South Tees Hospitals
NHS Foundation Trust

Quality Accounts 2019-2020

Version 5, 16th September 2020

Annex 2: Statement of directors' responsibilities in respect of the quality report.... 150

PART ONE - Statement on Quality from the Chief Executive

I am delighted to introduce the 2019/2020 Quality Report as Chief Executive of South Tees Hospitals NHS Foundation Trust.

Patient safety and quality remains integral to everything we do and we are committed to ensuring our resources are used effectively in order to provide safe services and deliver high standards of care for our patients.

In this report we have outlined our key achievements and successes against the quality priorities that we identified for 2019/20 and also describe the quality priorities that we have set for 2020/21.

Our clinicians are amongst the best in the country. They're well trained and provide the best care they can but they haven't always been listened to when it comes to the way services should be organised.

This was something hospital watchdogs told us in the summer of last year (2019) that we needed to fix.

Since the autumn, the trust has undergone a number of significant changes. We're now empower our clinicians to take the decisions about how we manage our resources and deliver care across our hospitals and services.

That same clinically-led approach is the way they have worked together to meet the COVID-19 challenge:

- In just 12 short weeks, as our clinicians separated our hospitals into COVID and non-COVID units and began the gradual process of re-establishing services, they delivered 3,400 theatre operations and provided a tenfold increase in virtual outpatient appointments.
- Our laboratory colleagues were amongst the first in the country to develop round the clock on-site testing for COVID-19 and moved mountains to quickly set up a service to test patient and staff swabs 24 hours a day, seven days a week – working continuously to improve turnaround times which rapidly decreased from over 24 hours to less than six hours.

- At the height of the pandemic, our critical care team was providing care to 26 patients with COVID, as well as critically ill patients with other conditions. Throughout this period the critical care and theatre teams worked together to ensure urgent non-COVID-related surgery could continue.
- This work helped to ensure that more than 130 patients were able to be admitted electively from theatres to critical care between 2 March and 4 May alone.
- Our cancer physicians worked with cardiothoracic surgeons and other clinical colleagues to deliver more stereotactic radiotherapy to treat early stage lung cancer as an alternative to cancer surgery due to the risks associated with COVID.
- Community nurses continued to visit their most vulnerable patients to deliver vital care in their own homes, including those who had tested positive for coronavirus. This meant changing the way care was delivered.
- At the Friarage, colleagues who came together on the Ainderby and Mowbray wards enabled non-critical COVID-19 patients from across the Dales and elsewhere to receive inpatient care, closer to home.
- And our procurement team sourced and delivered a staggering 5.3 million items of personal protective equipment – including 600,000 items to neighbouring hospitals and local care providers.

Every member of the South Tees family - nurses, midwives, doctors, allied health professionals, scientific teams, administrative, support staff and volunteers – has done so much for each other, our patients and our communities.

Moving forward, the delivery of safe patient care remains of paramount importance to our clinicians, who work tirelessly to provide the very best care day in and day out. In the last year they have delivered more than 2.7 million patient contacts across our services and we know the vast majority have received excellent care.

Colleagues are now actively encouraged to report incidents and when a Never Event occurs, clinicians carry out a thorough investigation of the incident to determine the cause and put in place steps to reduce any re-occurrence.

Reducing gram negative blood stream infections (GNBSI) is a national priority with the aim of a 50% reduction in healthcare associated GNBSI by 2021. The burden, particularly of E.coli, is challenging and requires reliable auditing to establish the potential multiple causes of GNBSI's. During 2019/2020, the trust reported a total of 632 cases of the three GNBSI organisms which are part of national surveillance (E.coli 468; Klebsiella species 117; Pseudomonas aeruginosa 47). Of these, 130 cases were classed as trust-apportioned (20.5%) as defined by the Department of Health definition. This is a 12.3% decrease in total cases compared to 2018/19.

The Trust is committed to ensuring that patients have a positive experience of the Trust and that patient feedback is acted upon to inform service improvements. The 1000 Voices programme has allowed for the capture of 'real time' data at ward level and includes FFT feedback. The Trust has utilised Meridian software to roll this out electronically via the use of ipads that are available on wards and departments for completion by patients, carers, relatives and parents. During 2019/20 a total of 7541 responses were received and patients gave the Trust an overall rating of 9.03 out of 10. Ninety seven per cent of patients surveyed described their experience of our service as very good or good.

The Trust is committed to improving the patient experience within the Outpatient setting. A Task and Finish Group was established in October 2019 and a detailed action plan has been developed and implemented, this is monitored via the Patient Experience Sub Group.

A review of working practices within the Ophthalmology OPD administration team has been undertaken and new working practices implemented.

There was a programme of monthly Governor Drop-in sessions arranged for 2019/20 to all outpatient departments however due to COVID-19 Pandemic these visits have been suspended for the time being but will re-commence once guidance is received to allow this. The Mystery Shopper initiative has been developed and was due to be launched in the outpatient departments during patient experience week, but was cancelled due to COVID 19. The Mystery Shopper will be launched in September 2020.

The Trust is also participating in the 'Moving to Good' programme that is a collaborative improvement programme organised by NHSE/I and is also in the process of re-launching the STAQC ward accreditation programme.

Despite challenging financial pressures on our services, and the NHS as a whole, we have seen some significant improvements this year which we are immensely proud of.

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

Sue Page

Chief Executive

PART TWO - Priorities for Improvement and Statements of Assurance from the Board

Priorities for improvement

Review of progress with the 2019/20 quality priorities.

In last year's Quality Account we identified the following as our quality priorities for 2019/20:

Quality Priorities 2019/20		
Safety	**Clinical Effectiveness**	**Patient Experience**
Improve recognition and reporting of patient safety incidents and ensure lessons learnt are embedded across the Organisation (including pressure ulcers and medication safety)	Ensure patients have a safe, effective and timely discharge	Develop the patient experience programme using the Meridian system to increase patient feedback including 'hard to reach' groups
Reduce harm from HCAI with a focus on Gram-negative bacterial bloodstream infections	Ensure there is recognition and appropriate management of patients who are clinically deteriorating, including compliance with the escalation pathway	Review the way complaints are investigated and standardise complaint responses
Reduce the occurrence of 'Never Events' and ensure there is a focus in safe surgical practice	Ensure that patients' pain is managed appropriately and effectively	Improve the OPD experience (via Governor drop-ins, secret shopper and better communication via all channels)
	Agree and implement the 'End of Life Care' Strategy	

Patient Safety

Safety
Priority: Improve recognition and reporting of patient safety incidents and ensure lessons learnt are embedded across the organisation (including pressure ulcers and medication safety)
Rationale Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare. Reporting incidents supports the NHS to learn from mistakes and to take action to keep patients safe. The fair or just treatment of staff supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame. This allows us to have open, honest and transparent communication with our patients and their families. Supporting staff to be open about mistakes allows valuable lessons to be learnt so the same errors can be prevented from being repeated. We recognise feedback is a valuable contribution to the development of better quality healthcare and are therefore committed to identifying lessons learned from incidents and near misses to ensure services across our organisation can be improved. • Serious Incidents will be identified and reported to our commissioners within the mandated timeframes • Development of standardised incident report form • Establishment of a Datix user group, terms of reference and minutes of meetings. • Implement Datix champions in all staff groups
Agreed Actions A robust incident reporting action plan will be developed describing specific actions which will include: • Completion of a comprehensive review of incident management process including discussing with staff at all levels and all staff groups to understand barriers to reporting by end Q1 2019/20

- Undertake review of different reporting mediums offered by our current software provider, Datix by end Q2 2019/20.
- Review of the 'Incident Reporting Policy (G60) to ensure that it reflects agreed processes as well as best practice by end Q1 2019/20.
- Develop and implement a standardised incident report form on Datix for use across the Trust as well as short forms that can feed into the main system by end Q2 2019/20.
- All new starters receive a session on incident reporting at Trust Induction March) evaluate effectiveness in Q2.
- Focused work on wards/departments to ensure staff have the skills and knowledge to recognise, report and investigate incidents in a timely manner. A work programme will be developed to support this by end Q1 2019/20.
- Outstanding incidents are reviewed on a weekly basis as part of the Patient Safety wall.
- A weekly review of open harm events with QBP's (Quality Business Partners) and patient safety will commence with the aim of closing down incidents within the week that they are reported. This will be fully embedded across all centres by end Q2 2019/20.

Measures of Success

- Approval of the revised 'Incident Reporting' Policy
- Implementation of improved system for reporting incidents – worked with TVN's (Tissue Viability Nurses) and ED and Clinical & Diagnostics
- Increase in the number of Incidents reported – including Near Miss reporting in groups of historically "low reporting" staff
- Serious Incidents will be identified and reported to our commissioners within the mandated timeframes
- Development of standardised incident report form
- Establishment of a Datix user group, terms of reference and minutes of meetings.
- Implement Datix champions in all staff groups

Progress

Completion of a comprehensive review of incident management process including discussing with staff at all levels and all staff groups to understand barriers to reporting by end Q1 2019/20

This piece of work has been undertaken in all clinical areas by the Quality Business Partners (QBP's) with groups of staff providing feedback on barriers including:

- Fear
- Not enough time
- Time consuming to complete
- Don't get any feedback

Project leads (Patient Safety and Legal Services Lead and one of the QBP's) will be meeting with the Director of Education and Research to review how their training tools can be used to support some of the work required on improving culture.

There is a Patient Safety section on Trust induction every month for all new Trust staff which covers elements of incident reporting and culture.

Undertake review of different reporting mediums offered by our current software provider, Datix by end Q2 2019/20.

The Trust continues to work towards the procurement of the Datix Cloud system which includes a Voice Recognition incident reporting Application. Work continues to streamline coding structure and the layout of the Incident Reporting form.

Review of the 'Incident Reporting Policy (G60) to ensure that it reflects agreed processes as well as best practice by end Q1 2019/20.

The Incident Reporting Policy (G60) was approved at Patient Safety Sub Group (PSSG) in September 2019 and was presented to the Operational Management Board (OMB) in October 2019 for ratification. The Policy has now been ratified and uploaded onto the staff Intranet and re-distributed.

Policy G60b relating to the management of Serious Incidents (SI's) is currently being reviewed to reflect the impending changes nationally.

Develop and implement a standardised incident report form on Datix for use across the Trust as well as short forms that can feed into the main system by end Q2 2019/20.

Due to the lack of a Datix facilitator since April 2019, this task has not been completed but is in progress. A Datix facilitator is however now in post and has developed a short form for pressure ulcer reporting for the Emergency Department.

All new starters receive a session on incident reporting at Trust Induction (March)-evaluate effectiveness in Q2

Incident reporting has increased from April 2019 to February 2020. Due to COVID-19 incident reporting numbers decreased in March and April 2020, however appears to be starting to increase again in the last 2 weeks of April.

Increase number of incidents reported on Datix

There were 21,020 incidents reported on Datix in 2019/20 compared with 16,369 in the previous year. This represents a 28% increase and demonstrates significant progress in developing a positive reporting culture.

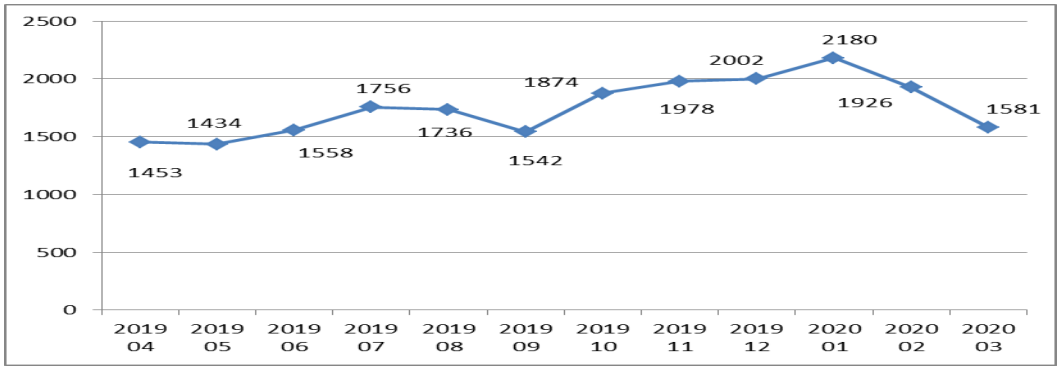


Figure 1: Number of Incidents Reported during 2019/20

The table below shows the number of incidents reported by staff group during 2019/20, with 77% of incidents being reported by nursing staff.

	Total	**Percentage**
AHP	*1708*	8
Blood Transfusion Practitioner	*36*	>1
Medical	*675*	3.2

	Total	**Percentage**
Nurse	*16265*	77
Other	*1995*	9
Private Company	*1*	>1
Scientific	*187*	>1
Student	*21*	>1
Technical	*247*	1.2
Trainee	*97*	>1
Total	*21232*	

Table 1: Number of incidents reported by Staff Group 2019/20

More progress continues to be required around medical staff reporting on Datix, achieving 0.1% of an increase of reporting numbers over the year from 3.1 to 3.2% of all incidents logged on Datix. The introduction of a reporting Application is expected to improve this with the implementation of the Datix cloud software in the coming months.

Focused work on wards/departments to ensure staff have the skills and knowledge to recognise, report and investigate incidents in a timely manner. A work programme will be developed to support this by end Q1 2019/20.

This has been delayed due to lack of Datix support staff. Some work has been undertaken by QBP's in this respect. This action is continuing.

Responding to Incidents training commenced in January. A review meeting was held on 17 March 2020. The training was well received but due to COVID-19 this was suspended.

Outstanding incidents are reviewed on a weekly basis as part of the Patient Safety and Quality wall.

This is embedded practice and has helped secure an improvement in the number of historic open incidents that can be closed down. A process for managing corporate incidents is being established. A threshold of incidents that are expected to be open at any given time for each particular centre is being developed, as there will always be a proportion of 'open' incidents.

A weekly review of open harm events with QBP's (Quality Business Partners) and patient safety will commence with the aim of closing down incidents within the week that they are reported. This will be fully embedded across all centres by end Q2 2019/20.

This process has been embedded across the centres.

Approval of the revised 'Incident Reporting' Policy

The Policy has been approved at PSSG and ratified. As per previous comment, the updated G60b policy is currently being reviewed in light of changes nationally that are taking place.

Serious Incidents will be identified and reported to our commissioners within the mandated timeframes

Medical staff engagement in this area has improved with the patient safety manager being informed verbally of incidents that have occurred that may be serious incidents/ never events, prior to these being reported through the formal process, implying that staff are becoming more aware of potential SI's and reporting these as soon as these are identified.

Establishment of a Datix user group, terms of reference and minutes of meetings.

This has been delayed due to a delay with the launch of Datix Cloud and also due to COVID-19.

Implement Datix champions in all staff groups

This action will be picked up as part of the establishment of a Datix user group and will either combine with or be linked with the Patient Safety champions.

Pressure Ulcer Incidents

The Datix reporting form for pressure damage has been amended following staff feedback and the launch of national reporting guidelines.

The changes include

- Alignment with NHS England guidance relating to pressure ulcer definitions.
- Prompt questions within the investigator section to strengthen learning.
- Introduction of reporting of pressure damage on first skin assessment (within Emergency Department)
- Process review for determining if harm has acquired.

In addition reporting pressure damage was also included in the tissue viability link nurse training.

Medication Incidents

- Any serious medication incidents are shared across the organisation via the safety@southtees alerts system or via learning templates
- Common themes or significant incidents lessons learnt are shared with nursing staff across the organisation in 'Monthly Pharmacy focus' which commenced in January 2019
- Local education and training is provided to clinical teams across the organisation - 'learning from errors and incidents' is delivered by the ward based clinical pharmacy teams
- All lessons learnt from pharmacy medication incidents are shared at the departmental weekly huddle and via email and included in the minutes from the huddle.

Safety
Priority: **Reduce harm from HCAI (Healthcare Acquired Infections) with a focus on Gram-negative bacterial bloodstream infection**
Rationale Reducing gram negative blood stream infections (GNBSI) is a national priority with the stated aim of a 50% reduction in healthcare associated GNBSI by 2022/2023.

Progress

- Conduct robust surveillance and review of cases of GNBSI to have a targeted approach for interventions that specifically aim at preventing the most common sources of GNBSIs-Thematic analysis on-going. Surveillance processes are in place to ensure accurate data is entered and submitted to the IPCT and Public Health England databases
- Implement interventions targeted at reducing common sources of GNBSI -Audits and initiatives are on-going
- Ensure prompt identification of people who are at risk of developing an infection so that they receive appropriate treatment as part of surveillance and thematic analysis
- To identify issues with continence that may lead to patients developing GNBSIs-Through on-going audits and collaborative working with the continence group
- Provide training tailored towards preventing device related infections and GNBSI-ANTT 95% training completion targeted for end of Quarter 4

The three GNBSI organisms which are part of national surveillance include Escherichia Coli (E. coli), Klebsiella and Pseudomonas aeruginosa (P.aeruginosa). The trust has demonstrated reductions in E. coli bacteraemia figures for 2019/20 compared with 2018/19 as follows:

Organism	2018/19	2019/20	% difference
E.coli	128/517 (25%)	81/468 (17%)	-6%
Klebsiella	37/135 (27%)	34/117 (29%)	+2%
P. aeruginosa	11/37 (30%)	15/47 (32%)	+2%

Table 2: Percentage comparison of GNBSIs for 2018/19 and 2019/20

During 2019/2020, the trust reported a total of 632 cases of the three GNBSI organisms which are part of national surveillance (E.coli 468; Klebsiella species 117; Pseudomonas aeruginosa 47). Of these, 130 cases were classed as trust-apportioned (20.5%) as defined by the Department of Health definition. This is a 12.3% decrease in total cases compared to 2018/19.

Collaborative working continues with the wider community as part of the Tees-wide collaborative which supports a number of initiatives within the community setting. In addition a detailed retrospective audit of 5 sets of notes per month continues to build up a significant dataset to potentially enable correlations with patient-related contributory themes in the challenge to identify causes of E. coli infections.

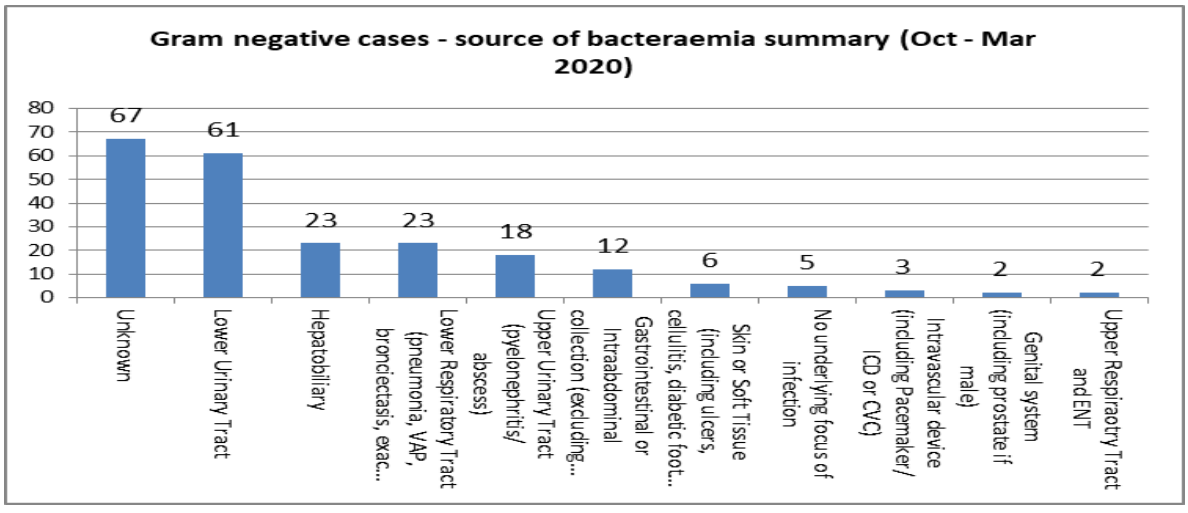


Figure 2: GNBSI source of bacteraemia

Interventions and ongoing actions:

1. Urinary Tract Infections (UTI's) remain the leading cause of GNBSIs. In response to the ambition of a 50% reduction in healthcare associated GNBSI by 2022/2023, the trust has a

GNBSI annual plan with initiatives and reduction strategies to reduce rates of GNBSIs including promotion of hydration (for staff and patients), central venous catheter care and training and education for staff through ward toolbox teaching and Aseptic Non-Touch Technique (ANTT).

- Hydration awareness stalls were in place in June 2019, July 2019 and in October 2019 to improve staff and public hydration awareness.
- Hydration stations are actively promoted for staff within clinical areas.
- Urine matrix and colour charts distributed to clinical areas in September 2019 to aid assessment of hydration status.

In working collaboratively with the Trust special interest continence group, measures to reduce the number of urinary catheter insertions have been implemented including promotion of the use of bladder scanners; a catheter point prevalence audit was conducted at South Tees in May 2019. All patients who had catheters were audited for compliance with the catheter pathway, appropriate use of the urine bag, diagnosis and treatment of UTI and management of continence.

The catheter pathway informs appropriate reasons for catheterisation, plans for removal of catheters according to clinical need to prevent unnecessary prolonged catheterisation, associated urinary tract infections and subsequent bacteraemia.

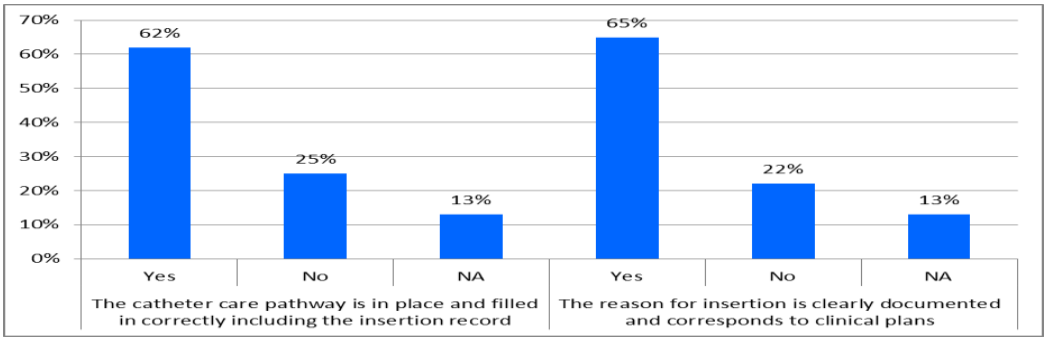


Figure 3: Point prevalence catheter pathway audit (May 2019)

The catheter pathway was found to be widely used in patients who had catheters (62%) in May 2019. In order to gain assurance of appropriate continence management and plans that are put in place for patients who are being discharged with catheters, staff were surveyed to see if they were familiar with the continence formulary and if they were aware of the discharge arrangements for patients who had urinary catheters. 62% of staff advised they were familiar with the continence formulary and 99% of staff knew the appropriate arrangements required for patients who were being discharged with urinary catheters (Figure. 3).

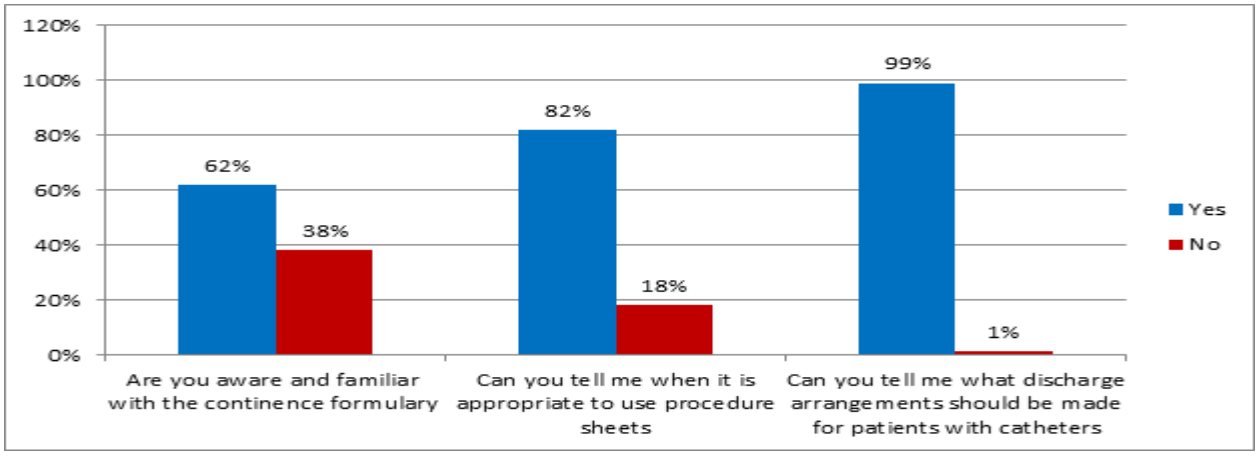


Figure 4: Staff survey of continence management and discharge plans for patients who have urinary catheters

Catheter prevalence audits are set to continue in 2020/21 led by the Frailty team.

1. ANTT is a set of principles designed to reduce the risk of infections during an invasive procedure and is fundamental in reducing GNBSIs associated with line/catheter and wound infections.

   A trust wide targeted programme has been developed to cascade ANTT training which commenced in March 2019 to ensure appropriate management of invasive procedures; with an increased focus on critical care areas where patients have a variety of invasive devices.

   In April 2019 an external review of ANTT practices focussing on cannula management was carried out at South Tees which has enabled a targeted educational approach including a 'glove awareness' initiative. The Trust target of 95% ANTT training delivered has been achieved in critical care areas. Trust-wide ANTT training compliance is around 80%. An ANTT audit programme will be in place in 2020/21 to enable continued surveillance of practice.

2. Critical care patients are recognised to be at higher risk of GNBSIs because of invasive devices which are known to increase infection risk in patients. In April 2019 the 'Blue Pillow Initiative' trial was initiated in critical care areas aimed at reducing line infections through the use of a dedicated pillow for the head (reducing risk of inadvertently placing a pillow that may have been used to assist in positioning near a central 'neck line' and increasing risk of contaminating the neck line). Although there was no reduction in cases of GNBSIs in blue

pillow areas by the end of March 2020, the use of blue pillows demonstrates good practice that has now been embedded into practice.

3. A “traffic-light” system of water jug lids was devised and piloted on a general gerontology ward to improve recognition and management of reduced fluid intake. This project was led by clinicians and supported by infection prevention and control team by identifying priority areas for rolling out the project; in terms of high catheter use and a higher incidence of GNBSI areas. The pilot received good feedback; with results shared in September 2019 and planned for roll out across the organisation. Hydration champions will be identified within clinical areas to assist with the roll out.

The ambition to reduce GNBSI by 50% by 2022/23 is on-going. The next step would be for the trust to set local realistic targets of around 6-10% reduction year on year with focussed efforts based on thematic analysis.

Safety
Priority: **Reduce the occurrence of ‘Never Events’ and ensure there is a focus on safe surgical practice**
Rationale Never Events are considered unacceptable and eminently preventable incidents. Harm free compassionate care in the operating theatre should be a fundamental element of the Trust’s operating theatres vision. All healthcare staff involved in clinical practice in a patients’ theatre journey have a common goal which is to prevent harm and deliver safe patient care to the highest standards. Although Never Events are rare, two recent events both occurring in the operating theatres on the James Cook Hospital site have identified several factors that contributed to these Never Events in December 2018 and January 2019. Following the detailed investigation reports it is apparent that work is required to strengthen the use of the World Health Organisation (WHO) Theatre Checklist to ensure effective team communication, verification of the correct operation and correct site surgery. As a result the Time Out Checklist needs to be underpinned by standards and training, it requires full engagement from all disciplines in the theatre multi-disciplinary team as it will not work in isolation.

A review of the contributing human factors identified that there are team factors to be taken into account and addressed, including leadership, culture and behaviours as well as clarity of individual roles and accountability in relation to the 'Time out'.

Staff should feel empowered to use the 'Stop' phrase to raise concerns. All theatres now have a 'STOP, I am not happy' phrase visible within each operating theatre. A 'Sign out' phase has been included on the swab count board to ensure compliance by the theatre scrub team. Incident forms also need to be completed as soon as an error is detected. Staff allocation has now been amended to clearly identify the lead in each theatre on a daily basis and that the Safer Surgery SOP/LocSSIP (Local Safety Standard for Invasive Procedures) needs to be available in each theatre and the Safer Surgery Policy also requires review.

Actions

All of the above and compliance with all aspects of safer surgery processes should be therefore reassessed across all staff groups through the establishment of an MDT (multi-disciplinary team) Safer Surgery Group to formulate the required actions and learning to improve safer surgery compliance. The following lessons learnt have been identified:-

Ensure everyone is aware who the senior theatre team member is and who is in charge day to day.

Operating surgeon responsibility – the operating surgeon should always perform the safer surgery 'Time out'. 100% compliance with formal time out/sign out.

Concerns should be raised or escalated immediately to senior theatre staff so that a timely decision can be made and guidance given.

The introduction of a 'nurse educator role' within theatres similar to ICU (intensive care unit) is currently being explored since this is currently lacking and would provide some assurance that all staff are trained appropriately to their roles.

All new members of staff from the MDT should have completed their local induction (inclusive of safer surgery presentation) – this could be overseen by the above Nurse Educator for Anaesthesia.

Promoting an open and honest culture of reporting incidents when errors have been identified.

In addition, through the establishment of the MDT Safer Surgery Group, there should be a renewed focus on the safety critical sign out process in accordance with existing Trust LocSSIP standards of practice. The team should also be focused on the 'Sign Out' phase which should be fully observed and performed after the final count is performed and before the patient is woken from anaesthesia with all medical staff present. This is included in the Trust's annual audit plan.

The observational audit is undertaken weekly in one theatre, and all theatres are covered within the audit throughout the year.
Measures of success • Zero tolerance with Never Events • 100% compliance with required time-outs • 100% compliance with completion of the WHO Surgical Checklist • 100% compliance with the 'Sign Out' process • LocSSIP's available and embedded in all areas

Progress

Consistent with the Trust's improved safety and reporting culture, in 2019/20 there were eight Never Events reported meeting the serious incident criteria, where potential harm was identified. Four of these related to surgical or anaesthetic practice. The Trust agreed that Safer Surgery would be a Trust Quality Priority and this report sets out the work and the learning that has taken place to implement safer surgery practices across the Trust with the aim of eliminating 'Never Events' by 31st March 2022. The Trust is also participating in the 'Moving to Good' Programme' organised by NHSE and NHS Improvement for Organisations rated by the Care Quality Commission as 'requiring improvement'.

During the last 12 months there have been two audit mornings held which focused on safety. A multidisciplinary representation of those teams involved in recent Never Events presented to a wide audience of colleagues including theatre staff, surgeons and anaesthetists. As a result of this a Safer Surgery Oversight Group has now been established to implement safer surgery practices across the Trust working towards eliminating Never Events. The group has developed a 'Safer Surgery Improvement Plan' which is a comprehensive working document that outlines actions required, by whom, expected dates of completion and evidence to support completed actions and sustained improvements to monitor and track that risks have been reduced. The plan outlines four main themes which have been identified through the learning following the eight Never Events:

- Organisational Factors (addressed through the Trust's improvement plan and renewed focus on empowering clinical leadership since October 2019)
- Team Factors
- Sharing and Learning and Training
- Human Factors

The Safer Surgery Oversight Group was led by one of the Medical Directors with group membership made up of key clinical and patient safety personnel and meets fortnightly to maintain focus and momentum. Terms of reference have been established which set out the purpose and connectivity of the group into the wider organisation. It also identifies the members, frequency, and the overall aims and objectives of the Group.

The Clinical Director in Oral and Maxillofacial Surgery has been identified as the Human Factors lead and alongside other anaesthetic consultant colleagues has rolled out a programme of training sessions on Human Factors. These have been well attended by theatre staff, with 64 staff attending the training so far. Initially the focus has been on anaesthetic and surgical colleagues undertaking the training. Staff feedback has been excellent; all staff completed an evaluation to provide evidence and a summary of the session. The Human Factors training has also identified additional factors relating to patient safety to consider within the improvement plan.

