South Tees Hospitals
NHS Foundation Trust

Quality Account 2021-2022

June 2022

PART ONE - Statement on Quality from the Chief Executive

I am pleased to introduce the 2021/22 Quality Report as Chief Executive of South Tees Hospitals NHS Foundation Trust.

Over the last year we have continued to empower our clinicians to make the decisions about how we allocate resources and deliver care.

This clinically led approach has been at the heart of our response to COVID. Since the start of the pandemic, our fantastic clinicians have provided care for more than 6,000 patients with COVID-19.

In December 2021, a year after becoming one of the world's first world's first COVID vaccination centres, our infectious diseases team became one of the first in our region to offer new antibody and antiviral treatments to eligible patients when they first test positive for coronavirus.

Despite the huge success of the national vaccination programme and development of improved treatment options, this year has continued to be marked by the huge impact of the pandemic on our colleagues and communities.

The onset of the Delta variant in the summer of 2021 was replaced by Omicron in winter the same year and quickly saw COVID-19 community infection rates surpassing the previous record peak seen in January 2021. The slower increase in the number of people requiring hospital care during the Omicron surge spoke to the importance of the vaccination programme.

Despite the success of the vaccination programme and development of new treatment options, however, Omicron played a significant role in the winter of 2021/22 being one of the most challenging we have ever experienced, and I want to say an enormous thank you to all our colleagues for again going above and beyond.

As we look ahead to next year and our ongoing recovery from COVID-19, the safety and wellbeing of our patients, service users and colleagues, underpinned by the quality of the care we provide, will be at the centre of our mission to put safety and quality first.

As just one example of the many examples of this mission in practice, colleagues and teams have continued to roll out our STAQC (South Tees Accreditation for Quality of Care) programme to celebrate excellence, safety and quality across our wards and services.

As we continue our recovery from COVID-19, we will carry on empowering our clinicians to take the decisions about how we manage our resources and deliver safe, quality care across our hospitals

and services for children, adults, families and our communities with the singular goal of putting safety and quality first.

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

Signed:

Sue Page CBE
Chief Executive

Date: 23/06/22

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

Priorities for improvement

Review of progress with the 2021/22 quality priorities.

In last year's Quality Account, we identified the following as our quality priorities for 2021/22.

Quality Priorities 2021/22		
Safety	**Clinical Effectiveness**	**Patient Experience**
Increase incident reporting by 10% per year. This will also mean an increase in incidents reported to the National Reporting and Learning System (NRLS)	To develop and implement a Quality & Safety Strategy for the Trust	Reduce the incidence of avoidable category 3 and 4 pressure ulcers in order to positively impact on patients who are most at risk
Reduce the occurrence of Incidents with Harm, including Never Events, by training 90% of relevant staff in Human Factors	Identify and reduce unwanted variation by participating in the Getting it Right First Time (GIRFT) programme and implementing recommendations	Establish a Trust-wide inclusive patient experience user group which represents the diverse range of patients who come into contact with our services
Develop and implement a robust plan for the organisation to move over to the new Patient Safety Incident Response Framework when it is published and launched in 2022	To continue delivering the Trusts end of life strategy and use local and national data sources to identify areas for improvement for mortality	Using Always Events methodology, improve the patients' experience in the area of letters and written communication to above 90% through a 'task and finish' groups
	Complete all relevant NICE quality standards assessments in order to: Understand the priority areas to focus on quality improvement • Identify potential areas for local audit • Identifying services that are of poor quality	
	Ensure patients have a safe, effective and timely discharge	

PATIENT SAFETY

DOMAIN – Patient Safety	
Quality Priority	
Increase Incident Reporting by 10 per cent per year. This will also mean an increase in incidents reported to NRLS.	
End of Year Position	**Fully Achieved**

Rationale

Following on from the patient safety culture improvement work undertaken with the Trust during 2020/21, it was agreed that the Trust should continue to develop its incident reporting culture.

By increasing the number of reported incidents staff will feel that their concerns are listened to and acted on. High reporting levels are indicative of a positive safety culture and provide assurance within the organisation.

Agreed Actions

How will we do this?

- Implement the Datix Cloud IQ system, including the Mobile Phone App 'Datix Anywhere' to enable staff to report an incident on a mobile device in real time
- Facilitate engagement with staff and ensure incidents are reported and reviewed as soon as possible
- From July 2020, a regular weekly upload to NRLS will commence
- Introduce Patient Safety Ambassadors within wards and departments; the role will eventually incorporate a Datix champion element who will also support the increased reporting of incidents

Measures of Success

- Increase in the numbers of incidents reported, including the reporting of 'near miss' incidents
- Increase the numbers of incidents reported by groups of staff who historically may not have been high reporters of incidents
- Improved outcomes from relevant sections of the 2021 Staff Survey
- Implementation of the Patient Safety Ambassador role

End of Year Progress

There has been a sustained increase in the number of incidents reported throughout the year, with the Trust achieving a 15% increase in incident reporting against the 10% target, year on year as demonstrated in the graph below.

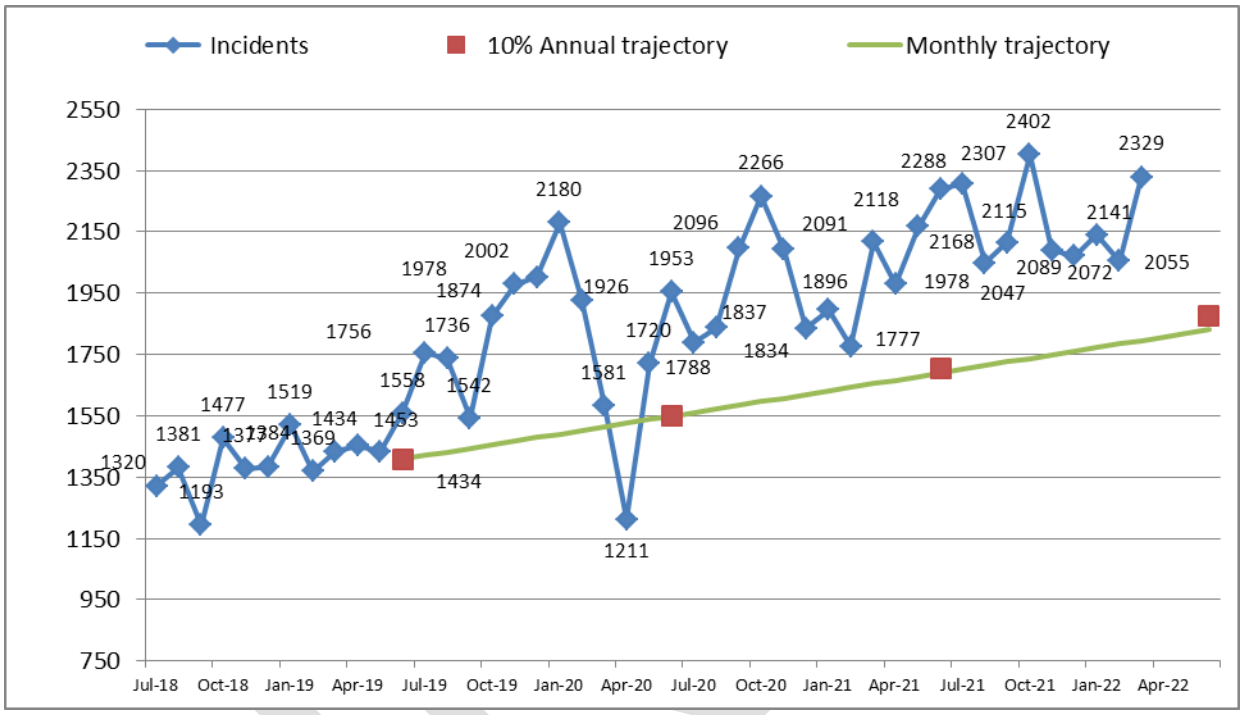


Figure 1: Incident Reporting Figures from July 2018

High levels of reporting of 'near miss' incidents (an unplanned event that did not result in injury, illness or damage, but had the potential to do so) is known to avoid more serious outcomes in the future; providing organisations with great opportunities to learn from when things go right. Near Miss Reporting within the Trust increased by 33% in 2021/22, from 976 during 2020/21 to 1302 in 2021/22.

