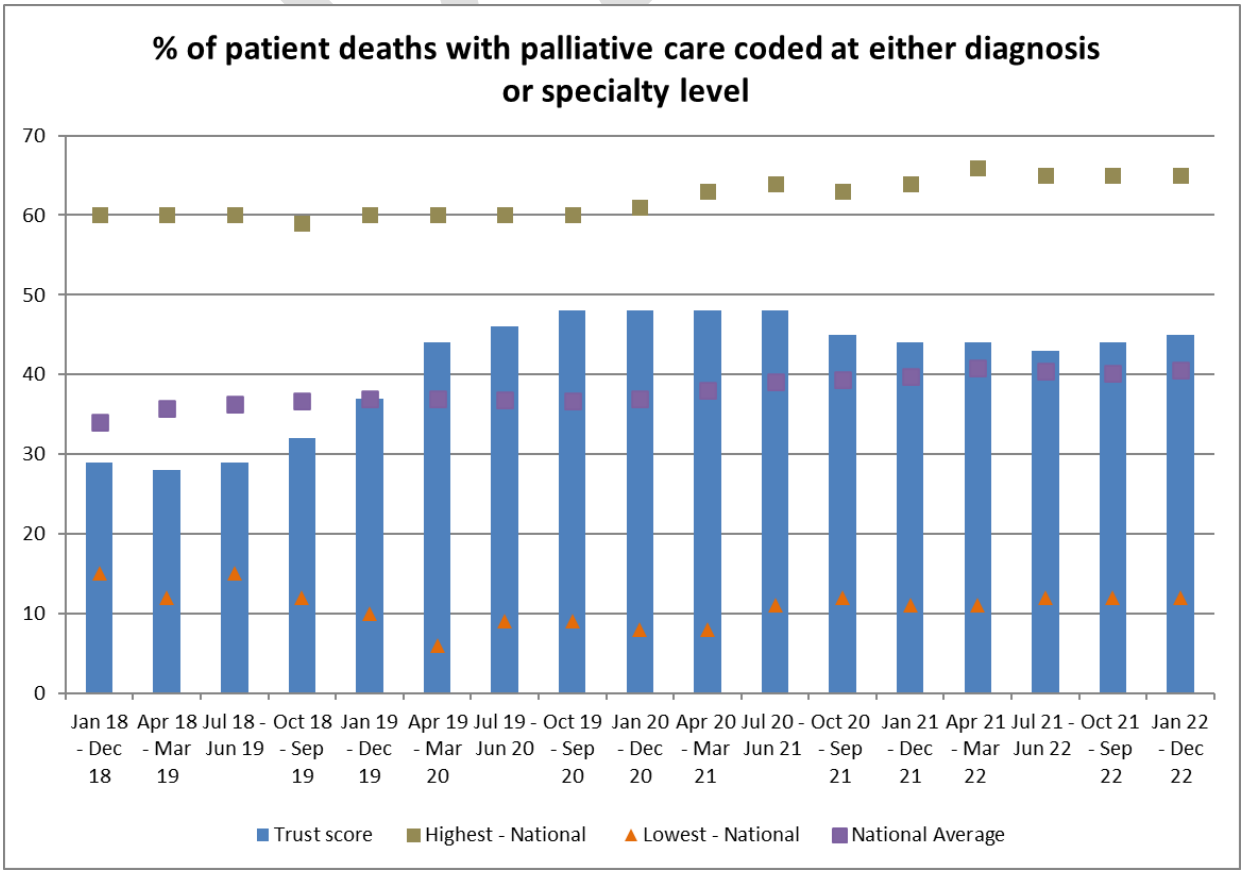


Figure 10: Percentage of Patient Deaths with Palliative Care Coded (Data source: NHS Digital)

The percentage of patient deaths with specialist palliative care coding has been higher than the national average in the last twelve reporting periods and this indicator is stable in the last five at about 45%. This reflects the work that was done to ensure that all the specialist palliative care provided to patients was captured in the coding used to calculate SHMI. This involved a comparison between two digital systems used to record the care provided.

The Trust has taken the following actions to improve the indicators and therefore the quality of its services:

- The Trust has governance committees which monitor and respond to mortality information and the Quality Assurance Committee in particular coordinates hospital safety and improvement activity.
- The Trust regularly reviews the range of statistics available to monitor hospital mortality, establishing the Medical Examiner Service in May 2018 (the first in the North-East), overseeing trust and specialty level case note reviews of hospital deaths so that common themes can be identified, and lessons can be learnt to improve the quality of its services.

The number of deaths in the Trust is variable from year to year, depending on the severity of respiratory and other seasonal infections each year and the pattern during the COVID-19 pandemic was unlike any previous year in the Trusts' history. However, the trend outside the seasonal variations and the pandemic years has remained stable over a long period of time, despite an aging population and increasing complexity of the conditions patients have when admitted to hospital. Work likely to affect mortality rates, particularly in elderly patients admitted to medical wards, includes sustained work on identification and management of deteriorating patients (the National Early Warning Score is electronically recorded in the Emergency Departments and Acute Assessment Units as well as all wards of the hospital), identifying and managing patients with sepsis, prevention of falls, and work identifying patients' level of frailty and providing appropriate support.

Patient reported outcome measures

Patient reported outcome measures (PROMs) measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires. This health status information is collected from patients through PROMs questionnaires before and after a healthcare procedure and provides an indication of the outcomes or quality of care delivered to NHS patients (http://www.hscic.gov.uk/proms). The score reported is an adjusted health gain score based on case mix, a higher number indicates a better health gain.

NHS Digital has not released any data beyond the 2020/21 data published in the Quality Account last year.

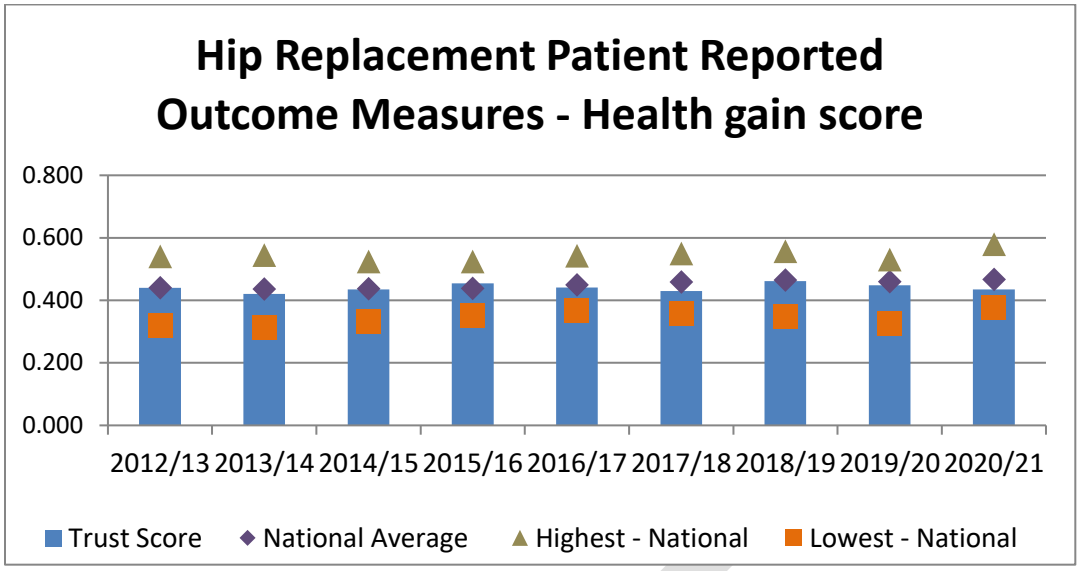


Figure 11: Hip Replacement PROMS (Data source: NHS Digital)

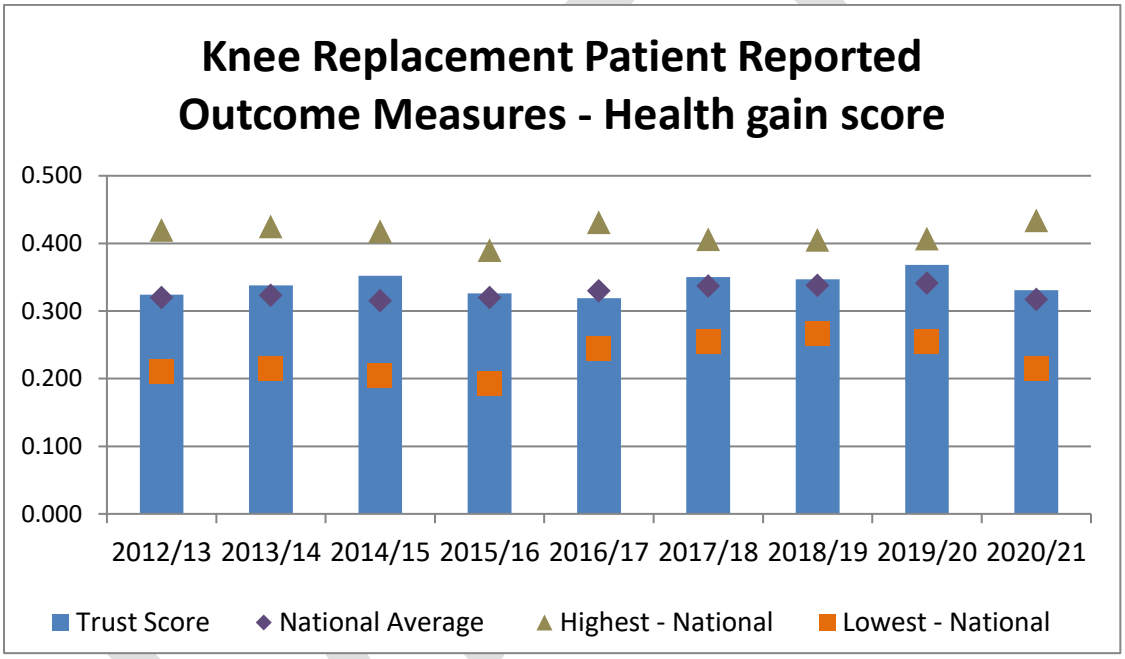


Figure 12: Knee Replacement PROMS (Data source: NHS Digital)

South Tees Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- The specialist review and pre-assessment process ensures that patients are offered the procedure likely to deliver the most benefit and best outcome.
- The health gain scores for hip replacements and knee replacements are in line with the national average.
- Production of data has been disrupted by the COVID-19 pandemic.

The Trust has taken the following actions to further improve these scores, and therefore the quality of its services:

- Providing regular feedback of the scores to clinical teams and benchmarking performance across the NHS and other hospitals in the North-East, through a regular report produced by the North-East Quality Observatory Service (NEQOS), to ensure the quality of services is maintained.

30-day readmissions

The data from NHS Digital was not available at the time of publication.

Responsiveness to the personal needs of its patients during the reporting period

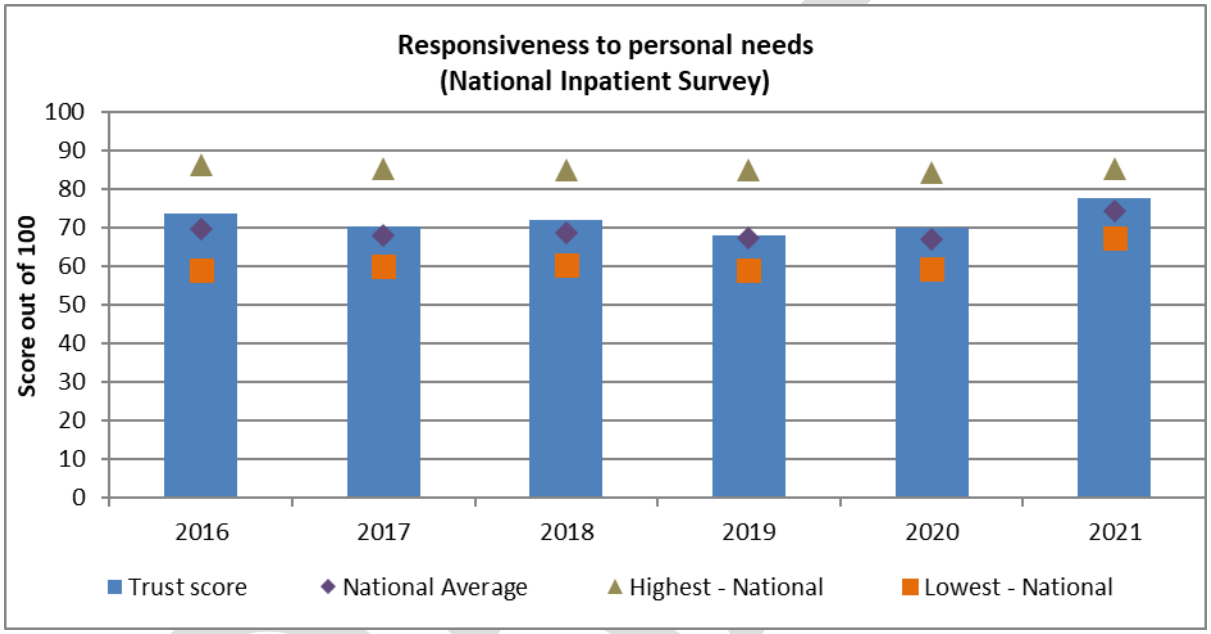


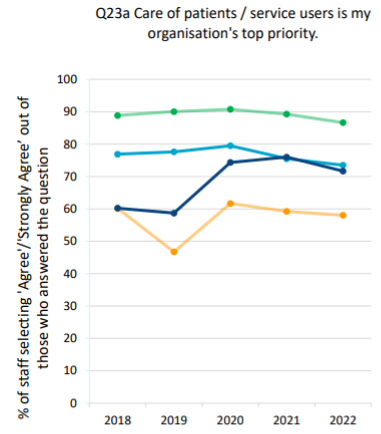
Figure 13: Responsiveness to personal needs results from National Inpatient Survey

The South Tees Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

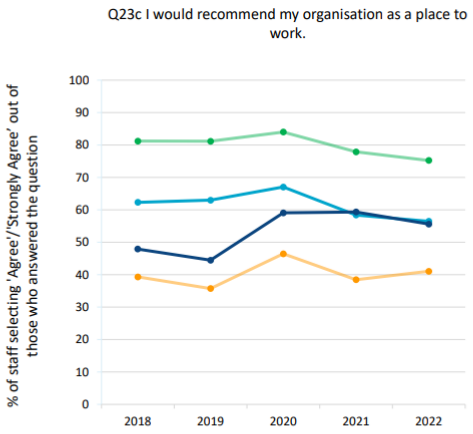
- The data shows that the Trust continues to score above the national average.