The Safer Surgery Improvement Plan was developed following an external review by NHS England and NHS Improvement during the period of 1st January 2018 to 30th November 2019 of surgically related Never Events. A visit to the operating department by senior nursing leaders in January 2020 identified similar themes to the external review. In addition to this, NHSE and the Trust commissioned an external review by Airedale NHS Trust which took place on the 24th February to support our improvement plan around safer surgery. It had been identified by all stakeholders that this review would provide significant benefit to the trust by gaining an understanding of the current systems and processes of Never Events. This would also determine whether or not there were additional common factors not already identified in our own internal analysis processes and to identify any additional improvement actions, beyond those already in place that the Trust should consider to minimise the risk of recurrence of similar Never events. We are awaiting the report from Airedale and this is anticipated to be received within the next few months.

A Local Safety Standards for Invasive procedures (LocSSIP) Group within the trust has been established and is developing LocSSIP's across a range of procedures. The trust LocSSIP group is made up of clinicians from across the trust and has been meeting since November 2018. Progress on the development of LocSSIP's is outlined in the Safer Surgery Improvement Plan tracked under Organisational Factors and progress reviewed through the oversight group. All LocSSIP's will be audited on an 18 month rolling programme with the outcomes being published on the trust intranet page.

The safer surgery improvement plan is a 2 year project therefore work will continue on this priority.

Clinical Effectiveness

Priority: Ensure patients have a safe, effective and timely discharge

Rationale

Unnecessarily prolonged stays in hospital are bad for patients. Tackling long stays in hospital will reduce the risk of patient harm, disability and unwarranted cost. Congestive hospitals struggle to deliver the best care, reduced bed occupancy through improved flow greatly improves the working and care environment. (NHS Improvement 2018)

Every day in hospital is a precious day away from home. We want to embed a home first mind set across our health and social care system, the aim is to do everything we can so that our patients, especially older people, can continue to enjoy their lives in their own home environments. For the few that cannot go home from hospital we should endeavour to minimise delays as patients move to a location most suited to meeting their needs.

Patients with a length of stay over seven days are defined as 'stranded' and patients with a length of stay over twenty one days are defined as 'long stay' patients.

A 'delayed transfer of care' (DToC) occurs when a patient is ready to leave a hospital or similar care provider but is still occupying a bed. Delays can occur when patients are being discharged home or to a supported care facility, such as a residential or nursing home, or are awaiting transfer to a community hospital or hospice. (Please note this terminology is no longer used)

The benefits of reducing the time that a patient occupies an acute hospital bed are clear, but achieving this has proven difficult, particularly in the winter period. Long stay patients account for about 8% of overnight admissions generally and have an average length of stay of 40 days nationally (NHS Improvement).

The term 'patient flow' refers to the ability of a health care system to manage patient effectively and with minimal delays as they move through stages of care. The consequences of poor flow are known:

- ED becomes crowded, stressful and unsafe.
- Patients are admitted as outliers to areas that are not best suited to manage their care.
- Ambulatory care services may fill with patients waiting for ward admission.
- In patients are shuffled between wards to make capacity for newcomers.

- Staff are over stretched and routine activity slowed down dramatically.
- Clinical outcomes are measurably worse, particularly for frail older people who may suffer more harm events and may decondition due to the extended stay in hospital beds.
- Patient and carers time is wasted due to delays and slow care process and their experience is adversely affected.

Reasons for delays relate very much to the communication and interface between the acute provider and social or continuing health care. Delays can also be classified using a national 'Clinical Utilisation Review' (CUR) tool which measures and monitors patient need for an acute bed. The main delay categories associated with 'CUR not met' are;

- Awaiting assessments
- Medications and intravenous therapies
- Access to diagnostics
- Access to therapies

The average CUR 'not met' in the acute setting in 2018/19 was 34.0%.
These delays can be compounded if internal processes are not robust, specifically our Model Ward approach based on SAFER principles (NHSI, 2017):
S – Senior review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.
A – All patients will have an expected discharge date and clinical criteria for discharge. This is set assuming ideal recovery and assuming no unnecessary waiting.
F – Flow of patients will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10 am.
E – Early discharge. 33% of patients will be discharged from base inpatient wards before midday.
R – Review. A systematic multi-disciplinary team review of patients with extended lengths of stay (>7 days – 'stranded patients') with a clear 'home first' mindset.
The CUR 'not met' reasons, the need to further embed SAFER principles along with the need for optimal communication with local authority and clinical commissioning group colleagues form the basis of the improvement action required:

Actions

- Implement the use of the discharge care plan as part of the new nursing documentation pack on all adult in patient wards by end May 2019.
- Regular review of delayed discharge and length of stay metrics and associated actions put in place. This will take place operationally at a weekly 'discharge wall' and strategically at a monthly meeting attended by key staff members of the acute Trust, local authorities and the CCG.
- Increase focus on the increasing population of frail patients; pilots of multidisciplinary frailty team approaches to planning transfers and discharge.
- Implement criteria led discharge on three wards by the end of Q2 and eight wards by the end of Q4.
- Implement a robust model of working for the Patient Resource and Flow Team. By end Q2.
- Ensure improvement plans in place for CUR 'not met' categories are in place by end Q2 (Awaiting assessments, medications and intravenous therapies, access to diagnostics, access to therapies).
- Embedded frailty screening for all people aged over 65 within all admission routes to enable earlier targeted assessment and intervention by end Q3.
- Implement engagement programme with Clinical Directors (CD) to optimise the use of SAFER principles via a new CD forum by end Q2.

Measures of Success

- Decreasing rate of delayed transfers of care to below the 3.5% upper threshold.
- Decreasing average length of stay in the acute setting – individual directorates to set own targets by end Q2 relative to baseline to achieve either top quartile or top decile against national benchmarks.
- Decreased number of discharge related PALS and patient complaints.
- Improving trend of discharges before 12 midday, towards the Trust target of 35% by the end of Q4 with a stepped target of 25%.
- Set baseline and improvement trajectories for decreasing length of stay in patients with clinical frailty by end Q1.
- Decreasing levels of harm in patients with frailty. Baseline and improvement targets to be set by end Q2 and monitored via Datix and the frailty dashboard.

Progress

Implement the use of the discharge care plan as part of the new nursing documentation pack on all adult in patient wards by end May 2019.

- The new nursing documentation pack has been developed and rolled out which includes a discharge care plan that is initiated at the point of admission to enable safe and effective discharge. We have supplemented this with a pilot of a "STOP" initiative on four wards which ensures the nurse in charge has the final oversight of the discharge of their patients and the patient has the information to empower them to challenge any aspects of their discharge arrangements. This pilot will be evaluated and scaled up across wider parts of the organisation through 2020/21. There will continue to be improvements made such as including clear discharge pathways in the documentation to enable effective discharge planning.

STOP Initiative

Regular review of delayed discharge and length of stay metrics and associated actions put in place. This will take place operationally at a weekly 'discharge wall' and strategically at a monthly meeting attended by key staff members of the acute Trust, Local Authorities and the CCG.

A weekly "Where best next?" group has been established that brings together senior management, the patient flow team and clinical matrons to identify opportunities for improvement and lead change to reduce the length of stay for patients including improving discharge processes. A strategic group has been established that meets monthly that includes the acute Trust, Local Authorities and CCG.

Increase focus on the increasing population of frail patients; pilots of multidisciplinary frailty team approaches to planning transfers and discharge.

A new frailty liaison team has been established to identify patients with frailty and support ward teams to expedite timely and safe discharges.

Implement criteria led discharge on 3 wards by end Q2 and 8 wards by end Q4

We realised with the implementation of the '"Where best next?" Group that the focus needed to be on embedding the SAFER principles to then enhance this with Criteria Led Discharge during 2020/21.

Implement a robust model of working for the Patient Resource and Flow Team by the end of Q2

Clinical leadership has been established as an integral element of the patient flow team to inform effective decision making relating to right time, right place, right patient that is clinically determined.

Ensure improvement plans in place for Clinical Utilisation Review (CUR) 'not met' categories are in place by end Q2 (Awaiting assessments, medications and intravenous therapies, access to diagnostics, access to therapies)

An improvement plan has been developed to address the reasons for delay within the CUR 'not met' categories. A discharge delays escalation process has been developed to manage delays on a continuous basis. Daily automated reports from Medworxx (a clinician decision-making support tool) have been developed that are circulated to managers where action is required to reduce delays.

Embedded frailty screening for all people aged over 65 within all admission routes to enable earlier targeted assessment and intervention by end Q3.

Frailty screening is in place.

Implement engagement programme with Clinical Directors (CD's) to optimise the use of SAFER principles via a new CD forum by end Q2

The Clinical Policy Group has engaged with discussions relating to SAFER principles and opportunities to improve patient flow. Regular updates and discussions will continue with the group to inform the patient flow improvement plan.

Measures of success:

Decreasing rate of delayed transfers of care to be below the 3.5% upper threshold

Whilst we have not consistently achieved the upper threshold of 3.5%, the organisation has progressed actions to reduce the number of delayed transfers of care. An organisation wide improvement plan 'getting back to our best' has been developed that includes improving patient flow and discharge.

There has been a focus on implementing SAFER, improvements around repatriation processes, implementing the choice policy and timely discharge. The Clinical Utilisation Review (CUR) system Medworxx is a key tool for identifying delays and tracking improvements following intervention.

Decreasing average length of stay in the acute setting – individual directorates to set own targets by end Q2 relative to baseline to achieve either top quartile or top decile against national benchmarks

Medworxx reports are circulated to identify patients in a hospital bed who are ready for discharge and those waiting over 14 days to support the clinical review of patients to reduce the length of stay for patients where appropriate.

One example of an initiative is that the Trust implemented a Diagnostic Virtual Ward from mid - January 2020 which enables a patient to be discharged home but have a test within an inpatient timescale which reduces their length of stay in hospital. A co-ordinator then tracks the appointment, attendance and result to inform the patient's consultant.

Decreased number of discharge related PALS and patient complaints

Numbers look consistent with last year with no significant decrease in numbers. We will continue to work on further discharge initiatives that improve patient experience and safety such as the "STOP" project.

Improving trend of discharges before 12 midday, towards the Trust target of 35% by the end of Q4, with a stepped target of 25%.

A list of potential discharges for the day and next day is shared with the clinical matrons and the patient flow team on a daily basis. Wards are encouraged to use the discharge lounge and plan for discharge the day before a planned discharge so that patients can be discharged before 12 midday, when appropriate. Further action is ongoing to focus on any delays in requesting and processing medications as well as timely discharge letters to facilitate discharge before midday.

Set baseline and improvement trajectories for decreasing length of stay in patients with clinical frailty by end Q1

Throughout 2019-20 we have increased frailty screening across the organisation on all appropriate wards. We have also implemented a daily frailty report linked to the daily transfers of care report. Frailty scores are now displayed on all our patient status at a glance boards and this information follows the patient between wards. The daily report has replaced the frailty dashboard and contains details relating to length of stay and services accessed in the community i.e. falls and therapy. These features within the report enable it to be used by ward teams during discharge planning. In addition, a new frailty liaison team has been commissioned and this team will from March 2020 use the report to target patients with frailty, supporting ward teams to expedite timely and safe discharges. This work remains ongoing and we anticipate demonstrable gains in length of stay in Q1 & Q2 of 2020-21 once the team is in place.

Decreasing levels of harm in patients with frailty. Baseline and improvement targets to be set by end Q2 and monitored via Datix and the frailty dashboard

Decreases in the levels of harm in patients with frailty have not been seen as expected. The end of year position is anticipated to be very similar to 2018-19. Our work to better understand harms in this group has confirmed that prolonged hospital stays, deconditioning and the management of new confusion greatly increases the risk of harm. In light of these findings we can focus the function of the new frailty liaison team to reduce lengths of stay in those patients they see and as a consequence impact on rates of harm.

Clinical Effectiveness

Priority:
Ensure there is recognition and appropriate management of patients who are clinically deteriorating, including compliance with the escalation pathway

Rationale

Early recognition of patients who are deteriorating is essential to enable appropriate intervention and prevent further deterioration to the point of requiring resuscitation and avoidable admission to a Critical Care unit. Early recognition aims to reduce the risk of patients needing to stay longer in hospital, not recovering fully or dying.

The Trust has utilised an electronic system to record physiological observations since October 2014.

VitalPAC is a suite of platforms that focuses on timely and appropriate physiological observations using the NEWS 2 model.

Progress

Monitoring of physiological observations / e-observations

The e-observation solution VitalPAC continues to be used to monitor observations, the frequency determined by the acuity of illness. The performance side has become more challenging over the year as compliance of physiological observations cannot be easily viewed by ward based clinicians to drive improvement in practice. The contract for VitalPAC is coming to an end and therefore we are embarking on a tendering process. There is a requirement to have a monitoring solution that provides information readily available on physiological observation performance, escalation and response in line with the 'Recognition and response to patient deterioration' algorithm.

Adult in patient audit of acuity of illness and level of care

In March, 2020 an annual point prevalence study was conducted to determine the acuity of illness and the level of clinical burden of each adult patient within the organisation. The following data collected;

- Level of care (ICS)
- Frequency of observations – appropriateness to level of acuity
- NEWS2 score – Scale 1 / 2

- Recognition of acute illness
- Escalation in line with the recognition and response to deterioration algorithm
- Response to the recognition and response algorithm
- Stratified Treatment Escalation Plan (STEP) form completed
- DNARCPR (Do Not Attempt Cardio Pulmonary Resuscitation) forms completed

This audit requires presenting and sharing at appropriate forums however this was delayed due to Covid-19 but the audit has now been shared.

G136 Recognition & Management of the Acutely Ill & Deteriorating Patient Policy Update

The Trust policy related to the recognition and response to the deteriorating patient has been reviewed and updated to reflect national guidance and recommendations.

Commissioning for Quality and Innovation (CQUIN)

One of the confirmed CQUIN measures for 2020/21 is to report on the recording and compliance of NEWS2, recognition, escalation and response time for unplanned Critical Care admissions. In the future it is planned for the sepsis nurses role to become more generic in order for us to deliver on data collection, reporting and service improvement. This will support the achievement of the deteriorating patient CQUIN measure.

Call for Concern (C4C) – Patient and relative activated Critical Care Outreach (CCO)

C4C has been approved via the Acutely Ill Patient Group and the Nursing and Midwifery forum with an implementation plan detailing a phased approach with commencement date of April 2020. An awareness campaign has been supported by Public Relations with readiness to implement. The phases are as follows;

- Phase 1 - Patients discharged from Critical Care and patients admitted with a Learning Disability
- Phase 2 – Patients that have been reviewed by Critical Care Outreach
- Phase 3 – All adult inpatients

Community / Acute Interface NEWS2 – update

A successful application attracted funding from Academic Health Science Network (AHSN) to undertake a service evaluation to enhance the use of NEWS2 (a tool to measure patient deterioration) across the patient pathway from community settings to acute. The National Early Warning Score 2 (NEWS2) has been implemented in selected areas in the primary care setting and across the North East Ambulance Service. This was with the intent to enable a quantifiable

physiological assessment of a patient's clinical condition at any point in the patient pathway and provide a commonality of language when escalating an acutely unwell patient. The quarter 4 report is due in June, followed by a project end evaluation.

Agreed Objectives

- Embark on tendering process to attract an e-observation solution that can be easily adopted by clinical staff and provides real time information on compliance of physiological observations, escalation and response to the deteriorating patient
- Share findings of the adult in patient audit of acuity of illness and level of care
- Systems have been put in place to respond to the collection of data and reporting post COVID
- Activate plan to introduce C4C post COVID
- Community / Acute Interface NEWS2 – update

Clinical Effectiveness
Priority: **Ensure that patients' pain is managed appropriately and effectively in the patient setting**
Rationale Good pain management improves patient experience and outcomes. It is a marker of good care and clinical effectiveness in all age groups. In older adults and those with clinical frailty pain can be a contributing factor to delirium. Development of delirium frequently impacts on length of stay and contributes to delayed transfers of care (DToCs) and patient harm. Effective pain management is reliant on: • Timely and appropriate prescribing • Regular assessment of pain using an appropriate and validated tool • Safe administration • Evaluation of analgesia using an appropriate and validated tool

Progress

Achieved

- Algorithms of referral reviewed in line with the Specialist Palliative Care (SPC) Team and Pain Management Team, circulated again as refresher and both are available on the Intranet for staff to access.
- Pain assessment of patients through the Quality Indication Collection (QIC) audit across all inpatient areas, particularly relating to reassessment of pain, to be reported through clinical standards.
- Preceptorship – Elements of pain management are covered throughout the programme, also there is a dedicated session as part of this.
- Meridian IT system implemented with report access and utilisation increased with user participation in all centres demonstrating improvement in patient experience regarding Pain Management.
- Work completed with the Quality Business Partners regarding collation of complaints/PALS (Patient Advice and Liaison Service) etc. around specific pain management criteria and lessons learned shared
- Pain management is one of the measurements included in the 'real Time' patient feedback and scores for this are included in the monthly quality report. During the last 3 months of 2020/21 the pain management score from patients was 9.54 in January, 9.52 in February and 9.50 in March therefore confirming that patients consider their pain to have been managed appropriately.
- Within ED Intentional Rounding is undertaken to provide assurance to the Directorate to ensure that patients are receiving high quality care, patient centred care and key themes are discussed at the daily communication huddle.
- Learning from complaints, compliments, incident reporting and quality metrics are triangulated to ensure safety of the service and these are discussed at the weekly centre oversight meeting and information is displayed for team dissemination.
- Intentional Rounding in the Emergency Department has been successfully implemented and embraced by the team around pain management, re-assessment remains a challenge
- Frailty team pilot established with Band 7 lead and x1 Band 6 due to commence in post in March, further B6 post unfilled to liaise regarding frailty

Partially Achieved – Further Development Required

- Training Needs Analysis against a Gap Analysis has been deferred to 2020/21 as this has not been completed with conflicting priorities, particularly within the acute pain team and lack of resources. The Pain team keep a database of all attendance at their training and this is shared with individual ward managers.
- Liaison with Acute Pain Team regarding development of 'Toolbox Teaching' as a roll out programme from the pain team across all Centres, then to attend Leadership Day/ Safety@SouthTees to launch. Pain team currently only cover a cluster of wards that 'pay' into their service so we do have disparities.
- The plan for 2020/21 is to review strategic direction of acute pain team once establishment completed to provide service across trust site.
- Liaison with the Consultant Nurse for Critical Care regarding VitalPAC and the future developments and how this may support pain assessment – awaiting confirmation from Company and direction of travel from Trust.
- On-going review of collation of data regarding bespoke training, further discussions required regarding centralisation of this.
- On-going work around the national audits within the Emergency Department relating to both Paediatrics and fractured neck of femur. These continue to require improvements in respect of pain management.
- Review of interface with SPC team and Acute pain team - Initial discussions regarding some integrated working around pathways and training.

Progress with Agreed Objectives

- Review referral process for the pain team to ensure service meets clinical need **– Completed**
- Undertake a centre / ward level training needs analysis to identify training needs in relation to pain by end Q4. This has been deferred to 2020/21 as resource within the pain team is currently being reviewed.
- Respond and focus training activity of the pain team in response to training needs analysis. **This will be completed in 2020/21.**
- Integrate pain management training within preceptorship training **– Completed**
- Increase focus on the use of specialist guidance such as older adults prescribing guidance. This includes correct use of pain assessment chart; QIC has been partially completed and will continue in 2020/21. Initial work to embed within QIC has started – further work re frailty and pain to be considered.

- Development of frailty team has been delayed due to recruitment and impact of COVID-19.
- Explore opportunities to integrate pain assessment and evaluation within VitalPAC – this will continue in 2020/21.
- Implementation of the Meridian system in May 19 will facilitate triangulation of patient experience data with quality indicator compliance **– Completed**

Clinical Effectiveness

Priority: Ensure that patients who are at the end of life and their families receive high quality care in their preferred place.

Rationale

South Tees Hospitals NHS Foundation Trust places great emphasis upon preventing avoidable deaths however when preventing death is no longer an option we will continue to treat and support our patients throughout their last months and weeks of life. To achieve our strategy we have been guided by three key national documents:

Ambitions for Palliative and End of Life Care- a framework for local action 2015-2020 (National Palliative and End of Life Care Partnership: 2015) and *One Chance to get it right (Leadership Alliance for the Care of Dying People: 2014)* and the *NHS Long Term Plan (2019).*

The ambitions document proposes six ambitions. The trust is committed to ensuring that as an organisation that we make the ambitions a reality, through strong leadership commitment and empowerment. The six ambitions are:

- Each person is seen as an individual
- Each person has fair access to care
- Maximising comfort and well being
- Care is coordinated
- All staff members are prepared to care
- Each community is prepared to help

Progress

Agree and implement the 'End of Life' Care Strategy

The Trust has an 'end of life' care strategic group with a work programme which was started in 2018 and extends to 2022. The work programme reflects the key strategic intents of the Trusts 'end of life' strategy for adults. The strategy has been developed over the last 10 months in collaboration with key stakeholders and is currently going through the ratification process however this has been delayed due to Covid-19.

A consultant in palliative medicine in the acute service is currently being recruited to. It is recognised that the medical consultant position in the organisation will be pivotal to the success of the strategy.

Have a robust system in place for identifying complaints that relate directly to end of life care and set improvement trajectory by end Q2.

Systems are now in place to categorise complaints. These are fed back to the end of life strategy group on a bi monthly basis. There are very few complaints relating to end of life care. In the last quarter there were 490 deaths and 3 complaints. Themes are used to focus training provided by the specialist palliative care team and will form the basis for the palliative and 'end of life' care champions training. The patient experience team managed complaints through the Trust's complaints process.

Define baseline of number of dying patients assessed by the Specialist Palliative Care Team by the end of Q1 and set increasing targets for Q2, Q3 and Q4.

A baseline has not been defined. The community team in particular has faced significant workforce challenges however Hospital Mortality Monitoring data for the numbers of patients reviewed by the team during inpatient settings has increased. This data looks at how many patients who died in hospital received care from the specialist palliative care team.

Have a system in place to gather specific feedback on the patients and family's experience of end of life care provided by the Trust by end Q2 (current system focusses on the bereavement service at the point of registration of death).

The medical examiners speak to all families of patients who die in an acute ward. They obtain verbal feedback and refer on any concerns to the respective clinical teams or through the PALs/complaints process. In the Hambleton and Richmondshire locality a bereavement survey is sent out to families with their consent of those who have used the services of the end of life care co-ordination team. In

addition discussions are ongoing regarding establishment of a robust bereavement survey across the organisation in partnership with the patient experience team.

Review of documentation used in the care of patients in the last days of life is being undertaken. This includes the medical treatment summary and also the care plan for 'end of life' care (care plan 25) and is being undertaken in partnership with the North of England Clinical Network Supportive, Palliative and End of Life Care Group. This will form the basis for new documentation to be introduced in the organisation and incorporated into any electronic record keeping templates.

Participation in the National Audit of the Care of the Dying (NACEL) will demonstrate improvements in the documented evidence of individualised care planning.

The NACEL audit was completed in 2018 & 2019. The results of the audit are below. Review of documentation used in the care of patients in the last days of life is being undertaken. This includes the medical treatment summary and also the care plan for 'end of life' care (care plan 25) and is being undertaken in partnership with the North of England Clinical Network Supportive, Palliative and End of Life Care Group. This will form the basis for new documentation to be introduced in the organisation and incorporated into any electronic record keeping templates which are introduced in the trust to replace current paper medical records.

An action plan is currently being developed for the 2019 results which have only recently been received into the trust. This will be presented at the next 'end of life' strategy group meeting as subsequent meetings were cancelled due to Covid-19.

The environment in which care is provided to the dying in the acute hospitals will improve. This includes bereavement and mortuary services.

A 'task and finish' group is in place working on improving the environment following the Fresh Eyes visit from hospice UK team. The dragonfly logo has been embedded as a recognisable symbol in the trust for 'end of life' care and bereavement. This has been incorporated into signage; leaflets will be used by clinical ward teams to indicate that there is a patient dying on the ward in order to improve the patients and their families' privacy and dignity. In addition improvements are nearing completion in the mortuary viewing room and light boxes have been installed in the corridor which leads to the mortuary. This has improved the lighting and ambiance for families and staff who use the corridor. There are now rooms on ward 37/15/Medical assessment unit for private discussions with the family. The relative rooms in A&E, the chapel and ablution rooms have been refreshed and updated. New prayer mats have been purchased and signage is being improved.

Comfort packs have been rolled out to the Friarage. Children's bags are in use in James Cook University Hospital. Some progress has been achieved with the Friarage site however this has been

delayed due to the public consultation (which has now concluded) as there was uncertainty around emergency care provision. There is however a robust action plan in place for taking the changes forward to create a secret garden area for families, provision of overnight accommodation for families, updating the relative's rooms and ensuring the chapel is available for all to use. A meeting of the 'task and finish' group was convened at the end of February with the Friarage team review plan and progress. A Bereavement service has now commenced at the Friarage.

Expansion of the Specialist Palliative Care Team to provide face to face assessments 7 days a week and reach groups of patients who currently do not receive consistent access to assessments

This has not been achieved due to workforce changes and resource. The team is currently undergoing a full service review. Seven day working is one of the objectives to be progressed as part of the review process. No date has been agreed for the seven day service to commence.

Demonstrable increasing use of Internet and intranet websites that provide guidance for staff and patients/families regarding end of life care.

The intranet and intranet web pages are currently being updated. The webpages had the following number of views:

Palliative medicine: 1,315 (compared to 1,119 in 2018)

End of Life: 619 (compared to 521 in 2018)

South Tees team: 1,638

James Cook team: 1,036

Hambleton & Richmondshire team: 692

The intranet only pulls monthly statistics but for January 2020 the palliative page had 278 views (247 in Jan 2019) and End of Life had 365 (314 in Jan 2019).

The Trust will have a range of polices to support staff in the provision of palliative and end of life care.

The trust policies have been updated as they had reached their review date. The policies have been updated based upon national guidance. Care in the last days of life and after death (Adult) policy and Registered Nurse and Allied Health Professionals (Advanced Critical Practitioners) Verification of Expected Adult Death (No G154) have both been reviewed and updated.

All staff employed by the Trust will have access to training in end of life care.

Training for staff. Significant progress has been made however this still requires further work. To date we have achieved: -

- Induction: there is a 15 minute session for all staff new to the organisation
- Basic life support training: there is a short session on end of life care
- Preceptorship training: there is a 2 hour session on end of life care
- E-learning: priority training modules on the e-ELCA will be made available on the new STRIVE website. The recommended modules need to be completed in every 5 year cycle. The intention that this will be linked to ESR however due to technical difficulties with the platform this has not yet been achieved and no date has been agreed for this to be completed.
- Advance care planning workshops: led by the Consultant in Palliative Care. 2 workshops held (7 consultants, 7 GP's and 7 senior nurses attended)
- Training delivered for paramedics within Yorkshire Ambulance Service and North East Ambulance Service
- The specialist palliative Care team has an education group which meets regularly and the group is actively recruiting palliative and end of life champion roles within clinical areas.
- Dying matters conference on the 15th May 2020. This is open to all clinical teams within South Tees and within the Tees valley area. Due to COVID-19 this has been postponed.
- External funding has not been secured for a palliative and 'end of life' care educator in the trust. Trusts which appear to be doing well with the National Audit of Care at the end of life (NACEL) and Care Quality Commission assessments have established education facilitators which helps to support embedding of new practice and implementation of tools to support excellent care. Discussions are starting with the hospice to look at putting in a joint bid to Macmillan Cancer Support for funding.
- Meeting held with Health Education England representatives. They are approaching Teesside University to refresh the 'end of life' care workbook and make this available on line. This is suitable for unregistered staff in the clinical and non-clinical setting.

Trust participation in "dying matters" week and general awareness raising of end of life care.

In 2019 the Specialist palliative care team had a stall in the atrium of James Cook hospital each day during the dying matters week which provided information for the public, our patients and our staff. A community nursing team in Bedale also held a drop in session for the public with information on end of life care. This year the trust had ambitious plans to participate in the dying matters week which was scheduled for the 11th-17th May. The theme this year was to be 'Dying to be heard'. An end of life care conference was planned for the 15th May in South Tees Research, Innovation and Education Centre (STRIVE). This was being hosted by the specialist palliative care team. A market place event was being hosted in the Atrium at JCUH on the 12th May and in the Friarage Hospital on the 13th May. The plan included a number of different stalls with the theme of advance care planning. In addition the trust was also involved in supporting a Tees Dead Good Festival (based on the festival held in York each year). This is a programme of events where the aim is to raise the profile of death and dying and includes visits to mortuary's, crematoriums, films, death cafes, talks etc. Unfortunately due to the Covid 19 outbreak these events have been postponed. It is uncertain at this time whether these events will be able to go ahead later in the year or will be postponed to next year.

Summary

There has been partial achievement of this priority. The specialist palliative care team does not have a 7 day service however there is a consultant on call Out of Hours (OOH) available to provide advice to professionals. The intention is to establish a 7 day service as part of the service review.

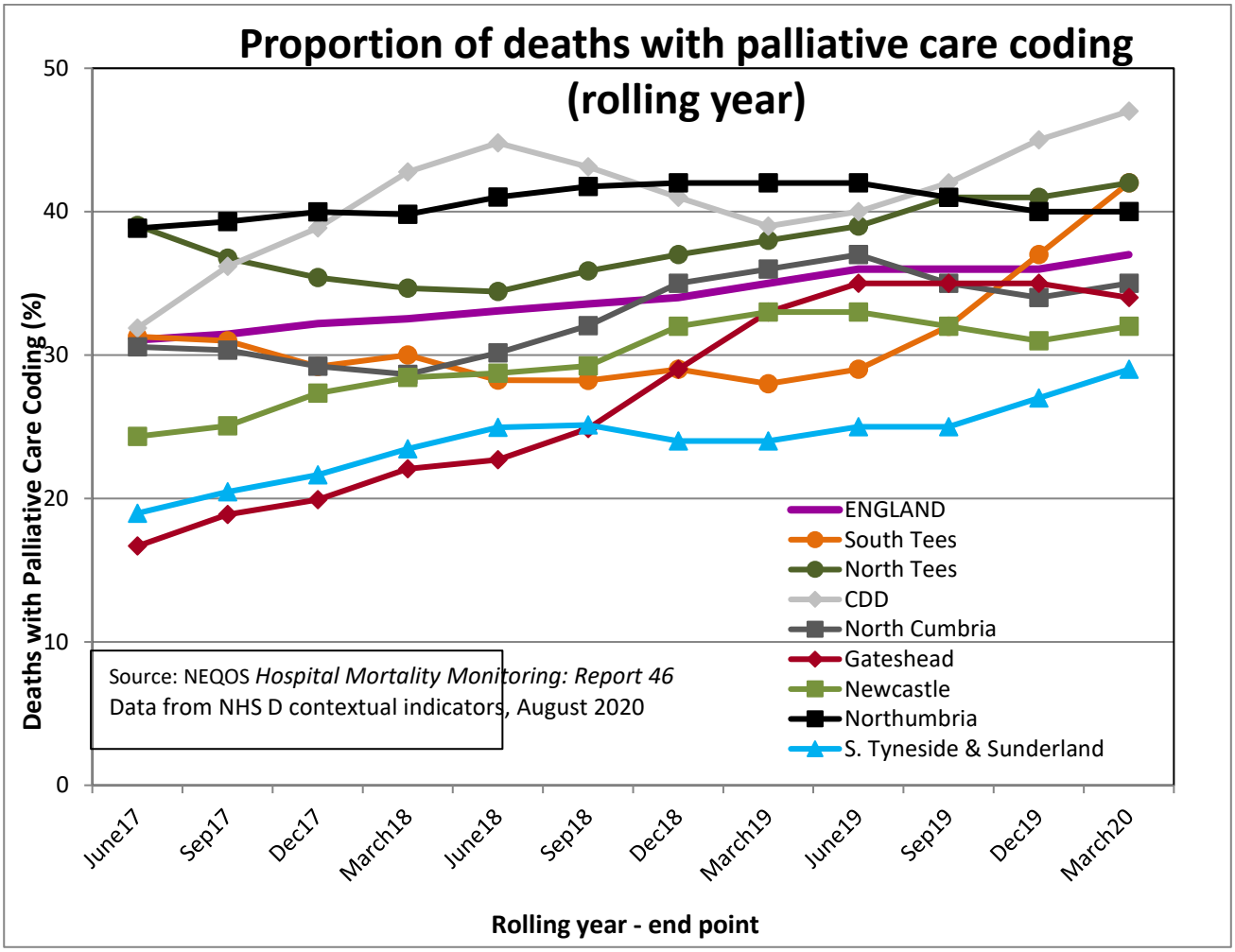


Figure 5: Proportion of deaths with palliative care coding

Theme	JCUH	FHN	National
Recognising the possibility of imminent death	n/a	n/a	n/a
Communication with the dying patient	6.6	5.4	7.8
Communication with families and others	5.3	5.3	6.9
Needs of families and others	n/a	n/a	6

Individual plan of care	5.2	6.5	7.2
Families and others experience of care	No submission	No submission	7
Workforce and provision of specialist palliative care	6.3	3.8	7.4

Table 3: National Audit of the Care of the Dying (NACEL) 2019 results.