The percentage of incidents reported by medical staff increased from 2.4% during 2020/21 to 3.9% during 2021/22, with nursing staff reporting 80.6% of incidents during 2021/22, compared to 77.1% during 2020/21. The increased reporting rate within these key staff groups demonstrates the cultural work undertaken within the Trust. This has begun to make an impact, and this will continue to be prioritised with the implementation of the Restorative Just Culture approach across the organisation.

The outcome of the 2021 Staff Survey also provided evidence of the improved reporting culture within the Trust, in that 76.9% of respondents stated they would feel secure in raising concerns

about unsafe clinical practice, compared to 72.2% in 2020. Similarly, there was also an increase in the percentage of staff feeling confident that the organisation would address their concerns. Both outcomes were well above the national average.

The Trust has 11 Patient Safety Ambassadors (PSAs) who are now in post. They are responsible for promoting key patient safety messages within their Clinical Collaborative and are senior medical and nursing staff with an interest in patient safety. Each PSA will contribute to patient safety governance within their Collaborative and will be the key link between the Patient Safety Faculty and their Collaborative, ensuring that national, regional and local learning is shared widely across the organisation.

Quality Priority	
Reduce the occurrence of incidents with harm, including Never Events, by training 90 per cent of relevant staff in Human Factors	
End of Year Position	**Fully Achieved**

Rationale

As we move towards implementing a Just Culture approach within the Trust, our Human Factors training programme is core to our development of skills within patient safety.

Patient safety training and education incorporates learning from incidents, improving team dynamics, human factors training and understanding the affect and effect of our behaviour on one another (civility/decency).

We will be offering formal training, training within teams (in situ) and simulation training to move towards a Just Culture as our norm.

We are also offering training via external agencies in patient safety investigation, human performance and empathy and will offer at least one full Trust patient safety day to ensure that the messaging is widespread and can be accessed by everyone in the Trust.

Agreed Actions

How will we do this?

We will provide training across the suite of programmes as set out below:

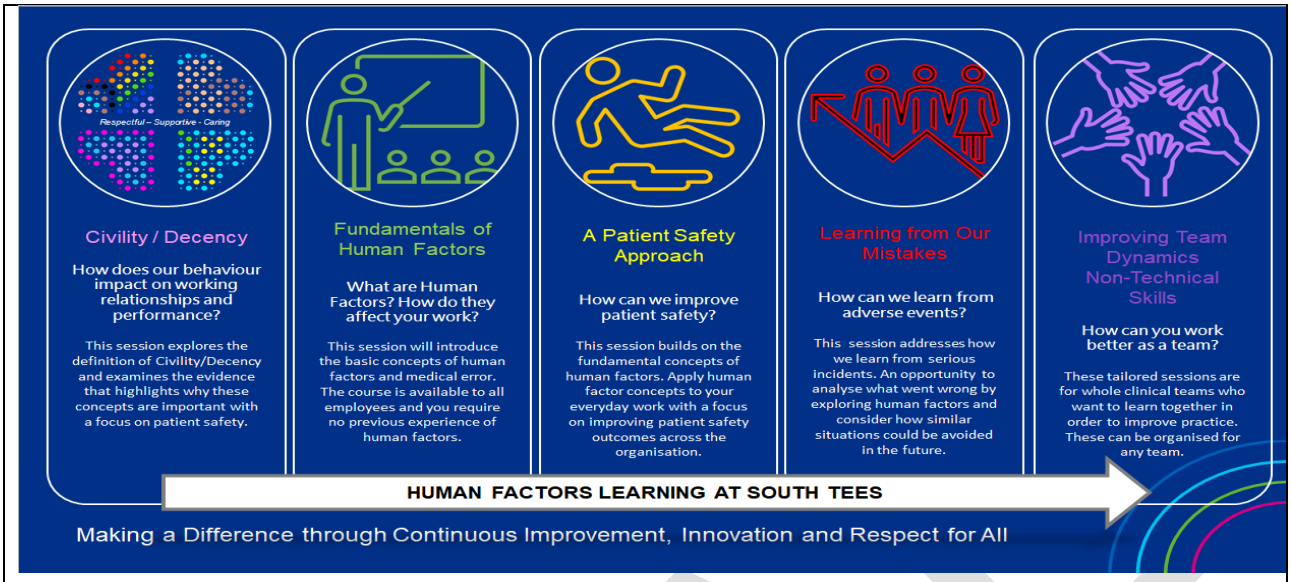


Figure 2: Human Factors Learning

Subject to COVID-19 restrictions, we will be offering 1,200 additional places across our internal and external courses

Measures of Success

- Courses are able to run
- Attendance at courses
- Feedback via evaluation
- Changes in patient safety and culture questions/responses in staff survey results

End of Year Progress

As of March 2022, Human Factors sessions are running weekly from the South Tees Research Innovation and Education (STRIVE) academic centre (both face to face and virtually).

We have found better attendance when sessions are created for specific teams and in a timely manner so that staff can be rostered in advance to attend. Below is a summary of the number of people who have attended the courses over the last year, up to the 31st March 2022.

Human Factors Training		Civility Training		Human Factors and Civility at Induction		
					Med	General
Quarter 1:	273	Quarter 1:	43	Quarter 1:	N/A	N/A
Quarter 2:	102	Quarter 2:	N/A	Quarter 2:	247	101
Quarter 3:	211	Quarter 3:	242	Quarter 3:	48	144
Quarter 4:	181	Quarter 4:	330	Quarter 4:	85	302
Total	767	Total	615	Total	380 (Med induction) 544 (Gen induction)	
Total contacts	**2306**					

Table 1: Human Factors Training Attendance

Feedback from Evaluation

Largely the feedback for session content has been well received. This information has been delivered at both senior and junior levels via the Human Factors faculty. Feedback from some of the participants is included below:

'Fantastic session. Great open conversations. Would love to be involved in improving systems etc. that are affected by human factors'

'Thank you very much a very good session delivered by a passionate educator'

'Really good informative session and would definitely recommend this to other colleagues. May benefit from more real-life videos of things going wrong to learn from this further'

'Very clear and focused. Case reports prove extremely useful to help jog our memories to avoid similar mistakes in our practice'

Changes in patient safety

The results from the 2021 NHS Staff Survey show continued improvements within the patient safety domains. There was also an increase in the number of colleagues who feel patient care is the organisation's top priority and who would recommend the Trust as a place to work.