The South Tees Hospitals NHS Foundation Trust intends to continue to capture and analyse patient experience to improve its services by creating opportunities for increased engagement and involvement with our patients, their relatives and carers.

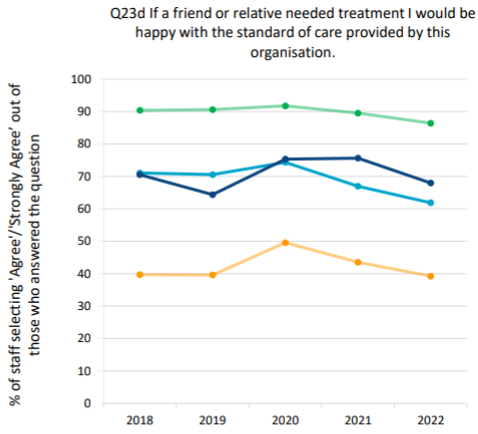
Staff FFT



	2018	2019	2020	2021	2022
Your org	60.2%	58.7%	74.4%	76.0%	71.7%
Best	88.8%	90.0%	90.8%	89.3%	86.6%
Average	76.9%	77.6%	79.5%	75.5%	73.5%
Worst	60.1%	46.7%	61.7%	59.2%	58.0%
Responses	406	2227	2441	2846	3324



	2018	2019	2020	2021	2022
Your org	47.9%	44.5%	59.1%	59.4%	55.6%
Best	81.2%	81.2%	84.0%	77.9%	75.2%
Average	62.3%	63.0%	67.1%	58.4%	56.5%
Worst	39.3%	35.7%	46.5%	38.5%	41.0%
Responses	409	2218	2443	2851	3321



	2018	2019	2020	2021	2022
Your org	70.5%	64.4%	75.3%	75.6%	68.0%
Best	90.4%	90.6%	91.8%	89.5%	86.4%
Average	71.1%	70.6%	74.3%	67.0%	61.9%
Worst	39.7%	39.6%	49.6%	43.5%	39.2%
Responses	406	2214	2444	2847	3322

Table 4. Percentage of staff who would recommend the Trust (Data source: NHS Digital)

The South Tees Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has made significant improvements over the last three years and this year we remain at or above the sector average. Whilst there has been a slight drop in the score in 2022, this is consistent with the other NHS organisations.

The South Tees Hospitals NHS Foundation Trust intends to take the following actions to further improve this percentage and thereby the quality of its services.

- The Trust will continue to work with staff to improve the quality and safety of care we provide to our patients and has introduced a number of mechanisms to promote the provision of excellent patient care. As well as promoting in the staff bulletin, briefings, and other communication, it has introduced STAQC (South Tees Accreditation for Quality of Care) standards for clinical areas and STAR awards which recognise excellent achievements by staff.
- The Clinical Policy Group, which involves all clinical leaders, continues to make decisions on the best way for the organisation to allocate resources and deliver excellent patient care.

Venous thromboembolism risk assessments

Our most recent data regarding venous thromboembolism (VTE) risk assessment (January 2023) shows 89% compliance against our target of 95%. This is against a figure of 88.8% for the whole year 2022. While we accept that occasional patients do not receive a VTE risk assessment or prophylaxis, we believe that the majority of non-compliances relate to problems with data collection rather than clinical omission. For example, completion of a VTE risk assessment is currently recorded on the CAMIS digital administration system by ward staff manually noting the completion of a risk assessment. Within the past year many wards have moved from paper prescriptions to electronic prescriptions (including VTE risk assessment). When auditing VTE risk

assessment on the electronic prescription system, we see that every ward audited has higher levels of completed VTE risk assessments than recorded on CAMIS.

We aim to move to using the electronic prescription system as our trust wide method of recording and reporting VTE risk assessment once this is fully rolled-out. The majority of non-compliances come from the acute admissions wards, primarily Same Day Emergency Care (SDEC) at JCUH. When we conducted an audit of SDEC in January 2023, all eligible patients had a VTE risk assessment completed, however none had been recorded on the CAMIS system. This ward alone accounted for about half of the recorded non-compliances in the Trust in December 2022.

VTE risk assessment data continues to be reviewed and discussed at quarterly Thrombosis Committee meetings, with escalation to the Clinical Effectiveness Steering Group where appropriate. VTE continues to be a high clinical priority within South Tees Hospitals NHS Foundation Trust.

Clostridioides *difficile* (C. *difficile*) Infections rates

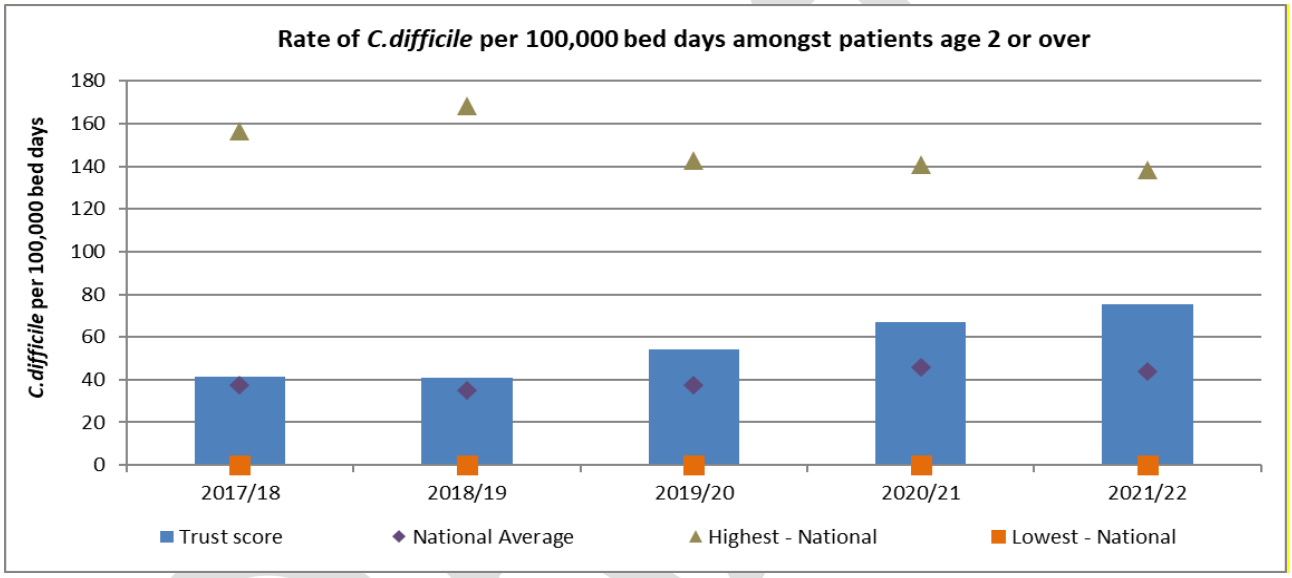


Figure 14: Rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over. (Data source: NHS Digital)

The South Tees Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust is committed to driving down healthcare acquired infections and achieved its lowest ever incidence Clostridioides *difficile* (C. *difficile*) infections in 2018/19, with subsequent slight increases again the following year, which continued through 2020/21 and 2021/22..
- The Trust reports healthcare associated CDI cases to UK Health Security Agency via the national data capture system against the following categories:
    - Hospital onset healthcare associated (HOHA): cases that are detected in the hospital 2 or more days after admission (where day of admission is day 1), and
    - Community onset healthcare associated (COHA): cases that occur in the community (or within 2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks.

The Trust is required under the NHS Standard Contract 2022/23 to minimise rates of Clostridium *difficile* infection to below 111 or less so that it is no higher than the threshold level set by NHS England and Improvement.

The South Tees Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services.

- The Trust has a comprehensive recovery action plan for the prevention of trust-attributed C. *difficile* infections which is monitored through the Infection Prevention and Control Strategic Group and reported through to the Safe and Effective Care Strategic Group.
- All trust-attributed cases have a Structured Review panel undertaken. Panel reviews are chaired by the Deputy Director of Infection Prevention and Control (DDIPC) or a senior infection prevention and control (IPC) nurse and supported by integrated care board (ICB) colleagues. If the panel agrees that there were no issues in care, then the case may be discounted from the total for internal performance measurement purposes only, as nationally the financial sanctions for C. *difficile* have been removed and the 'appeals' process is no longer in use. Identifying a single root cause in cases of C. *difficile* is challenging and is often associated with one or more influencing factors; patient factors e.g., existing long-term conditions, and/or medical factors such as the requirement for antibiotics or laxatives and/or processes.
- Learning from the Structured Review process and aligned to the recovery plan the Trust has implemented a monthly C. *difficile* task and finish group and an escalation to the fortnightly senior nursing team meeting to complete actions reporting into the wider organisation.

Patient safety incidents

The national publication of the required patient safety incident data has been delayed meaning that this was not available from NHS Digital at the time of publication. Information about our work on patient safety is included in section 2.1 of this report.

Patient Friends and Family Test

The 2022/23 patient Friends and Family Test (FFT) data is provided in section 3.4 of this report.

3. Overview of quality of care and performance indicators

3.1 South Tees Accreditation for Quality of Care

The South Tees Accreditation for Quality of Care (STAQC) program was established in July 2020 to establish a comprehensive assessment of the quality of care within all clinical areas.

Accreditation is defined as the development of a set of standards so that areas for improvement can be identified and areas of excellence celebrated. Experience shows accreditation programmes can drive continuous improvement in patient outcomes and increase patient satisfaction and staff experience at ward and unit level. Using a collective sense of purpose teams can support communication, encourage ownership, and achieve a robust programme which measures and influences care delivery.

There are 128 wards, units, teams, and departments that are eligible for accreditation, which consists of:

1. Pre-assessment review of key outcome data, for example, nurse sensitive indicators, complaints and patient experience, a staff survey, human resources metrics such as sickness and appraisal records.
2. An 'on the day' assessment: the 'general' assessment tool comprises 163 items under the key headings of Culture of Compassionate Care, Well Led, Safe Care, and Effective Care which are assessed by documentation review, patient interviews, multi-disciplinary team staff interviews, ward manager interview, medical staff interviews and an environmental review.

We have specialist accreditation tools for theatres, paediatrics, maternity, ambulatory departments, Critical Care and the Emergency Department.

Accreditation assesses a balance of process and outcome data, environmental impact on care delivery, teamwork, impact on and relationships with relevant services along the patient pathway, staff and patient feedback, evidence of learning and continual improvement.

Work undertaken during 2022/23

There has been a continued focus during 2022/23 to embed the STAQC accreditation program into all the clinical areas. Baseline accreditations have been included as the starting point of the formal process for some wards and departments, providing the clinical areas with a baseline report detailing their current standard and expected timebound actions required to achieve either gold or diamond accreditation.

The accreditations achieved during 2022/23 were:

- 17 diamond accredited areas
- 22 gold accredited areas
- 8 silver areas
- 10 baseline areas

Post accreditation checks for the areas initially accredited at the start of the program are now underway to ensure robustness and standards are maintained after accreditation. One day per month the team are working through assurance visits. 13 have been completed.

Diamond accreditations	33	**Key actions:** • Ensure genuine readiness vs eagerness to prevent lack of sustained progress and change. • STAQC team maintain comprehensive work plan transparent to all teams. • Constant focus on shared ownership. • To conduct a service evaluation of the programme so far. • Look to further refine and develop the programme.
Gold accreditations	31	
Silver awards	9	
Baseline accreditations	10	
Total eligible wards, teams, or units	128	

Table 5. Summary of STAQC progress and key learning to date.

Summary

There have been significant achievements in 2022/23 and many reasons and opportunities for local teams to celebrate their achievements along their STAQC journey.

It's like a ward managers handbook

A worthwhile challenge with an outcome to make us proud of our everyday work

The whole team took ownership of the STAQC process and used it as an opportunity to celebrate safe and effective practice

STAQC is an apprehensive time but also an exciting time, as we are able to showcase what we do best

Figure 15: Team celebrations and feedback about STAQC

The plan for 2023/24 is to achieve eight accreditations per quarter. This is based on the STAQC team capacity and redeployment, team preparedness and engagement, and operational pressures.

3.2 Patient safety indicators

1. Safeguarding, Mental Capacity Act, learning disabilities

Adult Safeguarding

Safeguarding is a positive duty placed on all staff under Section 42 of the Care Act (2014) to promote the wellbeing of vulnerable people and protect them from harm whether the harm is intentional and irrespective of whoever causes the harm. Safeguarding duties are rooted in law; based around the protection of human rights. As a public authority the Trust must follow the Human Rights Act (1998) in everything it does and treat people in accordance with their rights. The Trust has a clear outline of executive accountability within governance structures, which provides a framework for the sharing of learning across services. This sharing has been strengthened by an ever-growing cohort of Safeguarding Champions (currently over 100) within clinical teams.

During 2022/23 the team have provided regular collaboration with partner agencies within the Teeswide Safeguarding Adult Board (TSAB) and North Yorkshire Safeguarding Adult Board (NYSAB) sub-groups, participating in guidance and policy development, performance reports and multi-agency audits, and engaging with communities during safeguarding weeks.