The table below details the key recommendations from the audit.

Recommendations		**Trust Position**
1.	Improve documentation of specific aspects of care proposed and discussed at end of life	Review the templates used for documentation of the medical team plans and related communication for the dying person
2.	Gather the perceptions of the bereaved about the care delivered to their deceased family member	Explore the possibility of assessing this through more formally documented capture of feedback from next of kin that is already obtained by the Medical Examiners. In addition conduct a survey of experience of bereaved persons in partnership with the patient experience team
3.	Provide mandatory/priority training to all staff related to end of life care	Underway as a priority item of the End of Life Strategic Group work plan
4.	Provide opportunity for face to face assessment of the dying patient 9-5 seven days per week by specialist palliative care team	Underway as a priority item of service development/review for the Integrated Specialist Palliative Care service
5.	Provide opportunity for communication skills training for staff	Explore the potential for this through the Education group of the Integrated Specialist Palliative Care Team

Table 4: Draft key recommendations

Patient Experience
Priority: **Develop the Patient Experience Programme using the Meridian System to increase patient feedback including 'hard to reach' Groups**
Rationale The Trust is committed to ensuring that patients have a positive experience of the Trust and patient feedback is obtained to inform service improvements. The 1000 Voices programme has allowed for the capture of 'real time' data at ward level and includes FFT feedback. The 'real time' data provides feedback on issues identified for improvement. It has been recognised that further work is needed to expand on the work that is currently taking place to ensure feedback from 'hard to reach' groups is captured. FFT data shows that patients are generally satisfied with the care they receive however the Trust response rates are very low and well below the national average.
Actions A robust Patient Experience action plan will be developed by the end of May 2019 highlighting specific actions which will include: • Implementation of the Meridian IT system across the Trust • Use Meridian to increase the FFT response rates • Use of Meridian to increase the reporting of 'real time' feedback specifically within inpatients • Re-launch the FFT programme within Outpatients • Implement a system to identify specific 'hard to reach' groups utilising Meridian • Use of the Patient Experience Facilitators to facilitate feedback from the 'hard to reach groups • Work with TEWV (Tees, Esk and Wear Valley) mental health services to capture feedback from patients who have mental health diagnosis in the acute setting • Implementation of a feedback questionnaire following closure of complaints to identify service improvements • Review of processes in the Trust to gain patient feedback in relation to Trust and local objectives

- More focused work and triangulation of available data to inform a robust programme to support service improvement
- Ensure the Patient Experience Subgroup sets the strategic direction for patient experience

Measures of success

- Roll out of Meridian with increased responses (Q1)
- Increased FFT reporting to a statistically significant number of responses
- Utilisation of patient/service users in the core construction of any evaluative and improvement initiatives
- Demonstrable evidence of improvement initiatives as a result of patient feedback
- FFT Programme implemented in OPD and increase response rates including A&E
- Feedback obtained from identified 'hard to reach' groups
- Improve patient experience for patients with mental health diagnosis
- Feedback from complaints closure survey
- Increase the number of 'real time' feedback responses to 800 a month across inpatient areas (currently c360)
- Established and effective Patient Experience Subgroup and service user forum (Q1)

Progress

The Meridian programme has been rolled out utilising iPads for inpatient surveys and these are available on all wards and departments, for completion by patients, carers, relatives and parents. Additional support to complete the survey is provided by the Therapeutic Care Team for patients who are unable to complete the surveys independently however patients, carers, relatives and parents are encouraged to complete the survey to ensure the patient's unbiased experience is given. The Meridian programme is also utilised to send text messages to patients attending for emergency treatment, radiological procedures, and out-patient appointments or patients receiving care in their own home.

The data from the surveys informs the Domains held on the Meridian programme and is utilised by Ward and Departmental Managers who are able to review the feedback they receive and share this with their teams. This provides information which will empower them to make real time improvements based on their patients' experience of the care and treatment.

The information is also shared with the Patient Experience Sub Group which identifies and targets service improvement related to the patient experience. Figure 6 shows the scores across all domains Trust wide in 2019/20. This enables Wards and Departments to implement local improvements at ward or department level using patient feedback. Patient stories are identified through the Meridian system and patients are invited to share their experience at the Trust Board and the Patient Experience Sub Group.

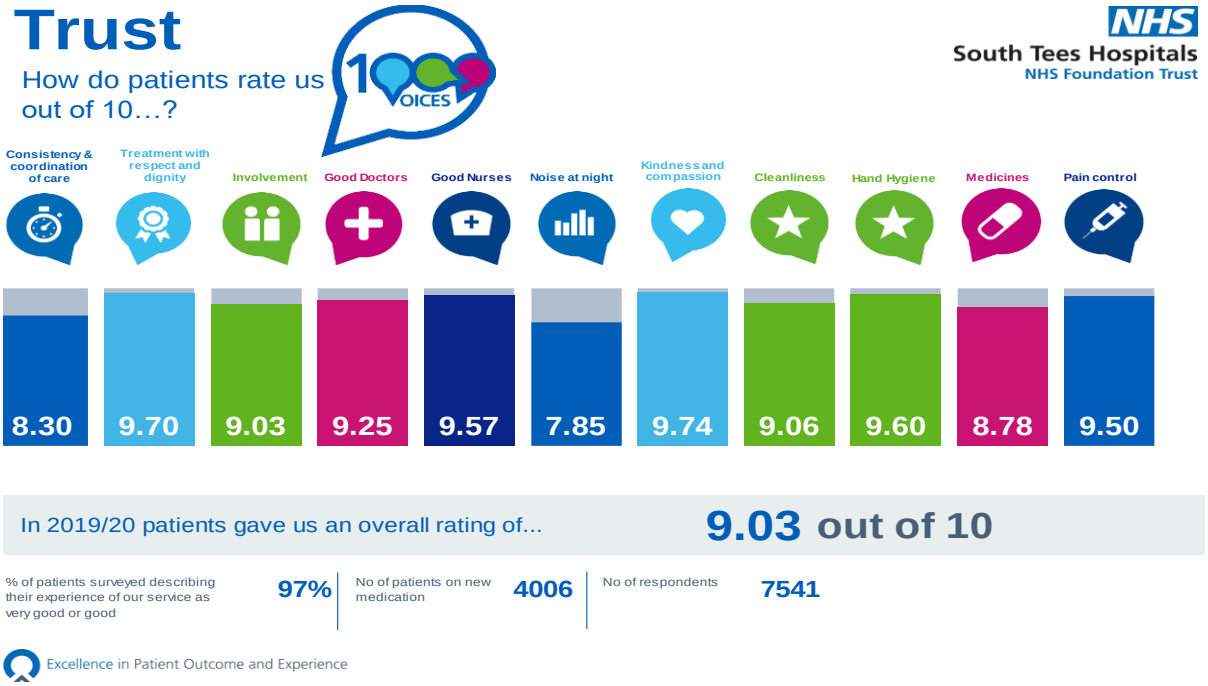


Figure 6: Domain scores 2019/20

To ensure the surveys are user friendly sentiment analysis (faces depicting happy to sad faces) have been added to ensure children, young people and patients who have a learning disability, understand the response they are providing. Collaborative working with the multidisciplinary team, such as the Learning Disabilities Specialist Nurse and external organisations, such as Healthwatch has taken place, to gain feedback from 'hard to reach groups'.

Patient Experience
Priority: Review the way complaints are investigated and standardise complaint responses
Rationale Our values are to deliver high quality care that puts the patient and their families first and to have open, honest and transparent communication with patients at all times. It is our belief that

everyone has a right to have their views heard, acted upon and resolved quickly and professionally. This reflects our behavioural standards, in that we want our patients and their families to feel safe, cared for and confident in their treatment.

Our staff will ensure patients and their families and carers who give any type of feedback regarding their treatment will receive and be treated according to their clinical needs and their care will not be compromised in any way. Equally, families and carers will not be treated in a negative way because they have raised concerns or made a complaint.

The patient remains the focus of the complaints process and the Trust aims to ensure that concerns and complaints are handled thoroughly without delay and with the aim of satisfying the complainant whilst being fair and open with all those involved. We recognise feedback is a valuable contribution to the development of better quality healthcare and are therefore committed to identifying lessons learned from complaints so that services across our organisation can be improved.

Actions

A robust complaints management action plan will be developed by the end of May 2019 highlighting specific actions which will include:

- Completion of a comprehensive review of the complaints management process to agree and clarify roles and responsibilities.
- Review of the 'Receiving Patient Feedback and Handling Patient Complaints' Policy (G01) to ensure that it reflects agreed processes as well as best practice.
- Develop and implement a standardised complaint response template for use across the Trust.
- Develop a quality assurance process for reviewing a proportion of complaint responses to ensure they conform to agreed standards.
- Ensure national guidance is reviewed and considered as part of the continued development of the complaints management service.
- Focused work on wards/departments to ensure staff are equipped with the skills and knowledge to manage complaints at an early stage and resolved locally where possible, prior to escalation to PALS or a formal complaint.

- Ensure complaints are closed within the agreed timescales.

Measures of success

- Approval of the revised 'Patient Feedback and Handling Patient Complaints' Policy
- Development of standard response template letter for complaint responses
- Development of a quality assurance process for reviewing complaint responses
- Reduction in the number of formal complaints
- 5% reduction in the number of re-opened complaints – baseline 2018/19 (12%)
- Increase in the percentage of complaints closed within the agreed timescales – target 80% - stretch target 85

Progress

A task and finish group commenced in September 2019 which included all stakeholders involved in the complaints process within the Trust. The task and finish group reviewed how complaints were managed and investigated from receipt of the complaint through to the written response being provided. The Group completed the work in December 2019. The new Patient and Carer Feedback Policy, which includes the complaint process, was produced and ratified in February 2020 and implemented on 1 March 2020. The new complaint process ensures that the management of a complaint is consistent throughout the organisation.

The new process acknowledges that the best way to manage a concern is at ward or department level. The process for raising a concern and how to escalate this is displayed on the patient experience ward boards at the entrance to all wards and departments for staff and patients. Assistance can be sought from the Patient Experience Team/PALS to advocate in the process, when required.

A standard template response letter has been developed using the guidance from The Patient Association, 'Good Practice Standards'. The template is designed to allow the personalisation of the response to the individual but also provides the appropriate information to include, who has carried out the investigation, how this was done and the response to concern raised is clearly identifiable.

A weekly meeting was reinstated for the leads for the Centres to monitor the timeframes for response. This allows the teams to identify early any concerns in meeting the timeframes to ensure

early escalation takes place with the aim of meeting the timeframes for completion for all written complaint responses.

The planned roll out the new Patient and Carer Feedback Policy across the organisation was delayed due to the COVID 19 Pandemic. The roll out will resume when the guidance permits this.

Patient Experience

Priority: Improve the Outpatients Department (OPD) Patient Experience

Rationale

The Trust is committed to ensuring that when patients attend for an outpatient appointment they have a positive experience.

Investigation of PALS data demonstrated that a significant amount of contacts were with regard to outpatient appointments (21%), with patients unsure of when their appointment was and unable to contact the relevant department, or in some cases unsure of what their appointment was for.

- Actions
- A robust patient experience action plan will be developed by the end of June 2019 highlighting specific actions which will include:
- Review of communication letters to patients to ensure adequate and effective communication, this will include information relating to accessible information and asking patients if they would like the information in another format. This review will consider the information sent pre-appointment, information provided during appointments and post-appointment follow up.
- Strengthen the governor ‘drop-in’ programme to ensure that robust action plans are put in place to address issues identified during their visits and ensure that there is evidence that actions have been completed within agreed timescales. Feedback will be provided quarterly to the Quality Assurance Committee (QAC) and the Council of Governors to provide assurance that actions identified have been implemented.
- Ensure there are robust systems in place to respond to patient feedback relating to outpatient appointments.
- Implementation of a ‘secret shopper’ initiative within OPD’s to inform future improvement work.

- Re-launch the FFT programme within Outpatients.

Measures of success

- Completion of baseline assessment of information communicated to patients relating to outpatients appointments.
- Programme of Governor's drop in sessions and evidence of actions taken following these visits.
- Implementation of the 'secret shopper' initiative across the Trust.
- Reduction in the number of PALS queries relating to OPD appointments.
- Introduction of FFT within Outpatients.

Progress

A Task and Finish Group was formed in October 2019 and the appropriate stakeholders for the outpatient departments were invited to be involved in developing a detailed action plan that is monitored at the Patient Experience Sub Group. There were a number of areas of focus for the T&F group and these included communication needs, written and verbal, waiting times for appointments and in departments and information displayed in departments.

Reviews of the Information Technology (IT) systems have taken place to ensure that critical information about the patients communication requirements have been documented and all Trust staff are aware of their role in gaining and using this information. The documentation used by all of the outpatients departments has been reviewed and a trust standard has been agreed and is used by the external company for sending out appointments.

The posters displayed in OPD have been reviewed and out dated information has been removed and it has been agreed that information relevant to the department must be displayed. All OPD must display the Accessible Information Standards (AIS) poster informing patients to provide the details of their communication requirements. All information from the Trust now details the AIS to ensure every opportunity is taken to gain the communication requirements.

A review of administration practices within the Ophthalmology OPD has been undertaken. New working practices have been implemented and staff are now carrying out role specific duties, which include answering telephones and picking up voicemails, this is to ensure all patients enquiries are responded to. This will be monitored through the PALS and the number of concerns received relating to telephone calls not being answered and voicemails not being returned. This will also be reported on via the Patient Experience Sub Group.

There was a programme of monthly Governor Drop-in sessions carried out in 2019/20 to all outpatient departments. Unfortunately due to the COVID-19 Pandemic the visits were discontinued however these will re-commence once guidance is received to allow this. The actions identified following the visits have been shared with the OPD Manager for consideration and action. The Governor Drop-ins action plan is shared with the Patient Experience Sub Group on a quarterly basis.

The Mystery Shopper has been developed and a leaflet with a questionnaire attached has been produced. The leaflet will be available in all OPD, at the main entrance to all hospital sites and on the Trust web-site. The information from the surveys will be fedback to the OPD and an action plan presented to the Patient Experience Sub Group on a quarterly basis. This was due to be launched in the outpatient departments during patient experience week; this was cancelled due to COVID 19. The Mystery Shopper will be launched in September 2020.

2020/21 Quality Priorities

The Trust has agreed the following priorities for 2020/21 following a consultation process.

Quality Priorities 2020/21		
Safety	**Clinical Effectiveness**	**Patient Experience**
Increase incident reporting by 10% per year. This will also mean an increase in incidents reported to the NRLS.	To identify, develop and implement a Quality Strategy for the trust and embed an agreed approach to quality improvement methodology	Continuing work to further develop the patient experience programme using Meridian, specifically focusing on implementation of the new FFT guidance and 'hard to reach' groups.
Reduce the occurrence of Never Events and ensure there is a focus on safe surgical practice including improving the safety culture within theatres and continue the LoCSSIPs work.	To implement and embed the STAQC accreditation process for the trust and the Quality Assurance framework	Embed the revised complaints management process within the trust in line with the revised Patient and Carers Feedback Policy
Improve the quality of incident investigations at all levels including those for Serious Incidents and those reported on Datix.	Ensure patients have a safe, effective and timely discharge	Improve the Outpatients Department (OPD) experience through 'task and finish' groups to review and continue the work that has taken place during 2019/20.

Patient Safety

Safety
Priority: **Increase incident reporting by 10% per year. This will also mean an increase in incidents reported to the NRLS.**
Agreed Actions A robust incident reporting action plan will be developed describing specific actions which will include: • Completion of a comprehensive review of incident management process including discussing with staff at all levels and all staff groups to understand barriers to reporting – engage medical and nursing colleagues

- Complete review of coding structures and usage
- Review of incident types that are uploaded to NRLS to try and increase the threshold of what we upload
- Implement Datix Cloud IQ including Datix Anywhere Mobile reporting App.
- Develop reporting mechanism to show number of incidents reported by 1,000 bed days.
- Develop and implement a standardised incident report form on Datix for use across the Trust as well as short forms that can feed into the main system
- All new starters receive a session on incident reporting at Trust Induction
- Focused work on wards/departments to ensure staff have the skills and knowledge to recognise, report and investigate incidents in a timely manner. A work programme will be developed to support this
- Outstanding incidents are reviewed on a weekly basis as part of the Patient Safety wall.
- A weekly review of open harm events with QBP's (Quality Business Partners) and patient safety will continue with the aim of closing down incidents within the week that they are reported.

Measures of success

Implementation of improved system for reporting incidents – worked with TVN's (Tissue Viability Nurses) and ED and Clinical & Diagnostics. Coding structure is simplified.

Increase in the number of Incidents reported – including Near Miss reporting in groups of historically "low reporting" staff.

Development of standardised incident report form – continuing.

Implementation of Datix Cloud IQ.

Establishment of a Datix user group, terms of reference and minutes of meetings. Implement Datix champions in all staff groups.

Safety

Priority: Reduce the occurrence of Never Events and ensure there is a focus on safe surgical practice including improving the safety culture within theatres and continue the LoCSSIPs work.

Rationale

The Trust has already agreed that Safer Surgery would continue to be a Trust quality account priority. As a result of this a Safer Surgery Oversight Group was established in 2019 to implement safer surgery practices across the Trust working towards eliminate Never Events. The group is led by a Medical Director and group membership is made up of key clinical and patient safety colleagues.

The group has developed a Safer Surgery Improvement Plan which is a comprehensive working document that outlines actions required, by whom, expected dates of completion and evidence to support completed actions and sustained improvements to monitor and track that risks have been reduced. The plan outlines 4 main themes:

- Organisational Factors (addressed through the Trust's improvement plan and renewed focus on empowering clinical leadership since October 2019)
- Team Factors
- Sharing and Learning and Training
- Human Factors

The aim is to implement safer surgery practices across the Trust to eliminate Never Events by 31st March 2022. The System Improvement Team across the Tees Valley is supporting the Moving to Good Safety Programme of which South Tees is a part.

Actions required:

To monitor delivery of the key milestones set out in the Safer Surgery improvement plan through implementation of the following key milestones:

- Trust policy, best practice standards and good governance is fully embedded in theatres and anaesthetic practice overseen by the safer surgery oversight group.
- Team factors – Ensure that all team members work in an open and respectful culture, where questioning and speaking up is encouraged.
- Sharing and learning to ensure that learning is embedded across the department and wider organisation
- Training and Human Factors to ensure staff have the opportunity to reflect, learn and understand why errors occur in the theatre and anaesthetic setting.
- The Safer Surgery Oversight Group will continue to meet monthly to track delivery and progress of set actions to maintain momentum and operational grip.

Measures of success

The Safer Surgery Improvement Plan sets out under each of the headings the actions required so that progress with these can be monitored to ensure these are on track.

- Required outcome
- Action required by who/lead person
- Expected date of completion
- Evidence to support the action has been completed
- Evidence of sustained improvement and that the risk has been reduced.

This is then signed off as completed by the Oversight Group.

Safety

Priority: Improve the quality of incident investigations at all levels including those for Serious Incidents and those reported on Datix.

Agreed Actions:
A robust incident reporting action plan will be developed describing specific actions which will include:

Focused work on wards/departments to ensure staff have the skills and knowledge to recognise, report and investigate incidents in a timely manner. A work programme will be developed to support this.

- Establish what training is required (Training Needs Analysis) – Investigation, Reporting an incident, Obtaining data from the system, Dashboards.
- Full programme of Incident investigation training including SMART objectives
- A cohort of incident "investigators"
- Review RCA (Root Cause Analysis) toolkit and implements Institute for Healthcare Improvement "Patient Safety Essentials" toolkit.
- Datix Cloud implementation - Investigation module
- Prepare for the introduction of Patient Safety Incident Response Framework (PSIRF)

Clinical Effectiveness

Priority: To identify, develop and implement a Quality Strategy for the trust and embed an agreed approach to quality improvement methodology

Rationale

Quality Strategy

As a Trust we need to ensure that we focus on quality – clinical, corporate, teaching, research, medical. In all areas we need to ensure that we self-assess our performance and where appropriate nationally accredit our services to provide assurance of our performance and mitigate areas of poor performance.

All our staff contribute to delivering a quality service (whether clinical or non-clinical), and carry a personal responsibility to ensure that risks to deliver effective care are reported and recorded, our senior teams have the responsibility to ensure that these risks are managed and mitigated.

Our quality strategy will be underpinned with the CQC domains of

- Safe – reduce harm, mortality, ensure all staff are appropriately trained and registered for their role, sharing good practice
- Well Led – ensuring all staff understand their core role within the safety of their professional remit, developing via research networks new evidence based practice

- Effective – improving outcomes, following best practice and evidence, developing new techniques
- Caring – improve the experience of our patients, their carers, and our staff

Quality Improvement

The CQC Inspection in 2019 found that STFT required improvement across leadership, organisational development and quality improvement. Prior to March 2019 Leadership development was localized at the level 5 apprentice level with ad hoc registration at level 7. There was no organisational development team or strategy and there was no quality improvement team or strategy.

Operationally, within South Tees Research, Innovation and Education (STRIVE) there was the ability to streamline processes and expand partnerships for accredited programmes however there was no operational capacity for new teams or staff.

Scoping in 2019/2020 outlined that there was no overarching strategy or approach to the process for Quality Improvement within South Tees NHS Foundation Trust. It was agreed by the Senior Leadership team that a scoping exercise should be carried out to understand what is or isn't happening within the organisation and to gain feedback on what our suggested approach should be and to make a number of recommendations. This work will be led and supported by the Trust's new Clinical Support Unit which is an integral part of our improvement plan and work to empower clinical leadership around the way the organisation allocates resources and provides care.

The recommendations were to develop a STFT programme for quality methodology, providing training in a range of QI methodologies to ensure the best practice per problem is used. Recognising the complexity of QI methodologies and the wide range of services within the Trust this approach would ensure the appropriate breadth of change programmes teaching would be available within STFT.

Our strategic intent is to create a culture of transformation, collaboration and quality improvement at STFT. To enable this we will build a system for continuous learning through continuous, quality improvement, leadership and organisational development.

Actions Required

Quality Strategy

STFT will develop a quality strategy to ensure that each area can self-assess performance, manage their key performance indicators and provide assurance against national standards.

Quality Improvement

Work with finance to re-base STRIVE management budget using resources within tariffs as appropriate to generate a new team to deliver leadership training (non-accredited), quality improvement training and organisational development, timeline developed to meet strategic intent.

Develop a quality improvement strategy and methodology for the Trust.

Measures of Success

Quality Strategy

Development of QuEST – Quality and Experience at South Tees

Development of ward accreditation process: self-assessment against accreditation in all areas (clinical and non-clinical), maintenance of accreditation and positive movement in accreditation scales.

Quality Improvement (QI)

- Transformation of the approach to QI
- A common language for QI
- Resonance and ownership of the process
- Consolidation of current skills base into consistent approach

Development of leadership confidence and capability in QI, leading to improved patient outcomes, improved service provision and so improved patient care, embedded via leadership programmes and QI training.

Clinical Effectiveness

Priority: To implement and embed the South Tees Accreditation for Quality of Care (STAQC) accreditation process for the trust and the Quality Assurance framework

Rationale

Developing a set of standards against which to measure quality of care is central to demonstrating improvement. Accreditation brings together key measures of nursing and clinical care in to an over-arching framework to enable a comprehensive assessment of the quality of care at ward, unit and team level. The concept of STAQC originated in 2012 with the implementation in July 2014. This was suspended in 2016 but is now being refreshed as a key strategy to ensure excellence in patient care and is aligned with other quality priorities and the Trusts improvement plan. There is also a clear ambition in the Trust to align this with the CQC inspection framework and 'get back to our best'.

Wards and departments will be assessed against multiple standards grouped together under the following headings:

- Culture of compassionate care
- Well led
- Avoidable harm
- Effective Care

It is expected that this will provide ward to board assurance, create a platform for continuous improvement in patient safety and patient experience and improve accountability. Above all this should create a culture of pride and accomplishment and will be supported by personal and professional development.

The process includes an initial briefing, self-assessment, quality assurance visits and feedback. This will be supported by a robust data collection methodology has been developed using Meridian as a platform and will be linked to an integrated performance framework for the Trust.

A system of silver and gold awards is to be used for accreditation.

Clinical Effectiveness

Priority: Ensure patients have a safe, effective and timely discharge

Rationale

Unnecessarily prolonged stays in hospital are bad for patients. Tackling long stays in hospital will reduce the risk of patient harm, disability and unwarranted cost. Congestive hospitals struggle to deliver the best care, reduced bed occupancy through improved flow greatly improves the working and care environment. (NHSI 2018)

Every day in hospital is a precious day away from home. We want to embed a home first mind set across our health and social care system, the aim is to do everything we can so that our patients, especially older people, can continue to enjoy their lives in their own home environments. For the few that cannot go home from hospital we should endeavour to minimise delays as patients move to a location most suited to meeting their needs.

Patients with a length of stay over seven days are defined as 'stranded' and patients with a length of stay over twenty one days are defined as 'long stay' patients.

A 'delayed transfer of care' (DToC) occurs when a patient is ready to leave a hospital or similar care provider but is still occupying a bed. Delays can occur when patients are being discharged home or to a supported care facility, such as a residential or nursing home, or are awaiting transfer to a community hospital or hospice.

The term 'patient flow' refers to the ability of a health care system to manage patient effectively and with minimal delays as they move through stages of care. The consequences of poor flow are known and described earlier in the report.

- Pain management
- Awaiting Assessments – social care and rehabilitation

These delays can be compounded if internal processes are not robust, specifically our Model Ward approach based on SAFER principles (NHSI, 2017):

S – Senior review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.

A – All patients will have an expected discharge date and clinical criteria for discharge. This is set assuming ideal recovery and assuming no unnecessary waiting.

F – Flow of patients will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10 am.

E – Early discharge. 33% of patients will be discharged from base inpatient wards before midday.

R – Review. A systematic multi-disciplinary team review of patients with extended lengths of stay (>7 days – 'stranded patients') with a clear 'home first' mindset.

The Clinical Utilisation Review (CUR) 'not met' reasons, the need to further embed SAFER principles along with the need for optimal communication with local authority and Clinical Commissioning Group colleagues form the basis of the improvement action required:

Actions

- Evaluate the "STOP" initiative and consider scaling this up to other wards. The initiative ensures the nurse in charge has the final oversight of the discharge of their patients and the patient has the information to empower them to challenge any aspects of their discharge arrangements. There will continue to be improvements made such as including clear discharge pathways in the documentation to enable effective discharge planning. Further information on this is included earlier in the report.
- Regular review of delayed discharge and length of stay metrics and associated actions put in place. This will take place operationally at a weekly ''Where best Next?'' meetings and strategically at a monthly "Home First" system-wide meetings attended by key staff members of the acute Trust, Local Authorities and the CCG.
- Embed the role of the frailty liaison team to increase the focus on the frail patients to ensure they are admitted to the most appropriate clinical environment to maximise chances of early discharge and prevent of deconditioning.
- Embed the SAFER principles – having a focus on criteria led discharge and ensuring an estimated date of discharge is set based on clinical evidence.
- Implement a robust model of working for the integrated discharge team and the integrated Single Point of Access.
- Ensure improvement plans for CUR 'not met' categories are in place and implement an escalation process using daily automated reports sent to managers from Medworxx.

Measures of success

- Decreasing rate of delayed transfers of care to be below the 3.5% upper threshold
- Decreasing average length of stay in the acute setting – individual directorates to set own targets by end Q2 relative to baseline to achieve either top quartile or top decile against national benchmarks
- Decreasing number of patients with a length of stay over 21 days
- Improving trend of discharges before 12 midday, towards the target of 33% by the end of Q4
- Decrease in the 'CUR not met' rate using Medworxx analysis. Reduction on the 2019/20 position of 35.54%
- Reduction in the delays for the main categories associated with 'CUR not met' reason codes
- Decreased number of discharge related PALS and patient complaints
- Set baseline and improvement trajectories for decreasing length of stay in patients with clinical frailty by end Q1
- Decreasing levels of harm in patients with frailty. Baseline and improvement targets to be set by end Q2 and monitored via Datix and the frailty dashboard.

Patient Experience

Priority: **Continuing work to further develop the patient experience programme using Meridian, specifically focusing on implementation of the new FFT (Family and Friends Test) guidance and 'hard to reach' groups.**

Rationale

The results of the National surveys carried out by the Care Quality Commission (CQC) identified that only a small percentage of patients using the Trust's services were being offered the opportunity to provide feedback on their experience of the services they had used. The Trust aims to ensure that all patients using the many services across the organisation

are provided with an equal opportunity to feedback their individual experience of the service used.

How we will do this?

- Develop bespoke surveys to gain patient feedback on services and care pathways
- Work in partnership with patients
- Implementation of the new FFT guidance
- Extend the text messaging service to OPD and patients receiving care in their own home.
- Develop bespoke surveys to reach all patient groups
- Develop surveys to gain feedback on new services and initiatives, for example, virtual clinics and visiting restrictions.
- Develop and implement the Carers survey to capture feedback from 'hard to reach groups'
- Develop the Bereavement survey to capture experience of end of life care.

How will we know we have done this?

- Met Key Performance Indicators (KPI) for inpatient surveys set for all wards
- Patient feedback informs improvement work, 'you said, we did'.
- Patient involvement in reviewing or developing new services and care pathways
- Improvement across all domains in the 1000 voices programme

Progress with actions will be reported through the Patient Experience subgroup and the Quality Assurance Framework.

Patient Experience

Priority: **Embed the revised complaints management process within the trust in line with the revised Patient and Carers Feedback Policy.**

Rationale

It was recognised that there was an inconsistency across the Trust in the way that complaints were being investigated and also with the written response that was sent to the complainant. An end to end review of the complaints process was carried out from September 2019 to December 2019. The Patient Experience and Carers Feedback Policy was ratified in February 2020 and the new complaints process, detailed in the policy, has been implemented across the Trust.

How will we do this?

- Produce a standardised investigation process for complaints that mirrors the investigation process used for an incident, to ensure a consistent approach across the organisation.
- A lead investigator is allocated for all complaints coordinate the investigation process
- Ensure all elements of the complaint are understood, investigated and responded to the complainant's satisfaction and within the appropriate timeframe.
- Embed the revised complaints management process within the Trust in line with the revised Patient and Carers Feedback Policy.

How will we know we have done this?

- Increase in complaints being closed within the response timeframes.
- Decrease in reopened complaints relating to the complaint not being investigated appropriately.

Patient Experience
Priority: Improve the OPD experience through 'task and finish' groups to review and continue the work that has taken place during 2019/20.
Rationale It has been recognised through patient feedback received through PALS that the out-patient department (OPD) experience could be improved upon. The main areas for improvement identified were communication, waiting times for appointments and delays in the OPD.
How will we do this? • Continue with the on-going work with the T&F group work in relation to communication, waiting times for appointments, the patient experience of the OPD and information provided to patients. • A standard operating procedure (SOP) is being developed for reception staff greeting patients to the department, this includes, the 3 point check and AIS communication question. A SOP has also been developed for answering the telephone to ensure that there is a Trust standard for responding to telephone communication. • Monitor and be reactive to patient feedback from surveys, Governor Drop In's, Mystery Shopper, PALS and complaints about the OPD experience. • A comprehensive training package is underway for new staff and a rota for role specific duties, including answering the telephone, working on reception and pulling notes for clinics is in place.
How will we know we have done this? • Reduction in PALS and formal complaints in relation to the OPD. • Increase in positive feedback from patients through surveys regarding the OPD experience.