As stated earlier, the overall incident reporting rate has seen a 15% increase during the past year. This is a positive sign of an organisational safety culture that encourages the sharing of incidents so that we can learn and explore why they occurred. The increase in incident reporting demonstrates that staff feel able to speak up without fear of repercussions. This internal openness and transparency fosters a culture of continuous learning and improvement.

The graph below demonstrates that overall numbers of Serious Incidents and Never Events are reducing within the organisation. Sharing these incidences using Human Factor principles and through patient safety training allows us to share key safety messages and learning with front line staff.

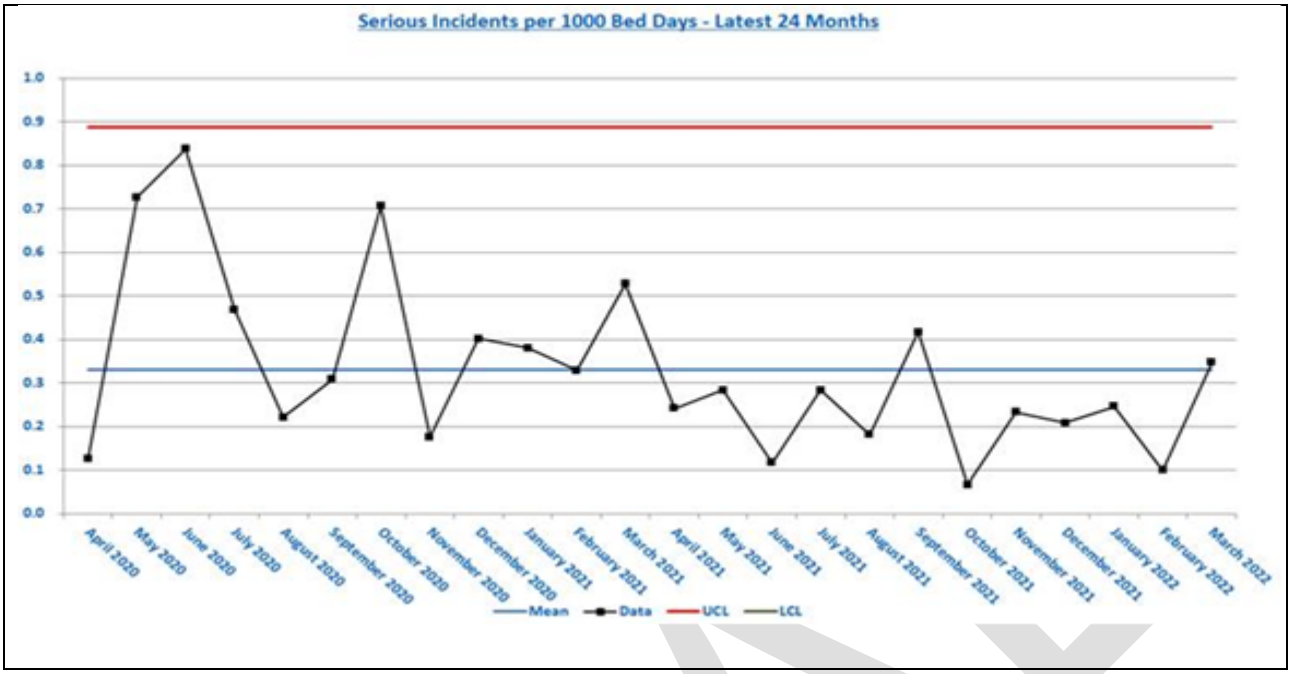


Figure 3: Serious Incidents per 1000 Bed Days Over the Last 24 Months

DOMAIN – Patient Safety	
Quality Priority	
Develop and implement a robust plan for the organisation to move over to the new Patient Safety Incident Response Framework when it is published and launched in 2022	
End of Year Position	**Partially Achieved**
Rationale	
In March 2020, NHS England and NHS Improvement published the introductory Patient Safety Incident Response Framework (PSIRF). The new framework was implemented through a phased approach with a number of nationally appointed 'early adopter' Trusts and Commissioners working to implement it during the course of this year.	

Although wider implementation across the NHS was planned in 2021, this was delayed, and non-early adopter organisations (including the Trust) must continue to use the existing Serious Incident Framework until told otherwise by NHSE/I.

A thematic analysis will be undertaken in order to determine the category of incidents the Trust chooses to investigate, and the level of investigation required. Under the new framework, each organisation must develop a Patient Safety Incident Response Plan (PSIRP), setting out how incidents have been identified and investigated.

The framework seeks to establish proportionate responses to incidents and recognises that some incidents will not require any further investigation

Agreed Actions

How will we do this?

- The Patient Safety Team will attend a nine-module learning programme "Patient Safety Incident Investigations" commissioned by NHS England and Improvement (North-East and Yorkshire) and share the learning and new knowledge during 2021/22.
- The Patient Safety Team has commenced a review of the patient safety incident reporting data over the last three years, from 1st April 2018 to 31st March 2021. During 2021/22 and via a Task and Finish group, themes need identifying and triangulating to review this data alongside patient safety concerns highlighted through complaints, mortality review processes, coroners' inquests, litigation claims, infection prevention and control-related audits, and other relevant clinical audits which have been completed.
- The group will make recommendations in order that they can determine the categories for investigation.
- A Task and Finish Group will be established with the output of this being the Patient Safety Incident Response Plan (PSIRP).
- The Trust will agree our PSIRP with our lead commissioners, NHS Tees Valley CCG, who will assure effective application of local PSIRPs and PSII standards.
- Develop a strategic plan to prepare the Trust for the implementation of the PSIRF
- Achievement of a cultural change will be key to the success of this with the need for organisations to establish behaviours of an 'effective and compassionate patient safety reporting, learning and improvement system underpinned by openness and transparency.

Measures of Success

Early measures of success will be that internal and external stakeholders are fully engaged in developing the Trust's PSIRP, and that the Trust meets the timescales set by NHSE&I in terms of the implementation steps.

End of Year Progress

In November 2021, NHSE/I issued guidance to NHS organisations in relation to preparing for the publication of PSIRF. Feedback from the early adopter Trusts highlighted a number of unintended consequences relating to PSIRF and therefore NHSE/I have asked Trusts not to progress with their thematic analysis of incident data, until amended guidance is provided. The previous implementation timescale of April 2022 will no longer apply, and it is now anticipated that a 'soft launch' of PSIRF will take place in June/July 2022, with Trusts working towards the transition from the Serious Incident Framework over the following 12 months.

Trusts have instead been asked to review their patient safety infrastructure in preparation for publication of PSIRF. NHSE/I has advised Trusts to review their arrangements to ensure:

- there are clear and robust arrangements for how patients and their families will be engaged with, involved and supported following the occurrence of patient safety incidents
- the 'Just Culture' approach is fully implemented
- the national Patient Safety Incident (PSI) Investigation standards (March 2020) are fully implemented

The role of the Patient & Family Liaison Officer (FLO) has been implemented following the training of 20 Trust staff during Quarter 4. A number of patients and families are now being supported by FLOs and a further cohort of staff will be trained in the next quarter.