The Trust has a robust process of monitoring and reporting on activity, trends and themes and linking learning with relevant work streams for the effective use of resources. In 2022/23 there have been 660 safeguarding concerns (1% decrease for the same period in the previous year), with 117 relating to Trust factors (an 18% decrease from the previous year). Key areas of learning have been in relation to discharge, pressure ulcers and medication.

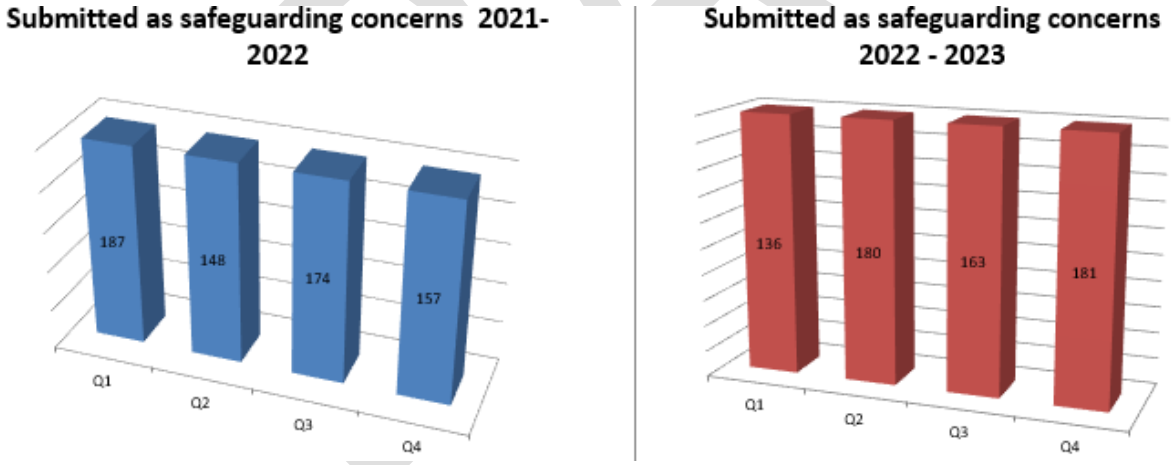


Figure 16: Safeguarding concerns 2021-22 and 2022-23

Summary

Two areas have been identified for development in 2023/24:

1. Strengthening a trauma informed practice approach within safeguarding.
2. Developing a process that allows assurance monitoring for advocacy referrals. This will be led by our Safeguarding Educator and MCA lead.

A new Safeguarding Adults Practitioner has begun working with the team. A dietician by background she has significant experience in safeguarding issues involving nutrition and will lead safeguarding awareness raising during Nutrition and Hydration week 2023.

Safeguarding Children

The Safeguarding Children Team are key members of the multi-agency safeguarding systems that are in place to protect children and young people. The role is to ensure that staff identify and advocate for vulnerable children, identify safeguarding concerns and take action in the form of timely referrals to children's social care and specialist support services. The Team continues to represent the Trust at South Tees Safeguarding Partnership meetings and actively contribute to the multi-agency work programme across the Partnership. They contribute to multiagency Child Safeguarding Practice Reviews and Domestic Homicide Reviews and participate in identifying learning and implement action plans.

- The team take an average of 1400 calls from Trust staff and partner agencies each quarter.
- Trust staff make an average of 450 safeguarding children referrals per quarter.
- Paediatric consultants carry out approximately 130 child protection medicals per year.
- The team undertake regular audits to gain assurances around safeguarding practice and during 2022/23 has completed the following:
    - Quality of SAFER referrals made by Maternity, Paediatric Ward and Emergency Department (ED). The frequency of audits in each area is reduced when good results are sustained, and support provided if any issues are identified.
    - Midwives' attendance at Initial Child Protection Conferences (ICPC's). Sharing results with maternity community managers and reasons for non-attendance has improved attendance from 52% to 71%.
    - Multiagency Hidden Males Audit. The results showed the name of fathers or relevant males was not recorded consistently. This has been a focus of training and another audit is planned.
    - Exploitation Screening Tool in Children and Young Peoples Emergency Department (CYPED). This was a base line audit following changes to questions asked in CYPED. The results showed the tool was effective in identifying children at risk and prompted staff to consider exploitation but was reliant on correct data input at triage.

The safeguarding children team have also led and contributed to the development of several standard operating procedures and have led the development of policies including Domestic Abuse and Children in Hospital (Section 85). They are proactive in disseminating key safeguarding messages and learning from both local and national reviews. To support this process the Safeguarding Educator has created a Safeguarding Facebook page which has been well received by staff and is proving to be an effective means of information sharing across the organisation.

Safeguarding Champions have been identified and are given regular updates and information to disseminate to staff. They are offered one-to-one supervision by the safeguarding team and have secured office space at Friarage Hospital which increases the visibility of the team across the sites. The team also provide supervision to many other staff groups across the organisation. All community midwives are required to have 12 weekly supervisions and compliance has been over 98% throughout 2022-23 despite organisational pressures.

Summary

There has been a significant amount of work undertaken during 2022/23. Key achievements are:

- Establishment of Safeguarding Champions and Facebook page
- Maintaining attendance at supervision despite significant pressures on maternity staff.
- Good attendance at ED liaison meetings and positive feedback from group members.
- Maternity and Neonatal Unit liaison meetings will be embedded in practice this year.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental capacity oversight sits within the safeguarding team. A full time Mental Capacity Act (MCA) Lead commenced in post on 1 September 2022. Revised bespoke and mandatory training was put in place and delivered by our Safeguarding Educator and MCA Lead.

A review of the MCA process and preparation for the new Liberty Protection Safeguards (LPS) which is expected to replace Deprivation of Liberty Safeguards (DoLS) has taken place, with greater visibility of the MCA Lead across the Trust and timely escalation of complex patients to multidisciplinary team meetings. Triangulation of relevant audits with data from other internal sources and from partner agencies is accessed and used throughout the organisation.

Daily ward visits and reinforcing of learning have improved referrals related to DoLS since the MCA Lead started in post in September 2022.

Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
52	64	56	45	46	50	65	113	76	101	95	121

Table 6: Numbers of DoLS referrals April 2022 – March 2023

There have been 884 urgent authorisations or standard applications to assess safeguards in place for patients deprived of their liberty which is 14% increase from 2020-21 when 670 applications were made.

A quality assurance process takes place three times per week scrutinising ward-based MCA/DoLS practice through an audit of 15 criteria ranging from decision specific capacity assessments, risk assessments and LPS compliance. After each audit the ward receive feedback highlighting good practice, areas needing focus and any concerns. This information is also shared with the Assistant Directors of Nursing for each clinical collaborative, matrons and the ward managers.

An MCA pathway was developed following discussions with ward staff in order that there was clarity of process regarding capacity assessments and best interest (BI) decision making. The description of the decision is not limited and staff are provided with a range of different pathways dependent on the decision needed.

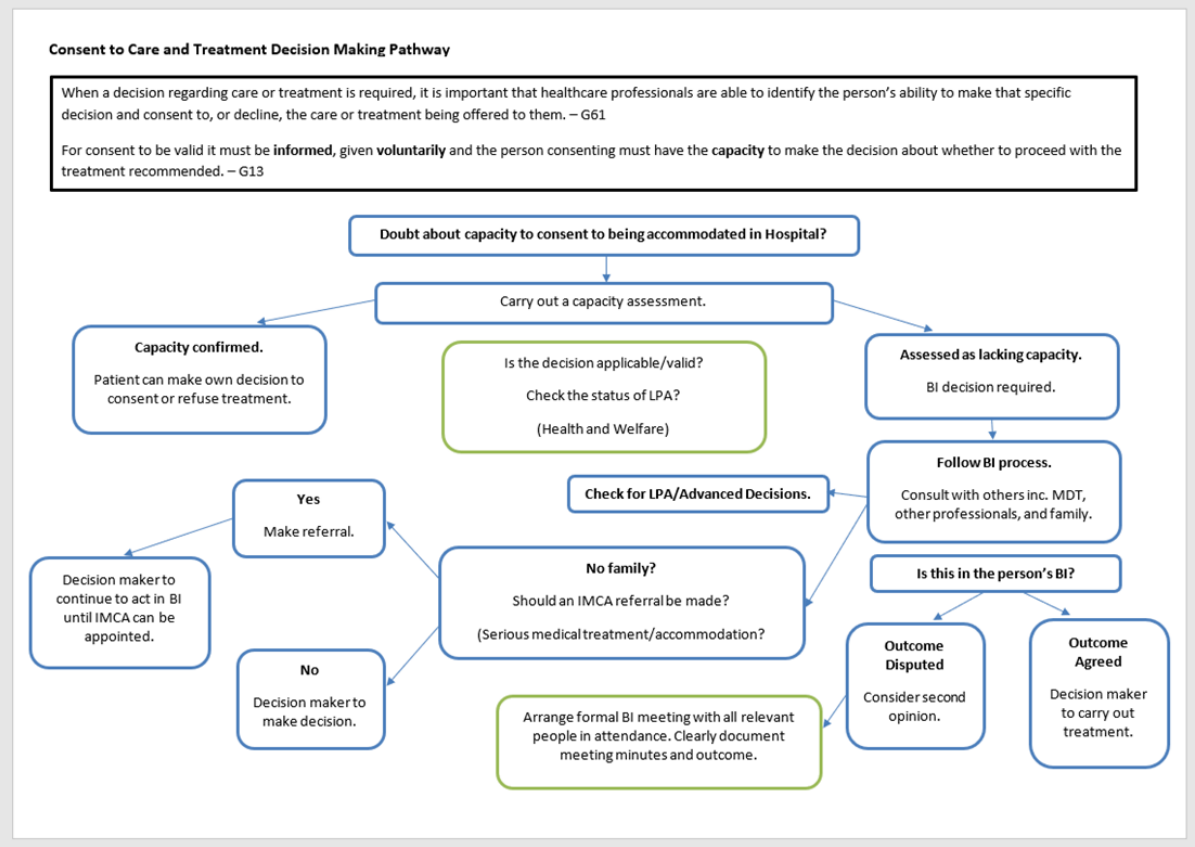


Figure 18: Mental Capacity Act pathway

A new risk assessment was created and introduced in November 2022 for use during triage in the Emergency Department to prompt capacity and consent conversations. This is completed for any patient who presents with self-harm or a mental health presentation at triage.
There are currently 77 MCA champions across the Trust who promote good practice. We also use our dedicated intranet page, Facebook and Twitter posts to communicate key messages to a wide staff population.

Summary
Significant changes have been made to ensure patient safety, staff training, support and the Trust's legal duties are maintained and upheld. The MCA Lead has been involved in local and national networks in order to ensure the Trust was keeping up with the expected changes and was writing a business case to be LPS ready when announcements were made, however LPS has been put on hold by the current Government.

Visibility and engagement with wards across all our clinical collaboratives is in place and the MCA Lead is sighted on all DoLS applications for quality assurance.

This has resulted in significant improvements in documentation of assessment of capacity, best interest decision making and DoLS as noted in the CQC inspection report. There remains work to do to fully embed the processes established, but the robust monitoring of compliance provides good assurance that this will rapidly be achieved.

Learning Disabilities

People with a learning disability tend to have poorer physical and mental health than the general population. On average the life expectancy of women with a learning disability is 17 years shorter than for women in the general population. On average the life expectancy of men with a learning disability is 14 years shorter than for men in the general population (NHS Digital, 2018).

- Approximately 2.16% of adults in the UK are believed to have a learning disability.
- Approximately 2.5% of children have a learning disability.

The Trust has worked closely with the NorthEast and North Cumbria Learning Disability Network to standardise documents for use across the region. During this period a hospital passport, hospital pack and training pack have been designed and produced.

E-learning in learning disability awareness was made mandatory for all staff in August 2022. The training includes a bespoke film produced by the Twisting Ducks Theatre Company to raise staff awareness of the importance of making reasonable adjustments and the use of the hospital passport. In March 2023 81.59% (7926) staff had completed the learning disability mandatory awareness training.

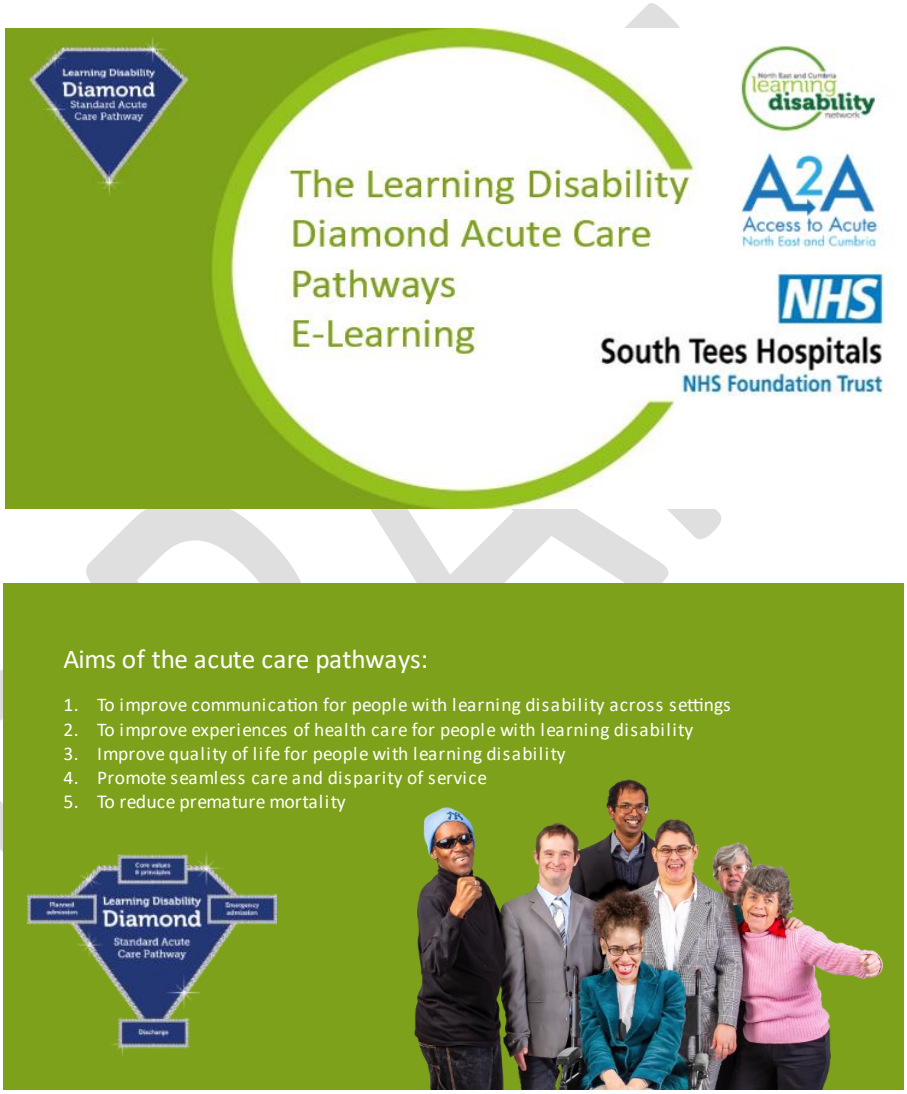


Figure 19: Learning disability diamond acute care pathways e-learning

The Learning Disability Partnership Group meets bimonthly. It is well attended by internal and external representatives, with people with lived experience taking an active role.