Statements of Assurance from the Board

Review of services

During 2019/20 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 PALS of these relevant health services.

The income generated by the relevant health services reviewed in 2019/20 represents 91.5% of the total income generated from the provision of relevant health services by the South Tees Hospitals NHS Foundation Trust for 2019/20.

Participation in Clinical Audit

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. We know that high quality clinical audit enhances patient care and safety, and provides assurance of continuous quality improvement.

During 2019/20, 67 national clinical audits and 3 national confidential enquiries covered relevant health services that South Tees Hospitals NHS Foundation Trust provides.

During 2019/20, South Tees Hospitals NHS Foundation Trust participated in of 93% national clinical audits and 100% of national confidential enquiries which it was eligible to participate in.

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 2019/20 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

Title	Eligible	Participated	% cases
Assessing Cognitive Impairment in Older People / Care in Emergency Departments	✓	✓	100%
BAUS Urology Audit: Cystectomy	✓	✓	100%

Title	Eligible	Participated	% cases
British Association of Urological Surgeons) (BAUS)Urology Audit: Female Stress Urinary Incontinence	✓	x	0%
BAUS Urology Audit: Nephrectomy	✓	✓	100%
BAUS Urology Audit: Percutaneous Nephrolithotomy	✓	✓	100%
BAUS Urology Audit: Radical Prostatectomy	✓	✓	100%
Care of Children in Emergency Departments (Royal College of Emergency Medicine (RCEM)	✓	✓	100%
Case Mix Programme (CMP) Also includes Cardiac Intensive Care (Intensive Care National Audit & Research Centre (ICNARC) data)	✓	✓	100%
Elective Surgery - National PROMs Programme (Patient Reported Outcomes Measure)	✓	✓	Pre-op: 111.8% Post-op: 60.8%
Endocrine and Thyroid National Audit	✓	x	0%
The Falls and Fragility Fracture Audit Programme (FFFAP) The Fracture Liaison Service Audit (FLS-DB)	✓	✓	100% of cases identified
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	✓	x	0%
Major Trauma Audit (TARN)	✓	✓	100%
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	✓	✓	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme	✓	✓	100%
Medical and Surgical Clinical Outcome Review Programme – National Confidential Enquiry into Patient Outcome and Death - NCEPOD Dysphagia in Parkinson's Disease	✓	✓	Ongoing
Medical and Surgical Clinical Outcome Review Programme – National Confidential Enquiry into Patient Outcome and Death - NCEPOD In	✓	✓	100%

Title	Eligible	Participated	% cases
Hospital Management of Out of Hospital Cardiac Arrests			
Medical and Surgical Clinical Outcome Review Programme – National Confidential Enquiry into Patient Outcome and Death - NCEPOD Long Term Ventilation: Balancing the Pressures	✓	✓	0% - no eligible cases, however organisational data has been submitted
Mental Health - Care in Emergency Departments (RCEM)	✓	✓	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Adult Asthma Secondary Care	✓	✓	48%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	✓	✓	47%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Paediatric Asthma Secondary Care	✓	✓	62%
National Audit of Breast Cancer in Older People (NABCOP)	✓	✓	100%
National Audit of Cardiac Rehabilitation (NACR)	✓	X	0
National Audit of Care at the End of Life (NACEL) 1	✓	✓	100%
National Audit of Seizure Management in Hospitals (NASH3)	✓	✓	100%
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	✓	✓	4%
National Bariatric Surgery Registry (NBSR)	✓	✓	100%
National Cardiac Arrest Audit (NCAA)	✓	✓	100%

Title	Eligible	Participated	% cases
National Cardiac Audit Programme (NCAP) - National Adult Cardiac Surgery Audit	✓	✓	100%
National Cardiac Audit Programme (NCAP)- Myocardial Ischaemia National Audit Project MINAP	✓	✓	100%
National Cardiac Audit Programme (NCAP)- National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	✓	✓	100%
National Cardiac Audit Programme (NCAP)- National Heart Failure Audit	✓	✓	100%
National Diabetes Audit – Adults: National Core Diabetes Audit	✓	X	0%
National Diabetes Audit – Adults: National Diabetes Foot Care Audit	✓	✓	100%
National Diabetes Audit – Adults: National Diabetes Transition	✓	✓	100%
National Diabetes Audit – Adults: National Diabetes Inpatient Audit (NaDIA) -reporting data on services in England and Wales	✓	✓	100%
National Diabetes Audit – Adults: NaDIA-Harms - reporting on diabetic inpatient harms in England	✓	✓	100%
National Diabetes Audit – Adults: National Pregnancy in Diabetes Audit	✓	✓	100%
National Early Inflammatory Arthritis Audit (NEIAA)	✓	✓	<50%
National Emergency Laparotomy Audit (NELA) Year 6	✓	✓	100%
National Gastro-intestinal Cancer Programme: National Oesophago-gastric Cancer (NOGCA)	✓	✓	100%
National Joint Registry (NJR)	✓	✓	>95%
National Lung Cancer Audit (NLCA) 1, 2	✓	✓	100%
National Maternity and Perinatal Audit (NMPA) 1	✓	✓	100%

Title	Eligible	Participated	% cases
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP) 1, 2	✓	✓	100%
National Ophthalmology Audit (NOD)	✓	✓	76.50%
National Paediatric Diabetes Audit (NPDA) 1	✓	✓	100%
National Prostate Cancer Audit	✓	✓	100%
National Smoking Cessation Audit	✓	✓	100%
National Vascular Registry	✓	✓	100%
Neurosurgical National Audit Programme 2	✓	✓	100%
Paediatric Intensive Care Audit Network (PICANet) 1, 2	✓	✓	100%
Perioperative Quality Improvement Programme (PQIP)	✓	✓	Ongoing
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): Antibiotic Consumption & Antimicrobial Stewardship	✓	✓	100%
Sentinel Stroke National Audit programme (SSNAP) 1, 2	✓	✓	100%
Serious Hazards of Transfusion: UK National Haemovigilance Scheme	✓	✓	100%
UK Cystic Fibrosis Registry	✓	✓	100%
Falls and Fragility Fractures Audit programme (FFFAP): National Hip Fracture Database	✓	✓	100%
Falls and Fragility Fractures Audit programme (FFFAP): National Audit Inpatient Falls	✓	✓	100%
National Gastro-intestinal Cancer Programme: National Bowel Cancer Audit (NBOCA)	✓	✓	100%
Society for Acute Medicine's Benchmarking Audit (SAMBA)	✓	✓	100%
Surgical Site Infection Surveillance Service	✓	✓	100%
UK Cystic Fibrosis Register	✓	✓	99%
UK Parkinson’s Audit	✓	✓	100%

Table 5: National Clinical Audits

The reports of 15 national clinical audits were reviewed by the provider in 2019/20 and South Tees Hospitals Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Title of Audit	Actions
Royal College of Emergency Medicine (RCEM)Pain in Children	There were areas of good practice in that all patients were offered analgesia and all patients were assessed for pain within 15 minutes on arrival. There were also areas for improvements: • Pain score 1-10 was not recorded in the 50 cases • Difficulty in differentiating mild/moderate/severe pain • Pain score was only re-evaluated in 2 cases out of 50 The team have now made changes to staff education, there are discussions at directorate meetings and we have updated the way electronically prescribe so that if prescribing analgesia the system will ask for a pain score.
NACEL audit (National Audit of Care at End of Life)	• Review medical care summary documentation templates in conjunction with NECN review • Established bereaved persons survey annually • Implement 'priority training' in end of life care • Seven day 9-5 face to face assessment by specialist palliative care nurse • Identify accessible communication skills training for Trust staff
National Cardiac Arrest Audit (NCAA)	• Letter to be sent to appropriate Clinical Director for all patients identified as unexpected non-survivors to make them aware of these patients and asking them to review as part of M&M meetings. • Information also to be sent to the Clinical effectiveness/Mortality Surveillance team to check if they have been reviewed in M&M meetings
National Audit of Dementia Round 4	• Continue to promote "John's Campaign" and open visiting. • Review dementia patient leaflets and ensure wards have sufficient supply.

	• Include prompts to strengthen documentation relating to discharge arrangements within the nursing pathway (discharge care plan). • Relaunch via patient experience facilitators the carers survey • Feedback and escalation of patient experience data via clinical standards and patient experience sub group • Establish partnership working to share patient feedback and experience data with TEWV • Develop a "Forget Me Not" prompt ("what's important to me") for above the bed • Review and relaunch dementia training to include delirium management and include key messages from carers
National Diabetes Foot Care Audit	• Continue to increase the number of patients who self-refer – Darlington team are working on a group of actions to address this • Reduce major amputation rate – STEES team looking at Root Cause Analysis for amputations
National Pregnancy in Diabetes Audit	• Antenatal care offered regularly in the Diabetes clinics and Self-referral pre-conception clinics • Multidisciplinary clinic twice a week • An audit planned to undertaken on steroids and diabetes in pregnancy
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	• To continue active surveillance of these infections. • To continue to input data to the national website for these infections by the 15th of each month. • To continue to hold case reviews for Trust-apportioned cases of C difficile and all cases of MRSA bacteraemia.
(National) Maternity and Perinatal Audit (NMPA)	• Continuous self-assessment against Baby Friendly Initiative (BFI) standards and external reassessment every 3 years
National Ophthalmology Audit (NOD)	• The team plan to do PROMs for cataract pathway
NCEPOD Perioperative Diabetes	• Write a new peri-op guideline including all current guidance – specifically identifying high risk patients, change to HbA1c targets, identification of DM patients

Management– 'Highs and Lows'	
NCEPOD – Acute Heart Failure (HF): Failure to Function	There were 15 key recommendations in the report most of which are already in practice in this Trust. Actions put into place: • A monthly HF MDT composed of all elements described in the recommendations apart from palliative care, largely as a result of inadequate palliative care resources. • Follow a simple care pathway, the Nurse Practitioner group cover 24/7 so would be a much more robust group of staff to engage with for the pathway
National Paediatric Bronchiectasis Audit	• Improve assessment of aetiology of bronchiectasis, particularly as the investigations recommended would alter clinical management; • Increased sputum being sent for microbial testing in the stable state and in exacerbations, again which would directly alter management; • Increased number of patients being taught airways clearance techniques by a respiratory physiotherapist.
National Prostate Cancer Audit	• All patients with suspected prostate cancer that have no contra-indications are undergoing pre-biopsy multparametric MRI. • Plans are in place to introduce trans perineal biopsies in 2020.
Serious Hazards of Transfusion (SHOT)	The team reported that the majority of the actions have been completed in relation to the report with the exception of recommendations around IT infrastructure. A business case has been submitted and included as part of the trust IT project with implementation likely to be around 2-3 years
National Smoking Cessation Audit	• To employ a clinical lead with admin support • For the clinical lead to work closely with clinical and pharmacy colleagues to improve the prescribing of NRT • To write a strategy for South Tees Smoke Free

Table 6: National Clinical Audit Reports

Local Clinical Audits

The reports of local clinical audits reviewed by South Tees NHS Hospitals Foundation Trust in 2019/20 are shown below, and the Trust intends to take the following actions to improve the quality of healthcare provided.

Title	Actions
VTE Prophylaxis Review Audit in Orthopaedics	• Posters must continue to be kept in the doctors' room to remind doctors about completion of the VTE prophylaxis assessment • Regular reminders during morning meetings to continue to take place to ensure that VTE assessment completion
Assessment of bite marks in children presenting as potential non-accidental injuries	• Highlight the results of the audit to the wider paediatric team. • Audit results to be presented in front of paediatrics team to highlight the findings. • Investigate why paediatricians are not currently referring suspected bite marks for a forensic dental review. • Agree a pathway regarding dental referrals at designated doctor's forum. • Illustrate results of the audit at the next designated doctors forum in June 2019 to compare results from neighbouring trusts and agree a pathway.
Audit to confirm relevant medical information is included in referrals to Children Social Care	• Emails to be sent to practitioners who had made good referrals • Findings from audit to be presented at A&E Meetings – focus to be on demographic details • Making SAFER referrals (Situation, Assessment, Family factors, Expected response, Referral and recording) to continue to be included in safeguarding training • Safeguarding staff to promote good practice within the department face to face with practitioners • Visual aids and information about referrals to be displayed in A&E as part of the "safeguarding areas of focus plan"
Nursing and Care Home Better Care Fund (BCF) 'MUST' Audit	• Further training will be delivered on MUST (a screening tool to identify malnutrition), but focusing on a smaller number of care homes, which will hopefully mean that improvements are more dramatic than seen in this audit.

Surgical Management and care of women with Ectopic Pregnancy	Highlight to staff: • The necessity of completing pathway 9 for Ectopic pregnancy. • That all women have pre op section completed. • All women have post op pain assessment documented. • All women have been given and discussed the ectopic leaflet.
Audit of Bedside Transfusion Practice	• Continue to train regarding importance of observations and the need to consent the patient prior to a non-emergency transfusion or document that it was in patient's best interest when it was an emergency. • Risk alert to be distributed Trust-wide about the completion of the assessment. • Ward managers informed and Transfusion Associated Circulatory Overload assessment discussed with consultants.
Do ENT patients on ward 35 of JCUH get appropriate VTE prophylaxis	• Use of ward round sheets: Importance emphasized in Clinical governance (CG) meeting • Drug kardex to be by bedside for ward round: Nursing staff aware • Daily check of VTE assessment: By following instructions on ward round sheets
Antibiotic prescribing for ENT patients in ward 35 at JCUH	• Always add a review date: Importance emphasized in Clinical Governance meeting • Write the indication and stop/review date, importance emphasized in CG meeting • If antibiotic reviewed, add another review / stop date, Importance emphasized in CG meeting
First Seizure Clinic/Blackout clinic Audit (NICE CG 137)	• Clinics will not be cancelled for any other reason than bank holidays. • All MRI scans to be performed within six weeks of request.
Antibiotics prescription in neurosurgery	• Establish whether or not every antibiotic prescription needs to be discussed with the microbiology or Infectious Diseases (ID) team and when it is acceptable to follow guidelines • If an intended duration is unknown, write down a review date so that the long term plan is followed up and not forgotten or discussed with relevant teams involved.

	• Inform prescribing members of neurosurgery team to write the indication for the antibiotic course even if the source is unknown, that should be documented
Safe initial prescribing of Acitretin for psoriasis in adults in relation to cholesterol level	• Assess overall Cardiovascular Disease (CVD) risk by performing QRISK3 score • Colleagues informed to perform QRISK3 score prior to commencement – nursing staff will complete in OPD. QRISK3 shortcut to be added to dermatology department desktops to remind clinicians to assess QRISK • Document if patient has a pre-existing medical which requires statin therapy and recommend statin therapy via GP if so • Highlight any conditions in which risk assessment tool is not needed as patients may already require statin therapy • Perform baseline cholesterol profile prior to commencement of Acitretin and to include total cholesterol/ HDL ratio • Informed colleagues to request baseline cholesterol profile with total cholesterol/HDL ratio prior to commencement of Acitretin • Recommend statin therapy via GP if QRISK3 score >10% • Inform GP if score >10%
Case Note Audit - Record Keeping, community nursing	• A clear history / summary / initial assessment and plan of care should be recorded in the patient's record. • All new staff members will be given a copy of the Standard Operating Procedure (SOP) and contact activity documents and be shown the processes by their mentor. • Disease specific care plans will be applied to individualise the care given and used to document information at each review. If the patient does not have a care plan linked disease the clinical review care plan should be used. • Ethnicity should be recorded – this is a National standard. • If care is discussed with the patient / carer, this should be clearly documented. • It should be documented that written information has been given to the patient / carer. • Next of Kin should be recorded.

	• Staff will make an effort to contact the patient by phone 3 times before sending an 'invitation for assessment' letter giving the patient 4 weeks to respond.
Aseptic Non-Touch Technique (ANTT) compliance	• ANTT group training sessions are delivered by IPC • provide cannulation training • Equipment change to promote good practice - The trust is looking at changing cannulas from ported to non-ported cannulas in an effort to discourage staff from using the top port
MRSA management	• Continue to highlight lack of side room capacity as a risk for the organisation through submission of Datix reports
Retained tampon - WHO checklist audit, Serious Incident, Never Event	• 'Tampons' removed from the instrument sets • Tampon added to the count board (permanently) along with the swabs, blades etc. • The swab count policy was amended to include the tampon • WHO checklist audit carried out to ensure all counts meet standards
Adapted NHS Protect Audit	• Medication delivery to be received by authorised members of staff and to be secure • The implementation of Omnicells in each area will enforce the above standard
Controlled Drugs	• Senior nursing to provide individual feedback to ward managers and education and training to ward staff when necessary • Implementation of Omnicells

Table 7: Local Clinical Audit Reports

Getting it Right First Time Programme (GIRFT)

Getting It Right First Time (GIRFT) is an NHS improvement programme delivered in partnership with the Royal National Orthopaedic Hospital NHS Trust. 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.

Importantly, GIRFT is led by frontline clinicians who are expert in the areas they are reviewing. This means the data that underpins the GIRFT methodology is being reviewed by people who understand those disciplines and manage those services on a daily basis. The GIRFT team visit every trust carrying out the specialties they are reviewing, investigating the data with their peers and discussing the individual challenges they face.

The national programme comprises a series of 40 surgical and medical work streams and since 2014 there have been 23 deep dive visits to the Trust, including 2 re-visits to Orthopaedics and Vascular Surgery. The most recent visit has been to Endocrinology on 18th October 2019. There are also visits planned in the coming year to Respiratory, Cranial neuro-surgery, and Diabetes. The Trust has also been notified of work stream roll-outs to Neonatology, and Plastic Surgery, Burns and Hand Surgery. Deep dive visits to these areas will commence from February 2020.

The table below provides an outline of the Trust's participation in the GIRFT programme.

Specialty	Initial Visit	Re-Visit	Future Proposed Visit/Re-visit 2019/20
Acute & General Medicine	23/09/2019		
Anaesthetic & Perioperative Medicine	19/12/2018		
Breast Surgery			13/03/2020 (postponed)
Cardiology	25/09/2019		
Cardiothoracic Surgery	31/08/2017		
Cranial Neurosurgery	29/09/2016		31/01/2020
Dermatology	27/03/2019		
Diabetes			22/05/2020
Emergency Medicine			To be arranged
Endocrinology	18/10/2019		

Specialty	Initial Visit	Re-Visit	Future Proposed Visit/Re-visit 2019/20
ENT	08/01/2018		
Gastroenterology	30/08/2019		
General Surgery	03/12/2018		
Geriatric Medicine	Did not participate		
Hospital Dentistry	03/07/2019		
Intensive & Critical Care	18/07/2018		
Lung Cancer			18/06/2020
Mental Health CAMHS			
Neonatology			To be arranged
Neurology	15/05/2019		
Obstetrics & Gynaecology	17/07/2017		
OMFS			To be arranged
Ophthalmology	10/05/2017		
Orthopaedic Surgery	31/01/2014	01/10/2018	
Orthopaedic Trauma Surgery			
Outpatients			
Paediatric Critical Care			
Paediatric Gen Surgery	01/02/2018		
Paediatric Orthopaedics (Trauma & Elective)			To be arranged
Pathology			
Plastics/Burns/Hand Surgery			To be arranged
Radiology	11/03/2019		
Renal	06/03/2019		
Respiratory			07/01/2020 (postponed)
Rheumatology			
Spinal Surgery	05/07/2017		
Stroke	15/03/2019		
*Surgical Site Infection Audit	2017/2018	May-Oct 2019	

Specialty	Initial Visit	Re-Visit	Future Proposed Visit/Re-visit 2019/20
Urology Surgery	15/03/2017		
Vascular Surgery	05/10/2016	12/10/2018	

Table 8: GIRFT Programme

*Surgical site infection (SSI) is an important area of focus for GIRFT. Post-surgery infections can cause significant harm to patients and result in increased hospital stay, readmissions and re-operations. They are also a significant cost to the NHS. Participating in the survey is an opportunity to better understand our trust's SSI rates, to review and improve local practice, and to report on this to the Trust management and Board.

Communication is a vital part of ensuring GIRFT's successes within the organisation. By having a clear vision of the benefits that GIRFT can bring into the Trust, engaging staff through communicating that vision, and ensuring that the processes are designed in a way that is not burdensome for the clinicians, the Trust is able to fully embrace GIRFT as a key enabler towards delivering a cycle of continuous improvement for its patients.

South Tees Hospital Foundation Trust (STHFT) already has a well-established internal annual quality surveillance programme (QSP) comprising of 74 specialised services (including sub-services). As future GIRFT programmes are beginning to align to NHS England and NHS Improvement to capture both provider and clinical insights, it has become evident that both programmes should be affiliated to a central in-house repository. There are therefore plans in place to ensure the inputs and outputs of the GIRFT programme will, as far as possible be integrated within these existing programmes of work.

Annual Quality Surveillance Programme

As part of the Quality Assurance and Improvement Framework (QAIF) all specialised services including cancer are subject to the quality surveillance process.

The Trust is required to complete annual self-declarations against a set of clinical quality indicators where information is not available through existing data sources. The declarations are a statement of compliance endorsed by the Chief Executive (or delegated authority) and are submitted through the Quality Surveillance Information System (QSIS) web portal. The submission deadline is set to 30 June every year.

There are a total of 74 specialised services on the South Tees Hospitals NHS Foundation Trust's directory of services. As well as submitting self-declarations each year, some of these services are also required to submit data as part of the Specialised Services Quality Dashboards (SSQD). Previously QSIS was separated from the SSQD platform – now all information can be accessed in one place on QSIS.

Annual Assessment Outcomes

All annual self-declarations were completed by the submission deadline of 30 June 2019. A further request to complete self-declarations for 7 services against the "rare disease insert" was made and these were completed by a submission deadline of 30 September 2019.

In total 73 specialised services were required to undertake the self-declaration process throughout 2019, and the annual assessments were notified to the Trust in January 2020. Options were derived following the completion of the annual assessment process which included commissioner review of the Trust's self-declarations and other quality information including specialised services quality dashboard (SSQD) alerts, CQC reports, Healthcare Quality Improvement Partnership (HQIP) audits and other relevant national clinical audit flags.

The annual assessment outcomes will be used by regional commissioning teams to monitor the quality of service delivery and compliance with NHS England/Improvement's service specifications.

The table below details all specialised services annual assessment outcomes. The options for surveillance are summarised as follows:-

Option 1 – ROUTINE Surveillance:

Annual assessment has confirmed that the service is either 100% compliant with no risks identified or services that have not reached 100% compliance, but the regional teams have determined that this is not a material issue.

Option 2 – ENHANCED surveillance:

Provider Action – where it is agreed the non-compliance is amenable to a short-term action plan (6 months), the Trust will be required to submit a Service Development Plan (SDIP). This will be specified within the contract and monitored via contractual processes.

a) **Commissioner Action –** where it is identified that the non-compliance is not amenable to a short-term action plan, the commissioner will notify the Trust, within 6 months of the discussion, of the action that they intend to take to ensure a sustainable compliant service in the future.

b) **Provider and Commissioner Action –** where it is determined that the non-compliance in one service is amenable to both a short-term and longer-term action plan.

There are **37** services under **routine** surveillance and a further **36** services under **enhanced** surveillance, 23 for provider action, 10 for commissioner action and 3 for both provider and commissioner action; these are demonstrated in Table 9.

Services Routine Surveillance	**Services Enhanced Surveillance**
Acute Kidney Injury (Adult)	Adult Critical Care: Cardiac Intensive Care Unit (JCUH) ***Commissioner action***
Assessment and Preparation for Renal Replacement Therapy including establishing dialysis access)	Adult Critical Care: General Critical Care Unit (JCUH) – ***Commissioner action***
Cancer Anal (Adult)	Cancer Brain and Central Nervous System: Brain and other rare brain tumours – ***Provider action***
Generic Brain (CNS)	Cancer Brain and Central Nervous System: Non-surgical – ***Provider action***
Cancer Gynaecological: Local Gynae Team (Diagnostic Service)	Cancer Brain and Central Nervous System: Pituitary – ***Provider action***
Cancer Skin (Adult)	Cancer Brain and Central Nervous System: Spinal – ***Provider action***
Cancer Chemotherapy Adult: Chemotherapy ITC	Cancer Gynaecological: Specialist Gynaecology Team – ***Provider action***
Cancer Services for Teenagers & Young Adults: TYA Designated Hospital at JCUH	Cancer Head & Neck (Adult): Local Head & Neck Support Teams – ***Commissioner and Provider action***
Cancer Unknown Primary	Cancer Head & Neck (Adult): Specialist Head & Neck Team – ***Provider action***

Services Routine Surveillance	Services Enhanced Surveillance
Cardiology: Cardiac Magnetic Resonance Imaging (Adult)	Cancer Head & Neck (Adult): Specialist Thyroid Team – ***Provider action***
Cardiology: Electrophysiology and Ablation Services (Adult)	Cancer Oesophageal & Gastric (Adult): Specialist Upper GI Team – ***Provider action***
Cardiology: Implantable Cardioverter Defibrillator and Cardiac Resynchronisation Therapy (Adult)	Cancer Specialised Kidney, Bladder & Prostate (Adult) – ***Provider action***
Cardiology: Primary Percutaneous Coronary Intervention (Adult	Cancer: Kidney Service – ***Provider action***
Colorectal: Complex Inflammatory Bowel Disease	Cancer Chemotherapy Adult: Chemotherapy Higher Intensity – ***Provider action***
Colorectal: Faecal Incontinence (Adult)	Cancer Chemotherapy Adult: Clinical Chemotherapy – ***Provider action***
Complex Gynaecology: Recurrent Prolapse and Urinary Incontinence	Cancer Services for Teenagers & Young Adults: TYA Designated Hospital at the Friarage – ***Commissioner action***
Complex Gynaecology: Severe Endometriosis	Cancer Acute Oncology Service – ***Commissioner and Provider action***
Complex Gynaecology: Urogenital Anorectal Conditions	Cardiac Surgery (Adult) – ***Provider action***
Cystic Fibrosis	Cardiology: Inherited Cardiac Conditions (All Ages) – ***Provider action***
Haemato-oncology	Complex Disability Equipment – Prosthetics (All Ages) – ***Provider action***
Implantable Hearing Aids for Microtia, Bone Anchored hearing Aids and Middle Ear Implants (All Ages)	Complex Spinal Surgery (All Ages) – ***Provider action***
In Centre Haemodialysis	Ear Surgery: Cochlear Implants (All Ages) – ***Commissioner action***

Local Breast Cancer Team	External Beam Radiotherapy Services delivered as part of a Radiotherapy Network (Adult) – ***Provider action***
Services Routine Surveillance	**Services Enhanced Surveillance**
Local Colorectal Services (Colorectal Cancer MDT)	Haemodialysis to treat established renal failure in the home – ***Provider action***
Neonatal Critical Care	Local Lung Cancer Team – ***Commissioner and Provider action***
Neurosciences: Specialised Neurology (Adult)	Major Trauma (Adult) – ***Commissioner action***
Neurosurgery (Adult)	Major Trauma (Children) – ***Commissioner action***
Paediatric High Dependency Care	Neuro-interventional Services for Acute Ischaemic & Haemorrhagic Stroke – ***Commissioner action***
Specialised Endocrinology Service (Adult)	Paediatric Intensive Care – ***Commissioner action***
Specialised HIV Services (Adult)	Paediatric Medicine Endocrinologyy and Diabetes – ***Provider action***
Specialised Immunology (All Ages)	Paediatric Surgery (& Surgical Pathology, Anaesthesia & Pain) – ***Provider action***
Specialised Ophthalmology (Adult)	Peritoneal Dialysis to treat Established Renal Failure – ***Provider action***
Specialised Ophthalmology (Paediatrics)	Skull Base Service – ***Provider action***
Specialised Orthopaedics (Adult)	Specialised Burn Care (All Ages) – ***Commissioner action***
Specialised Services for Infection Diseases (Adult)	Specialised Services for Haemoglobinopathy Care (All Ages) – ***Commissioner action***
Spinal Cord Injuries (All Ages)	Specialised Vascular Service (Adult): Arterial – ***Provider action***
Thoracic Surgery (Adult)	

Table 9: Services under Surveillance

Specialised Services Quality Dashboards (SSQD)

The SSQDs are designed to provide assurance on the quality of care by collecting information about outcomes from healthcare providers. SSQDs are a key tool in monitoring the quality of services, enabling comparison between service providers and supporting improvements over time in the outcomes of services commissioned by NHS England. For each SSQD, there is a list of agreed measures for which data is to be collected. These measures are included in a "metric definition set". The information provided by the SSQDs is used by NHS England specialised services commissioners to understand the quality and outcomes of services and reasons for excellent performance.

The table below lists the STHFT specialised services that required submission of data against a set of metrics for 2019/20:-

Specialised Service	*Internal/External Source Requirements	Comments
Adult Critical Care: • General Critical Care • Cardiac Intensive Care	External Source Data (Intensive Care and National Audit & Research Centre (ICNARC) Required quarterly	Populated via ICNARC and validated by Trust
Cancer Specialist Services: • Bladder & Prostate • Kidney	Provider data Required quarterly	New requirement from Q3 only
Cardiac Surgery	External Source Data (Hospital Episode Statistics (HES) Required quarterly	New requirement for 2019/2020 Data populated from external source and validated by Trust

Specialised Service	*Internal/External Source Requirements	Comments
Cardiology: • Cardiac Magnetic Resonance Imaging (Adult) • Electrophysiology & Ablation Services • Implantable Cardioverter Defibrillator and Cardiac Resynchronisation Therapy (Adult) • Primary Percutaneous Coronary Intervention (Adult)	Provider data Required quarterly Provider data Required quarterly Provider data Required quarterly Provider data Required quarterly	New requirement for 2019/2020 Provider data populated and validated by Trust Provider data populated and validated by Trust Provider data populated and validated by Trust Provider data populated and validated by Trust
Colorectal: • Faecal Incontinence (Adult)	Provider data Required quarterly	Provider data populated and validated by Trust in Q3 & Q4
Complex Disability Equipment – Prosthetics (All Ages)	Provider data Required quarterly	Data required for Q1 & Q4 only
Cystic Fibrosis (Children)	Provider and external source data requirement quarterly	Provider data populated and validated by Trust
External Beam Radiotherapy Services Delivered as part of Radiotherapy Network	External Source Data (Public Health England (PHE) Required quarterly	Data populated from external source and validated by Trust
Hepatobiliary and Pancreas – Cirrhosis of the Liver (Adults)	External Source Data (HES) Required quarterly	Data populated from external source and validated by Trust
Implantable Hearing Aids for Microtia, Bone Anchored Hearing Aids and Middle Ear Implants (All Ages)	Provider data Required quarterly	New requirement from Q4 2018/19 Data has not yet been submitted by the Trust

Specialised Service	*Internal/External Source Requirements	Comments
In Centre Haemodialysis (ICHD)	External Source Data (Renal Registry) Required quarterly	Data populated from external source and validated by Trust
Neonatal Critical Care	External Source Data (Clevermed) Required quarterly	Data populated from external source and validated by Trust
Neuro-interventional Services for Acute Ischaemic & Haemorrhagic Stroke	External Source Data (Sentinel Stroke National Clinical Audit Programme (SSNAP) Annual requirement	Data populated from external source and validated by Trust. To be submitted in Q4 only
Paediatric Intensive Care	Provider and external source data quarterly requirement	Provider data populated and validated by Trust
Specialised Burn Care: • Adults • Paediatrics	External Source Data (IBID) Required quarterly	Data populated from external source and validated by Trust
Specialised Endocrinology Services (Adult)	Provider data Required quarterly	Data populated for Q4 2018/19 only
Specialised Human Immunodeficiency Virus (HIV) Services (Adult)	External Source Data (PHE HARS) Required annually	Data populated from external source and validated by Trust
Specialised Immunology (All Ages)	External Source Data (MDAS) Required quarterly	Data populated from external source and validated by Trust
Specialised Services for Haemoglobinopathy (All Ages)	Provider data Required annually – NB One indicator required quarterly	Provider data populated and validated by Trust

Specialised Service	*Internal/External Source Requirements	Comments
Spinal Cord Injuries: • Adult • Children	External Source Data (NSCID) Rolling annual requirement/quarterly	Provider data required only for Q1 to meet rolling year requirement
Specialised Vascular Services (Adult): Arterial	Provider data Required quarterly	Data not yet submitted by the Trust for 2019/2020
Thoracic Surgery (Adult)	Provider data	New requirement for 2019/2020 Provider data populated and validated by Trust

Table 10: Specialised Services

*Data is either pulled directly from a national data source or is submitted by the Trust

Clinical Research

Clinical research is a national and Trust priority. South Tees NHS Foundation Trust is part of the Clinical Research Network North East and North Cumbria (CRN NENC). There is a clear link between research activity, clinical effectiveness and improved patient experience. A recent large-scale study demonstrated that patients cared for in NHS hospitals that have a high level of participation in clinical research have lower mortality rates and improved clinical outcomes. This effect was not just limited to those people who took part in the trials, but was significant across the entire patient population. It is therefore important that the Trust continually develops clinical research, bringing new therapies and new treatments to the people of Teesside and the wider population.