The Trust has commissioned external 'Just & Restorative Culture' training for 50 key staff, which commences in early April 2022. Discussions and awareness raising has begun, in order to share the concepts and methodology of the just culture approach with wider staff groups, and the just culture approach has also been included within the Terms of Reference of the Adverse Events Review Group and MDT patient safety meetings, which will influence how these meetings are conducted.

The PSI Investigation standards are in the process of being implemented with the Trust's investigative approach. One of the standards specifies that patient safety investigations are to be led by staff at Band 8a and above, who have undertaken a specific number of hours of human factors and patient safety training. There will be resource implications in order for this

particular standard to be implemented successfully within the Trust. Implementation of the standards will be monitored by the Patient Safety Steering Group.

Patient Safety Specialists

The NHS Patient Safety Strategy (2021) introduced the role of the Patient Safety Specialist (PSS), and the Trust now has a number of colleagues in these roles from a variety of clinical and professional backgrounds. Patient Safety Specialists are the lead patient safety experts in the Trust, working full-time on patient safety.

DOMAIN – Clinical Effectiveness	
Quality Priority	
To develop and implement a Quality and Safety Strategy for the Trust	
End of Year Position	**Fully Achieved**

Rationale

Patient safety and quality are integral to the Trust and to ensuring that patient safety is at the forefront of patient care and that the care provided is of a high quality.

One of the priorities from 2020/21 was to develop a quality strategy which meant that both quality and safety are pivotal. Therefore, a combined Quality & Safety (Q&S) strategy was developed.

In March 2020, NHS England and NHS Improvement published the introductory Patient Safety Incident Response Framework (PSIRF). The new framework is being implemented through a phased approach with a few nationally appointed 'Early Adopter' Trusts and commissioners working to implement it during this year.

The PSIRF sets out changes to the approach which will be taken by the NHS as a response to patient safety incidents. The current system Serious Incident Framework (SIF) is a reactive process which can also be rigid and bureaucratic and may fail to reduce the recurrence of harm. The aim of the PSIRF is to refocus systems and processes and improve the quality of investigations, whilst bringing a sustained reduction in risk and changing behaviours to this more proactive approach. The PSIRF should support the NHS to further improve patient safety by outlining how providers should respond to patient safety incidents and how and when a patient safety investigation should be conducted. This approach will be incorporated into the Q&S Strategy.

Achieving cultural change will be key to the success of our strategy and the delivery of the PSIRF, with the need for organisations to establish behaviours of an effective and compassionate patient safety reporting, learning and improvement system underpinned by openness and transparency, Just Culture and continuous learning and improvement.

Agreed Actions

How will we do this?

- Staff pledges made will be collated, with the output from these being incorporated into the Quality & Safety Strategy to ensure that the staff voice is heard and captured
- Review Floor to Board Governance
- Strengthen organisational learning
- Training and education available to all staff
- Strengthen process and policy
- Positive culture change within the organisation
- Develop the Quality & Safety Strategy and publish it by the end of October 2021

Measures of Success

- Staff pledges are collated and shared
- The Quality and Safety Strategy is published
- Staff can talk about the strategy, its implementation and the evidence to support it

End of Year Progress

The Trust's Quality and Safety Strategy was approved by the Quality Assurance Committee during Q3, incorporating the pledges made by our staff. It has been shared and talked about across the organisation whilst being drafted and is included in the Trust's improvement plan as a key enabler.

A review of the governance structure for the Quality Assurance Committee and its reporting and connecting groups has been completed and implemented. This has included the development and implementation of a Collaborative Assurance Framework (CAF) which has been shared across the operational structure within the Trust.

Opportunities to strengthen organisational learning and education have been enhanced by internal support from STRIVE, external training programmes around Civility and a Just Culture and the introduction of new roles, including Safety Ambassadors and Family Liaison Officers.

DOMAIN – Clinical Effectiveness	
Quality Priority	
Identify and reduce unwanted variation by participating in the Getting it Right First Time (GIRFT) programme and implementing recommendations	
End of Year Position	**Fully Achieved**

Rationale

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 daily. The GIRFT team visit every Trust observing the specialties they are reviewing, investigating the data with their peers and discussing the individual challenges they face.

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 can fully embrace GIRFT as a key enabler towards delivering a cycle of continuous improvement for its patients.

The Trust already has a well-established internal annual Quality Surveillance Programme (QSP) comprising of seventy-four 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.

Agreed Actions

How will we do this?

- Ensure the Trust participates in all relevant GIRFT deep dives

- Ensure that action plans are clinically led and are implemented following recommendations from deep dives to demonstrate service improvement
- Ensure good practice is shared across the Trust and GIRFT data is triangulated
- Maintain regular communication with the regional GIRFT implementation managers
- Ensure relevant groups/committees are briefed regularly on the outcome of GIRFT visits and any subsequent action plans

Measures of Success

- Reports and triangulation from GIRFT visits
- Evidence of implementation of agreed action plans and service improvement
- Communication regarding good practice
- Liaison with the regional GIRFT manager
- Production of regular progress reports to committees

End of Year Progress

South Tees Hospitals NHS Foundation Trust (STHFT) has established a central support function to facilitate and co-ordinate the GIRFT programme on behalf of the organisation. This is overseen by the Corporate Quality Surveillance team, with support from the operational administration staff and clinical colleagues within the collaboratives.

Since 2016 there have been 32 initial deep dive GIRFT visits to the trust with a further 6 re-visits. During 2021/2022, 7 virtual deep dive visits were undertaken in the following services:

- Emergency Medicine 11 May 2021
- Paediatric Critical Care (Operational Delivery Network) 10 June 2021
- Oral & Maxillo-Facial Surgery 5 August 2021
- Geriatric Medicine 12 October 2021
- Rheumatology 29 October 2021
- Neonatology 17 February 2022

The Trust's Urology services were also re-visited locally in October 2021 and participated in the network review on the same day.

Observation notes have been received identifying recommendations for improvement as well as notable good practice for each of the specialties. The potential improvement opportunities (main cross-cutting themes) include coding, specifically relating to more accurate coding of specialty

and treatment function codes. A coding review is currently underway at the Trust and specialties are meeting with colleagues in the coding team on a regular basis to ensure accurate recording of specific clinical information. Specialties are also working to ensure implementation of GIRFT's 5-point plan for reducing litigation costs as this has also been a cross-cutting theme for potential improvement. Each specialty has its own further areas for improvement noted within action plans.

At Trust level the recommendations outlined within observation notes have been collated and developed into a single implementation action plan. The site-specific implementation plans have also been populated with recommendations outlined within national reports, so that services can benchmark themselves against these national recommendations.

A schedule of meetings with clinical leads and relevant service managers took place in quarters 3 & 4 and in 2021/2022 a total of 27 specialty implementation plans were reviewed and updated during this timeframe. Following agreement by the Quality Surveillance/GIRFT Group, GIRFT implementation plans will continue to be reviewed and updated on a 6 monthly basis, facilitated by the Quality Surveillance Team, to ensure specialties are meeting agreed timescales for completion of actions, support can be offered as required either internally or with support from GIRFT regional implementation managers, and effective monitoring can take place through the Trusts governance structure.

The Quality Surveillance Team is currently in the process of mapping cross-cutting themes and service improvements within the master implementation plan to incorporate a range of mechanisms required to measure and assess clinical effectiveness across such areas as clinical audit, clinical outcomes, quality improvement and benchmarking data. It will also enable the specialty teams to share good practice.