The Trust's external website has been redesigned with easy read information accessible from the main page. Easy read appointment letters are sent out to patients who are identified as having a learning disability.

We know the first step to making sure reasonable adjustments are made is the early identification of patients, which depends on safe sharing of information. We have worked closely with Tees Esk and Wear Valley (TEWV) NHS Foundation Trust to draw up a Partnership Sharing Agreement to enable relevant data to be shared from the learning disability trust. Holgate Primary Care Network have also shared data in 2022. During 2022/23 we received data on 553 patients from Tees Esk and Wear Valleys NHS Trust (January 2023) and Holgate PCN (August 2022). At the end of quarter 4 2022/23 we had 1610 patients identified as having a learning disability.

In January 2023 we submitted our national LD audit data for the fifth consecutive year. The results will be published in May 2023. This is linked to the NHS England Learning Disability Improvement Standards, as is the Trust Learning Disability Improvement Plan.

In 2022/23, we have had 17 deaths reported of inpatients with a learning disability (ten male, seven female), the average age at death was 58 years. The death of any patient with a learning disability in the Trust is examined by a Medical Examiner and a subject judgment review (SJR) takes place. The SJR is submitted to the external Learning Disability Mortality Reviewer for scrutiny and data collection. If any concerns or actions are identified, there is a more in-depth focused review. During 2022/23 we had two focused reviews. The Learning Disability Mortality Action Plan is currently being updated to evidence the actions following SJRs and monitor any emerging themes.

Summary

Good progress has been achieved during 2022/23. We have continued to increase the number of patients identified with a learning disability, year on year, with the largest increase in 2022/23. The Trust now employs 18 registered learning disability nurses in a variety of roles across the organisation. Funding for the role of Acute Learning Disability Liaison Nurse has been secured and once appointed, will increase the availability of clinical support to both patients and staff, and ultimately improve patient outcomes.

During 2023 the Oliver McGowan Learning Disability and Autism training tier 1 is expected to be introduced, with tier 2 to follow. Integral to both tiers are people with a learning disability and people with autism. We are in the process of updating our friends and family (FFT) survey to make it more accessible, and to enable relevant patients and carers to be contacted by phone.

Patients who miss outpatient appointments need to be identified and additional support put in place. This is part of the NHS improvement audit and is recognised to improve patient outcomes and reduce health inequalities. A Fairer Access Working Group are meeting monthly with an aim to identify and reduce the number of outpatient appointments where the patient ‘did not attend’ or ‘was not brought’. Using Trust data, the group have identified paediatrics and maternity as services with the greatest number of missed appointments. The safeguarding team are working to produce an adult focussed Was Not Brought Policy in 2023.

2. Falls

Falls can have a physical and psychological impact upon patients and contribute to added health needs, lengthening hospital stays, deconditioning, and increased frailty. Ensuring patients are assessed and care plans developed in a timely manner occurs best when all parts of the system are aware of risks, preventive measures, methods of assessment, evidence-based responses, and where access to expertise, and training and development is robust. The section below sets out what has been achieved during the previous year and what is planned for the coming year.

Work done during 2022/23

- Completed a full trust policy review in relation to falls.

- 250 inpatient healthcare assistants (HCAs) and support staff trained in falls prevention.
- 53 student nurses trained in falls prevention.
- Extended training offer to SERCO staff in ward areas.
- Seven ward areas provided with bespoke training to support their falls prevention work.
- Contributed to the development of electronic assessments, reviewing current provisions and ensuring new systems are NICE guidelines compliant.
- Enabled all allied health professionals (AHPs) to have Patientrack access, which helps to ensure all professionals hold accountability for documenting their role in falls prevention.
- Contributed to creation of best practice guidelines regarding BP measurement as part of patient falls risk assessment.
- Completed Best Practise in Dementia facilitator training to support reducing falls rates within the Trust as part of a broader, comprehensive approach to safer mobility within hospital. Preparing materials for roll out in April 2023 and to develop a cohort of dementia champions in inpatient ward areas.
- Creation of monthly Falls Champions Forum with two identified link nurses in all inpatient areas, and recently addition of physiotherapy, occupational therapy, dietetics and pharmacy staff, stressing the importance of multidisciplinary working.
- Developed workstream directly with therapeutic care and dementia teams to ensure patients are seen at the right time, by the right person.
- Created prompts within existing reporting systems to engage with the Falls Lead if a patient has two or more falls during the same inpatient admission. Thirty reviews have taken place through this process.
- Introduction of yellow socks for patients with elevated falls risk. This visual method helps ensure patients are identified throughout the admission and ward transfer processes.
- Patient care plans introduced on the Clinical Decisions Unit at Friarage Hospital. Falls have reduced since implementation and staff feedback has been positive.
- Contributed to learning following reviews of multiple fallers and serious incidents within ward areas with recommendations for practice and supporting the actions agreed.
- Reduced waiting list for assessment in community from 20 weeks to 10 weeks with further resources identified to reduce further.
- South Tees wide strategy is in development, for which the team has been shortlisted for a Healthwatch award.
- Delivered training across the community pathway. 90 staff members from health, social care and partner organisations have been trained since October 2022.
- 48 therapists booked onto a falls and balance exercise training programme to ensure older people who fall get the best evidence-based interventions.
- Continue to promote www.steadyonyourfeet.org across the pathway which has been developed to inspire behaviour change and reduce the risk of falls. South Tees is an active partner.

Summary

This year has focused on the systems we use to identify and respond to falls for patients, recognising the learning opportunities for the organisation, the delivery of education and increasing awareness of the need for falls prevention assessment for patients at risk. To enhance our work, we have identified the need for a Trust wide Falls Group, who represent inpatient and community services, so that we can share learning, enhance communication, and build a clearer learning and development plan. The following activities have begun and will continue throughout the next 12 months.

- Development and embedding of a Trust wide Falls Steering Group.
- Quality improvement process mapping, to clarify the patient journey from admission through to discharge from the point of the fall. The aim is to review processes, systems, and responses which are working well and those which need further development.
- Benchmarking exercise to identify where falls prevention and post fall work is currently happening, and aligning this with responses to frailty, deconditioning, delirium, and dementia care pathways.
- Review the impact of falls work, including financial cost / benefit analysis, return on investment and productivity data.
- Reimagining the falls curriculum, to identify additional learning approaches and methods for engagement across the Trust.
- Community falls summit planned for 26 April 2023, bringing together our partners and agencies to share learning.

3. Duty of candour

There is a professional duty of candour for healthcare staff and also a statutory duty of candour. They have similar aims – to make sure that those providing care are open and transparent with the people using their services, whether or not something has gone wrong. The statutory duty also includes specific requirements for certain situations known as notifiable safety incidents.

During 2022/23, the Trust has continued to strengthen the approach to duty of candour across the organisation. There have been education sessions provided to clinical staff to raise awareness of the regulatory and good practice elements of duty of candour and to promote the potential of the process to drive up the quality of care within the organisation.

Compliance with all elements of the statutory duty of candour is proactively and closely monitored within the Trust, with a monthly compliance report presented at the Patient Safety Steering Group. Any exceptions are routinely followed up by the Patient Safety Team until there is evidence that duty of candour requirements have been fully met. Across the year, the Trust has seen increasing compliance against all aspects of the duty of candour.

To enhance the Trust's approach to fulfilling the duty of candour, the role of the Family Liaison Officer (FLO) has continued to be embedded during 2022/23. The purpose of the FLO role is to facilitate the delivery of duty of candour, engaging with and supporting patients and/or families following the occurrence of a harmful patient safety incident, and enabling the meaningful involvement of the patient and/or family in the subsequent patient safety investigation. There are currently 40 trained FLOs within the organisation, and a further training cohort is planned in June 2023.

To further strengthen the engagement and support provided to patients and/or families involved in patient safety incidents, the Trust has been successful in being awarded funding from the Academic Health Sciences Network to commission Restorative Practice training for two cohorts of staff during 2023. The course will study the ethos of a restorative approach in response to the impact of harmful events and relationship strain within health settings. This focus will explore the needs of impacted individuals and the context for restorative responses to healthcare harm.

In summary, the Trust continues to promote openness and transparency as the default position for working with our patients and their families.

4. Maternity

Our maternity services are a core part of what is delivered both locally and regionally, with ongoing work continuing to improve maternity care, based on the findings and recommendations from recently published national maternity inquiries, investigations and reports. Below is a summary of our achievements, along with some areas which need further attention and focus.

Figure 20: Photograph of some members of the South Tees Maternity Service

During 2022/23 the South Tees Maternity Service has reviewed all the actions from the Shrewsbury and Telford inquiry led by Donna Ockenden and implemented changes to ensure we are meeting the seven immediate and essential actions required of all maternity service providers. This work has included changes in how we review maternity patient safety incidents, the experiences of women, birthing people, babies and families, and how we provide assurance about the quality and safety of our service. The regional maternity team which included service users visited our unit in May 2022 to review how we are meeting these actions. The team were happy that we met all the requirements of these seven actions. The team commented that staff felt comfortable in raising issues, there was a strong training culture, there was clear visibility at Trust Board and Local Maternity System level of the unit. The Trust was also noted as having an active Maternity Voices Partnership (MVP) with good service user involvement.

An MVP is an NHS working group comprising women and their families, commissioners, and providers (midwives and doctors) working together to review and contribute to the development of local maternity care. The local MVP has appointed new co-chairs and is increasing its presence in the community by speaking to women, birthing people and families who are using our services. Members of a working group are reaching out to our ethnic minority women and birthing people who are using our maternity services.

As part of our quality and safety work we have also met all the requirements for the ten national maternity safety standards defined by NHS Resolution.

A preterm birth clinic has been established supported by a preterm birth specialist midwife. This team are working closely with the Local Maternity and Neonatal System and the Maternity and Neonatal Safety Improvement Programme to deliver the best outcomes for the preterm baby.

Results

The national maternity survey results for 2022 showed the South Tees Maternity Services were rated much better than expected for one question, better than expected for six questions and somewhat better than expected for seven questions. The service scored in the top 20% of Trusts on 33 questions and in the bottom 20% on one question out of a total of 59. This question related to choices of where to have your baby. This may have been reflective of the change of use of the co-located midwifery led unit at James Cook University Hospital during the Covid-19 pandemic. Midwifery staffing has meant this unit has not yet fully reopened.

Further details about this and other national surveys reported during 2022/23 are detailed in section 3.4 of this report.

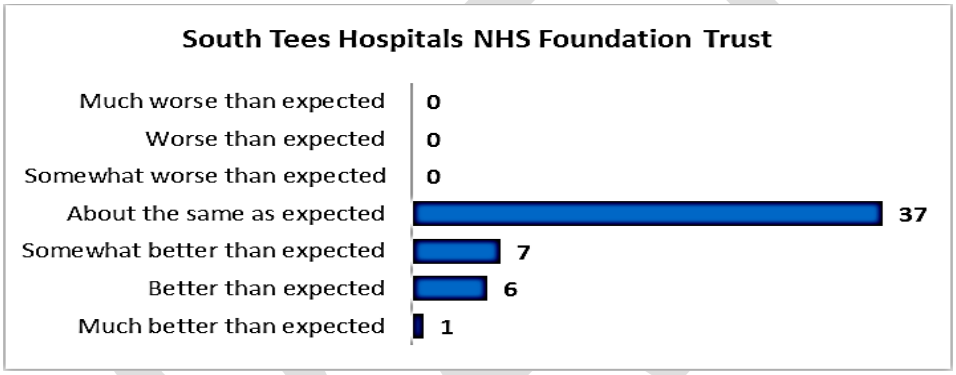


Figure 21: Results of the 2022 National Maternity Survey

We measure how happy women are with their care through patient experience surveys. Our friends and family test results show that on average 90% of women rate their experience of care as either very good or good.

We have achieved all our obstetric training requirements for 2022/23 with over 90% of midwives, obstetric doctors and support workers attending face to face training.

As part of the Saving Lives Care Bundle we are required to undertake carbon monoxide monitoring. We have achieved 90% compliance with this at booking and 85% compliance at 36 weeks since July 2022. Foetal growth risk assessments were also completed in 97% of pregnancies.

Summary and next steps

We have led a project to improve access to maternity care for vulnerable women, birthing people and families. This project is a collaboration with the family hubs which are being coordinated by the local councils.