The Trust's active engagement in research is reflected by the high number of research studies being undertaken.

The number of patients receiving relevant health services provided or sub-contracted by South Tees Hospitals NHS Trust in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee is 3196. In 2018/19 the Trust recruited 3691 patients enrolled in 196 different research studies while in 2019/20 the Trust recruited 3196 patients enrolled in 162 different research studies. While the number of recruits decreased by 14%, the year-on-year

fall was less than the overall 40% fall experienced by the NHS Trusts across the North East and North Cumbria region.

The Trust is routinely meeting the NIHR (National Institute for Health Research) target deadlines (40 days from receiving a complete research application) for setting up new trials to help ensure that there are minimal avoidable delays to research activity and income. The Trust created a formal research alliance with two other NHS Trusts (North Tees and Hartlepool Hospitals NHS Foundation Trust and County Durham and Darlington NHS Foundation Trust) in order to increase patient opportunities to participate in research known as the Durham Tees Valley Research Alliance (DTVRA). As part of this restructure there is a streamlined management tier and a single combined research study set-up team designed to help ensure that research study opportunities are shared across all 3 Trusts and fully utilised.

The Trust continues to successfully deliver major NIHR grant-funded trials and this year has been awarded an NIHR grant in trauma and orthopaedics, as well as other commercial research grants.

Patient Engagement

We routinely appoint patient representatives to the steering committees of our NIHR grant funded studies and carry out other patient and public involvement activity for individual trials, for instance focus group sessions.

Goals Agreed with Commissioners – use of the CQUIN Payment Framework

A proportion of the South Tees Hospitals NHS Foundation Trust's income in 2019/20 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.

Submission of CQUIN data was suspended nationally for Q4 due to COVID-19 and NHSE has also suspended all CQUINs for 2020/21 due to the current pandemic.

Further details of the agreed goals for 2019/20 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

The table below demonstrates the income conditional upon achievement of the CQUIN measures and the payment received by the Trust for the last 2 financial years.

	Income conditional upon achievement of the CQUIN measures	*Payment received by the Trust*
2018/19	*£11.18m*	*£11.21*
2019/20	*£5.77m*	*£5.77*

Table 11: CQUIN Income

Care Quality Commission Compliance

1. Background

In July 2019 South Tees NHS Hospitals Foundation Trust received a report from the CQC following an inspection in January and February 2019. The Trust received an overall rating of 'requires improvement' and the report contained 26 'must do' recommendations and 22 'should do recommendations. A detailed action plan has been developed for all recommendations and this has been submitted to CQC. Delivery of the action plan is overseen by a fortnightly Oversight Group and a small Huddle Group meets daily to review and challenge sources of evidence.

2. Progress

Following monthly meetings of the CQC Oversight Group it was agreed that a series of 'confirm and challenge' sessions would be arranged throughout January and February 2020 with operational and director leads. These sessions focussed on the 'must do' recommendations and have facilitated discussions relating to evidence, action plans, assurance and risk.

The sessions have also provided the opportunity to identify where support is required to progress specific actions. Whilst each 'must do' recommendation is made up of a series of specific actions the confirm and challenge sessions have concluded with an overall assessment of where the Trust is against the entire CQC recommendations. Table 12 contains an overview of progress as of the 20th February 2020.

Assessment date	Overview		
20 February 2020		5	Off track
		10	Expected to deliver actions
		10	Completed actions
		1	Embedded in practice

Table 12: Overview of progress against CQC 'must do' recommendations

Good progress has been made for 21 of the 26 recommendations.

Five (5) recommendations are deemed to be off track however this is mainly due to specific actions and not the entire CQC recommendation. Mitigating actions are in place for each action that is deemed off track.

Ref	CQC Recommendation	Reason for 'off track' assessment	Mitigation
M6	The Trust must ensure that staff training compliance with Mandatory Training especially resuscitation training, safeguarding children (level 2) and safeguarding vulnerable adults (including mental capacity act and deprivation of liberty) safeguarding training meets the target of 90%	Achievement of Centre trajectories for resuscitation training	Additional training being delivered Trajectories due for completion by May 2020
M11	The Trust must ensure that there are at all times sufficient numbers of suitably skilled and qualified nursing and medical staff in line with best practice and national guidance (Emergency Department)	24/7 Consultant presence not available in ED (this links to another must do recommendation M9, compliance with Major Trauma Standards.	Work with Specialised Commissioning to review funding to externally mandated model CCG funding for integrated Primary Care/ED assessment

M14	The Trust must review the role of supernumerary coordinators and the level of specialist pharmacy provision in Critical Care so they are in line with GPICS recommendations	Sufficient pharmacists to deliver GPICs compliance and 80% medicines reconciliation	Patient prioritisation Electronic prescribing funding secured for 2021
M26	The Trust must ensure there are sufficient numbers of suitably qualified staff, especially radiologists	Workforce review completed.	3 Additional radiologists in post from March 2020
M8	The Trust must take action to ensure that the environment is suitable for the purpose being used and is secure and compliant with current standards especially for paediatric patients and patients with mental health needs (Urgent & Emergency Care Centre & FHN)	Constraints associated with the Emergency Department Paediatric environment	M8

Table 13: Must do actions

Table 13 provides a summary of the metrics that are off track and the mitigating actions. The five 'off track' recommendations are included as workstreams within Phase 1 of the Improvement Plan under the main CQC workstream. This involves a weekly level of scrutiny by the Medical Directors, Directors of Nursing and Quality and Chief Operating Officer.

Quality Assurance Framework

NHS England and NHS Improvement (NHSE/I) have highlighted organisations that are excelling at ward accreditation. When used effectively ward accreditation can drive continuous improvement in standards and increase patient and staff experience. The South Tees Accreditation for Quality of Care (STAQC) is a methodology that has been developed and the CQC key Lines of Enquiry are embedded in the methodology.

The revised STAQC framework has been piloted in Critical Care and two ward areas. A deep dive into Critical Care using the STAQC methodology was undertaken on 20 January 2020. This enabled the process and standards to be tested and gave the Critical Care Team an assessment of what they need to do to commence their accreditation journey.

STAQC was due to be launched in April however due to Covid-19 this was delayed until July 2020. Publicity and a Trust wide workshop will take place to ensure clinical teams are engaged in the development of a Strategy and Assurance Framework for quality, safety and continuous improvement.

Well Led Review

A review of governance processes, including a board development workshop, was undertaken during September to December 2019 and this resulted in the development of a 'Well Led' Action Plan. Progress to date includes:

- Leadership Programme established
- 6 Clinical Directors attending the Northumbria Leadership Training programme
- Staff currently on Manchester MBA programme
- Board Development Programme commenced
- Senior Leadership Portfolios realigned
- Clinical Policy Group (CPG) has been established to strengthen clinical decision making and engagement including making decisions about how the organisation uses its resources and delivers care.
- Three Phase Improvement Plan approved by the Trust Board
- Communication and Engagement Strategy aligned to the Improvement Plan
- Staff engagement to define Trust Values
- Accountability Framework and supporting metrics under development
- Development of STAQC and a Quality Assurance Strategy
- Risk management policy updated subject to final approval
- Datix Cloud implementation
- New Integrated Performance report to be implemented

Moving to Good

'Moving to Good' is a collaborative improvement programme organised by NHSI/E. Through this programme South Tees NHS Hospitals Foundation Trust identified three objectives which are embedded in the overarching CQC Action Plan and include:

- Increase incident reporting and learning throughout the Trust
- To identify, develop and implement a Quality Strategy for the Trust and embed an agreed approach to Quality Improvement Methodology
- To implement safe surgery practices across the Trust in order to eliminate Never Events

The programme includes a series of workshops to support Trusts in developing their improvement plans. A 'Moving to Good' workshop focussing on governance was attended by the Director of Nursing & Quality, the Head of Governance and other team members. The programme addressed quality and corporate governance, accountability, assurance and reassurance and performance management. Included in the workshop were examples of board assurance frameworks and risk registers along with discussion on risk management processes and structures. There was also a discussion about the themes and lessons learnt from CQC well led inspections.

Monitoring Progress

Whilst the CQC action plan is grounded in the delivery of specific actions, quantitative and qualitative outcome metrics provide evidence that improvement is sustained and embedded in the culture of the organisation.

Work is underway to develop an Integrated Performance Framework for Directorates, Centres and the Trust Board. During 2020/21 the Trust Board will see a new style Integrated Performance Report bringing together clinical quality, operational delivery, workforce and financial metrics aligned to the CQC Key Lines of Enquiry.

These quantitative metrics are supplemented by qualitative metrics which have been scrutinised during the 'confirm and challenge' sessions. Whilst the detailed focus has been on the 'must do' recommendations, action plans have been developed to deliver the 'should do' actions. A series of confirm and challenge sessions are now planned for the 'should do' recommendations whilst maintaining focus on the 'must do's. As each recommendation is assessed as 'completed' further plans will be developed to ensure sustainability right across the Trust. Confirm and challenge will become an integral part of the emerging Performance Framework and further scrutiny will be applied through the Improvement Programme Board.

System Engagement

Engagement meetings continue to take place between the Trust and the CQC.

The Single Item Quality Surveillance Group led by NHSE/I continues to provide oversight, system monitoring and support. The system is providing support for a number of areas including Never Events.

NHS England and NHS Improvement (NHSE/I) have highlighted organisations that are excelling at ward accreditation. When used effectively ward accreditation can drive continuous improvement in standards and increase patient and staff experience. The South Tees Accreditation for Quality of Care (STAQC) is a methodology that has been developed and the CQC key Lines of Enquiry are embedded in the methodology.

NHS number and general medical practice code validity

South Tees Hospitals NHS Foundation Trust submitted records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

The percentage of records in the published data which:

Included the patient's valid NHS number was:

- 99.9% for admitted patient care;
- 100.0% for outpatient care; and
- 99.5% for accident and emergency care.

Included the patient's valid General Medical Practice Code was:

- 100.0% for admitted patient care;
- 100.0% for outpatient care; and
- 99.9% for accident and emergency care.

Information Governance (IG) toolkit attainment levels

Information Governance is assessed as part of a process of submitting compliance with Data Security and Protection Toolkit (DSPT), which has replaced the older IG Toolkit reporting function

and is based upon the National Data Guardians 10 Data Security Standards. The content of the DSP Toolkit has significantly changed; it has been updated to include more assurance around technical aspects of cyber security and information security compliance.

DPST also differs from the previous IG Toolkit which assessed performance against three levels (1, 2 and 3). The DSPT does not include levels and instead requires compliance with assertions and (mandatory) evidence items. These include a total of 40 assertions and over 130 pieces of mandatory evidence.

Due to the impact of Covid-19 a six-month extension has been provided for the 2019/2020 submission and this is now due on the 30th September 2020. An action plan regarding compliance is in place and is monitored at the bimonthly Information Governance Steering Group and reported to the Trusts Senior Information Risk Owner (SIRO).

Information on the submission due in September 20 will be included in next year's Quality Accounts.

Clinical coding

South Tees Hospitals NHS Foundation Trust was not subject to a Payment by Results clinical coding audit during 2019/20 by the Audit Commission.

Learning from Deaths

During 2019/20, 1,901 patients of South Tees Hospitals NHS Foundation Trust died. This comprised the number of deaths which occurred in each quarter of that reporting period:

439 in the first quarter;
438 in the second quarter;
516 in the third quarter;
508 in the fourth quarter.

By 31st March 2020, 1,846 case record reviews and 46 investigations have been carried out in relation to 1,901 deaths above.

In 42 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:

428 in the first quarter;

423 in the second quarter;
511 in the third quarter;
484 in the fourth quarter*

*This figure is accurate at the time of this report and the low number for Q4 relates to timely provision of notes to the Medical Examiner (ME) Service. Since there has usually been an incident reported and an investigation, the patient case notes are usually in high demand across several parts of the organisation and therefore the review cannot be carried out until these have been received.

Two deaths, representing 0.1% of the patient deaths during the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: -

1, representing 0.2% for the first quarter;
0, representing 0.0% for the second quarter;
1, representing 0.2% for the third quarter;
0, representing 0.0% for the fourth quarter.

These numbers have been estimated using an adapted version of the Preventable Incident, Survival and Mortality Study (PRISM) methodology. The Trust established a Medical Examiner Service in May 2018. Approximately 96% of deaths (those not referred for Coronial investigation) are scrutinised by Medical Examiners. Anywhere there may be a problem in care (or meet specific criteria) is reviewed by a central team led by Respiratory medicine and Renal consultants. Each review results in 2 grades, one for quality of care and one for preventability of the death.

The reviews highlighted the following learning points and recommendations:

- Investigation of patient's complaint of pain in his neck should have been investigated earlier, although it is beyond the experience of the reviewer as to how common this complaint is after a tracheostomy.
- if a urine test is requested and a sample sent for culture, it is imperative that the test results should be reviewed and acted upon in a timely fashion.

286 case record reviews and 0 investigations were completed after 31/03/2019 which related to deaths which took place before the start of the reporting period.

Deaths are reviewed by a central team led by Respiratory and Renal Consultants. Each review results in two grades, one for quality of care and one for preventability of the death.

Staff who 'Speak Up' (Including Whistleblowers)

Following the Mid Staffordshire NHS Foundation Trust Public Inquiry Sir Robert Francis QC made recommendations designed to make the culture of the NHS patient focused, open and transparent – one in which patients are always put first and their safety and the quality of their treatment are the priority.

There was an increasing recognition of the contribution staff can make to patient care through speaking up however there was a continuing problem with regard to the treatment of staff who raise genuine concerns about safety and other matters of public interest, and the handling of those concerns.

The review highlighted a number of people who reported victimisation or fear of speaking up which is unacceptable.

Sir Robert Francis concluded "Each time someone is deterred from speaking up, an opportunity to improve patient safety is missed". Every organisation needs to foster a culture of safety and learning in which all staff feel safe to raise a concern. "We need to get away from the culture of blame, and the fear that it generates, to one which celebrates openness and commitment to safety and improvement".

Figure 7: Process for managing concerns reported through 'Freedom to Speak Up'

In light of the recommendations outlined above the Trust introduced a new 'Freedom to Speak Up (FTSU) Raising Concerns (Whistleblowing)' Policy in 2016 and employed the services of an independent impartial service 'SeeHearSpeakUp' to manage concerns that were raised. It became

clear however that more needed to be done to support staff who had concerns to feel able to raise those concerns.

The Trust appointed two 'Freedom to Speak Up Guardians', Helen Smithies (Assistant Director of Nursing) and Laura Mills (Head of Facilities), both have been with the organization for many years and will be known to many staff. Supported by an Executive and Non-Executive Director leads they have developed a new policy, attended national training and developed a network of champions. FTSU awareness has been incorporated into the new Trust induction.

Reporting

A reporting tool was developed which enables staff to report concerns in a number of ways:

Anonymous notification – no one, including the guardians, knows your name. It is important when making an anonymous notification to provide sufficient details to allow for an investigation – for example, which area, ward or department you are referring to. The lack of identification means feedback cannot be given to an anonymous referrer.

Confidential notification – the guardians know your name but will not disclose it to anyone else. This allows the guardians to gather any missing or unclear information and to provide feedback following the investigation.

Open notification – you have agreed to your name being shared with the investigators. You will also be able to be provided with feedback.

In addition to the reporting tool staff are able to report their concerns in person to the Guardians or champions within the Trust. There is also a dedicated email account for staff to use.

Feedback to Staff

Staff receive feedback either by email or face to face depending on their preference, provided they have passed on their details and not reported their concerns anonymously. Staff are also asked to report detriment and this is monitored by the Guardians and reported back to the national office.

During 2019/20 there continued to be a steady increase in the number of concerns being raised although as the year progressed it became apparent that further development within the existing capacity would not be achievable and so a revised model with dedicated time will be developed in 2020/2021.

Total number of Cases raised	25
Raised Anonymously	6
Patient safety/quality	8
Bullying/Harassment	16
Number of staff suffering detriment	1

Table 14: Number of Concerns Reported in 2019/2020

Reporting against core indicators

In addition to the progress with our locally identified quality priorities and our performance against national performance targets, we also monitor measures from the NHS Outcomes Framework. The data reported below is data that is publicly available from NHS Digital; we have included benchmarking data where this is available. The most recently available data from NHS Digital has been used however, it should be noted that due to the nature of some of the measures and the data collection systems, the time period reported for some of the measures may be some time in the past.

The NHS Outcome Framework has five domains within which are grouped together measures for monitoring progress. The Quality Account regulations require a selection of these to be included in this report and these are described below under the heading of the relevant domain.

Domain 1 - Preventing people from dying prematurely

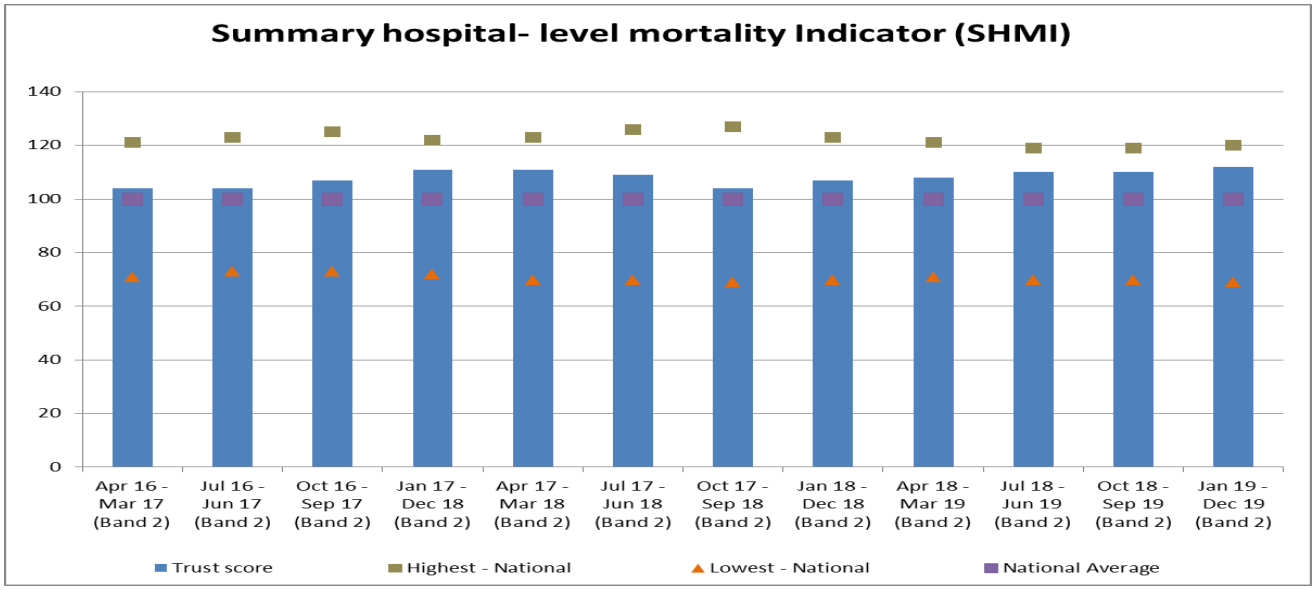


Figure 8: Summary Hospital Level Mortality Indicator (SHMI) (Data source: NHS Digital)

South Tees Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: the Trust experiences approximately as many deaths as would be expected, given the patients it serves and the range of services it delivers. Thus the SHMI is approximately 100 (i.e. observed and expected mortality rates are approximately the same). The categorisation of the SHMI into band 2 means that the mortality is within the expected range.

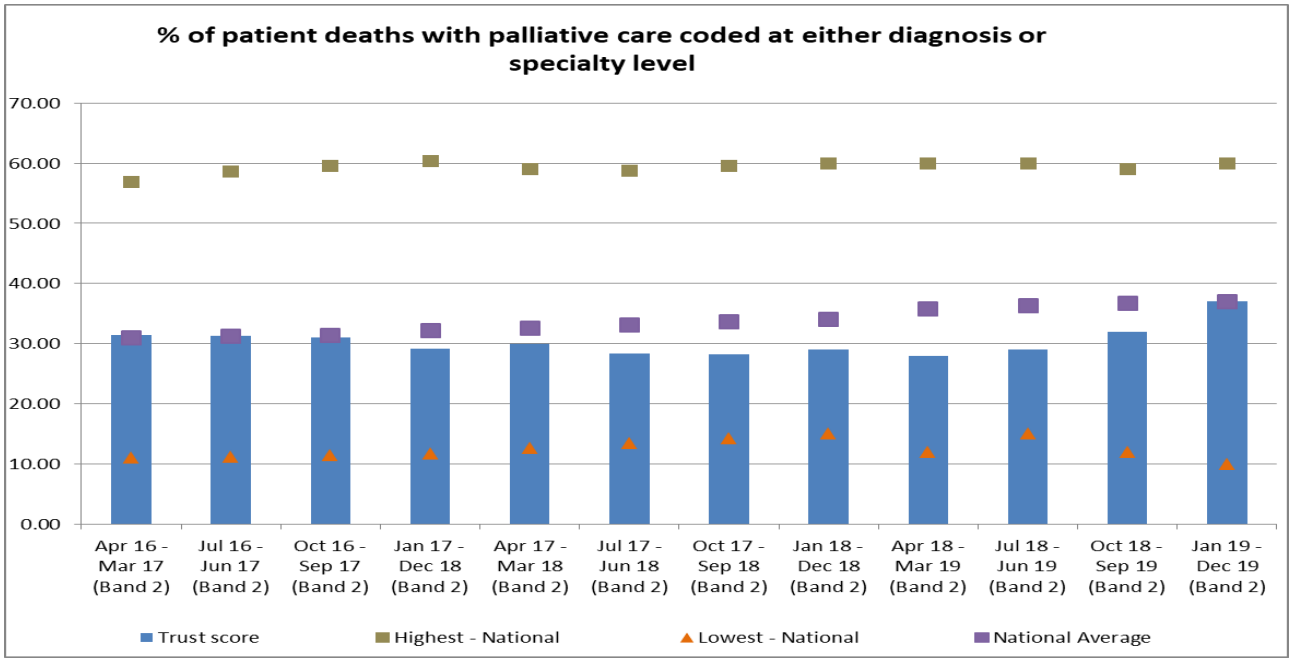


Figure 9: Percentage of Patient Deaths with Palliative Care Coded (Data source: NHS Digital)

The percentage of patient deaths with specialist palliative care coding is comparable with the national average and in the period Jan 2019 to Dec 2019 was 37.0% compared to 29.0% during the equivalent period last year. 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 is taking 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 Patient Safety Sub Group in particular coordinates hospital safety and improvement activity. This includes reviewing 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 trusts is variable from year to year, depending on the severity of respiratory and other seasonal infections each year. However, the trend outside these seasonal variations 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.

Domain 2 - Enhancing quality of life for people with long-term conditions

No applicable indicators.

Domain 3 - Helping people to recover from episodes of ill health or following injury

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 healthcare procedure and provides an indication of the outcomes or quality of care delivered to NHS patients (HSCIC website 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.

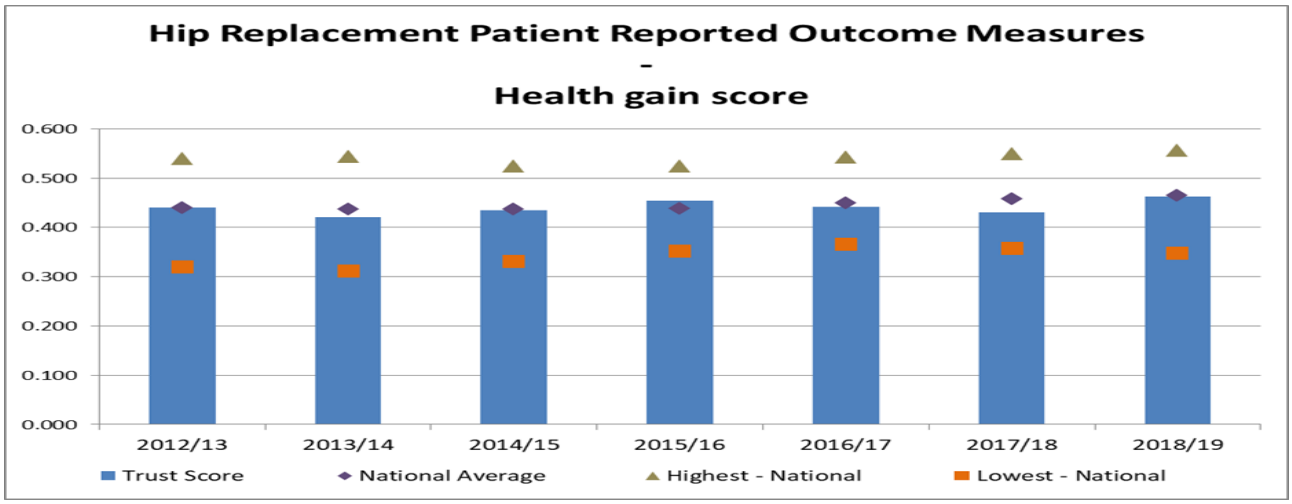


Figure 10 Hip Replacement PROMS

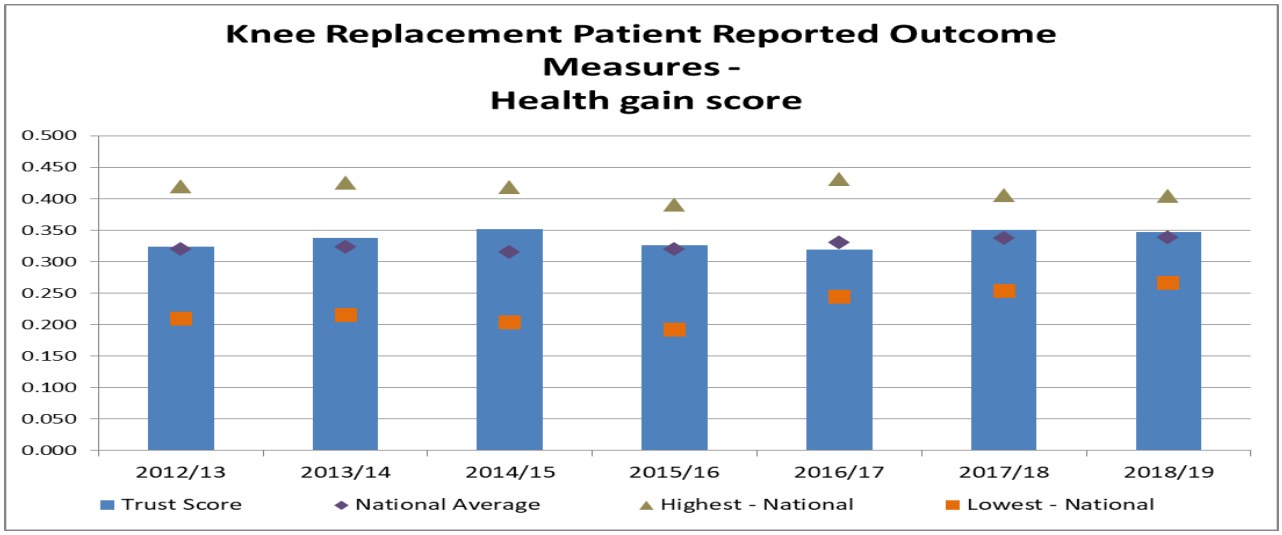


Figure 11: Knee Replacement PROMS (Data source: NHS Digital)

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.

The Trust has taken the following actions to 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.

Re-admission within 28 days

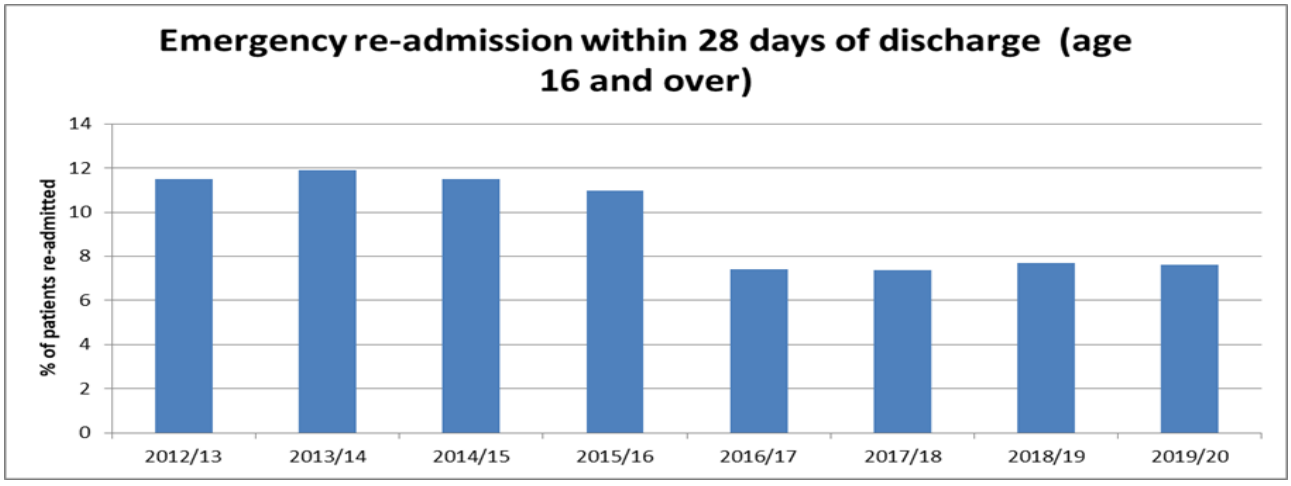


Figure 12: Emergency Readmissions Aged 16 and over (Data source: Local patient administration system)

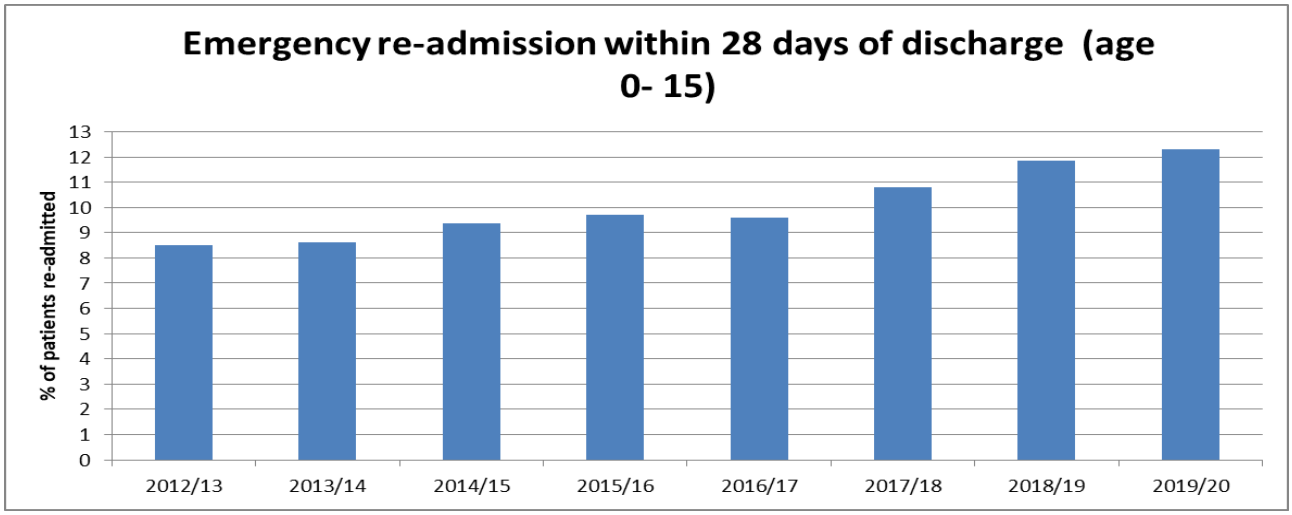


Figure 13: Emergency Readmissions Aged under 16 (Data source: Local patient administration system)

South Tees Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: the percentage of re-admissions for patients aged over 16 increased slightly from 11.9% in 2018/19 to 12.3% in 2019/20.