The Trust is now also engaging with GIRFTs High Volume Low Complexity (HVLC) programme which is focusing initially on driving improvement in six high-volume specialties of: ophthalmology, general surgery, trauma and orthopaedics (including spinal surgery), gynaecology, Ear, Nose and Throat (ENT) and urology. Supporting this work, with other surgical and medical specialties standardised pathways and best practice will be adopted, as well as pooling capacity and resources, to deliver excellent clinical outcomes and equity of access to care for its population.

DOMAIN – Clinical Effectiveness
Quality Priority
To continue delivering the Trusts End of Life Strategy and use local and national data sources to identify areas for improvement for mortality

End of Year Position	Partially Achieved

Rationale

The Trust is committed to delivery of the End of Life (EoL) 2020-2023 Strategy.

When preventing death is no longer an option, the strategy sets out a 3-year plan explaining how we will continue to treat and support our patients throughout their last months and weeks of life. Our strategy is underpinned and guided by three national key 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)
- One Chance to Get It Right (Leadership Alliance for the Care of Dying People: 2014)
- NHS Long Term Plan (2019)

The Trust is committed to system working and delivering on the priorities of our Integrated Care System, whilst ensuring that we make the ambitions a reality through strong leadership, commitment and empowerment.

Our six ambitions are as follows:

Figure 4: End of Life Ambitions

To achieve our ambitions, the Trust will work collaboratively with colleagues in primary care and the voluntary sector, including the Teesside Hospice and Clinical Commissioning Groups. Working in this way, will embed the principles outlined by the Leadership Alliance. There are five foundations to be successful in our vision: -

- Personalised Care Planning
- Involving and Supporting
- Education and Training
- 24/7 Access
- Leadership

Delivery of the Strategy is overseen by the Chief Nurse and the Chief Medical Officer. The EoL Strategy Group, reports into the Quality Assurance Committee and is responsible for the implementation of the strategic objectives and for measuring progress.

Agreed Actions

How will we do this?

To continue delivering the Trusts EoL strategy we will:

- Use local and national data sources to identify areas for improvement for mortality
- Draft a work plan for 2021/22 and ensure this is signed off by the Trust and shared both internally and externally with our partners
- Develop and deliver the plan under the six main work stream headings which aligned to the 6 ambitions set out above
- Progress and monitor the action plan through the EOL Strategy Group

Measures of Success

The Personalised Care Programme aims to have specialist care for all patients within the palliative care remit. The 'My Care Wishes' folder is a focus for personalised and supported care information. Training for staff will be rolled out to embed this new initiative, with measures of success being identified for each objective below.

Involving and Supporting

Specialist Palliative Care (SPC) teams will promote Dying Matters and have focused conversations and deliver early interventions with patients, families and carers. We will use the direct feedback from our completed bereavement survey to support our ongoing service development and improvements as required.

Education and Training

Training and education are vital and key to delivering our aims, objectives and ambitions. It will ensure our patients and staff are supported and will be given the tools to fulfil our patient's needs. This will be delivered by a designated palliative care training facilitator working together with a medical educator colleague to educate and train all staff.

24/7 Access

This has been included from 2019 however due to the pandemic it remains a focus through 2021/22. There will be further collaborative working across the Trust, supporting our EoL patients with ongoing care needs.

Leadership

The external/national lead will support with the SPC service review and upcoming collaborative workshop to ensure service alignment and service development. Palliative care will be included in the development of the Trust Nursing, Midwifery and Allied Health Professional (NMAHP) Strategy.

End of Year Progress

Caring for a person who is in the last days of their life is one of the most important responsibilities, and our clinicians provide individualised care for patients who are at the end of life, considering their wishes and those of their loved ones.

End of life care is everyone's responsibility, and the Trust policy and training of colleagues is in line with this with this important principle. Not all patients at the end of life require specialist palliative care but where this is required, this is provided through multi-disciplinary teams and underpinned by:

- Anticipation and management of deterioration in the patient's stage of health and wellbeing
- Advance care planning in accordance with patient preferences
- Patient choice about place of care and death
- Effective co-ordination of care across all teams and providers of care (in statutory, voluntary and independent sectors) who are involved in the care of patient and family

Specialist palliative care is provided by multi-disciplinary teams that can include consultants in palliative medicine, nurse specialists, specialist social workers and experts in psychological care. Due to national challenges around the recruitment of palliative care consultants, the Trust will continue to develop new palliative care models next year.

The Trust will also continue to work closely with local authorities and other partners to ensure that everything possible is done to ensure people who are ready to return home with social care support, are able to access this as quickly as possible.

Monitoring and delivering the End-of-Life Work Plan has been a key focus during the last 12 months. All members of the extended End of Life Care Team have attended an 'away day' in September 2021 to evaluate the service following the introduction of the new clinical collaboratives. Bereavement surveys were suspended during COVID-19. These will be resumed in-line with the Trust's recovery plan. Data is collected across the Trust via End-of-Life Care surveys, both nationally and locally. The National Audit of Care at the End of Life (NACEL) audit demonstrated excellent results for the End-of-Life Care documentation.

A new leadership team was confirmed and priorities for the service were discussed, with the following work streams being agreed:

Wider End of Life Care

The End-of-Life Care Strategy group has been reviewed and refocused, including the appointment of a new chair. The End-of-Life Care Strategy has reviewed its aims and objectives and now includes representation from a variety of clinical backgrounds.

Workforce

A business case for a 7-day service for acute and community services has been developed and is due to be presented for approval in Early Q1 2022/23. Funding for 2 Whole Time Equivalent (WTE) Specialist Palliative Care consultants having been secured and for which recruitment has been attempted on several occasions without success. Therefore, an alternative model is being proposed to include a Nurse Consultant and potentially GPs with a special interest in palliative care.

Service modelling

The National End of Life/Specialist Palliative Care model using the National Institute for Health and Care Excellence (NICE) definition and specialist, targeted and universal care is being implemented access the Trust, to include integration across the health and social care sector, covering both acute and community provision.

Caseload and Pathways

These are being revised to reflect the service delivery model described above and the best patient experience.

Education

Several 10-minute End of Life training and teaching video clips have been developed and shared across the Trust, which will complement our planned comprehensive education model.

DOMAIN – Clinical Effectiveness	
Quality Priority	
Complete all relevant NICE quality standards assessments in order to: • **Understand the priority areas to focus on quality improvement** • **Identify potential areas for local audit** • **Identifying services that are of poor quality**	
End of Year Position	**Partially Achieved**
Rationale	
The National Institute for Health and Care Excellence (NICE) is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health. NICE guidance aims to ensure that promotion of good health and patient care in the NHS are in line with the best available evidence of clinical and cost effectiveness. NICE publish new and updated guidance on their website as and when it is finalised or updated. The guidance is checked to ensure it is relevant to services provided by our Trust and then, when considered relevant, it is sent to the Trust Lead/Clinical Director (CD) for that specialty, informing them of the new or updated guidance, and asking for their compliance status against the key recommendations, which is one of the following: 1. Fully compliant 2. Partially compliant with an intention to be fully compliant 3. Partially compliant – do not agree with all the guidance 4. Partially compliant – due to other factors including environment/funding/commissioning 5. Do not intend to implement – mitigation in place and alternative guidance is being followed 6. Not applicable NICE Quality Standards (QS) are a set of specific, concise statements that act as markers of high quality, cost-effective patient care, covering the treatment and prevention of different diseases and conditions. Derived from the best available evidence such as NICE guidance and other evidence sources accredited by NHS Evidence, they are developed independently by NICE, in collaboration with	

the NHS and social care professionals, their partners and service users, and address three dimensions of quality: clinical effectiveness, patient safety and patient experience.