We are moving to electronic maternity notes (Badgernet) in April 2023, with the aim of improving care for our women/birthing people by giving access to a personalised care plan where they can add comments, see outcomes of visits and work with their midwife to plan their care. The midwifery and obstetric team will also be able to access notes more easily.

Our last maternity CQC inspection was in 2015, when an overall rating of good was given. In line with the new CQC maternity inspection framework, we anticipate the Trust will be inspected again during the next 12 months.

A working group will be established in early 2023 to review induction of labour. We currently have the highest induction of labour rates in the North East. This will look at the whole induction pathway from decision making to labour. This will include how women/birthing people are involved in the decision making around induction. There is also ongoing work being completed around birth choices including place of birth.

Nationally there will be a single delivery plan for maternity services, and this will be implemented across the NHS in 2023.

3.3 Clinical effectiveness indicators

1. Research

The Trust is a partner organisation within the Clinical Research Network for the North-East and North Cumbria (CRN NENC) and supports the CRN NENC to deliver and lead high quality research as part of the National Institute for Health Research (NIHR) portfolio.

We are part of the Tees Valley Research Alliance (TVRA). This alliance combines the research and development departments from our trust and North Tees and Hartlepool NHS trust into one alliance which provides a more efficient research set up and delivery service that attracts external research sponsors. The aim is to share information on studies so that all patients across the Tees Valley are offered the same opportunities to take part in cutting edge clinical trials. A clear strategy and annual improvement plans outline our priorities for research in the TVRA.

There is a clear link between research activity, clinical outcomes and improved patient experience. Over the last year there have been many position statements from professional bodies (Royal College of Physicians, General Medical Council, Nursing and Midwifery Council) highlighting the importance of research and the need for all health professionals to be involved in supporting research, in addition to the need for Trust Board endorsement and support to enable and deliver these objectives.

As noted in part 2 of this report, the number of patients that were recruited during 2022/23 to participate in research approved by a research ethics committee was our highest recruitment to date at 5588 (across 157 studies), a 47% increase from last year. We have opened several large recruiting studies within our children's, and reproductive health portfolios which have contributed to this significant increase.

We have established a core Chief Investigator Support Service within the TVRA to provide sponsor related support and oversight for all TVRA sponsored studies and co-fund a post with MedConnect North to support the development of Med Tech and Investigator Initiated trials with an additional post planned for 2023/24. We have supported the establishment of three new Academic Research Units in the TVRA to provide specialist support and training for Chief Investigator led studies from Cardiology (Academic Cardiovascular Unit (ACU), Surgery (Academic Centre for Surgery (ACeS) and Perioperative care.

(https://www.southtees.nhs.uk/about/strive/research-team/academic-cardiovascular-unit/ and https://www.southtees.nhs.uk/about/strive/research-team/aces/).

These Academic units have been developed in partnership with Newcastle University, Hull York Medical School, Health Sciences at the University of York, and the Royal College of Surgeons (RCS) of England providing new opportunities for research fellows within the Trust. Both the ACU and ACeS have received successful funding awards from prestigious funders for new studies and support a range of existing studies led by STH Chief Investigators.

Successful contingency funding requests from the CRN NENC have enabled us to extend the already successful secondment of heart failure specialist nurses into research roles at NTH and add an additional secondment and initiate a similar scheme at STH with Band 6 nurse and Band 7 Dietician supporting Critical Care research along with a Band 7 Trauma Practitioner and a Paediatric Advanced Practice Nurse. Both TVRA trusts have signed up to become members of the global TriNetX platform (https://trinetx.com). This will allow greater visibility of our trusts to potential commercial research sponsors thus bringing more cutting-edge trials to our populations. It will also allow our own researchers to interrogate our trust-based patient information systems to support study feasibility review.

Nursing, Midwifery, AHP and Clinical Research Practitioner engagement in research

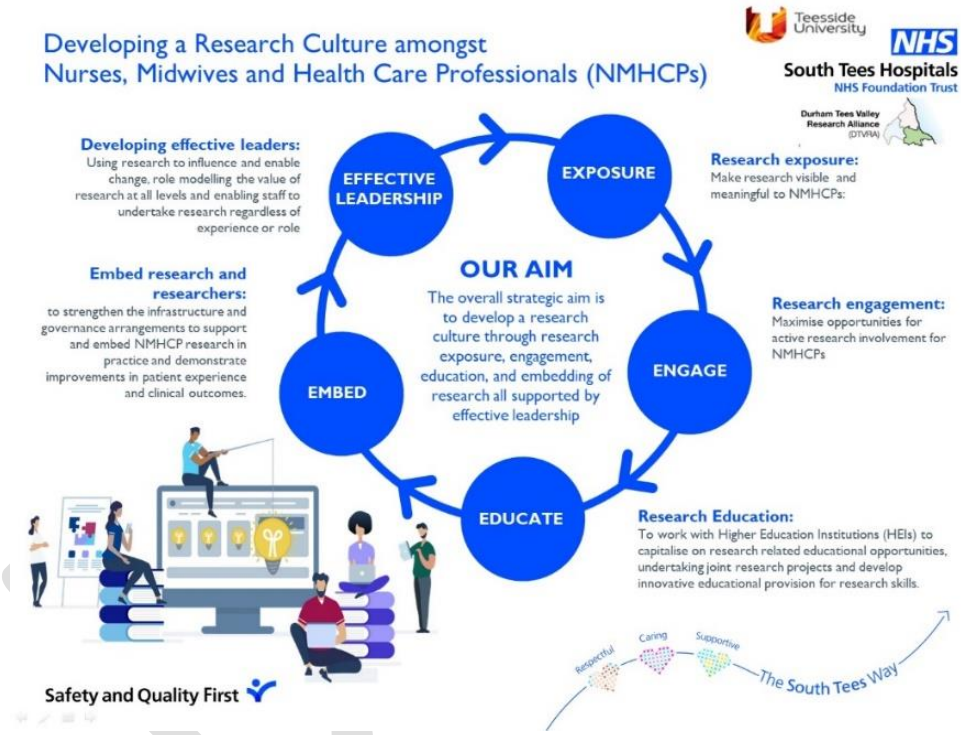


Figure 22: Developing a research culture graphic

Our Cancer Trials Team Leader has been appointed as the regional Clinical Research Practitioner (CRP) Lead for CRN NENC supporting CRP colleagues with accreditation and CRP engagement. Our Clinical & Operations Manager works closely with Directors and Associate Directors of Nursing in both trusts to progress the Nursing Midwifery and Allied Health Professional (NMAHP) research agenda, embed research and develop strategies for implementing the Chief Nursing Officer strategic objectives to increase engagement in research from this large staff group. We have an active “Research Support and Best Practice Council” at STH and “Be curious about research” campaign. We are currently in discussions with Senior Nurse Leaders to extend this council to NTH. We have increased the number of non-medical Principal Investigators this last year from 15 to 24 (16 STH, 8 NTH).

Patient Engagement

Feedback from patients who have participated in NIHR studies within the Trust is sought via the NIHR "Patient Research Experience Survey" with feedback reviewed quarterly at our Research and Development Directorate meetings. This year we have received very positive feedback from 179 research participants so far against an annual target of 190.

We routinely appoint patient representatives to the steering committees of our NIHR grant funded studies and carry out other patient and public involvement activity to inform the development of individual trials. We have significantly improved the content of staff facing and patient facing internet sites and are currently developing animations to explain the purpose of research and how patients can get involved.

Summary

South Tees is proud of its contribution to local and regional research, which drives improved clinical outcomes and improved patient experience. The research and development team are proud to have achieved their highest ever recruitment into NIHR portfolio trials this year, to be the highest recruiter regionally into two clinical specialties anaesthetics and perioperative pain, and diabetes, and having higher numbers of Principal Investigators (PIs) from non-medical staffing groups than ever before.

2. Getting it Right First Time (GIRFT)

GIRFT is part of an aligned set of programmes within NHS England designed to improve medical care within the NHS by reducing unwarranted variations. By tackling variations in the way services are delivered across the NHS and by sharing best practice between Trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.

South Tees Hospitals NHS Foundation Trust (STHFT) has established a central support function to facilitate and co-ordinate the GIRFT programme on behalf of the organisation. This is overseen by the Clinical Effectiveness team, with support from operational and clinical colleagues within the clinical collaboratives. In September 2022 we appointed a Senior Benchmarking Analyst who plays a pivotal role in supporting this process and triangulating our data.

During 2022/23 the trust engaged with deep dive visits within Orthopaedic Trauma Surgery and Pathology, with a further re-visit to the Cardiothoracic service. There was positive feedback for each service:

- The local GIRFT report for Pathology noted areas of exemplar practice, in particular with the working relationships between the pathology service and both Trust and primary care colleagues.
- The Orthopaedic Trauma Surgery visit report noted that *'mobilisation on the day after surgery is recorded as being one of the best in the country*'.
- In February 2023, the GIRFT national team published a delivery guide for '*Optimising the Transcatheter Aortic Valve Implantation (TAVI) Pathway*' based on work from James Cook University Hospital. A further GIRFT case study was also published to highlight this exemplary work from the Cardiothoracic team at South Tees Hospitals NHS Foundation Trust.

'James Cook University Hospital (JCUH) has delivered TAVI to patients who are either at high or intermediate risk for open heart surgery with suitable anatomy for the transfemoral approach under guidance of a multidisciplinary heart team since 2009. The JCUH team list four to five cases a day and have progressively optimised the pathway from referral to discharge and follow up, resulting in efficiencies such as shorter hospital stay, lower hospital costs, increased volume of TAVI procedures, better recovery, and improved clinical outcomes for patients.'

The recommendations GIRFT made following these visits have been added to the individual service implementation plans for review and action by the clinical teams. The Clinical Effectiveness team continues to arrange implementation plan review meetings with every service under the GIRFT remit.

In addition to individual service workstreams, the national GIRFT team have launched a High Volume Low Complexity (HVLC) workstream to support the recovery of elective care services post COVID-19 pandemic. This currently focuses on Day Case, Theatre Utilisation, Orthopaedics, Spinal, ENT, General Surgery, Urology, Ophthalmology and Gynaecology. Clinicians and senior leaders at the Trust have engaged with this programme and are working towards the improvements recommended.

In 2023 work began to overhaul and streamline the policy and process for the management of compliance and regulatory visits, inspections, and accreditation to ensure a robust central register for all external visits to the Trust.

3. Quality surveillance and peer reviews

As part of the Quality Assurance and Improvement Framework (QAIF) all specialised services including cancer are subject to the NHS England quality surveillance programme. There are a total of 74 specialised services on the South Tees Hospitals NHS Foundation Trust's directory of services. Historically trusts were required to complete annual self-declarations against a set of clinical quality indicators where information is not available through existing data sources. The declarations were a statement of compliance endorsed by the Chief Executive (or delegated authority) and were submitted through the Quality Surveillance Information System (QSIS) web portal by the submission deadline of 30 June each year. In February 2022 NHS England (NHSE) notified trusts that to reduce the burden on providers, specialised commissioning had made the decision to stop the annual self-declarations.

Some of these services were also required to submit data as part of the Specialised Services Quality Dashboards (SSQD). NHSE advised that the Specialised Services Quality Dashboard (SSQD) submission process would continue and be mandatory from Q1 2022/23. The QSIS web portal would transition to the Data Collection Framework (DCF) from Q3 2022/23, and subsequently would be through the Model Health System.

There have been 27 specialised services requiring submission of data to the Specialised Services Quality Dashboard (SSQD) against a defined set of metrics during 2022/23. Ten of these services require data that is automatically extracted by NHSE from an external source, 13 services require data to be submitted by the service provider and four services require both external and provider data. From Q4 2022/23 there is a new submission requirement for Cancer: Anal (adults) which will require provider data and bring the total of services on the dashboard to 28.

The Trust continues to monitor progress against actions for services that were deemed non-compliant following annual assessments in 2019/20 using a Service Development Improvement Plan (SDIP). The SDIP is now well embedded within the Trusts governance structure with reporting on a quarterly basis. The table below provides a summary of progress against these actions at the end of 2022/23.

Q4 2022/23		Number of actions	Actions completed	Actions mitigated	Actions ongoing
Total number of services	33	60	**24**	24	12
Number of cancer services (including subservices)	17	30	**8**	14	8
Number of specialised services	16	30	**16**	10	4

Table 7: Summary of progress with actions on the Service Development Improvement Plan.

During 2022/23 improvements made against outstanding actions include:

- Recruitment to interventional radiology with four posts filled which ensures the interventional radiology rotas for major trauma and vascular services were fully staffed from October 2022 and quoracy for some cancer MDT meetings is enhanced. The restorative dentist and chemotherapy day unit manager posts have also been filled. The adult critical care service has secured four consultant locums, and emergency department consultants moved to a 24/7 service on site from September 2022.
- Nurse training within the major trauma service is running at 50% of bands 3-7 in the emergency department completing the appropriate level of training. With the training programme gathering momentum it is anticipated that 85% of nurses will have completed by year end.

The regular peer review programme has not been resumed by NHS England (NHSE) but their Specialised Commissioning Quality Team were requested to undertake an external peer review visit of the spinal cord injury service at the Trust and this took place on 17 November 2022. The report was received in December 2022 and showed the service is fully compliant in all areas. Two areas of improvement were noted:

i. *Sustainability of workforce considerations should include resilience of medical workforce, succession planning within the leadership team, review of therapy services staffing and provision, clinical psychology service provision and the potential for expansion of roles (e.g. advanced nurse practitioners/advanced clinical practitioners).*

ii. *Lack of dedicated speech and language therapy (SLT) within the service.*

The service used the report to bid for monies from the transformation fund granted to the Northeast and Yorkshire region to support a reduction in variation within spinal cord services. £330K has been granted and allocated for SLT, psychology, nursing posts, physiotherapy and equipment.