Further work is currently being undertaken to determine the cause of the slight increase in emergency readmissions. Following conversations with clinical staff an audit is currently taking place to provide more clarity on the cause of this and an action plan will then be developed to reduce the number of readmissions.

Domain 4 - Ensuring people have a positive experience of care

Responsiveness to the personal needs of patients

	Trust Scores		Performance	
Domain	**2018/19**	**2017/18**	**80th percentile for 2018/19**	**Performance in top 20% for 2018/19**
Access and waiting	87.0	89.4	85.4	Yes
Safe, high quality, coordinated care	68.6	69.9	68.4	Yes

Better information, more choice	68.6	70.8	69.1	No
Building closer relationships	88.7	88.9	87.1	Yes
Clean, comfortable, friendly place to be	82.9	83.1	82.4	Yes
Overall	79.2	80.4	78.1	Yes

Table 15: Responsiveness to Personal Needs (Data source: https://www.england.nhs.uk/statistics/statistical-work-areas/pat-exp/sup-info)

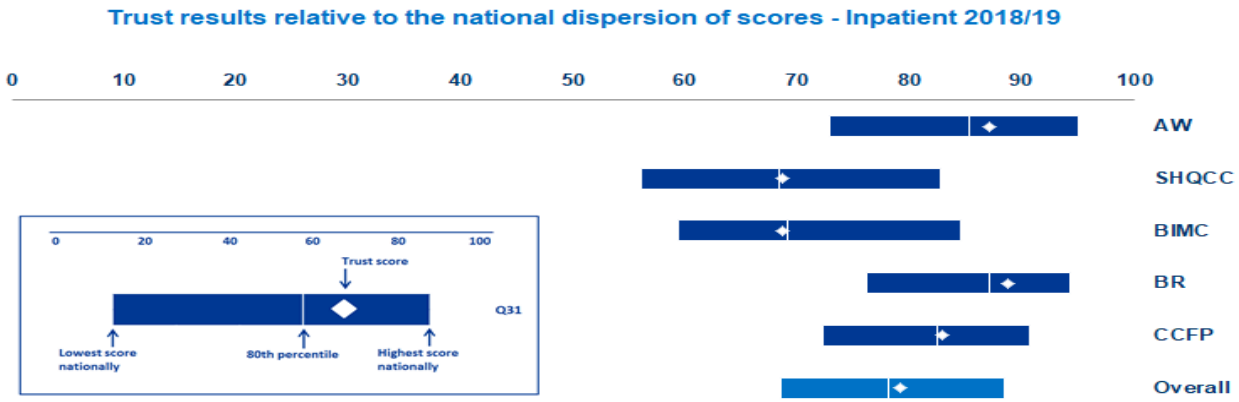


Figure 14: Responsiveness to Personal Needs (https://www.england.nhs.uk/statistics/statistical-work-areas/pat-exp/sup-info)

South Tees Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: the Trust clinical standards focus on delivering care in a sensitive and person-centred way.

The Trust's overall performance is in the top 20% nationally. The only domain where the Trust narrowly missed a top 20% performance score was the 'Better information, more choice' domain.

The Trust intends to take the following actions to improve this data and the quality of its services. The Trust continues to collect patient experience data and triangulate all patient feedback. The collection of inpatient feedback provides an immediate feedback to the wards thereby enabling staff to recognise and respond to patient queries and concerns immediately.

Staff who would recommend the Trust as a provider of care to their family and friends

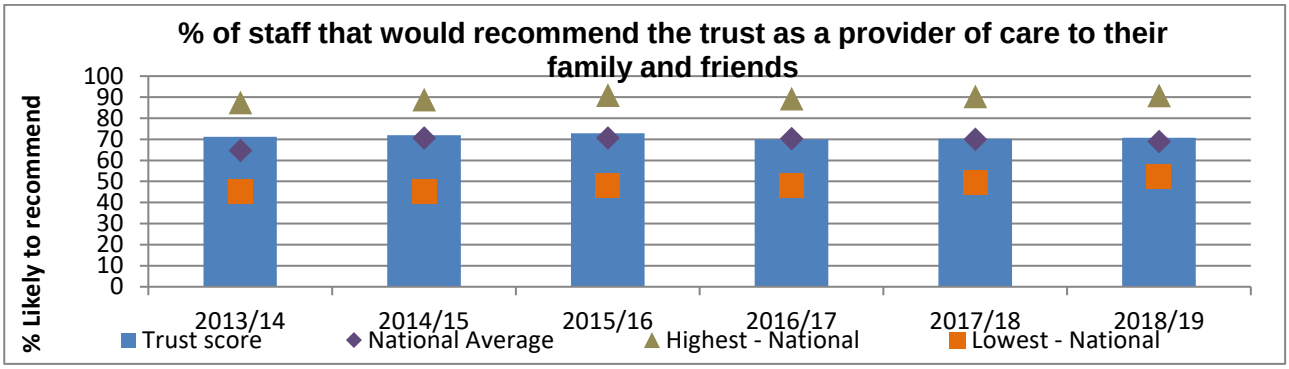


Figure 15: Percentage of Staff who would recommend the Trust (Data source: NHS Digital)

Figure 15 shows the percentage of staff who would recommend the Trust to their family and friends.

The South Tees Hospitals NHS Foundation Trust considers that this data is as described for the following reasons; the Trust scores have been consistent over the last 5 years.

The South Tees Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage and thereby the quality of its services. It continues to work with staff to improve the quality of care provided to patients. In addition the Trust promotes the achievements of staff in delivering high quality care through regular staff bulletins, staff briefings and providing other opportunities for staff feedback. The Trust has undergone a number of significant changes and is now empowering clinical leaders to make decisions around how the organisation allocates its resources and delivers care.

Domain 5 - Treating and caring for people in a safe environment and protecting them from avoidable harm

Patients that were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period.

The South Tees Hospitals NHS Foundation Trust considers that this data is as described for the following reasons; the Trust monitors compliance on a monthly basis and has achieved the required standard.

The South Tees Hospitals NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services; the completion of a VTE risk assessment is monitored

monthly through audit to ensure that the actions required following assessment are completed as well as recording that the assessment has taken place. Issues identified from the audit are further investigated and actions put in place to address any areas of concern.

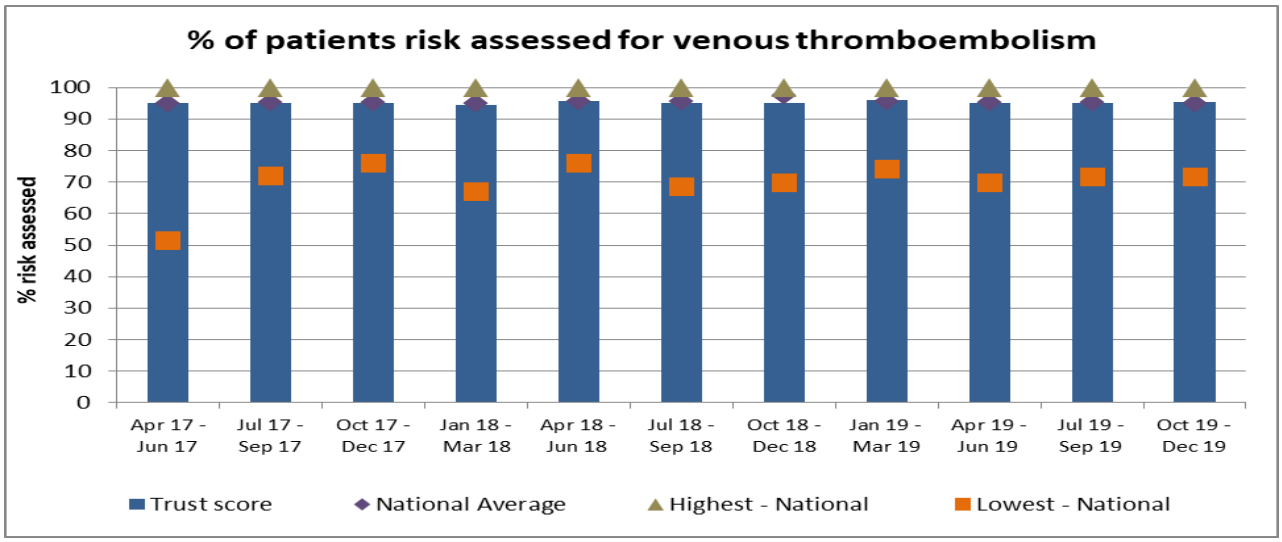


Figure 16: Percentage of Patients assessed for VTE (Data source: NHS Digital)

Clostridium difficile (C.difficile) Infections

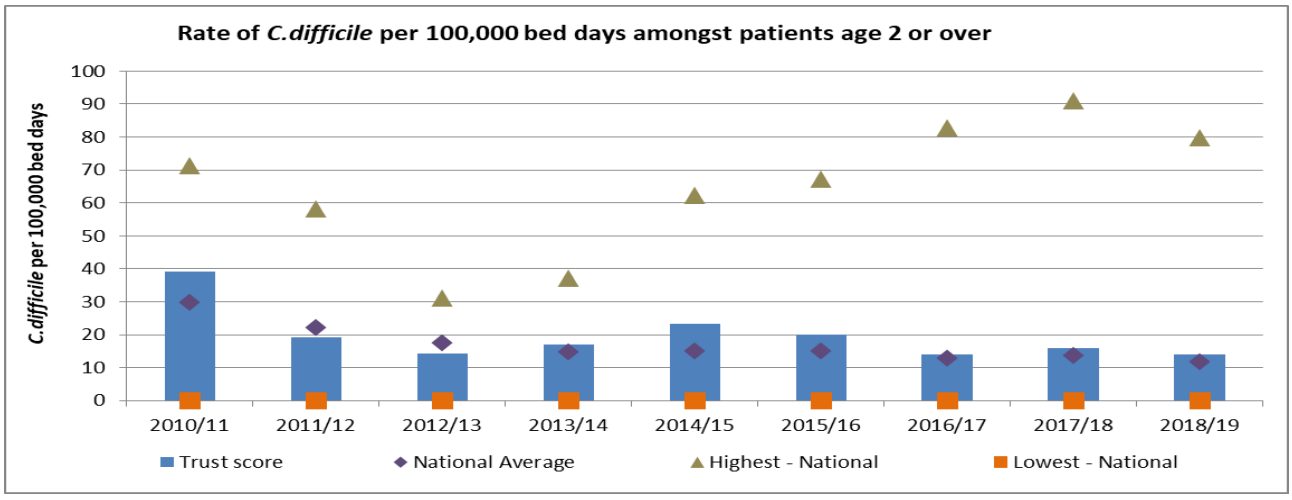


Figure 17: Rate per 100,000 bed days of cases of *C.difficile* infection reported within the Trust amongst patients aged 2 or over. (Data source: NHS Digital)

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 Clostridium difficile infections in 2018/19, as indicated in the graph above.

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 action plan for the prevention of trust-attributed Clostridium difficile infections which is monitored through the Infection Prevention Action Group. In addition to this all trust-attributed cases have a full root cause analysis and are reviewed at a panel chaired by the Director of Infection Prevention and Control or their deputy.

Rate of patient safety incidents reported within the Trust and the number and percentage of such patient safety incidents that resulted in severe harm or death

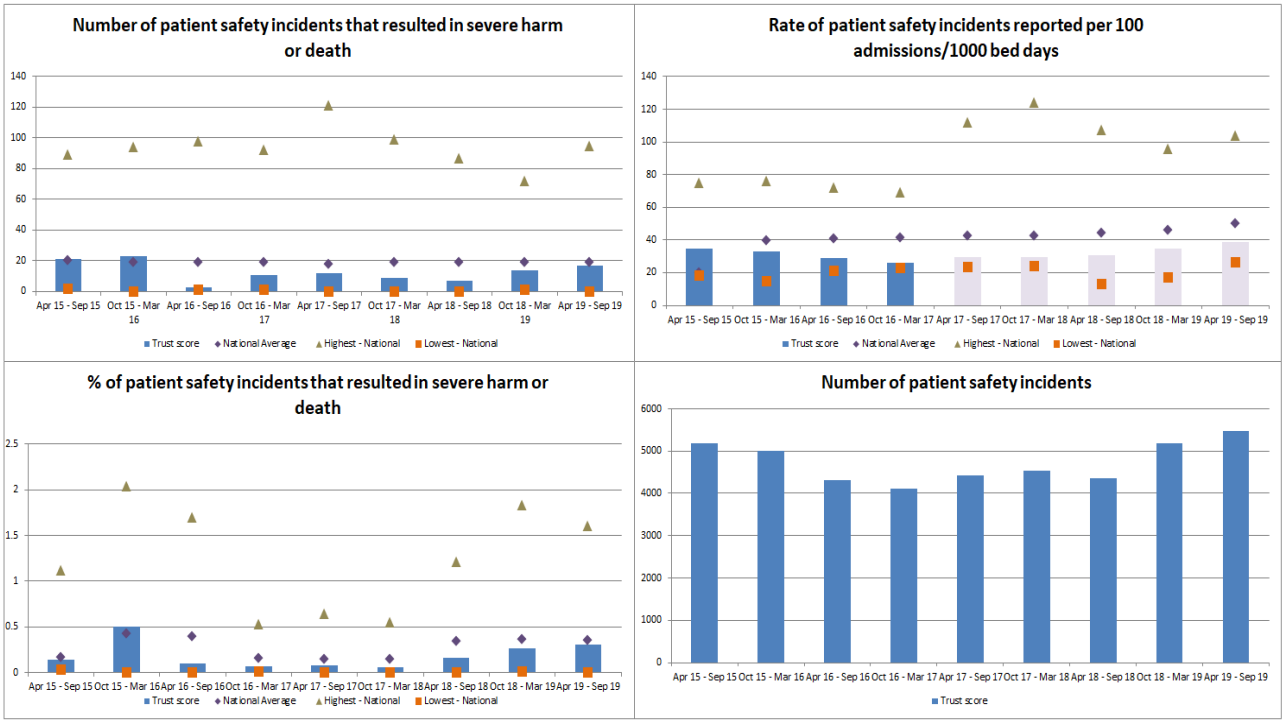


Figure 18: Rate of Patient Safety Incidents Reported (Data source: NHS Digital)

The indicator for patient safety incidents has changed from incidents per 100 admissions shown in blue above to that per 1000 bed days shown in light purple.

South Tees Hospitals NHS Foundation Trust considers that this data is as described for the following reasons; the Trust had recognised that the rate of incidents and the number of incidents reported had fallen.

Incident reporting was, therefore, previously identified as a Quality Priority and further information on the action taken to improve incident reporting is described in Part 2 of this report.

As shown in the graph, incident reporting has increased significantly over the last year. The Trust is currently exploring ways of making incident reporting easier, via the use of voice recognition software and other technology that should facilitate this process. Each indicator is governed by standard national definitions.

PART THREE – Other information

An overview of the quality of care based on performance in 2019/20 against indicators

This section of the quality account contains a review of our quality performance during 2019/20. It also includes comments on the development and content of the quality account provided by a range of external stakeholders.

We are continuously exploring new ways of improving quality and safety, making innovative use of the data collected.

Information about quality of care is collated in the form of a dashboard at ward, clinical centre and Trust level, and is reviewed monthly. This information is shared with the Board of Directors, Board of Governors, senior clinicians and managers to provide assurance the Trust is on track to deliver its key targets.

The following section reviews the work of a range of quality work streams during 2019/20; these have been selected as the key indicators by the Board that demonstrate the quality of care provided by this organisation.

Patient Safety

Pressure Ulcers

The development of pressure ulcers is recognised as a key indicator of the quality of care delivered and a fundamental aspect of patient care. Pressure ulcers are detrimental to patients in terms of their physical, psychological and social well-being, resulting in reduced quality of life (EPUAP 2014).

During 2019/120 the Trust continued to focus on reducing the number of pressure ulcers in both the acute and community settings. Overall, the trust did not achieve a reduction in the rate of pressure damage.

Preventing pressure damage remains a priority.

Actions to reduce pressure damage included:

- Changes to the reporting form for pressure ulcers has been strengthened to capture relevant information to enable ward managers and clinical matrons to ensure trends and themes are identified and that these then inform further improvement work.
- Nursing documentation has been reviewed and strengthened with additional prompts aligned to pressure ulcer prevention. In addition, a new comfort and pressure chart has been developed to prompt and record assessment and relevant evidence of interventions.
- The safety@stees collaborative, a safety focused monthly meeting, includes pressure ulcers as a standing agenda item and provides a regular opportunity to monitor performance and share good practice. More detailed analysis is conducted by wards teams and actions are monitored through the clinical standards meeting. Where additional support, expert advice or training is required, the tissue viability team provide this to our clinical staff, both on wards and within the patient's own home.
- Areas with heightened pressure damage rates have undertaken additional training and are supported by the tissue viability team.

Falls

Falls prevention remains a key priority for staff across the trust. During 2019/20 there has been a sustained focus on reducing falls and this has included interventions such as improvements to signage, continence and delirium care planning, medication reviews and interventions to prevent muscle loss, specifically for older and frail patients. By the end of 2019/20 fewer patients had fallen in the trust than in the previous 2 years.

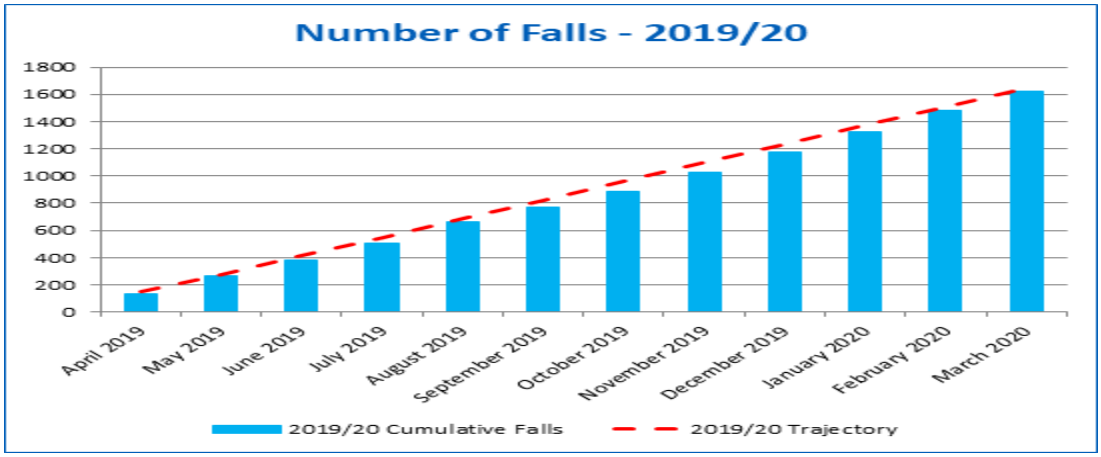


Figure 19: Patient Falls 2019/20

Actions to reduce falls include:

- Falls are reported via the incident reporting system and the reporting form for falls has been strengthened to enable more detailed reporting and identification of trends and themes to inform further improvement initiatives. Through analysis of incident data environmental issues such as light levels, weight of doors and toilet seat height identified as issues have all been addressed to reduce the incidence of falls.
- Nursing documentation has been reviewed and strengthened with additional falls prevention prompts aligned to the falls CQUIN
- The safety@stees collaborative meeting includes falls as a standing agenda item and provides a regular opportunity to monitor performance and share good practice. More detailed analysis is conducted by each ward and actions are monitored through our clinical standards meeting.
- On-going interventions include monitoring the completion of the Trust's fall's assessment to ensure individual patient's risks are being addressed. Examples include conducting a review of medicines where necessary and ensuring appropriate footwear is worn. There is also a system for flagging patients identified at risk of falling and these patients are discussed at ward rounds and this is highlighted on the patient boards.

Duty of candour

Central to the Trust's strategy to improve patient safety is its commitment to improving communication between healthcare professionals and patients and/or carers when a patient is harmed as a result of a patient safety incident. This communication is known as 'Being Open' and involves apologising and explaining what happened. It ensures communication is open, honest and occurs as soon as possible following an incident. 'Being Open' about what happened and discussing

incidents promptly, fully and compassionately can help patients cope better with the after-effects. Incidents can also incur extra costs through litigation and further treatment; openness and honesty can help prevent such events becoming formal complaints and litigation claims. 'Being Open' is a process rather than a one off event. The Duty of Candour is a statutory and regulatory requirement of the 'Being Open' process and applies when a patient safety incident results in moderate harm, major (severe) harm or death.

The Trust's process to discharge its Duty of Candour is described in the 'Being Open' policy which is available to all staff. An overview of Duty of Candour is included in the Trust's Induction programme. In addition the incident reporting system and investigation documentation includes prompts to ensure the Duty of Candour requirements are considered. An audit of incidents with a severity graded as moderate or greater is being undertaken in quarter 2 2019/20 and this is likely to result in improvements to the policy.

Adult Safeguarding

What is Safeguarding?

Safeguarding is a positive duty placed on all of us under section 42 of the Care Act (2014) to promote the wellbeing of vulnerable people and protect them from harm whether or not 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 we do and treat people in accordance with their rights.

In 2019-20 there were 573 safeguarding concerns; 115 relating to Trust practice and 458 relating to concerns externally. (Overall 37% increase on previous year).

Model of safeguarding within the Trust

The Safeguarding Adult Team triage all safeguarding concerns raised and allocate to an appropriate Clinical Matron taking into account work load and complexity. Those concerns most complex, reputationally risky or involing multilple services are managed by the team themselves. These include allegations of organisational or discriminatory abuse, where there are potential criminal charges or disciplinary processess against staff members**.** This includes working with the ward/department team to undertake an investigation providing evidence to the safeguarding meeting and working with those involved to instigate any resulting action plan.

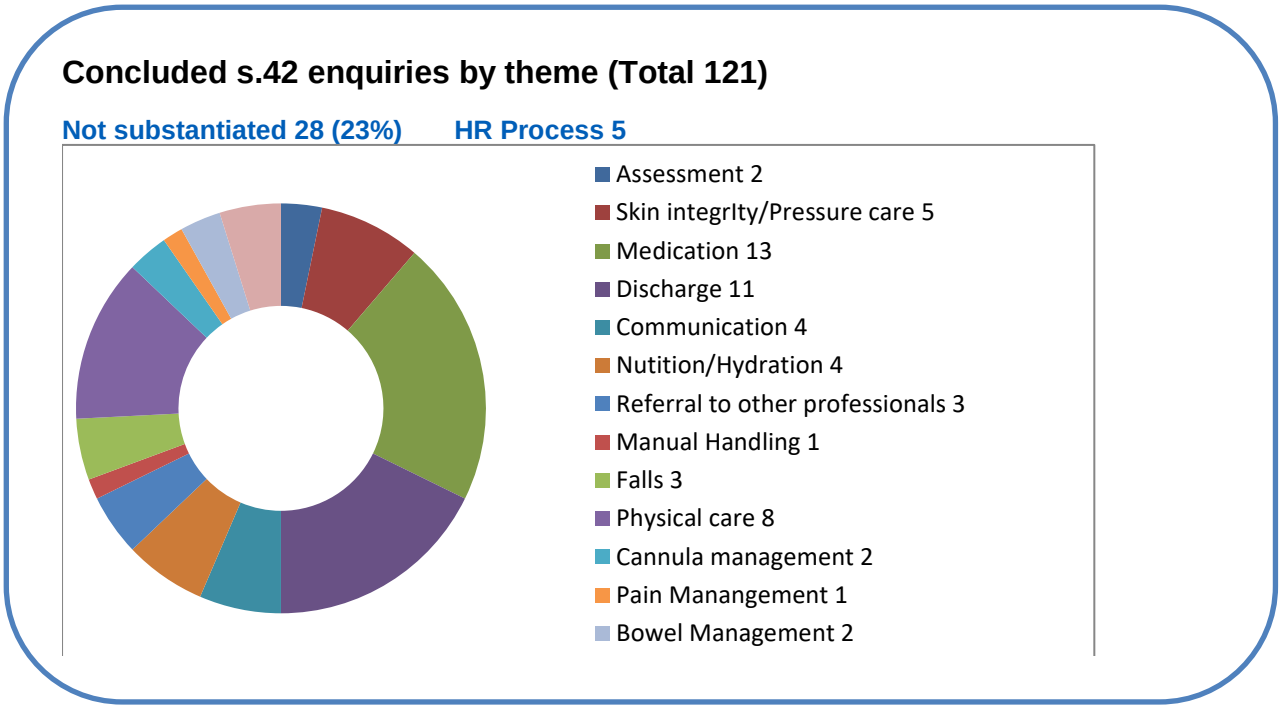
During COVID this model was revised to enable Clinical Matron cover to focus on the clinical areas; the Safeguarding Team managed all safeguarding activity. There are plans to review the model and adopt what is considered to be the best elements of practice.

Making safeguarding personal

The focus of the Making Safeguarding Personal (MSP) agenda is on safeguarding processes supporting the individual to develop or maintain a private life in safety and free from abuse. At its heart it is about people being enabled to live the life they choose.

Adults should be asked what outcome they would like from safeguarding procedures. This is audited on a quarterly basis. This has shown a significant improvement over the year from 44% in Q1 to 84% in Q4 with overall compliance across the year of 61%.

Themes of learning during 2019-20



Children's Safeguarding

Model of safeguarding children practice

The safeguarding children's team operate a model of duty nurse system (Mon-Fri) who visits ED, Paediatric and post natal inpatient areas each mornng and attend any child protection strategy meetings called for that day. Each member of the the team has a caseload of practitioners for whom they provide safeguarding supervision. In addition they represent the organisation at

interagency safeguarding meetings, contribute to training and professionally challenge interagency partners when necessary.

Model for Looked After Children (LAC) practice

A child is looked after by a local authority if a court has granted a care order to place the child in care, or a council's children's services department has cared for the child for more than 24 hours. Within 5 working days the Trust should be notified the child has become looked after and be provided with parental consent for an initial health assessment to be carried out by a paediatrician. The initial health assessment must be carried out within 20 working days. These are statutory time scales.

Following their initial health assessment, each child will have a review health assessment at a statutory interval for their period of time in care. Children under 5 years are reviewed every six months and children over that age annually. These reviews are requested, collated, distributed and quality assured by the LAC team but carried out by other provider Trust's.

The looked after children system is complex and highly interdependent on the timely actions of multiple agencies and multiple professionals within those agencies. Additionally a number of local children are placed in areas outside of the Trust footprint, and a number of children from outside our area are placed here. The looked after team has a role in statute and contract in relation to all of these children. Where a child is looked after by North Yorkshire County Council their health needs are coordinated by Harrogate District Foundation Trust. Data provided in the report therefore is in relation to South Tees Children. Middlesbrough has some of this highest numbers of children looked after in the country and numbers are growing.

The total number of looked after children as of 31/03/3030 is 987 which is an increase of 19% from the figure as per 31/03/2019.

Clinical Effectiveness

Dying in hospital – mortality

Hospital mortality rates; how many people die in different hospitals as a proportion of the number of people who are admitted to the hospital, are not easy to compare across the NHS. Simply knowing

how many people died at each hospital would be misleading as hospitals see different numbers of patients and provide different services to patients with different levels of risk. However, for an individual hospital or Trust it is important to monitor a number of measures of mortality as collectively they can provide alerts about the quality of care provided in the organisation.

The basic measure is to monitor the proportion of people who die in hospital and this number, known as the unadjusted mortality rate, is monitored on a weekly basis. Risk adjusted measures can take account of the different levels of risk to some extent. They are calculated by estimating the risk of death for each patient with specific medical conditions and comparing the actual death rate with the total estimated rate that can be expected from the predicted risks.

Mortality statistics are reported to the Trust Board on a quarterly basis and have been since 2008. These include the number of deaths, the unadjusted mortality rate and the Summary Hospital-level Mortality Indicator (SHMI), the NHS's official risk-adjusted mortality metric.

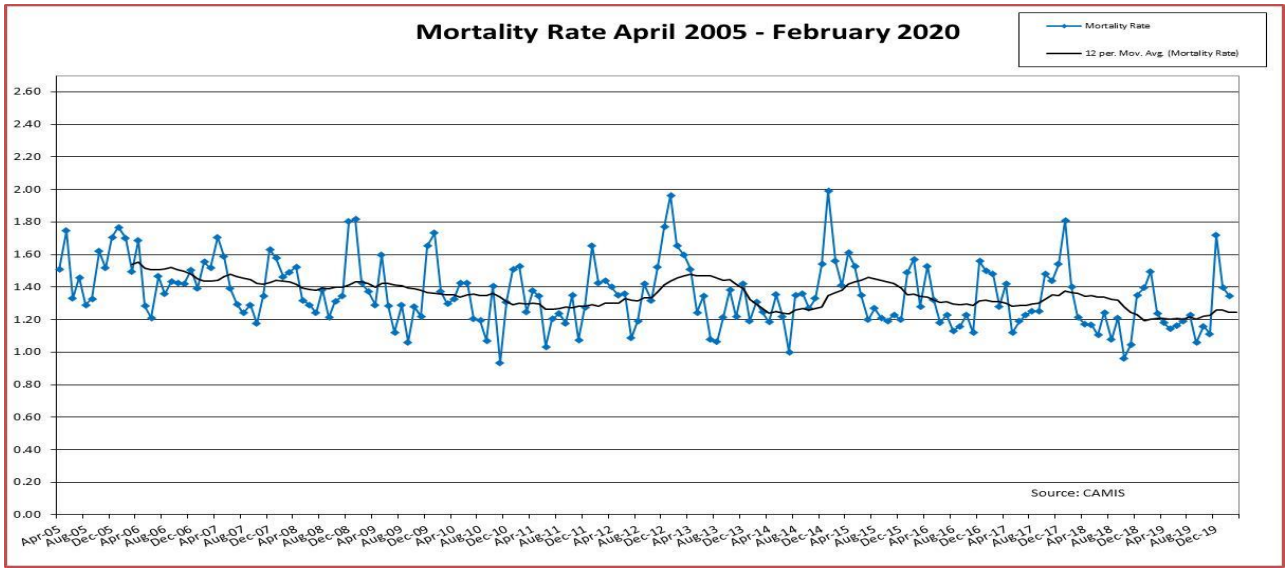


Figure 20: Unadjusted Mortality Rate April 2005 – Feb 2020 (including rolling 12 month averages) (*Source: CAMIS)*

It should be noted that in line with previous Quality Accounts information more recent data will be reported in next year's report to allow comparisons with previous years to be made.

Unadjusted mortality measures the number of deaths as a percentage of patient inpatient and day case spells, excluding well babies (less than 28 days old). It is most useful for seeing the pattern of deaths through time. Looking at the trend from April 2005 – February 2020 it can be seen that a winter peak is experienced in most years, especially in 2013, 2015 and 2017. The peak in January 2015 in particular was severe but of short duration and reflects the amount of respiratory infections in the community. The peak between October 2017 and January 2018 again reflects the amount

and severity of respiratory infections including influenza in the community, as primary causes of death and underlying other conditions such as sepsis, renal failure and other acute medical conditions. The winter peak for 2018-19 was relatively low and for 2019-2020 occurred earlier than usual in December 2019.