Agreed Actions

How will we do this?

- Complete a baseline assessment relating to Quality Standards that have not yet been assessed.
- Develop a project plan to improve compliance with Quality Standards and collate evidence to demonstrate compliance
- Ensure the fifty quality standards that have not been assessed are reviewed by the clinical teams and actioned appropriately
- Ensure the backlog of NICE Guidance is disseminated within the Trust to determine whether the Trust is compliant
- Where areas of non-compliance are identified, actions are implemented to obtain compliance or where non-compliance is agreed the risks of this will be documented appropriately and action taken where necessary to address risks
- Ensure Technology Appraisals are disseminated and reviewed
- Development of a further project plan to identify evidence of compliance through clinical audit
- Ensure the NICE Guidance tracker is accurate and reflects the current position
- Establish a robust system for managing NICE Guidance compliance going forward
- Ensure areas of non-compliance are escalated appropriately through the NICE Clinical Audit and Service Evaluation Group and upwards through the Clinical Effectiveness Steering Group

Measures of Success

- Backlog of NICE Guidance has been managed appropriately and compliance status obtained for all outstanding ones
- Review of the Quality Standards that have not been assessed
- Review of the 35 Technology Appraisals that have been disseminated
- Up to date NICE Guidance tracker with an established process for disseminating NICE Guidance within an appropriate timescale
- Evidence of implementation of Phase 1 of the NICE Project Plan
- Development and implementation of Phase 2 of the NICE Project Plan
- Regular reports showing progress made over the 12-month period

End of Year Progress
Increased resource and focus have enabled the NICE project work to see a vast improvement in the NICE guidelines position with the immediate focus having been on Technology Appraisals (TAs) and Highly Specialised Technologies (HSTs). All outstanding guidelines were disseminated to clinical leads for their assessment, whether they were applicable and implemented within the Trust. Once the implementation status had been confirmed, evidence has been sought to determine if the Trust is compliant against the guideline. As a result of this work, the NICE guidance tracker is updated regularly, with newly published and updated guidance and updated with the latest status returned by clinical staff. Of the original 530 guidelines (TAs and HSTs), at the start of the financial year, there remain only 13 where further supportive evidence is still required. Regular reports on progress have been shared through our quality governance structure. Whilst work has commenced on the Quality Standards, further focuses is still required to achieve full compliance.

DOMAIN – Clinical Effectiveness	
Quality Priority	
Ensure patients have a safe, effective, and timely discharge	
End of Year Position	**Partially Achieved**
Rationale	
Health and social care systems are expected to build upon the hospital discharge services developed since 19th March 2020. Systems were instructed to use the Government's additional investment to maintain discharge services through to 30 September 2021. There is a requirement that the reductions in the length of stay for acute admissions are improved upon year on year. As a result of the COVID-19 pandemic and the Government's additional investment, this quality priority has been carried forward from last year. Central to the delivery of effective and timely discharge planning is clinical leadership and good communication. This underpins the regular reviews of the treatment and care for people and ensures a consistent focus on the principles of personalised care. Daily morning board rounds to review every person and make decisions, informed by the criteria to reside, are the foundation for avoiding delays and improving outcomes for individuals.	

Transfer from the ward to a dedicated discharge area should happen promptly; for persons on Pathway 0 this should be within one hour of that decision being made, and the same day for people on all other pathways.

The 'Criteria to Reside' tool was developed in March 2020 with the Academy of Medical Royal Colleges and has since been reviewed with the collaboration of the British Geriatric Society. The tool equips clinical teams to have discussions and make decisions whether a person needs to stay in an acute bed to receive care. Where it is identified, the person no longer needs the support and services of an acute hospital, plans are put in place to secure the resources and services required to support a safe and timely discharge

NHS commissioned (acute and community) hospitals must integrate the daily reviews into their electronic patient information systems during 2021/22. This ensures live data is available for all agencies to work from and include those suitable for discharge, the number and percentage of people who have left the hospital, and delay reasons for those unable to be discharged in a timely way. This data forms part of the national data performance reporting arrangements.

There is a shared vision across the local Health and Social Care system to embed a Home First culture. The overriding principle is to ensure hospital stays are as short as possible, and that wherever possible, people are supported to return home to recover, regain their confidence and maintain their independence.

The overall objectives for the local health and social care system are:

1. To collectively improve patient flow throughout the hospital and community bed base

2. To embed proactive discharge planning processes that drive daily discharges and improve patient flow

3. To improve overall bed management and bed utilisation across the organisation

Having a Home First mindset is the guiding principle that everyone in the system will support people to return home if that is where they were admitted from and if they are safe to do so. The focus is on admission avoidance and providing wrap around services in the community.

The Trust is committed to this and recognises that appropriate and timely discharge planning is fundamental to the provision of effective health care, and to the wellbeing of the patient. Furthermore, that all patients who no longer meet the 'Criteria to Reside' in hospital should be discharged, or appropriately transferred as soon it is clinically safe to do so.

Agreed Actions

How will we do this?

- Develop a case management approach to transfers of care - developing the discharge team and engaging with other teams to facilitate timely discharges by August 2021
- Implement the SAFER approach - embed ward processes that improve discharge processes by September 2021
- Implement a Home First Service for patients returning home who need some support by September 2021
- Strengthen the Single Point of Access so that there is one contact number for the wards when seeking support for a patients discharge by September 2021
- Implement a weekly review of all patients with a long length of stay by July 2021
- Develop Patient Safety at A Glance (PSAG) boards to include criteria to reside assessments, ensuring Estimated Dates of Discharge (EDD) and Planned Date of Discharge (PDD) are visible and maintained by September 2021
- Develop and initiate staff engagement and training regarding new discharge processes by September 2021
- Initiate the Modern Ward Rounds Collaborative (National project) and embed by March 2022
- Develop Community Hospital pathways by October 2021

Measures of Success

- At least 95 per cent of patient's aged 65+ leaving hospital should be going straight home/usual place of residence either on discharge pathway 0 or pathway 1
- % Of patients not meeting the criteria to reside discharged by 5pm – target 70%
- % Of patients that have been in hospital over 7 days – target 40%
- % Of patients that have been in hospital over 21 days – target 12%
- A reduction in the % of patients re-admitted as an emergency admission within 30 days of a discharge
- A reduction in the average length of stay

End of Year Progress

Case management

During 2021/22, a transfer of care hub was created in collaboration with local authorities to support ward colleagues and social workers to return people safety home after their hospital treatment and help to ensure social care support is available in the community.

Some people may not need any help when they return home, but for those who do, the Transfer of Care Hub helps to ensure that the right care is in place at the right time and in the right place. It is best for people's health and wellbeing to be treated away from hospital, ideally in their own home, when safe to do so.