3.4 Patient experience and involvement indicators

South Tees NHS Trust aims to create opportunities for increased engagement and involvement with our patients their relatives and carers, in order to develop responsive and receptive patient centred services, as described in section 2.1 of this report. We have included here some of the other work of the patient experience team.

1. Patient surveys

Friends and Family Test (FFT)

We continue to provide the FFT percentage positive data to NHS England. This is the proportion of responses of 'good' or 'very good' to the question "Overall, how was your experience of our service?" The results for 2022-23 show we score the same as or above the national average in seven out of nine surveys.

FFT	Total No. of Surveys	Average FFT Score (%)	Average National Score (%)
A&E/UTC	7,192	79	76
Inpatient	7,776	97	94
Outpatient	16,017	96	93
Community	3,084	99	94
Antenatal	506	92	90
Birth	276	90	93
Postnatal Inpatient	455	96	92
Postnatal Community	12	96	91
Long COVID	33	83	94

Table 8 - Friends and Family Test scores (% positive responses) reported to NHS England 2022-2023

The results are shared with staff and monitored as part of the STAQC processes. The Patient Experience Steering Group monitors the results and ensures the feedback is used to make improvements where appropriate. It also monitors the number of responses and when appropriate considers how to increase the number of responses to ensure a representative sample in smaller services such as the long COVID clinic.

Local patient surveys

The Trust continuously collects feedback from patients and carers utilising local surveys, including for adult inpatients, maternity (at the four touch points of antenatal, birth, postnatal ward and postnatal community), outpatients, community, children and young people and emergency care settings. All wards and departments access feedback for their area to analyse. The feedback is shared with the staff highlighting good practice and identifying areas where improvements can be made by the teams.

National Surveys

The 2022 results are expected to be published in August 2023. The latest published inpatient survey results are therefore from 2021 and are summarised below,

In comparison with other trusts, we scored better than expected on 1 question and somewhat better than expected on 3 questions, with a statistically significant increase on one question and a statistically significant decrease on five questions. 1250 patients were asked to take part and 471 responded, a response rate of 41%. Further detail of the results are provided in the table below.

We share the results with staff, thanking them for their contribution to providing a positive experience of inpatient care. Areas of weakness are reviewed, and actions developed to address any areas for improvement are monitored through the quality governance structure.

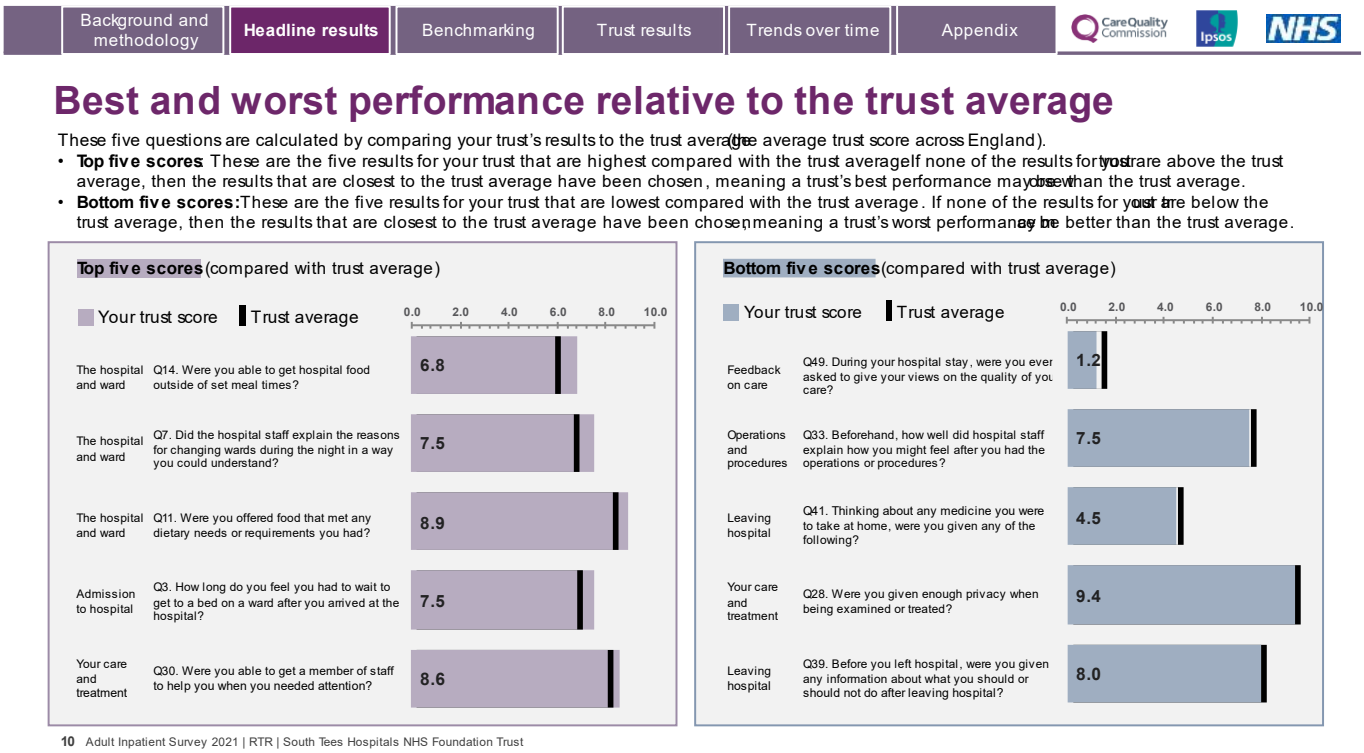


Figure 23: 2021 National Inpatient Survey results of our best and worst performance

National maternity survey

The national maternity survey was undertaken during February 2022 and the results were published by the CQC in January 2023. At the STHFT 321 women were included and 129 responded, giving a response rate of 40.31%. There were 59 questions and comparison is made against 120 NHS trusts. As noted previously in this report, the Trust scored:

- 'Much better than most trusts' in one question
- 'Better than most trusts' in six questions
- 'Somewhat better than most trusts' in seven questions
- 'About the same as other trusts' in 37 questions

None of the questions scored worse than other trusts. The STHFT scored in the top 20% of trusts on 33 questions and in the bottom 20% on one question.

A detailed review of the report and the comments received was undertaken. An action plan was developed to resolve issues with telephones not being answered when arranging a scan, and the birth reflections pathway regarding decisions about where to have a baby was reviewed. An induction working group has been set up to review feedback about inductions and involvement in decision making.

2. Patient information and the Accessible Information Standards

The Patient Information Policy was updated during 2022/23 in line with the current Accessible Information Standards (2016) and was approved in October 2022. All patient information is now placed on the Trust internet site and is easily accessible by patients and staff. To avoid patients being digitally excluded the information is downloadable for printing in the appropriate font size to meet the patient, carer or parents' requirements. The patient information provides two types of contact methods - telephone numbers and email address for patients who, for example, may not be able to use the telephone due to a health condition.

A report was provided to the Patient Experience Steering Group in March 2023 on the current position of patient information leaflets. A bank of patients and carers are in the process of being recruited to review all patient information, written and digital. The trust continues to promote the use of posters with QR codes, to download patient information, to reduce the amount of paper used and cost to the trust.

A workshop was held in October 2022 to review the Trusts position with regards to the Accessible Information Standards (AIS). Four objectives were identified, a baseline audit of current position, the scope was agreed with support from the clinical audit team. Mapping of processes to be held with internal and external stakeholders, providing training for staff to raise awareness and developing a policy and standard operating procedures, to ensure data capture and recording on trust systems and sharing with other sectors of health and social care.

3. Complaints, PALS and compliments

The Trust has a clear process for dealing with complaints, to ensure patients, carers and relatives feel able to raise their concerns without this adversely affecting their care. The process is detailed on ward and departmental noticeboards and can be found on the Trust website and in the patient experience leaflet. All correspondence issued by the Trust informs patients how to provide positive and negative feedback on the service they have received.

In 2022/23 there were 304 formal complaints received by South Tees Hospital NHS Foundation Trust (STHFT) a decrease of 10% on the previous year. The average number of formal complaints received each month is 25.

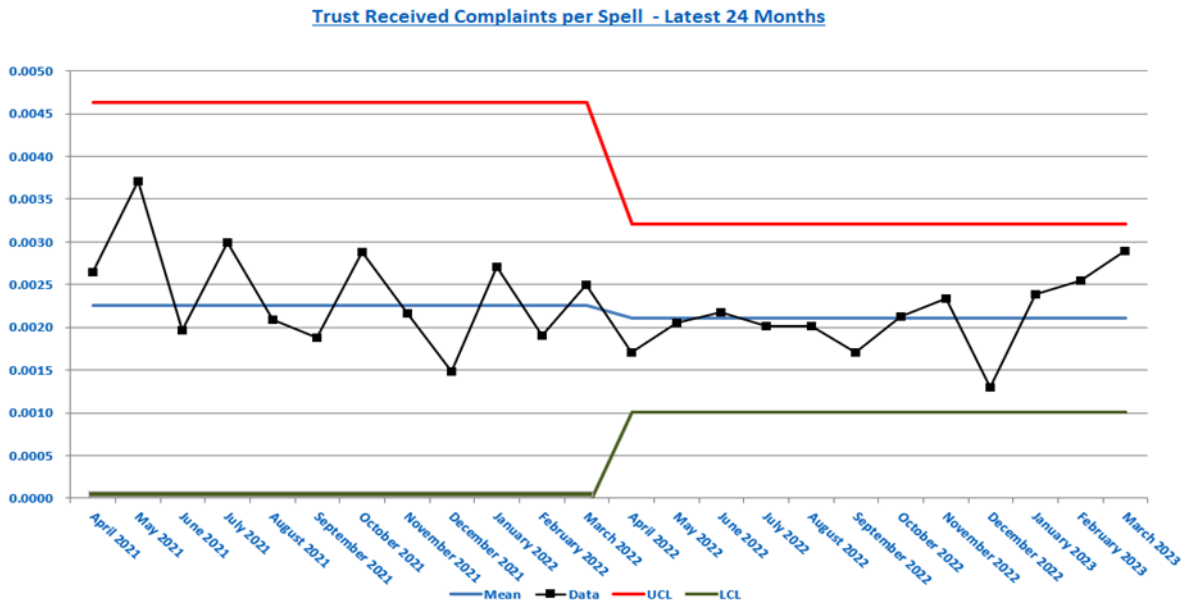


Figure 24: Trust received complaints per spell April 2021 – March 2023

Patient Advice and Liaison Service (PALS) concerns are forwarded to the appropriate clinician to respond to the complainant within the agreed 10 working day timeframe. The Trust has seen a downward trend in concerns being logged which is likely to be due to concerns being dealt with by the ward or department at source.

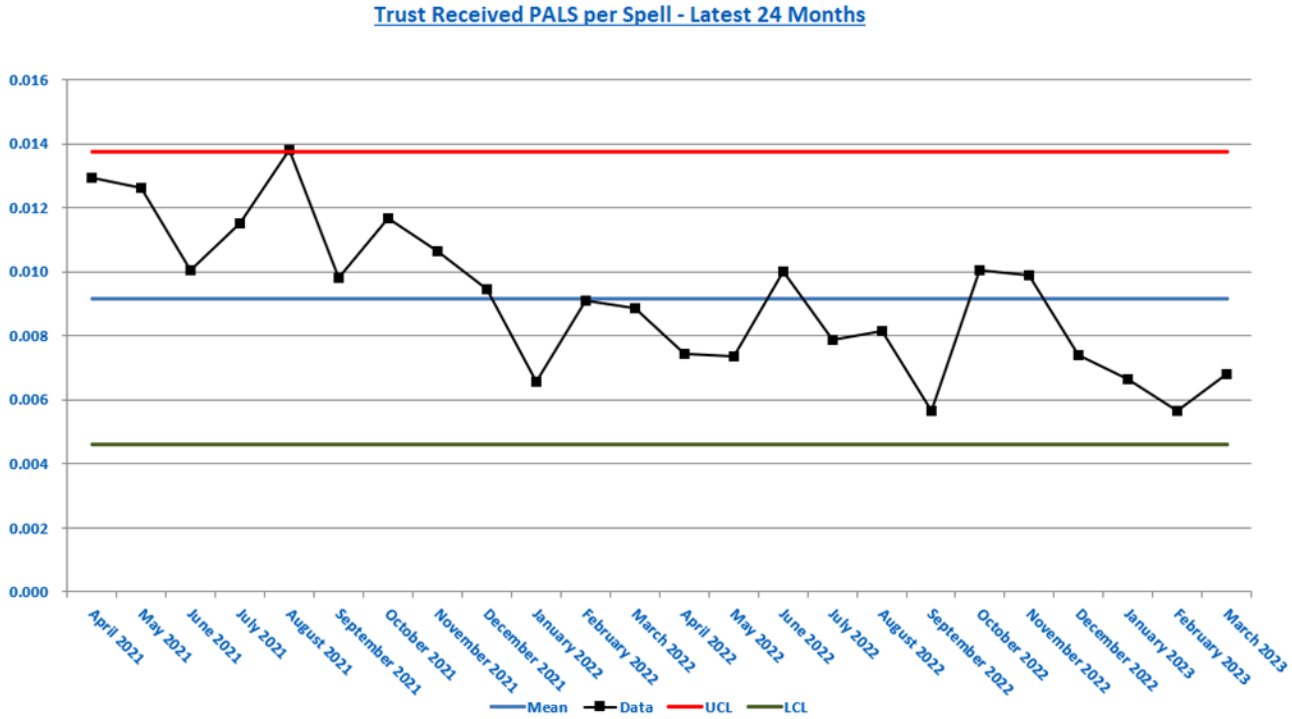


Figure 25: Trust received PALS per spell April 2021 – March 2023

The top three themes from complaints and PALS are;

- All aspects of clinical treatment.
- Communication and information given to patients.
- Delays and cancellations relating to outpatient appointments.

We aim to upload all compliments received by the Patient Experience Team to Datix and these are also shared with the wards and departments.