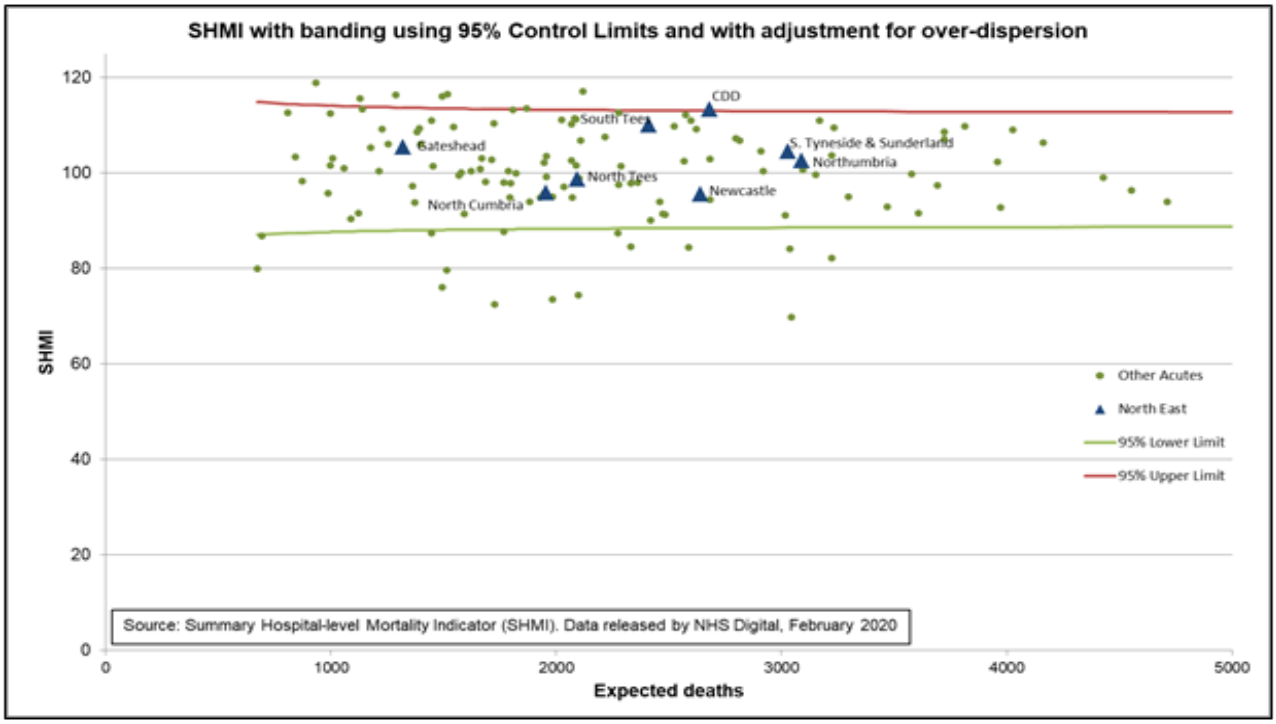


Figure 21: SHMI with 95% Control Limits and with adjustment for over-dispersion for Oct 2018 – Sep 2019 (*Source: SHMI Data Release NHS Digital May 2019*)

It should be noted that in line with previous Quality Accounts information more recent data will be reported in next year's report to allow comparisons with previous years to be made.

The Summary Hospital-level Mortality Indicator (SHMI) is designed to allow comparison between Trusts across the NHS. It includes deaths in hospital as well as deaths within 30 days of discharge from hospital. The SHMI for the Trust has been 'as expected' (i.e. within the amount of variation that can be anticipated by chance) in all data releases to date and the SHMI is currently 110 (Oct 2018 – Sep 2019). This means that the number of deaths in hospital or within 30 days of discharge from hospital is a little higher than the number expected using a statistical model.

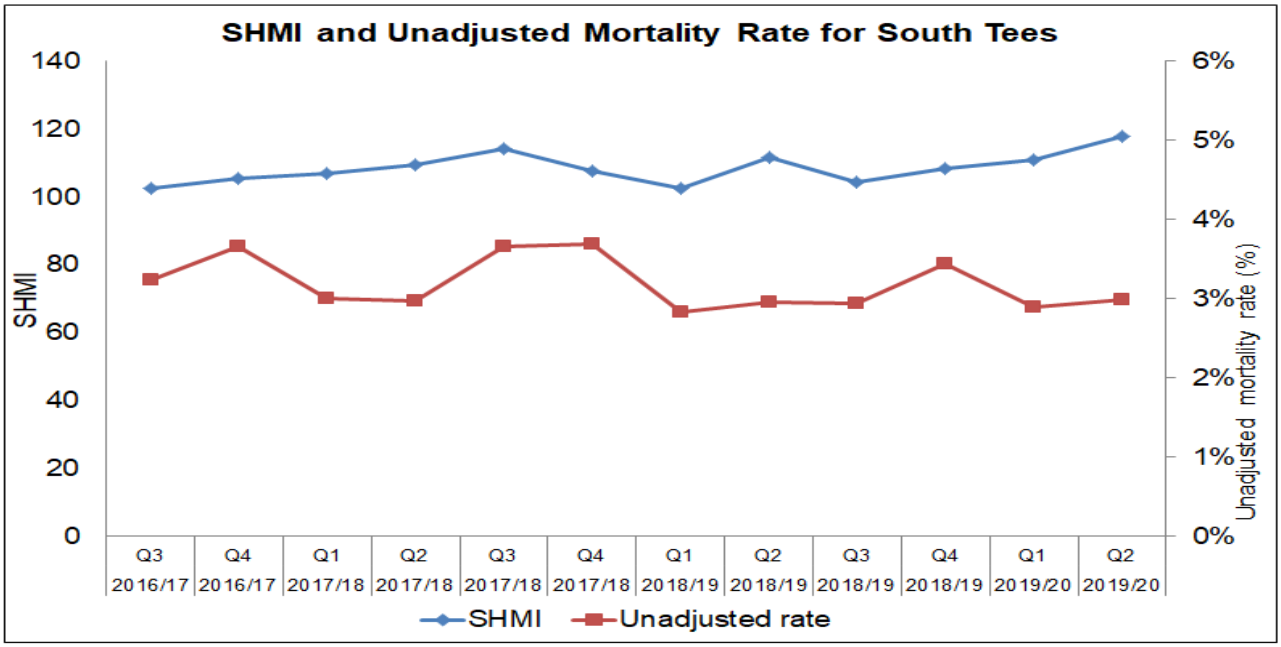


Figure 22: SHMI and Unadjusted Mortality Rate for South Tees (*Source: Data extracted from HED Feb 2020)*

The SHMI is monitored on a quarterly basis and broadly reflects the unadjusted rate for deaths included in the SHMI.

Re-admissions

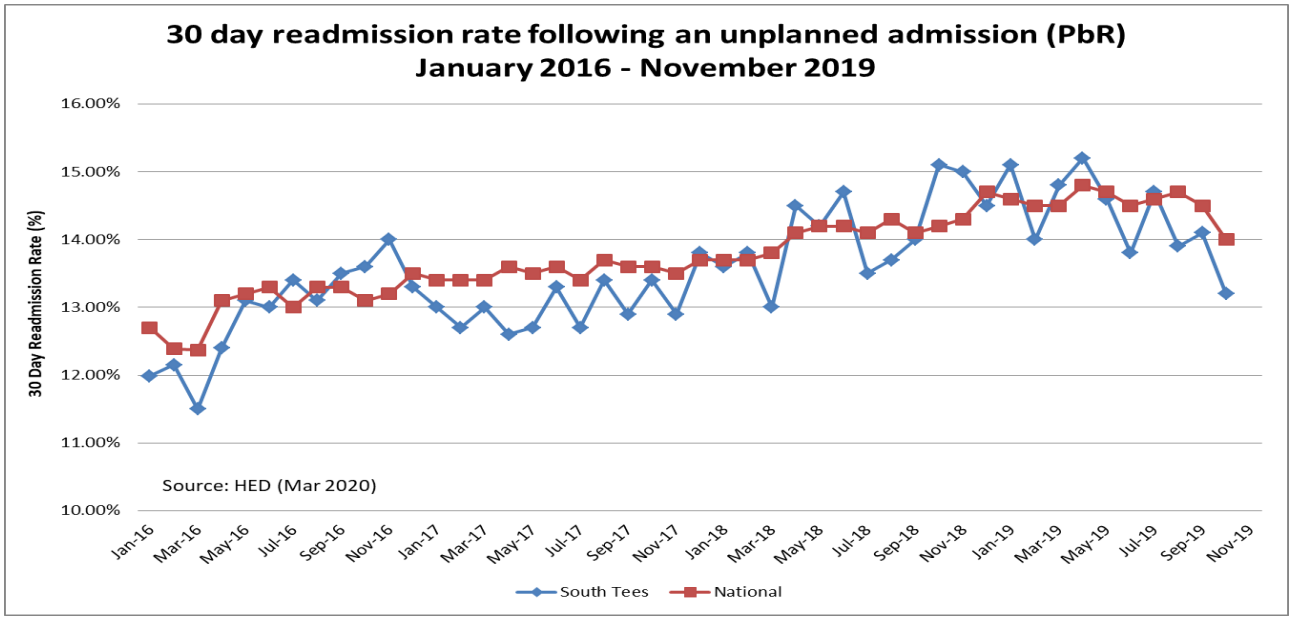


Figure 23: 30 day readmission rate following an unplanned readmission (Payment by Results)

Over the period illustrated, 30 day readmissions for the Trust has averaged 13.57% compared to the national average of 13.78%. For some patients this further admission is not linked to their recent hospital stay but for others, they have returned to hospital because of complications after their discharge. These complications may be related to their needs not being adequately established at pre-assessment, through to acquiring an infection during their hospital stay or due to their rehabilitation not progressing as planned. The graph demonstrates that the re-admission rate has stayed static over the period reported.

There has been considerable work undertaken in individual pathways, for example alcohol dependency, pain management and Chronic Obstructive Pulmonary Disease (COPD). The Rapid Response Service and the Integrated Community Care team will support those patients at high risk of re-admission.

Nutrition and hydration – getting the balance right

The Trust aims to:

- Ensure all patients are screened to assess their risk of malnutrition and that this information is appropriately acted upon
- Ensure we meet the needs of patients who require help with eating or drinking
- Provide choices of food and drink for people to meet their diverse needs making sure the food and drink we provide is nutritionally balanced and supports their recovery.

Patients are assessed on admission using the Malnutrition Universal Screening Tool (MUST), which is a validated screening tool to detect malnutrition in adult patients. The following graph demonstrates compliance with using the tool and taking the appropriate actions.

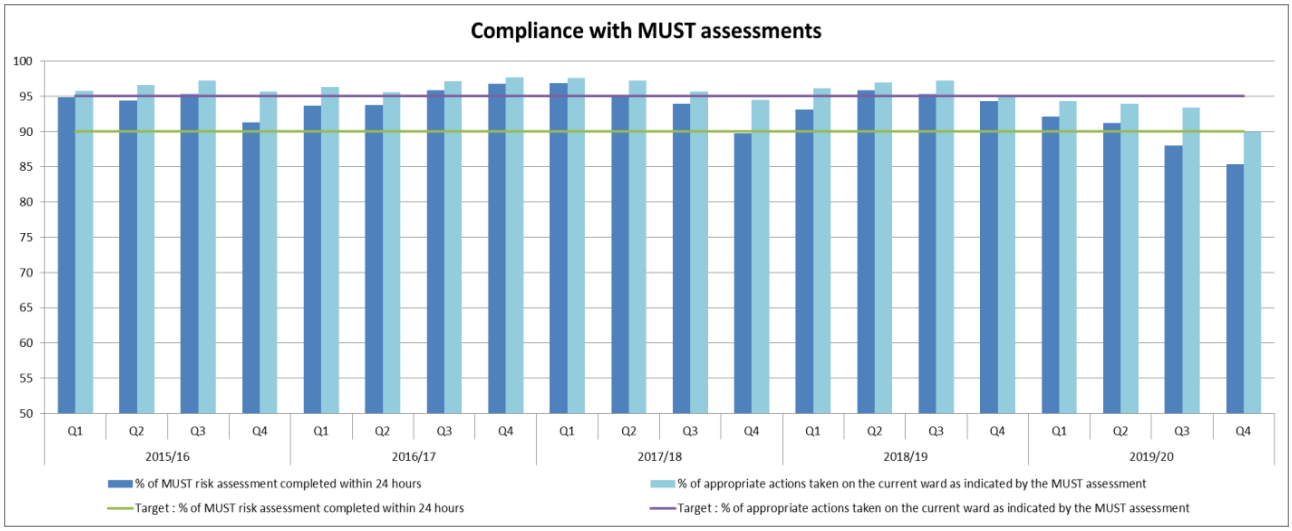


Figure 24: Compliance with Must Assessments (Data source: Local audit)

Compliance is monitored via ward managers monthly audits and the clinical assurance rounds, and where issues are highlighted targeted training is arranged locally.

It is anticipated that compliance will increase with the re-introduction of the internal ward accreditation scheme (STAQC), and MUST refresher training is also being provided.

Nursing assessments and screening tools for nutrition and hydration

As part of the review of the nursing care pathway documentation launched in January 2020, the screening tool (MUST) and care plan that we use to identify patients at risk of malnutrition has been revised and updated. Alongside this, the new documentation now also includes screening questions to identify patients who are having problems with swallowing which can also have significant impact on the ability to eat and drink adequately and safely.

International Dysphagia Diet Standardised Initiative (IDDSI) Implementation

The IDDSI Framework is an internationally agreed framework that has been developed for a number of reasons but most importantly for patient safety. Across the world, there have been a number of serious choking incidents related to poor understanding of previous terminology that was used for dysphagia (difficulty with swallowing), and particularly around the term ‘soft diet’. If dysphagia is not treated appropriately, it can result in choking, pneumonia, chest infections, dehydration, and malnutrition and weight loss. IDDSI promotes patient safety through using the same definition to describe the different levels of dysphagia - for all ages and care settings worldwide. Although work initially started on this in 2018, the implementation of the International Dysphagia framework has been a significant undertaking and an on-going project during 2019 to support the training and awareness-raising of staff and volunteers who are involved in the provision of food and fluids to

patients, to change menus and develop information resources for patients, carers and care providers and embed this into every day practice.

Transformation of Patient Meal provision

Much of the focus for the last year has been the extensive preparation for switchover to a new food supplier for the hospital meal provision at the James Cook site and a move to a 'bulk cook freeze system'. This required the development of a completely new menu range, whilst also ensuring that all special dietary requirements and national nutritional standards are met alongside the need for variety and balance to prevent menu fatigue.

The phased launch commenced at the end of October 2019, supported by intensive training sessions.

In addition to the menu changes an electronic ordering system was introduced. Meals are now ordered at ward level via I-pads - the key advantage being that patients get their first choice and trolley waste has reduced significantly, and the electronic system enables us to gather useful data to inform future menu changes. For any patients who have not been on the ward at the time of ordering, or have missed a mealtime, we have a flexible dining menu card which can be offered and regenerated in the hospital production unit and delivered to the ward.

Focus on Hydration

As part of a service improvement project led by the renal team, a 'traffic light' water jug system was piloted in June/July 2019. The RAFA unit was identified as the initial area to focus on due to the high incidence of patients being admitted with Acute Kidney Injury (AKI) Stage 1, and it was felt this could have a positive impact on AKI progression. Patients on the unit were given a water jug with a red lid at the start of the day. Once empty the jug was refilled and the lid changed to an amber colour and then eventually to a green lid. The aim being that, by the end of the day the patient would have consumed enough water to ensure that they were adequately hydrated.

An audit conducted prior to the implementation of this system demonstrated that the average daily oral intake of water per patient was approximately 500mls with no patients achieving over a litre of oral intake. Post implementation audits demonstrated average oral fluid intake had increased significantly. The pilot was widened to include ward 34 (orthopaedic ward with an emphasis on fracture neck of femur patients) with similar positive results

The plan now is to roll this project out trust wide, with an initial focus on Surgery and Trauma.

COVID-19

Nearing the end of the 2019-2020 period the Trust had to switch rapidly to preparation for the impact of the COVID-19 pandemic. Across the Trust all services were required to anticipate and plan for the rapidly changing patient needs both as a consequence of the illness itself or as an impact of the COVID-19 lockdown procedures that we were required to impose. The intelligence that we gained from other centres across the country indicated that there would be a significant increase in the patients needing to receive nutrition via enteral or parenteral feeding routes, and increased staffing resources needed within the critical care and respiratory areas.

Priority was given to training staff to increase specialist skills in these specialities, developing new protocols and care plans for the provision of nutritional care pathways, and producing patient information specific to managing the consequences of COVID on nutritional intake.
New ways of working had to be implemented to ensure that nutritional care continued for those patients out in the community who were unable to be seen for 'face to face' care, with the introduction of 'virtual' clinics and telephone support for care homes.

Seven Day Services

The government launched the seven day services programme to ensure that patients that are admitted as an emergency receive high quality consistent care, whatever day they enter hospital. Ten clinical standards were identified initially with four priority standards for implementation by 2020.

These four standards mean that emergency patients;

a) don't wait longer than 14 hours to initial consultant review
b) get access to diagnostic tests with a 24-hour turnaround time - for urgent requests, this drops to 12 hours and for critical patients, one hour
c) get access to specialist, consultant-directed interventions
d) with high-dependency care needs receive twice-daily specialist consultant review, and those patients admitted to hospital in an emergency will experience daily consultant-directed ward rounds

The Trust changed medical and surgical rotas during the acute phase of Covid-19 to ensure 7 day working.

The Trust is awaiting further guidance on how the Seven day services agenda will be taken forward and what shape assurance will take. It is anticipated that this will be put on hold for the time being given the Covid pressures.

Given that the Trust is currently in Covid recovery, the only way that we can be assured that we are compliant with standards a, b and c is to undertake another audit. Given the nature of ward rounds in South Tees, the Trust is compliant with standard.

The trust has been advised by the Regional Improvement Team – North (NHSEI) that there is no need currently to undertake another audit for regional submission in view of the on-going Covid-19 situation.

Due to current and anticipated increasing pressures upon systems in responding to the coronavirus (COVID19) pandemic, the spring Board Assurance Framework (BAF) submission requirement for the region had been deferred to Wednesday 30 September 2020 however given the ongoing pressures this has now been cancelled and clarity is currently being sought from NHSE/I Regional Medical Directors in regard to how they wish to seek assurance with the delivery of this agenda.

NHS Doctors and Dentists in Training

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” and NHSI has requested that there should be a statement in the Trust's Quality Account regarding this.

The vacancy rate was greatly improved in 2019/2020 compared to the previous year with the annual vacancy rate dropping from 6.4% to 3.9%. Vacancies have been covered in the main via re-adjusting rotas to accommodate the reduced number of Doctors. Vacancies have been actively recruited to throughout the year whilst an increased use of recruitment of Doctors via the Medical Training Initiative has helped to fill ST3+ level vacancies in a number of specialties.

Gaps on rotas tend to be short term due to sickness or emergency leave. The Medical Rota Team track Junior Doctor sickness and any Doctors hitting trigger points are picked up by the relevant team (e.g. postgraduate team for Foundation Doctors, Lead Employer Trust for LET employed Doctors). Advanced Nurse Practitioners are successfully being utilised to cover gaps in some areas, working alongside Doctors in training.

The medical rota team continue to fill approximately 95% of all locum shifts each month with the majority (approximately 91%) being filled by internal locum cover as opposed to agency. The regional locum bank (Flexishift) hosted by the LET is now well established and Locally Employed Trust (LET) Doctors are to be added to the bank from May 2020. The regional bank provides STHFT with access to an additional pool of LET employed doctors who work in other Trusts and GP surgeries. The team continue to utilise the master vendor agency HCL where required.

In line with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016, we have an established Guardian of Safe Working (GOSW), reporting quarterly to the Board and Workforce Committee, and a Junior Doctors' Forum meeting quarterly. Attendance at the Junior Doctor Forum has increased considerably following the August 2019 intake of Junior Doctors, with a number of members becoming accredited BMA representatives, taking up vacant seats on the Joint Local Negotiating Committee (JLNC).

Patient Experience

The Trust uses a number of sources to understand the patient experience in the organisation, and as discussed earlier in the report, the trust has implemented the 'real time' patient experience programme across all inpatient wards.

Complaints and PALS

In addition to this, we analyse our complaints, Patient Advice and Liaison (PALs) enquiries/concerns and compliments to understand the experience of our patients, with a view to continually improving this.

	2018/19	2019/20				
	Total	**Q1**	**Q2**	**Q3**	**Q4**	**Total**
Number of Formal Complaints	**378**	130	110	96	134	**470**
Number of PALs received	**2518**	613	669	536	694	**2512**
Number of Compliments	**261**	58	134	109	103	**404**

Table 16: Number of Complaints and PALS Concerns/Enquiries Received during 2019/20 (Source: Datix)

The table above shows that there has been an increase in the number of complaints reported during 2019/20 from the previous year, which represents an increase of 24%. The number of PALS received during 2019/20 remains about the same as 2018/19. There were 2512 PALS received in 2018/19 compared with 2518 in 2018/19. The number of compliments logged has increased however not all compliments will be formally logged on Datix, as many will be received at ward/department level.

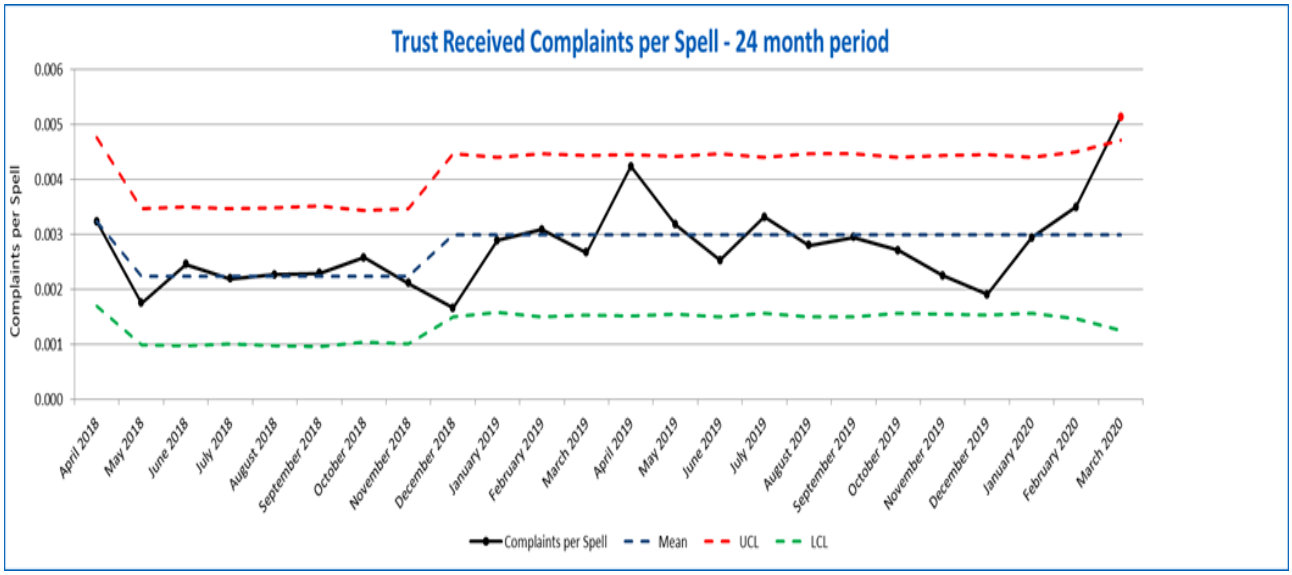


Figure 25: Complaints Received Over a 24 Month Period

The number of complaints received had increased in the last quarter. There were 39 complaints received in January and 48 in both February and March. This is exaggerated in the above graph due to the significant reduction in spells during March as a direct result of Covid-19.

Friends and Family Test (FFT)

The Trust continues to deliver the Friends and Family Test in line with national guidance. On 1 April 2019 the Trust commenced using a digital platform in all inpatient areas and maternity to collect the FFT. On 1 August 2019 the collection of FFT by text message for the Urgent and Emergency Care service was commenced, this service was also rolled out from 1 October 2019 in outpatient areas. The Trust performs well against national data with the percentage of patients that are very likely or likely to recommend, with performance generally in line or higher than the national average for inpatient areas and above the national average for maternity services. The percentage very likely or likely to recommend for Urgent and Emergency Care services is slightly lower than the national average.

Response rates are however lower than the national average and the Trust continues to try different methodologies to improve this. However, the introduction of 'key performance indicators' for all inpatient areas from 1 February 2020 has seen the response rate improve month on month.

	Apr-19				May-19				Jun-19			
	Response Rate		% likely to recommend		Response Rate		% likely to recommend		Response Rate		% likely to recommend	
	Trust	England	Trust	England	Trust	England	Trust	England	Trust	England	Trust	England
Inpatient	3%	24%	100%	96%	4%	24%	94%	96%	6%	25%	99%	96%
A&E	0%	12%	100%	85%	0%	12%	*	86%	0%	12%	*	86%
Antenatal			-	95%			-	95%			-	95%
Birth	0%	21%	*	96%	0%	20%	*	97%	0%	21%	*	97%
Postnatal ward			*	95%			*	95%			*	95%
Post natal			*	98%			*	98%			*	98%
Outpatient			-	94%			-	93%			-	94%
Community			100%	95%			90%	96%			-	95%

	Jul-19				Aug-19				Sep-19			
	Response Rate		% likely to recommend		Response Rate		% likely to recommend		Response Rate		% likely to recommend	
	Trust	England	Trust	England	Trust	England	Trust	England	Trust	England	Trust	England
Inpatient	6%	26%	99%	96%	13%	26%	97%	96%	14%	24%	97%	96%
A&E	0%	12%	*	85%	5%	13%	*	86%	5%	12%	81%	85%
Antenatal			-	95%			-	94%			-	95%
Birth	-	21%	*	97%	-	21%	*	96%	-	20%	*	97%
Postnatal ward			*	95%			*	96%			*	95%
Post natal			*	98%			*	98%			*	98%
Outpatient			-	94%			-	94%			-	93%
Community			-	95%			-	96%			-	96%

	Oct-19				Nov-19				Dec-19			
	Response Rate		% likely to recommend		Response Rate		% likely to recommend		Response Rate		% likely to recommend	
	Trust	England	Trust	England	Trust	England	Trust	England	Trust	England	Trust	England
Inpatient	14%	24%	98%	96%	12%	24%	97%	96%	13%	23%	97%	96%
A&E	5%	13%	83%	85%	4%	12%	82%	84%	5%	12%	84%	84%
Antenatal			-	95%			94%	95%			100%	95%
Birth	-	20%	*	97%	-	21%	*	96%	-	18%	*	97%
Postnatal ward			*	95%			96%	94%			100%	95%
Post natal			*	98%			*	98%			*	98%
Outpatient			-	93%			95%	93%			95%	94%
Community			-	96%			-	96%			*	95%

	Jan-20				Feb-20			
	Response Rate		% likely to recommend		Response Rate		% likely to recommend	
	Trust	England	Trust	England	Trust	England	Trust	England
Inpatient	19%	23%	97%	96%	20%	24%	96%	96%
A&E	5%	12%	87%	85%	5%	12%	82%	85%
Antenatal			100%	95%			97%	95%
Birth	-	19%	*	97%	-	20%	*	97%
Postnatal ward			100%	95%			100%	95%
Post natal			*	98%			*	98%
Outpatient			95%	94%			92%	94%
Community			-	96%			-	96%

Table 17: Family and Friends Test Data by Month Data source: NHS England

National Patient Surveys

National Adult Inpatient Survey 2018

The national survey of adult inpatients seen in July 2018 showed that a total of 600 surveys were returned completed therefore the trust had a response rate of 50%. The results were published by the CQC in July 2019 and showed:

The Trust scored in the top 20% of trusts of 27 questions. The trust scored in the bottom 20% of trusts on 2 questions, knowing what would happen next when leaving hospital and being given written information to support self-care when leaving hospital.

Overall the results reflect a positive patient experience in the questions asked in domains for, the emergency/A&E department, doctors and nurses, care and treatment, respect and dignity. Areas identified for improvement, communication and the discharge process.

National Maternity Survey 2019

There were 139 completed surveys from women who gave birth during February 2019 within the organisation with a response rate of 39%. The average score for each question showed an improvement from 82% in 2018 to 83% in 2019.

The Trust scored in the top 20% on 17 questions and scored in the bottom 20% on 2 questions, during pregnancy, the provision of a telephone number for a midwife or member of the midwifery team to contact and following the birth, having the opportunity to ask questions about the labour and the birth.

Overall the survey results reflect a positive patient experience in relation to the questions asked in the 3 domains, labour and birth, staff during labour and birth and care in hospital and after birth. Areas identified for improvement were, contact information in the antenatal period, discharge and communication after the birth. An action plan has been developed to secure and sustain improvements.

Urgent and Emergency Care Survey 2019

The national survey of Urgent and Emergency Care surveys patients attending type 1 services, which include A&E departments (casualty or emergency departments). Type 3 services include urgent care centres, urgent treatment centres and minor injury units. For adult patients seen at a type 1 service between October 2018 and March 2019 showed that a total of 315 surveys were completed therefore the trust had a response rate of 25%. For adult patients seen at a type 3 services between October 2018 and March 2019 showed that a total of 139 surveys were completed therefore the trust had a response rate of 33%

The survey findings for type 1 and 2 showed the average score was up 1.4% on 2016. The trust was in the top 20% of trusts on 17 questions and the bottom 20% in 0 questions. Areas of strength were in the domains for, waiting times, doctors and nurses, care and treatment, leaving A&E and respect and dignity

Children and Young Persons Survey 2018

The national survey of Children and Young Persons seen in November and December 2018 showed that a total of 260 surveys were completed with a response rate of 24%. The Trust scored in the top 20% of Trusts on 19 questions and in the bottom 20% of Trusts on 4 questions. The results have remained largely the same as in the 2016 survey.

The Trust scored better in four questions compared with other Trusts in the region for young people feeling; it was quiet enough to sleep when needed in hospital and the ward they stayed on was suitable for their age. For children and young people saying; staff spoke with them about how they were going to care for them and they were told what would be done before their operation or procedure. The Trust scored in the bottom 20% in four questions: Choice of admission dates, change of admission date, staff playing with children at all while they were in hospital and staff listening to children. Areas for improvement included a review of surgical admission dates and observational audits of staff playing with children and listening to children.