This work will continue to be taken forward next year alongside the strengthening of already-established processes to ensure the timely repatriation of patients to their local acute hospital following the completion of their specialist care. As well as ensuring continued timely access to tertiary and other specialist care for patients in our region, repatriation also ensures that more patients can continue the acute phase of their care closer to home.

The Discharge Hub has been set up and relocated, with system funding secured for four additional Transfer of Care Co-ordinators and a system lead. Additional staff have also been recruited as Transfer of Care Coordinators (Discharge Facilitators). A Trusted Assessment Form (TAF) has been trialled and rolled out across the organisation, along with a case management model.

Quality improvement and process mapping has been carried out with support from the Emergency Care Improvement Support Team (ECIST) and STRIVE to identify people who will potentially require support on discharge at the point they are admitted, preventing any delays in their discharge.

People who do not meet the criteria to reside are discussed on a daily system partners call, where support is obtained to plan for the patients' discharge.

SAFER

The Discharge Policy has been revised and approved by our Discharge Improvement Board, Clinical Policy Group and Patient Experience Steering Group and implemented across the Trust. Staff surveys have been completed to understand the impact of the new model, with these results being shared with the Team and at the Discharge Improvement Board. The Discharge Improvement Board is central to overseeing this important work and regularly receives updates on discharge related complaints, incidents and safeguarding issues in order to identify themes, share learning and take action to improve services and the experiences for our patients.

Through the Trust's governance structure, a patient flow action log has been developed and shared for use with ward teams, subgroups have been established to enable focused work to be carried out. This included a review patient leaflets and checklists, which have been distributed to

all wards. In addition, the discharge medication checklist has been included in all To Take Out medication (TTOs) as a prompt for nurses.

Home First

A new Home First service has been in place since January 2022 to provide care for people post discharge while their future needs are assessed. Pathways have been developed and discussed with Local Authorities, with an agreement that Social Workers carry out assessments by day 3. Specific training has been delivered in key areas, including Post-Acute Care Enablement (PACE), medication administration and how the Transfer of Care Hub Team identify people and its link with the Single Point of Access. Early indications and data show this model is effective in supporting people at home.

Single point of access

The Single Point of Referral (SPoR) and Social Care Administration Team have merged and there is now one contact telephone number for ward teams to ring.

Long Length of stay reviews

Twice weekly clinically led Multidisciplinary Team MDT reviews are in place and carried out on wards, following a review and analysis of data. Following escalation, system wide reviews of long length of stay patients are taking place monthly.

Model ward

Model ward processes continue to be embedded across wards areas, using the Medworxx and Patient Safety at a Glance (PSaG) boards and discharge flags. Data is captured and shared with ward managers and matrons to identify areas of good practice and areas for improvement. A presentation was delivered at the Trust-wide Patient Safety Day in March 2022 to promote good practice and engage teams in a discussion about barriers and what a good discharge looks like. Using the Meridian software, an audit of medication discharge checklists has been developed, with the addition of discharge questions now included in the weekly clinical assurance rounds.

Community pathways

Across all our Primary Care Hospitals a template for board rounds is in place for assigned discharge actions. The criteria for these beds have been reviewed, allowing the flexibility to use them to respond to both service and patient needs. Following a full review, the staffing resource

for supporting community hospital beds, care home rehabilitation beds and community support has been identified and confirmed. Scoping work has commenced for the Early Supported Discharge (ESD) services in Hambleton and Richmondshire and online stroke training is available for community staff.

Performance Metrics

Metric	Performance	Target
% Of patients aged 65+ leaving hospital went straight home/to their usual place of residence either on discharge pathway 0 or pathway 1	95.5%	95.0%
% Of patients not meeting the criteria to reside discharged by 5pm	54.7%	70.0%
% Of patients that have been in hospital over 7 days	50.0%	40.0%
% Of patients that have been in hospital over 21 days	18.0%	12.0%

Table 2: Discharge Performance

In addition to the above performance metrics, 3.5% of patients were re-admitted as an emergency admission within 30 days of being discharged year to date. This is compared to 3.3% in 2019/20. The average length of stay has remained static at 2.3 days with a decrease in the length of stay for elective patients and an increase for non-elective patients' year to date compared with 2019/20.

Further work is required to increase the number of people who are discharged by 5pm and no longer meet the criteria to reside.

DOMAIN – Patient Experience	
Quality Priority	
Reduce the incidence of avoidable category 3 and 4 pressure ulcers in order to positively impact on patients who are most at risk	
End of Year Position	**Partially Achieved**
Rationale	

The development of pressure ulcers is a key indicator of quality of care and patient experience. Pressure ulcers are detrimental to patients in terms of their physical, psychological and social well-being, resulting in reduced quality of life (EPUAP 2014). In addition, treating pressure ulcers costs the NHS more than £1.4 million every day (Guest et al. 2017).

A common misconception is that pressure ulcers are preventable. An early paper by Hibbs (1988) hypothesised that 95% of pressure ulcers were preventable and this became a widely cited statistic. However, later papers highlighted that Hibbs (1988) provided no empirical evidence for this figure. More recent work suggested that preventability may range between 50-60% (Downie et al. 2013).

This variability in the literature is important to note as pressure ulcer prevention is commonly held as a marker of good nursing care. However, on occasion, there are factors out of the control of the clinical team, particularly in the community setting. In addition, there is variation in reporting across the North East and North Cumbria Integrated Care System and wider, particularly in the community setting.

The Trust aims is to provide care which is evidenced based and to reduce the patient's risk of pressure damage wherever possible. The approach we are taking is a collaborative one, using mixed methods to optimise process, outcome and education.

Agreed Actions

How will we do this?

- Identify focus areas that are demonstrating an increasing rate of pressure ulcers across six wards, 3 ITU / HDUs and all our community services
- Commence a patient-centred improvement initiative that incorporates SMART actions under key headings of a. Education b. Pressure ulcer prevention c. Assessment and risk reduction d. Governance e. Patient experience
- Observe demonstrable progress of the action plan and provide progress reports against this plan as required
- Identify what measures are required to sustain improvements

Measures of Success

- Work in the acute setting will be focused on themes identified in our structured reviews and in the community, we will be piloting a different assessment tool to further optimise risk reduction
- A sustained decrease as intensive improvement support is withdrawn
- Formation of a Tissue Viability Council

- A review of metrics, measures and the format in which pressure ulcers are reported at the Trust
- Positive feedback from staff about their experience as part of a collaborative QI initiative
- Ward Managers and 'nurses in charge' to have attended refresh training by the end of Q3. Link nurses to have attended refresh training by the end of Q2, if required, and to have ongoing protected time to drive quality improvement work.

End of Year Progress

The Pressure Ulcer Improvement workstream has identified a simplified structured judgement review and reporting process for patients who have multiple pressure ulcers. This approach has been trialled within community teams and on three acute wards, before being rolled out Trust-wide.

The pressure area assessment tool has been reviewed and changed from the Braden to the evidenced-based PURPOSE-T assessment tool. This identifies adults at risk of developing a pressure ulcer and supports nurse decision-making to reduce that risk (primary prevention). The tool also identifies those with existing and previous pressure ulcers requiring secondary prevention and treatment. Led by the Tissue Viability Team, with the support of Nurse Educators, the PURPOSE-T has been implemented within the community setting and trialled on four acute wards. Focus work in critical care has also seen a reduction in device related pressure ulcers in this area, with the last case reported in November 2021.