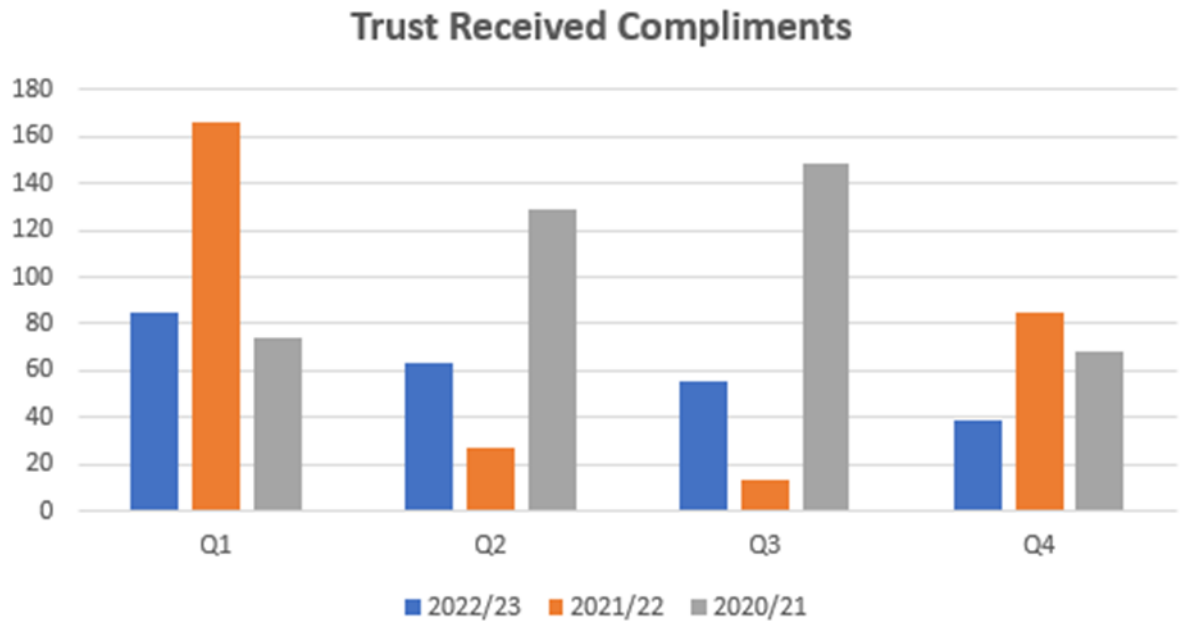


Figure 26: Trust received compliments logged on Datix 2020/21 – 2022/23

It should be noted that many compliments are received locally by the wards and departments, and although there is the facility for local areas to log their compliments on Datix, this is not a priority during times of staffing pressures. The data presented above will therefore under-represent compliments received.

Further work will be undertaken in 2022/23 to analyse the compliments received by the Trust. Themes are being added to Datix to enable further analysis of compliments to understand the patient's perception of good care and treatment.

3.5 Performance against key national priorities

	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	22/23 targets
Safety									
Clostridioides (C) *difficile* – meeting the C. *difficile* objective	61	43	48	41	89	79	138	140	N/a
All cancer – 62 day wait for first treatment from									
Urgent GP referral for suspected cancer	79.10%	81.10%	85.44%	82.65%	77.23%	75.52%	73.83%	59.88%	85%
NHS Cancer screening service referral	89.80%	89.00%	94.55%	87.14%	94.41%	62.77%	50.00%	68.71%	90%
18 weeks referral to treatment time (RTT)									
Incomplete pathways	93.20%	92.20%	91.45%	89.49%	83.33%	63.20%	65.37%	65.61%	92%
Accident & Emergency									
4 hour maximum wait in A&E from arrival to admission, transfer or discharge	95.80%	95.33%	95.68%	95.24%	88.35%	87.25%	75.52%	68.22%	95%
Diagnostic Waits									
Patients waiting 6 weeks or less for a diagnostic test	98.82%	99.15%	97.46%	98.26%	94.04%	72.57%	68.71%	77.57%	99%

Table 9: Performance against National Priorities

Key findings:

- C. *difficile.* The Trust recorded 140 cases of C. *difficile* during 2022/23. Further narrative can be found in part 2 of this quality account.
- Urgent GP referral for suspected cancer (62-day cancer wait target for first definitive treatment). Our year end performance was 59.88%. Recovery plans are in place to support improvement in the patient pathway and performance.
- 4-hour Accident and Emergency waiting time target. Year-end performance was 68.22%. Factors affecting the performance include an increase in acuity of patients, very high intensity users attending A&E and continued challenges in social care impacting the timeliness of patient discharge. Capacity within the hospital during the winter period has affected patient flow. Recovery plans are in place to address such issues.
- Referral to Treatment (RTT) 18-week target. Our year-end performance was 65.61%. Recovery plans and trajectories are in place to address areas of concern.
- Diagnostic Waits – (waiting 6 weeks or less). Our year-end performance was 77.57%. Recovery plans and trajectories are in place.
- As of the end of the 2022-23 financial year, the Trust has no patients who had waited more than 104 weeks from referral to treatment.

3.6 Additional required information

1. Seven-day services

Ten NHS Seven Day Hospital Services Clinical Standards were developed in 2013 to support providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency. Providers have been working to achieve all these standards, with a focus on four priority standards identified in 2015 with the support of the Academy of Medical Royal Colleges. The four priority standards were selected to ensure that patients have access to consultant-directed assessment (Clinical Standard 2), diagnostics (Clinical Standard 5), interventions (Clinical Standard 6) and ongoing review (Clinical Standard 8) every day of the week. Full details of all the clinical standards are available at: NHS England Seven-day-services clinical standards.

Trust Boards should assess, at least once a year, whether their acute services are meeting the four priority seven-day services clinical standards, using an updated board assurance framework (BAF) and guidance published in February 2022.

After the challenges of the COVID-19 response, the BAF for Seven Day Services re-focuses attention on the four key standards. An assessment against these standards was completed at South Tees in September 2022. The Trust is not comprehensively compliant with Standard 2 for ‘consultant review for all new admissions within 14 hours’ in every specialty throughout the week. This is due to more limited consultant presence on-site at weekends in specialities with smaller numbers of emergency admissions. The Trust is assured of timely senior clinical assessment for patients admitted as an emergency in all the higher volume specialties and when the patient is unwell or deteriorating. The Trust is also assured that arrangements are in place for daily senior review, and that there is safe access to diagnostic and consultant-led interventional services over the seven-day period, demonstrating compliance with these standards. Prompts for maintaining or improving compliance have been shared with Clinical Directors, and the self-assessment will be repeated annually.

2. Freedom to speak up

The goal of Freedom to Speak Up (FTSU) is to continue to change and improve the culture across the NHS. At South Tees, senior leaders, the Board and Chief Executive have been proactive in ensuring our service was strengthened and that the FTSU Guardians had access to senior leaders when needed. Over the last twelve months the model has seen continued improvements in the way it is implemented. There has been increased visibility, awareness, and accessibility to the FTSU Guardians for the 9,500 + colleagues within the Trust. This increased profile has helped the Trust to resolve concerns raised in a timely manner and seen positive outcomes recorded for the majority of concerns raised.

A wide range of data is collected by the FTSU Guardians and concerns raised are analysed for common themes. Information collected and collated in the last twelve months reflects the positive impact the model for speaking up has had for staff and patients between April 2022 and March 2023. A total of 101 issues were raised with the Guardians over this period, compared to 107 reported during 2021-2022 representing a small decrease of 8%.

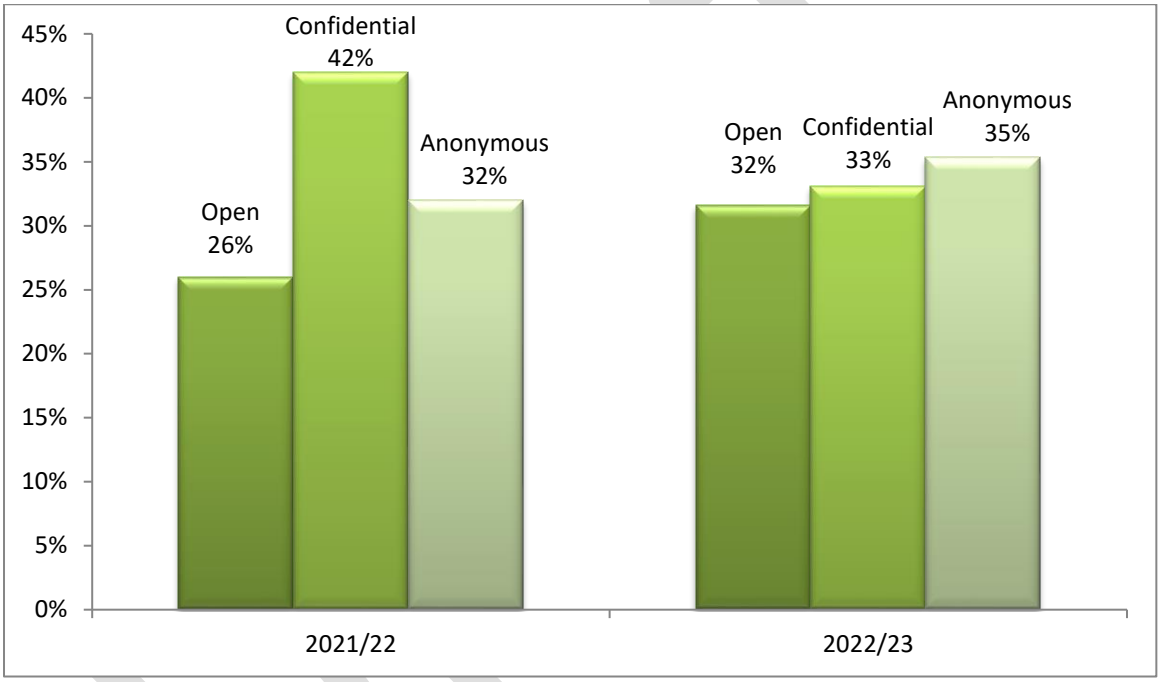


Figure 27: Number of issues raised with FTSU Guardians 2021/22 and 2022/23

The freedom to speak up questions in the NHS staff survey 2022 remain above the national average.

Staff Survey Question		2020/21 results	2021/22 results	2022/23 results	Comparison to 2022/23 national benchmarking
Q19a	I would feel secure raising concerns about unsafe clinical practice.	72.2%	76.9%	74.2%	70.8% (3.4%) ↑
Q19b	I am confident that my organisation would address my concern	58.7%	60.7%	58.3%	55.7% (2.6%) ↑

Q23e	I feel safe to speak up about anything that concerns me in this organisation	63.8%	64.7%	63.1%	60.3% (2.8%)
Q4	If I speak up about something that concerns me, I am confident that my organisation would address my concern	N/A	49.6%	48.1%	47.2% (0.9%)

Figure 28: Results of FTSU related questions in the National Staff Survey 2022

The Freedom to Speak up ethos and message has been embedded successfully across the Trust in all induction and preceptorship programmes. Links with the clinical educators for healthcare assistants (HCAs) and nurses trained overseas are now stronger. The FTSU Guardian team has also forged excellent links with the University of Teesside and we are regularly delivering sessions to student midwives, nurses and allied health professionals (AHPs).

The FTSU Guardian team also continues to reach out to other local organisations and has forged closer working links with our Military Freedom to Speak up colleagues and FTSU Guardians based at North Tees and Hartlepool, Tees Esk and Wear Valley, and County Durham NHS Trusts. There have been joint military South Tees awareness raising days and joint North Tees and South Tees staff inductions sessions at the University of Teesside.

Our network of Freedom to Speak up Champions from across the organisation continues to grow. Our champions range from administrative and clerical staff to consultant and military colleagues. Currently we have 21 confirmed Freedom to Speak Up Champions. The last champions training session was held in September 2022 with the lead FTSU Guardian and ten champions attending.

<u>How staff can speak up</u>

There are a number of ways that South Tees staff can speak up about issues that concern them around areas such as patient safety, staff safety, bullying and harassment, and leadership and communication issues. Whilst the FTSU team is a vital element within this model it is only one of a number of ways that staff can speak up. Detailed in the diagram below are the other ways in which staff who have a concern can speak up if the FTSU team is not their preferred route.

Figure 29: Ways in which staff can speak up about a concern

Staff can speak up either anonymously, confidentially, or openly to anyone in the above diagram. They can also speak up as an individual or as part of a larger group if they wish.

Following the closure of a concern, staff are given feedback from the investigator in relation to the concerns raised as long as this does not breach confidentiality rules. Feedback is given to the concern raisers and any other people or groups affected by the issues raised.

Nationally, one of the main barriers to staff speaking up about concerns they may have in relation to patient safety, staff safety and other issues that can be brought to the FTSU Guardian team is that of detrimental treatment. The latest version of the Trust's Freedom to Speak Up – Raising Concerns Policy now has a section around detriment that describes what detriment is or might look like and details what action will be taken in the event of detrimental treatment arising.

<u>Feedback from staff</u>
Guardians continue to receive feedback either by email or face-to-face depending on the preference of the concern raiser, provided they have passed on their details and not reported their concerns anonymously. Feedback is important to ensure the 'loop is closed' and staff are reassured their concerns are taken seriously and investigated.