National NHS Staff Survey, 2019

The survey was carried out from October to December 2019. The survey mode was mixed and the sample type was census with a response rate of 27% (2250 members of staff). There were 48 organisations in the benchmarking group with a median response rate of 46% (combined acute and community trusts)

Key findings were as follows:

Violence, Harassment & Bullying

Question	Improvement/ deterioration	2018	2019	National Average 2019
In the last 12 months how many times have you personally experienced	Deterioration	13.3%	14.3%	13%

physical violence at work from patients / service users, their relatives or other members of the public?				
In the last 12 months how many times have you personally experienced physical violence at work from managers?	Improvement	0.4%	0.2%	0.4%
In the last 12 months how many times have you personally experienced physical violence at work from other colleagues?	Improvement	1.6%	0.8%	1.1%
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?	Improvement	27.9%	25.6%	25.9%
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?	Deterioration	9.8%	12.5%	11.8%
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?	Deterioration	18.3%	18.8%	18%

Quality of Appraisals

Question	Improvement/ deterioration	2018	2019	National Average 2019
It helped me to improve how I do my job	Improvement	14.2%	15.7%	21.7%
It helped me agree clear objectives for my work	Improvement	27.1%	27.7%	34.8%
It left me feeling that my work is valued by my organisation	Improvement	24.6%	25.5%	32.5%
The values of my organisation were discussed as part of the appraisal process	The same	19.2%	19.2%	38.7%

Health & Wellbeing

Question	Improvement/ deterioration	2018	2019	National Average 2019
The opportunities for flexible working patterns	Deterioration	47.8%	42%	53.8%
Does your organisation take positive action on health and well-being?	Deterioration	15.9%	14.8%	27.8%
In the last 12 months have you experienced musculoskeletal	Deterioration	30.0%	34.3%	27.5%

problems (MSK) as a result of work activities?				
During the last 12 months have you felt unwell as a result of work related stress?	Deterioration	40.1%	45.4%	40%
In the last three months have you ever come to work despite not feeling well enough to perform your duties?	Deterioration	53.6%	61%	56.9%

Staff Engagement

Question	Improvement/ deterioration	2018	2019	National Average 2019
Motivation				
I look forward to going to work	Deterioration	50.8%	48.9%	58.6%
I am enthusiastic about my job	Deterioration	67.8%	67.4%	74.8%
Time passes quickly when I am working	Deterioration	75.6%	74.2%	78.1%
Improvements/ suggestions				
There are frequent opportunities for me to show initiative in my role	Improvement	68.5%	69.8%	73.5%

I am able to make suggestions to improve the work of my team / department	Deterioration	73.8%	71.1%	75.1%
I am able to make improvements happen in my area of work	Deterioration	50.2%	49.1%	56.5%
Recommendation of the organisation as a place to work/ receive treatment				
Care of patients / service users is my organisation's top priority	Deterioration	59.9%	58.8%	78%
I would recommend my organisation as a place to work	Deterioration	47.2%	44.2%	60%
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	Deterioration	70.2%	64.2%	71%

Immediate Managers

Question	Improvement/ deterioration	2018	2019	National Average 2019
The support I get from my immediate manager	Improvement	63.3%	65%	70.6%
My immediate manager gives me clear feedback on my work	Improvement	55.4%	56.7%	62.4%

My immediate manager asks for my opinion before making decisions that affect my work	Deterioration	50.8%	49.6%	56.3%
My immediate manager takes a positive interest in my health and well-being	Improvement	62.1%	63.2%	69.2%
My immediate manager values my work	Improvement	67.7%	68.2%	73.2%
My manager supported me to receive this training, learning or development	Deterioration	51.6%	45.7%	55.8%

Quality of care

Question	Improvement/ deterioration	2018	2019	National Average 2019
I am satisfied with the quality of care I give to patients / service users	Deterioration	79.0%	74.7%	81.6%
I feel that my role makes a difference to patients / service users	Deterioration	89.8%	87.2%	90.3%
I am able to deliver the care I aspire to	Deterioration	64.7%	60%	69%

Safety Culture

Question	Improvement/ deterioration	2018	2019	National Average 2019
My organisation treats staff who are involved in an error, near miss or incident fairly	Deterioration	50.0%	46.9%	60.5%
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again	Deterioration	62.9%	62.3%	71.3%
We are given feedback about changes made in response to reported errors, near misses and incidents	Deterioration	51.7%	50.4%	62%
I would feel secure raising concerns about unsafe clinical practice	Improvement	65.8%	67.5%	71.7%
I am confident that my organisation would address my concern	Improvement	49.9%	50.4%	60.4%
My organisation acts on concerns raised by patients / service users	Deterioration	59.6%	58.9%	73.9%

Morale

Question	Improvement/ deterioration	2018	2019	National Average 2019
I am involved in deciding on changes introduced that affect my work area / team / department	Improvement	44.3%	47%	52.8%
I receive the respect I deserve from my colleagues at work	Deterioration	74.1%	65.8%	72.4%
I have unrealistic time pressures	Deterioration	21.6%	19.5%	22.6%
I have a choice in deciding how to do my work	Improvement	49.6%	52%	56.3%
Relationships at work are strained	Improvement	41.5%	38.7%	46.8%
My immediate manager encourages me at work	Improvement	61.4%	64.4%	70.6%
I often think about leaving this organisation	Deterioration	37.3%	38.4%	27.7%
I will probably look for a job at a new organisation in the next 12 months	Deterioration	21.3%	23.5%	19.7%
As soon as I can find another job, I will leave this organisation	Deterioration	18.5%	18%	14%

Health and Wellbeing

We have taken an integrated approach to promote health and wellbeing, working with a range of partners to assist staff make healthier choices and to address the bio psychosocial factors that affect health.

There are a number of factors that affect staff wellbeing and this can be partly attributed to the fact that work can often be physically, emotionally and psychologically demanding. In addition, for many of our staff, our services operate for 24 hours a day, 365 days of the year. Financial wellbeing also plays a key part in maintaining good mental health.

Taking into account all of the above factors, we have developed a Health and Wellbeing Strategy which is underpinned by 5 themes, these include:

- Developing positive environments
- Ensuring our policies and practices support health and wellbeing
- Supporting a healthy body for all
- Encouraging a healthy mind and reducing stigma associated with mental health
- Promoting and supporting financial wellbeing

Poor mental health accounts for 23% of all ill health in England and affects more than 1 in 4 of the population at any one time. As a Trust we recognise that good mental health is linked to good physical health and education and this has been a key focus during the reporting year.

As part of our Health and Wellbeing Strategy, staff continue to have access to excellent Occupational Health and Wellbeing services, with specific focus on physical and mental health.

As a Trust our aims for 2020/2021 include:

- To achieve a 100% flu vaccination rate for our staff
- To officially launch the new Health and Wellbeing Strategy that links with our sickness absence policy and provides tangible supportive outcomes
- To support out staff and to ensure all staff challenge negative attitudes that impact the lives of those experiencing mental health challenges
- To provide bespoke mental wellbeing sessions, including individual group work
- To promote and provide EMDR therapy for those staff who have experienced trauma
- To provide access to services to improve the musculoskeletal wellbeing of our staff

Some of the key outcomes and improvements made during 2019/2020 are detailed below:

- Increase in availability of Functional Rehabilitation Sessions to enable staff to perform the manual handling tasks required by their role under the supervision and guidance of a manual handling advisor
- Increase in Postural Fitness Classes to support staff who are suffering with musculoskeletal symptoms predominately to their neck and/or shoulder(s) that are affecting or affected by their habitual postures at work
- Spinal Rehabilitation Programme for staff with acute or chronic low back pain
- Provision of monthly campaigns to promote physical and mental wellbeing. Some examples include Dry January, Cycle to Work Day, Sun Awareness, Stress Awareness, Time to Change and Change for Life
- Resilience, stress management and relaxation workshop
- Working in collaboration with partner agencies to provide support to individuals who are experiencing difficulties at work due to depression, anxiety, stress and/or other mental health conditions.
- Provision of menopause education sessions
- Our Flu Campaign has been the most successful on record and 82.5% of all staff were vaccinated.

Equality, Diversity and Inclusion

The Trust's strategic organisational goals are supported by the Equality Diversity and Inclusion (EDI) Steering Group, chaired by the Director of Human Resources and reporting to the Workforce Strategy Group and the Trust Board. The Trust continues to follow to the duties of the Equality Act 2010, which legally protects people from discrimination in the workplace and in wider society, and the Public Sector Equality Duty which supports the following:

- Better health outcomes
- Improved patient access and experience
- A represented and supported workforce
- Inclusive leadership

The Trust Equality, Diversity and Inclusion Group continues with membership representatives from across departments, staff side and members of advocacy, to ensure equality, diversity and inclusion is embedded into the organisation's strategic objectives. The Trust EDI objectives are:

- Becoming a leading organisation for promotion of opportunity and diversity, for challenging discrimination, and for promoting equalities of opportunities in employment and the services we provide.
- Creating an organisation which recognises the contribution of all staff, and which is supportive, fair and free from discrimination.
- Ensuring our staff have a positive experience at work, are offered opportunities to meet their full potential, and demonstrate the Trust's values
- Ensuring that our Trust is regarded as a model employer.

Table 18: Staff Equality and Diversity Information

Headcount - Gender	2019/20	2018/19
Female	7295	7052
Male	1608	1603
Grand Total	8903	8655

FTE - Gender	2019/20	2018/19
Female	6194.55	5962.41
Male	1478.47	1440.78
Grand Total	7673.02	7403.19

Headcount - Religious Belief	2019/20	2018/19
Atheism	979	811
Buddhism	23	21
Christianity	3848	3702
Do not wish to disclose	3084	3260
Hinduism	85	74
Islam	198	167
Judaism	3	2
Other	633	583
Sikhism	11	11
Undefined	39	24
Grand Total	8903	8655

FTE - Religious Belief	2019/20	2018/19
Atheism	883.10	732.5753
Buddhism	20.54	18.74
Christianity	3335.88	3207.48
Do not wish to Disclose	2572.00	2688.05
Hinduism	78.24	64.37
Islam	182.93	148.41
Judaism	2.96	2
Other	559.32	514.85
Sikhism	10.00	10.36
Undefined	28.07	16.33
Grand Total	7673.02	7403.19

Headcount - Sexual Orientation	2019/20	2018/19
Bisexual	19	23
Do not wish to disclose	2879	3099
Gay or Lesbian	86	69
Heterosexual	5875	5437
Other sexual orientation	6	4
Undefined	38	23
Grand Total	8903	8655

FTE - Sexual Orientation	2019/20	2018/19
Bisexual	17.92	19.97
Do not wish to disclose	2383.18	2549
Gay or Lesbian	82.84	66.01
Heterosexual	5158.18	4750.13
Other sexual orientation	4.60	3.6
Undefined	26.30	14.53
Grand Total	7673.02	7403.19

Headcount - Disabled	2019/20	2018/19
No	5534	5086
Not Declared	3084	3327
Undefined	54	16

FTE – Disabled	2019/20	2018/19
No	4818.73	4395.26
Not Declared	2603.17	2793
Undefined	43.77	10.9

Yes	226	220
Prefer Not to Answer	5	6
Grand Total	8903	8655

Yes	202.35	198.03
Prefer Not to Answer	5	6
Grand Total	7673.02	7403.19

The Trust EDI Steering Group meets also includes the Patient Experience Lead and integrates work from other local strategies (i.e. health and wellbeing, education, learning and development) to ensure our patients and carers have a positive experience . The work of the group has included the development of EDI network groups, providing a forum for individuals to come together, to share ideas, raise awareness of challenges and provide support to each other. The network groups identified so far are:

- Lesbian, Gay, Bisexual and Transgender Networks (LGBT+)
- Black Asian Minority Ethnic Network (BAME)
- Disability and Long Term Health Network (including Mental Health Network)
- Faith Network

The 'Rainbow Badge Initiative' was launched in the Trust in Autumn 2019 and gives healthcare staff a way to show that their place of work offers open, non-judgemental and inclusive care for all who identify as (lesbian, gay, bisexual, transgender+, (LGBT+). The + simply means inclusive of all identities, regardless of how people define themselves.

The Trust held Rainbow Badge events at James Cook University Hospital and Friarage Hospital, Northallerton in Autumn 2019, which were attended by over 600 staff who signed pledges in support of the initiative.

The Trust's commitment to EDI and EDI related training has continued, as an important opportunity to develop learning and continue the Trust's commitment to ensure all staff are free from discrimination, feel equally supported in career progression and opportunities and report the same levels of satisfaction with their role at the Trust. There is a focus on dignity at work training, as a mandatory requirement for all staff, which can be completed online. There is also opportunity for staff to attend other training such as unconscious bias training. The Trust continues to invest in leadership and staff development which advances equality, diversity and inclusion via our leadership development programmes and workforce development solutions, with regular updates provides to the Workforce Committee.

All Trust HR Policies are developed in partnership with trade union colleagues and brought to Joint Partnership Committee for signing by Director of HR or deputy and Staff Side Chair. Each Policy is

supported by an Equality Impact Assessment. Policies are applied consistently to ensure fair and open recruitment of people with protected characterises, as well as ensuring that staff with disabilities can access appropriate training and development, promotional opportunities, and flexible working arrangements.

The Trust Continues to work in partnership with regional colleagues, regarding the regional Great Place to Work strategic project and work with public sector and educational colleagues.

The trust has produced an annual equality, diversity and inclusion report which is available in addition to this quality account.

Sickness Absence

The Trust is committed to promoting and maintaining the health, safety and welfare of all staff and believe in encouraging its workforce to have good wellbeing, to live healthily and to achieve a good work life balance. Our Absence Management Policy and processes are designed to provide a framework to assist in the health and wellbeing of our employees and to promote a healthy workforce and provide efficient patient, safe and effective patient care.

We continue to focus on sickness absence and have made significant improvement to improve the support we provide to managers, ensuring that ensuring that both long and short term sickness is managed in accordance with the sickness absence policy.

We continue to work in close partnership with the Occupational Health Department and have developed case management forums to ensure that both staff and management are supported throughout the absence period, with a view to retaining, returning and rehabilitating staff into the workplace.

In additional to general occupational health advice and provision, we are working in partnership with a number of professional bodies offering support and counselling services and actively encourage staff to seek the help and support they need to aid their recovery.

In 2019/20 the average sickness absence rate for STHFT was 4.58% which is a slight decrease of 0.11% on the previous year. We have had a particularly challenging winter period which saw sickness absence rates increase to a high of 5.57 in January 2020.

Quality and Equality Impact Assessment

The need for a formal Quality and Equality Impact Assessment (QEIA) process as part of robust governance arrangements is well recognised. This process has been developed to ensure the trust has the appropriate steps in place to safeguard quality whilst delivering significant changes to service delivery and also understand the impact of the change either negatively or positively on any groups of the community which may be affected. The process is based on the guidance issued by the National Quality Board and the Equality Act 2010.

The Trust has a Quality and Equality Impact Assessment (QEIA) Policy that advises when changes to services are being planned, the impact on quality and equality must also be considered.

The QEIA process should be used to assess the impact that any new policy, service change or cost improvement programme may have on the quality of care provided to patients at South Tees Hospitals NHS Foundation Trust and provides a robust and consistent framework to both inform decision making and agree assurance metrics.

The impact on equality and diversity also needs to be assessed - whether people could be treated differently in terms of race, religion, disability, gender, sexual orientation, pregnancy, gender reassignment, civil partnerships or age. This supports the Trust in meeting its obligations under the Equality Act 2010 to undertake equality impact assessments.

QEIA's are monitored and reviewed on a monthly basis via centres, as part of reviewing the actual impact throughout the implementation stage and during the final review after the business plan has been implemented. Thereafter, review will be business as usual or at any change of circumstance

The Trust uses a standard Quality & Equality Impact Assessment tool and risks are assessed using a standard risk assessment matrix.

All QEIA's are presented at centre Governance Boards, prior to them being submitted and presented to the QEIA panel by the lead manager and/or clinician.

The completed QEIA is then presented by the service lead to the Trust QEIA Panel - Director of Nursing & Quality, Medical Director and Head of Patient Safety & Quality for final approval to progress. No change should be commenced without approval of the panel.

Regular reports are presented to the Quality Assurance Committee outlining QEIA's that have been discussed and approved.

During Covid-19 panels were held twice weekly to review service changes and then latterly services restarting, however these will be reported in more detail in next year's Quality Accounts.

Junior Doctors

STFT has a total of 514 doctors in training. Implementation of the 2016 Doctors in Training Contract has continued throughout 2019/20, with the majority of doctors in training transitioning onto the new contract by the end of the reporting year. It is expected that all doctors in training will be on the 2016 Doctors in Training Contract by early 2020.

The Junior Doctor Forum has continued to meet quarterly. Attendance has increased considerably following the August 2019 intake of junior doctors, with a number of members becoming accredited BMA representatives, taking up vacant seats on the Joint Local Negotiating Committee (JLNC).

As part of the new contract, doctors in training are able to submit exception reports in real time where they have worked additional hours to their rota or missed educational sessions due to staffing levels. Exception reporting continues to be at a low level in comparison with other Trusts. There have been 90 exception reports raised and the Guardian of Safeworking and Director of Medical Education continue to encourage junior doctors to exception report and to brief consultants.

The vacancy rate for junior doctors is 5.4%, 3% lower than 2018/19 financial year. Vacancies have been actively recruited to throughout the year but are also filled using alternative resourcing methods including internal locum, use of the master vendor agency HCL or by redesign of rotas where possible. Some specialities have appointed advanced nurse practitioners to work on rotas alongside doctors in training.

STHFT is part of the regional junior doctor bank run by Liaison on behalf of the Lead Employer Trust. We continue to have a high success rate in covering short term absences of 95%, plus out of hour's shifts for longer term vacancies utilising our own internal bank. The regional has provided STFT with access to an additional pool of LET employed doctors who work in other Trusts and GP surgeries.

Developing a Sustainable Workforce

- **Workforce Planning**
  Improving our approach to workforce planning with a focus on developing succession plans for the medical and nursing workforce to provide a better understanding of the skill gap in the current workforce and how to bridge that gap;
- Improving our approach to risk and governance by establishment a Senior Workforce Committee to focus on nursing workforce and related staffing, skill and capacity issues;

Tackling Bullying

As a Trust our aims for 2019/2020 have been continued into 2020/2021 and include:

- Working with NHS Improvement as pilot organisation for tackling bullying
- Review the Trust Values and involving everyone in translating our values into the tangible behaviours we want to see from each other, and to inspire us to keep improving our patient and staff experience.
  - Values and Behaviours workshop February 2020
  - Cultural engagement – what makes a good workplace culture May 2020
  - Dedicated focus group newly formed to address Trust wide issues
- Develop a South Tees values and behaviours competency framework and re-design our performance management framework to include behaviours as an integral part of performance appraisal – not just the ‘What’ but also the ‘How’
- Ensure behaviours are demonstrated from a Board level and staff are supported to hold people to account who do not exhibit appropriate actions.
- A Trust review of the structure, training and use of workplace investigators.
- We will roll out a programme of workshops aimed at preventing harassment and bullying within departments across the Trust.
- Increase in the number of bullying and harassment cases raised by staff
- Robust induction packages for all (including values and behaviours training)
- Data monitoring and analysis to be highlighted to the Workforce Committee with an action plan in place.

Employee Engagement

- Development of a Staff Engagement Strategy that encourages a strong sense of ownership, belonging and pride across the staff within the organisation. Initiatives include:
  - Development of a Trust identity
  - Review of our values, defining the supporting behaviours required to deliver our vision whilst holding each other to account
  - Development of our employee experience to enable us to recruit and retain the best
  - Develop and embed a culture of engaging leadership, strong management and effective communication
  - Recognising the need to formally acknowledge colleagues for the teamwork they provide, we introduced a Star Award which is designed to reinforce positive behaviour and develop positive culture changes across the organisation. During 2019/2020 we received 346 STARS

    reports under the themes of Teamwork, Going the Extra Mile, Attention to Detail, Communication and Dealing with Difficult Situations. We have received positive feedback from staff who have received the reports who feel genuinely honoured by their colleagues taking time to acknowledge them and the positive contribution they make to the patient experience.
  - In additional to the annual staff survey which was launched in October 2019, a Summer Staff Survey was implemented to provide staff with an opportunity to feedback on their experiences and to enable the Trust to check progress against key areas identified in previous surveys. The findings of both surveys were used to support the launch of the Staff Engagement initiative across the Trust. A total of 2,666 questionnaires were completed with a final completion rate of 32%. The findings from the Staff Survey were used to develop an action plan, in partnership with Trade Union colleagues, which was presented at Trust Board in early 2020. In addition, medical and dental staff survey results were disaggregated and used to develop specific focus on improving engagement with this cohort of staff. The results were shared with all Trust consultants and have been used to help inform the creation of the Clinical Policy Group, to improve clinical engagement, leadership and decision making, and the Trust Improvement Plan. As a result, Medical and Clinical Directors will be accountable for agreeing how the actions will be developed, implemented and measured.

Social Economic Responsibility

- We continue to support the local community and widen the accessibility of learning and development through the apprenticeship levy offering new starters and staff a vocational route to enter and progress within the organisation.
- We are actively recruiting to apprenticeship roles. Included are the Advanced Clinical Practitioners, Nursing Associates as well as Health Care Support and Business Administration.
- We offer graduates, through the Graduate Management Scheme, the opportunities to develop knowledge and skills operationally and strategically within their chosen field.

Recruitment

- Recruitment and retention of talented staff remains a challenge in key areas such as Anaesthetists, Critical Care Consultants, Acute Medical Physicians, Radiologists, Neuroradiology Interventionists and Nursing. We continue to hold nurse recruitment days and these have been successful with 380 new nurse appointments during 2019/20.
- In an attempt to maximise our employee offer, we have reviewed and developed our staff exit date, developed our on-boarding procedures and ensured flexible working policies are implemented consistently and fairly across all professions.
- During the reporting year we have held a number of targeted recruitment campaigns which included:
    - Headhunting approach
    - Developed our relationship with key master vendor clients
    - Continued our international recruitment campaign for nurses and we have welcomed 20 nurses from overseas
    - Targeted registered student nurses and return to practice nurses via specific open days and strong relations with local universities.

Day Nursery

Playdays Nursery is an excellent onsite facility, offering quality and flexible childcare for our staff's children whilst they are at work. It was awarded a 'good' rating following our recent Ofsted inspection. Nursery fees are competitive in comparison to other local nurseries, offering the staff assurance that their children are being cared for to a high standard.

Relationships with Trade Unions

We continue to develop our partnership with Trades Unions colleagues, with a Partnership Agreement which supports the following aims:

1. Promotes close co-operation between staff and managers within the Trust by providing a forum in which all matters affecting staff can be discussed and relevant information passed on. This includes NHS policies and strategies, Trust operational and financial performance, key Trust service strategies, objectives and projects e.g. corporate level/ large scale change management projects.

2. Provides opportunities for joint problem-solving in relation to issues affecting the well-being of employees and the efficient operation of the organisation. It is recognised good practice that management and staff side will consult on any significant decision that is likely to affect staff members.

3. Supports consultation in relation to key changes in our HR policies.

The Joint Partnership Committee (JPC) attended by both management and Staff Side colleagues meets on a monthly basis; agenda items including the areas summarised above. The NHS and Trust continues to be a changing and challenging environment with both management and Staff Side recognising that their interest are mutually compatible with the aim of preserve jobs and the quality of services.

Employment Policies

The Joint Partnership Committee ensures that HR policies and procedures are fit for purpose, reflective of any changes to employment law and support equality and diversity within the workplace. The JPC also provides Staff Side with an opportunity to be updated regarding other policies that are led by other corporate areas e.g. Freedom to Speak Up; Raising Concerns at Work policy. In 2019/2020, the Joint Partnership Committee (JPC) approved 11 policies which were then ratified by Operational Management Board (OMB) or more recently Clinical Policy Group (CPG). These policies included:

- Annual Leave and Bank Holiday Policy
- Education and Learning Policy
- Relocation Policy
- Nursing and Midwifery Revalidation Policy

- Facilities Agreement For Accredited Representatives Of All Recognised Trade Unions And Professional Organisations
- Notice Period Policy for Staff Employed under Agenda for Change Conditions of Service
- Probationary Periods Policy
- Volunteering and Work Experience Policy
- Trust Code of Conduct
- Honorary contract
- Reservist Policy

Performance against key national priorities

	13/14	14/15	15/16	16/17	17/18	18/19	19/20	19/20 Target
Safety								
Clostridium (c.) difficile – meeting the C.difficile objective	57	76	61	43	48	41	89	81
All cancers: 62 day wait for first treatment from :								
Urgent GP referral for suspected cancer	84.70%	85.30%	79.10%	81.10%	85.44%	82.65%	77.23%	85%
NHS Cancer Screening Service Referral	94.80%	92.60%	89.80%	89.00%	94.55%	87.14%	94.41%	90%
18 weeks referral to treatment time (RTT)								
Incomplete pathways	95.20%	95.70%	93.20%	92.20%	91.45%	89.49%	83.33%	92%
Accident & Emergency								
4 hour maximum wait in A&E from arrival to admission, transfer or discharge	96.70%	94.90%	95.80%	95.33%	95.68%	95.24%	88.35%	95%
Diagnostic Waits								
Patients waiting 6 weeks or less for a diagnostic test	99.60%	98.70%	98.82%	99.15%	97.46%	98.26%	94.04%	99%

Table 19: Performance against National Priorities

Table 19 shows the Trusts performance against key national priorities.

- C difficile – the Trust recorded 89 cases of C difficile during 2019/20 which was slightly over the target of 81 and this remains a focus for 2020/21..
- Urgent GP Referral for Suspected Cancer (62 day cancer wait target for first definitive treatment) – our year end performance was 77.23% against a target of 85%. Recovery plans are in place to support improvement in the patient pathway and performance.
- 4 hour Accident and Emergency waiting time target - our year-end performance was 88.35% against a target of 95%. Factors affecting the performance include an increase in acuity of

patients and very high intensity users attending A&E. 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 83.44% which is below the national target of 92%. Recovery plans and trajectories are in place to address areas of concern.
- Diagnostic Waits – (waiting 6 weeks or less) – our year-end performance was 94.04% with a target of 99%. Recovery plans and trajectories are in place to address areas of concern.

Annex 1: Statements from Clinical Commissioning Groups and Healthwatch and Scrutiny of Health Committee

To be added as received

HealthWatch North Yorkshire

Response received 08/09/2020.

Hello Linda

I'm responding in respect to the email that you sent to my Chairman - Chris Brackley last month. I joined Healthwatch North Yorkshire last week as their new CEO so this has been passed over to me. As I'm only on day six into the role, I'm afraid I'm not really in a position to give you any helpful comments or feedback unfortunately, and neither does Chris feel he's in a position to. Sorry.

It might, however, be useful for you and I to speak/meet at some point, and include anyone else you feel should join the conversation.

Thank you and I look forward to hearing from you.

Ashley Green
Chief Executive Officer
Healthwatch North Yorkshire

Annex 2: Statement of directors' responsibilities in respect of the quality report

Annex 2: Statement of directors' responsibilities in respect of 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 2017/18 and supporting guidance;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
- Board minutes and papers for the period April 2019 to May 2020
- Papers relating to Quality reported to the Board over the period April 2019 to May 2020.
- Feedback from NHS Tees Valley CCG requested 26/08/2020
- Feedback from North Yorkshire CCG requested 26/08/2020
- Feedback from Healthwatch South Tees requested 26/08/2020
- Feedback from Healthwatch North Yorkshire requested 26/08/2020
- Feedback from the Health Scrutiny Panel, Middlesbrough Council requested 26/08/2020.
- Feedback from North Yorkshire Scrutiny Health Committee requested 26/08/2020
- Feedback from Redcar and Cleveland Council requested 26/08/2020.
- Feedback from the Governors dated 02/09/2020
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated, 28/07/2020
- The 2019 national staff survey 18/02/2020
- The 2019 national inpatient survey dated 01/07/2020
- The Head of Internal Audit's annual opinion over the Trust's control environment – not required for 2019/20.
- CQC inspection report dated July 2019
- 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;
- 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; and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual (which incorporates the Quality Accounts regulations) (published at

www.monitor-hsft.gov.uk/annualreportingmanual) 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: How to provide feedback on the accounts

We welcome feedback on this report and suggestions for the content of future reports.

If you wish to comment please go to the Quality Accounts page on the Trust website (www.southtees.nhs.uk).

Annex 4: 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.

Aseptic Non Touch Technique (ANTT)

The Aseptic Non Touch Technique (ANTT®) is the standard intravenous technique used for the accessing of all venous access devices regardless of whether they are peripherally or centrally inserted.

Assurance

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

Better Care Fund (BCF)

The national fund was set up to support moving resources into social care and community services and to support the avoidance of admissions to hospital.

Board of Directors (of Trust)

The role of the Trust's 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

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.

Clinical Commissioning Group (CCG)

These are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. They are clinically led groups that include all of the Practitioner groups in their geographical area with the aim of giving GPs and other clinicians the power to influence commissioning decisions for their patients. These organisations are overseen by NHS England and manage primary care commissioning, including holding the NHS Contracts for GP practices.

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.

Criteria Led Discharge (CLD)

The lead clinician for a patient's care identifies the clinical criteria for their discharge. These criteria are discussed with the patient and the multi-disciplinary team and are recorded. A competent member of the multi-disciplinary team then discharges the patient when the clinical criteria for discharge have been met.

Datix

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

Daycase

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

Department of Health

The Department of Health is a department of the UK government but with responsibility for government policy for England alone on health, social care and the NHS.

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.

Echocardiogram (ECG)

An echocardiogram is a test that uses ultrasound to evaluate your heart muscle and heart valves.

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 System

Allows prescriptions to be transmitted and populated electronically, replacing paper and faxed prescriptions.

Emergency

An urgent unplanned episode of care.

Escherichia coli (E. Coli)

E. Coli is a Gram-negative, facultative anaerobe, rod-shaped, coliform bacterium of the genus Escherichia that is commonly found in the lower intestine of warm-blooded organisms.

Falls:

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.

Finished Consultant Episode

An NHS term for a consultant episode which has ended due to discharge, transfer or death. A consultant episode is the time a patient spends in the continuous care of one consultant using hospital site or care home bed(s) of one health care provider or, in the case of shared care, in the care of two or more consultants.

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 Trust's 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.

Gastroenterology

The branch of medicine that deals with disorders of the stomach and intestines.

Governance

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

GNBSI (Gram negative blood stream Infections)

A group of blood stream infections that include Escherichia coli *(E.Coli*), Klebsiella spp. and Pseudomonas aeruginosa.

HCAI

Health care associated infections. These are infections that are acquired as a result 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.

Healthcare Quality Improvement Partnership

The Healthcare Quality Improvement Partnership was established in April 2008 to promote quality in healthcare, and in particular to increase the impact that clinical audit has on healthcare quality in England and Wales. It is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and national voices.

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.

Hospital Episode Statistics (HES)

Hospital Episode Statistics is the national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere.

Hospital Standardised Mortality Ratio (HSMR) - this is a standardised tool for measuring mortality and is calculated using the ratio of observed (O) to expected (E) deaths. The observed number of deaths for a hospital is the sum of the actual number of deaths in that hospital.

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.

IAPT (Improving Access to Psychological Therapies)

Services that provide evidence based treatments for people with mental health issues, for example anxiety and depression.

Inpatient

Patient requiring an overnight stay in hospital.

Interventional Endoscopy

Is a minimally invasive procedure that involves the use of a thin, flexible tube (or scope) that is equipped with a camera and light at its tip

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.

MAR (Medicine Administration Record)

A report that serves as a legal record of the medicines administered to a patient by a health care professional.

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.

Meridian

IT programme that facilitates data collection surveys and audits.

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 is able to 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 Improvement (NHSI)

NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. It supports providers to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable

NEQOS (North East Quality Observatory Service)

Provides quality measurement for NHS organisations in the north east (and beyond), using high quality expert intelligence in order to secure continually improving outcomes for patients.

NEWS2

This is the latest version of the National Early Warning Score (NEWS), first produced in 2012 and updated in December 2017, which advocates a system to standardise the assessment and response to acute illness.

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

Is a system of paying NHS healthcare providers a standard national price or tariff for each patient seen or treated.

Plan Do Study Act (PDSA)

This is model for improvement that provides a framework for developing, testing and implementing changes leading to improvement. It is based in scientific method. The use of PDSA cycles enables changes to be tested on a small scale, building on the learning from these test cycles in a structured way before wholesale implementation. This gives stakeholders the opportunity to see if the proposed change will succeed and is a powerful tool for learning from ideas that do and don't work. This way, the process of change is safer and less disruptive for patients and staff.

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 Trust's and their private or voluntary sector equivalents.

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)

Is a systematic process for identifying “root causes” of problems or events including serious incidents to prevent a recurrence.

Secondary Uses Service (SUS)

The Secondary Uses Service is designed to provide anonymous patient-based data for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.

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.

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.

Ultrasound

Ultrasound is a type of scan that uses sound waves to produce images of the inside of your body. It’s used to detect changes in the appearance, size or outline of organs, tissues and vessels, or to detect abnormal masses, such as tumours.

Urinary Catheter

A urinary catheter is a latex, polyurethane or silicone tube that is inserted in to the patient's bladder via the urethra to allow urine to drain freely from the bladder for collection.