A section on the report template provided to investigators requires detail about how feedback was assimilated and used to improve services. Staff are also encouraged to report any detriment to the FTSU Guardians, and this is monitored and reported back to the National Guardians Office.
Feedback received in this reporting period has been overwhelmingly positive. When asked if they would feel happy to speak up about concerns in future, the majority of respondents replied that they would, with just one responding that they would not. When respondents were asked about their experience of raising a concern with the FTSU Guardians, they provided the following responses:

"Very good service listened well and was a good point of contact"
"Guardian Lead was great, listened to my concern"
"Felt comfortable and able to discuss all issues knowing I could proceed at a pace that I felt comfortable with"

3. Rota gaps for doctors and Dentists in training

Schedule 6, paragraph 11a of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 requires: "*The Board must receive a Guardian of Safe Working Report no less than once per quarter. This report shall also be provided to the Joint Local Negotiating Committee (JLNC), or equivalent. It will include data on all rota gaps on all shifts"*[1]. South Tees is committed to this request; our Guardian of Safe Working (GOSW) along with our medical workforce team provide routine reports to the Trust Board and JLNC.

In addition to this our GOSW meets regularly with the Chief Medical Officer (CMO) and members of his office to ensure we are all working towards addressing issues highlighted to the GOSW through exception reports or other avenues of escalation.

In particular, the CMO office and GOSW are working together, with surgical colleagues, to improve the working life experience of our junior doctors in surgical specialities.

Schedule 6, paragraph 11b of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 requires: "A consolidated annual report on rota gaps and the plan for improvement to reduce these gaps (which) shall be included in a statement in the Trust's Quality Account." As a Trust we have faced some difficulties regarding accurate and contemporaneous data regarding our junior doctor establishment and therefore the provision of accurate reports on gaps. We have recently procured a new rostering system which is designed for medical rotas, and we will be seeking to ensure that this rostering system is aligned to our Electronic Staff Record and finance ledger, resulting in accurate information across our systems and more dependable data.

The Trust aspires to triangulate data regarding rota gaps in each collaborative with information on quality and safety incidents as well as the number of exception reports raised in each area, giving us rich data about our clinical productivity as well as the safety of our staff and patients.
Our GOSW has led on work to analyse what 'safe medical rotas' look like in daytime hours and this work is continuing regarding assessing our safe staffing levels out of hours. This planning information will be incorporated into the new rostering system, so we have clarity on where we are, and are not, meeting safe staffing levels on medical rotas.

Over the last year we have implemented new policies regarding the management of gaps on junior rotas to ensure there is a consistent approach throughout the Trust, and adherence to these policies will continue throughout the next year. We continue to fill the majority of gaps on our rotas through realignment of staff (including our non-medical staff who contribute to medical rotas), locums through our regional locum bank (FlexiShift) hosted by the North-East Lead Employer Trust (LET), or our locally employed doctors.

[1] NHS-Doctors-and-Dentists-in-Training-England-TCS-2016-VERSION-11.pdf (nhsemployers.org)

Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

Annex 2: Statement of directors responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the 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 2018/19* and supporting guidance *Detailed requirements for quality reports 2018/19*
- the content of the quality report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2022 to March 2023
    - papers relating to quality reported to the board over the period April 2022 to March 2023
    - feedback from commissioners dated XX/XX/20XX
    - feedback from governors dated XX/XX/20XX
    - feedback from local Healthwatch organisations dated XX/XX/20XX
    - feedback from overview and scrutiny committee dated XX/XX/20XX
    - the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 5 May 2023
    - the [latest] national patient survey October 2022
    - the [latest] national staff survey 9 March 2023
    - the Head of Internal Audit's annual opinion of the trust's control environment 23rd May 2023
    - CQC inspection report dated 24/05/2023
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported 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
- [this point is only required where the foundation trust is not reporting performance against an indicator that otherwise would have been subject to assurance] as the trust is currently not reporting performance against the indicator [xxx] due to [xxx], the directors have a plan in place to remedy this and return to full reporting by [xxx]
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review

- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the board

.....Date.....Chairman

.....Date.....Chief Executive

Annex 3: Glossary of terms

18 Week RTT (Referral to Treatment)
This refers to the right to start your consultant-led treatment within a maximum of 18 weeks from referral, unless you choose to wait longer, or it is clinically appropriate that you wait longer. The Trust monitors this monthly.

A&E
Accident and Emergency (usually refers to a hospital casualty department) where patients attend for assessment

Acute
A condition of short duration that starts quickly and has severe symptoms.

Allied Health Professional (AHP)
Professionals (other than nurses) who work in health care teams to make the health care system function by providing a range of diagnostic, technical, therapeutic and direct patient care and support services that are critical to the other health professionals they work with and the patients they serve.

Assurance
Confidence, based on sufficient evidence that internal controls are in place, operating effectively and objectives are being achieved.

BadgerNet
BadgerNet's Maternity Notes is an online portal

Black, Asian and minority ethnic (BAME)
All ethnic groups except white ethnic groups; it does not relate to country origin or affiliation.

Board of Directors (of Trust)
The role of the Trusts board is to take corporate responsibility for the organisation's strategies and actions. The chair and non-executive directors are lay people drawn from the local community and accountable to the Council of Governors. The chief executive is responsible for ensuring that the board is empowered to govern the organisation and to deliver its objectives.

Care Quality Commission (CQC)
The Care Quality Commission (CQC) replaced the Healthcare Commission, Mental Health Act Commission and the Commission for Social Care Inspection in April 2009. The CQC is the independent regulator of health and social care in England. It regulates health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations. Visit: www.cqc.org.uk

Clinical audit
Clinical audit measures the quality of care and services against agreed standards and suggests or makes improvements where necessary.

CUR (Clinical Utilisation Review)
The CUR is a clinical decision support tool that enables clinicians to make impartial and objective, evidence-based assessments of whether patients are receiving the right care, at the right place, at the right time and for the right duration. It improves patient flow across the health economy.

Clinician
Professionally qualified staff providing clinical care to patients.

Commissioners
Commissioners are responsible for ensuring adequate services are available for their local population by assessing needs and purchasing services. Clinical Commissioning Groups are the key organisations responsible for commissioning healthcare services for their area. They commission services (including acute care, primary care and mental healthcare) for the whole of their population, with a view to improving their population's health.

Commissioning for Quality and Innovation (CQUIN)
'High Quality Care for All' document included a commitment to make a proportion of providers' income conditional on quality and innovation, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Consultant
Senior physician or surgeon advising on the treatment of a patient.

Council of Governors
The Governors help to ensure that the Trust delivers services which meet the needs of patients, carers, staff and local stakeholders.

Datix
IT system that records healthcare risk management, incidents and complaints.

Day case
Patient who is admitted to hospital for an elective procedure and discharged without an overnight stay.

Duty of Candour
The duty of candour is a statutory (legal) duty to be open and honest with patients (or 'service users'), or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future. It applies to all health and social care organisations registered with the regulator, the Care Quality Commission (CQC) in England.

Elective
A planned episode of care, usually involving a day case or in patient procedure.

Electronic Patient Record
Digital based notes record system which replaces a paper-based recording system. This allows easier storage, retrieval and modifications to patient records.

Electronic Prescribing and Medicines Administration (EPMA)
Allows prescriptions to be transmitted and populated electronically, replacing paper and faxed prescriptions.

Emergency
An urgent unplanned episode of care.

Fall
A fall is defined as an unintentional/unexpected loss of balance resulting in coming to rest on the floor, the ground, or an object below knee level.

Foundation Trust
A type of NHS Trust in England that has been created to devolve decision-making from central government control to local organisations and communities, so they are more responsive to the needs and wishes of their local people. NHS foundation Trusts provide and develop healthcare according to core NHS principles – free care, based on need and not on ability to pay.
NHS Foundation Trusts have members drawn from patients, the public and staff, and are governed by a Board of Governors comprising people elected from and by the membership base.

Governance
A mechanism to provide accountability for the ways an organisation manages itself.

Health care associated infections (HCAI)
These are infections that are acquired because of healthcare interventions. There are a number of factors that can increase the risk of acquiring an infection, but high standards of infection control practice minimise the risk of occurrence.

Healthwatch
Healthwatch are the national consumer champion in health and care. They have been given significant statutory powers to ensure the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services.

HSMR (Hospital Standardised Mortality Ratio)

This is a scoring system that works by taking a hospital's crude mortality rate and adjusting it for a variety of factors – population size, age profile, level of poverty, range of treatments and operations provided, etc. It is possible to calculate two scores – the mortality rate that would be expected for any given hospital and its actual observed rate.

Inpatient
Patient requiring an overnight stay in hospital.

InPhase
A suite of Oversight Apps to achieve swift, triangulated, compliance, assurance and monitor continuous improvement in the NHS

Integrated Care Board (ICB)
This is a statutory NHS organisation which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area.

Interventional Radiology (IR)

Interventional Radiology" (IR) refers to a range of techniques which rely on the use radiological image guidance (X-ray fluoroscopy, ultrasound, computed tomography [CT] or magnetic resonance imaging [MRI]) to precisely target therapy. Most IR treatments are minimally invasive

alternatives to open and laparoscopic (keyhole) surgery. As many IR procedures start with passing a needle through the skin to the target it is sometimes called pinhole surgery.

LocSSIP (Local Safety Standards for Invasive Procedures)
These are local processes/procedures in place to reduce the number of patient safety incidents related to invasive procedures, in which surgical 'Never Events' can occur.

Malnutrition Universal Screening Tool (MUST)
'MUST' is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition (under nutrition), or obese. It also includes management guidelines which can be used to develop a care plan. It is used in hospitals, community and other care settings and can be used by all care workers.

Medical Examiners
Review the death at time of death certification or referral to Coroners. Their work includes contact with the team that cared for the patient at time of death, review of case records and contact with the family to see if they have any questions or concerns.

Multidisciplinary Team (MDT)
A multidisciplinary team is a group of health care workers who are members of different disciplines (professions e.g., doctors, nurses, physiotherapists etc.), each providing specific services to the patient.

National Institute for Health Research (NIHR)
The NIHR (National Institute for Health Research) funds health and care research and translate discoveries into practical products, treatments, devices and procedures, involving patients and the public in all our work. NIHR ensure the NHS can support the research of other funders to encourage broader investment in, and economic growth from, health research. NIHR work with charities and the life sciences industry to help patients gain earlier access to breakthrough treatments, and train and develop researchers to keep the nation at the forefront of international research.

National Institute for Health and Clinical Excellence (NICE)
The National Institute for Health and Clinical Excellence is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. Visit: www.nice.org.uk

NCEPOD
National Confidential Enquiry into Patient Outcome and Death. The website for more information is http://www.ncepod.org.uk/

National Patient Survey Programme
The National Patient Survey Programme, coordinated by the Care Quality Commission, gathers feedback from patients on different aspects of their experience of recently received care, across a variety of services/settings.

NHS England (NHSE)
NHS England NHS England leads the National Health Service (NHS) in England

NEQOS (North-East Quality Observatory Service)
Provides quality measurement for NHS organisations in the North-East (and beyond), using high quality expert intelligence to secure continually improving outcomes for patients.

Overview and Scrutiny Committees
Since January 2003, every local authority with responsibilities for social services (150 in all) has had the power to scrutinise local health services. Overview and scrutiny committees take on the role of scrutiny of the NHS – not just major changes but the on-going operation and planning of services. They bring democratic accountability into healthcare decisions and make the NHS more publicly accountable and responsive to local communities.

PALS (Patient Advice and Liaison Service)
A service that offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.

Patient Reported Outcome Measures (PROMs)
PROMs measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires. This health status information is collected from patients through PROMs questionnaires before and after a procedure and provides an indication of the outcomes or quality of care delivered to NHS patients.

Payment by Results
A system of paying NHS healthcare providers a standard national price or tariff for each patient seen or treated.

Pressure Ulcer
A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful.

Providers
Providers are the organisations that provide relevant health services, for example NHS Trusts and their private or voluntary sector equivalents.

PSIRF (Patient Safety Incident Response Framework)
Sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Purpose T (Pressure Ulcer Risk Primary or Secondary Evaluation Tool)
Is a pressure ulcer risk assessment framework (PURAF) intended to identify adults at risk of pressure ulcer development and makes a distinction between primary prevention (applicable to those at risk of pressure ulcer development) and secondary prevention (applicable to those who already have a pressure ulcer). It has been developed for use in adult populations in hospital and community settings by qualified nursing staff.

Regulations
Regulations are a type of secondary legislation made by an executive authority under powers given to them by primary legislation in order to implement and administer the requirements of that primary legislation.

Research
Clinical research and clinical trials are an everyday part of the NHS. The people who do research are mostly the same doctors and other health professionals who treat people. A clinical trial is a particular type of research that tests one treatment against another. It may involve either patients or people in good health, or both.

Risk
The possibility of suffering some form of loss or damage or the possibility that objectives will not be achieved.

Risk Assessment
The identification and analysis of relevant risks to the achievement of objectives.

RCA (Root Cause Analysis)
A systematic process for identifying "root causes" of problems or events including serious incidents to prevent a recurrence.

Service user
An individual who uses a health care service, including those who are not in need of treatment, such as blood donors, carers or those using screening services.

Spell
A continuous period of time spent as a patient within a trust, and may include more than one episode.

SSKIN (Surface, Skin inspection, Keep moving, Incontinence and Nutrition)
A 5 step model for pressure ulcer prevention.

STAQC (South Tees Accreditation for Quality of Care)
STAQC is a ward / department accreditation programme which brings together key measures of nursing and clinical care into one overarching framework.

STRIVE (South Tees Research, innovation and education)
Is the academic centre at South Tees for research, innovation and education. The centre also includes library services.

Summary Hospital-level Mortality Index (SHMI)
The Summary Hospital-level Indicator (SHMI) reports mortality at Trust level across the NHS in England using standard and transparent methodology. It looks at deaths following hospital treatment which take place in or out of hospital for 30 days following discharge and is based on all conditions.

South Tees Hospitals NHS Foundation Trust
Includes The Friarage Hospital (FHN) and James Cook University Hospital (JCUH) and community services in Hambleton, Richmondshire, Middlesbrough, Redcar and Cleveland.

TEWV

Tees, Esk and Wear Valleys NHS Trust, supporting Mental Health and Learning Disabilities for County Durham and Darlington, Teesside, North Yorkshire, York and Selby.

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