Pressure Ulcer review panels are in place three times per week to discuss each patient with a category 3, 4, deep tissue or unstageable damage pressure ulcer. This is chaired by the Deputy Chief Nurse or Lead Nurse for Quality. Panels are held within wards and departments to encourage front line staff to attend. They provide a rapid review of the patient, identify immediate findings and establish shared learning. In line with NHS England guidance, this approach has improved our timeliness of reporting and escalating any SIs or SLEs, where gaps attributed to the Trust are identified. Pressure ulcer prevalence, for patients with existing pressure damage and who are frequently admitted to both the acute hospitals and the community case load, have been reviewed to improve reporting and learning.

Pressure Ulcer incident reporting has contributed to the Trusts focus on increased incident reporting. SIs for pressure ulcers have remained relatively static overtime with a robust reporting process in place, demonstrating continued commitment to reduction in pressure ulcers and patient harm.

Key documentation, including the repositioning record, comfort round, food chart, fluid balance and diarrhoea assessment have been removed from ward files and placed at the bottom of the patient's bed. This increased visibility for staff, ensures that care given is accurately documented contemporaneously.

An Intentional Rounding Audit Tool has been developed and placed onto the electronic Meridian System to reduce the amount of data inputted and therefore ensure timely feedback is provided at ward level. Audits were initially conducted daily and following five consecutive days of achieving over 90% compliance the audit were reduced to weekly for most wards.

At the end of Q4 and as part of the Trust's digital journey, the documentation used for daily skin checks, body map assessment, PURPOSE T tool, repositioning record charts and comfort round charts, have been added onto PatientTrack. This electronic record system allows assessment and recording at the patient bedside, software alerting at timed intervals and can retrieve and feedback real time data at ward level.

DOMAIN – Patient Experience	
Quality Priority	
Establish a Trust-wide inclusive Patient Experience user group which represents the diverse range of patients who come into contact with our services	
End of Year Position	**Partially Achieved**

Rationale

Utilising existing patient and carer participation groups, with different conditions, across the Trust to: -

- Understand the needs of patients and carers using the services
- Provide insights into how services impact on those using them
- Work with patients, as partners, to improve services and shape new developments
- Ensure patients are involved in improvement projects from the earliest stage
- Involvement in shaping the service they use
- Able to reach diverse groups of patients for ideas, feedback and suggestions – do not need to have a formal role.
- Involvement of carers through external partners
- Share good practice and raise areas of concern
- Build better working relationships with local communities, statutory and voluntary groups
- Help the Trust to communicate about services in ways that are accessible for all

Agreed Actions

How will we get there?

- Contact Clinical Chairs for each Collaborative to identify Patient and Carer Participation Groups (PCPG) which are already in existence
- Collate a list of active PCPG groups
- Develop a guide to planning and setting up a patient participation group
- Patient Experience to host a PCPG conference twice a year, bringing together the groups to share the work carried out
- Introduce Key Performance Indicators for PCPG

Measures of Success

- Formation of Patient and Carer Participation Groups across the organisation
- Create Key Performance Indicators (KPI)

End of Year Progress

The Patient Experience Steering Group includes wide and varied membership, with regular updates being provided from our statutory, voluntary and third sector partners on work that is taking place within our local communities and representing the voice of our patients. Every meeting starts with a patient story, where the group hears first hand of the great care and some of the challenges our patients experience from the Trust.

Outpatient letter templates have been reviewed, which has seen the numbers of templates being used reducing significantly, making letters easier for our patients to understand, and read. Work has also commenced on reviewing our patient information leaflets, with some areas, including our Emergency Department having these available via QR codes for patient to use on their mobile phones. In our ophthalmology department new check in kiosks have been introduced, with updates on their implementation being provide to the group.

Planning has commenced for the Patient Participation Group, with information collected on patient groups which are already in existence across the Trust. Due to the COVID-19 pandemic, we have yet to bring this work together. A patient participation conference has also made limited progress and as a result, this priority has been revised, refreshed and will be carried over as a Quality Priority to 2022/23.

DOMAIN - Patient Experience

Quality Priority	
Using Always Events methodology, improve the patients' experience in the area of letters and written communication to above 90% through a 'task and finish' groups	
End of Year Position	**Partially Achieved**

Rationale

It was identified through the Patient Experience Strategy Group that feedback from complaints and concerns raised by patients consistently identified communication as being one of the top themes. Concerns included were:

- Telephones not being answered
- Staff approach– administration
- Appointment letters not standardised, did not always have the correct information on them, the trust logo was not routinely used
- Patient information/leaflets not pertinent and/or past review dates
- Occasional delays in receiving test results to the patient and GP
- Changes to mediation sometimes not shared with the GPs in a timely way

Agreed Actions

Establish a Task and Finish Group to review communications with patients including: -

- Written communication – appointment letters
- Telephone calls – not being answered and voice messages not returned
- Staff approach – administration
- Patient information/leaflets – information that accompanied appointment letters
- Delays in receiving test results – to the patient and GP
- Changes to Medication – changes to medication made in OP appointments not always sent timely to the GP

Measures of Success

The task and finish group completed a review of communications relating to non-clinical issues. The identified themes and changes made have now been operationalised and continue to be monitored through patient feedback.

Appointment letters

Outpatient Appointment Letter Project – Reduce templates from over 2,000 down to 5-10 core templates. A standardised format ensures that letters from the Trust are instantly recognisable and simplify the content for ease of understanding.

This project was completed at the end of September 2021. New templates receive internal approval before being shared with external stakeholders prior to implementation. Accessible Information Standards (AIS) statements feature on all letters. Strict governance is in place around requests for amendments or new letters being created to ensure only "live" versions are used across the Trust.

Telephones

Several initiatives were put in place to ensure that telephone calls were answered, and answerphone messages were responded to in a timely way, which included:

- Providing an email address as an alternative
- Relocating telephone calls from reception desks to the office
- Ensuring answerphones are on or telephones are diverted to an appropriate member of staff if on annual leave
- Confirming key roles within wards and departments to answer telephone calls

The Patient Experience Team will ensure that enquirers contacting the Trust to raise concerns about telephone calls are answered and will identify the correct telephone number to ensure that it is still in use.

Staff approach

A customer care training course was put in place in April 2020 and there is a rolling programme for all administrative staff (reception/administrative/secretarial).

Patient information/leaflets

The Patient Experience Team is now managing patient information. The policy is currently under review to ensure the process for the creation and reviewing of existing patient information is embedded.

Changes to medication

Where required, patients are provided with medication request forms following their outpatient appointments. Currently, the patient takes this request form away and is required to take this to their GP. Following the success of patient letters being emailed to GPs, the trust, Clinical Commissioning Group and GPs are exploring the possibility of scanning medication request forms and sending them electronically. A proposal to trial this in Dermatology, Ears, Nose and Throat

and Oral and Maxillo-Facial Surgery has been made with a view to it being rolled out to other services.

End of Year Progress

The closing report for the Communication Task & Finish Group was presented to the Patient Experience Steering Group in August 2021. The chart below shows the 6 communication related concerns by subjects up to March 2022. Following the work of the Task and Finish Group, a reduction can be seen across all sub-subjects, except for staff attitude. These themes continue to be monitored across the organisation.

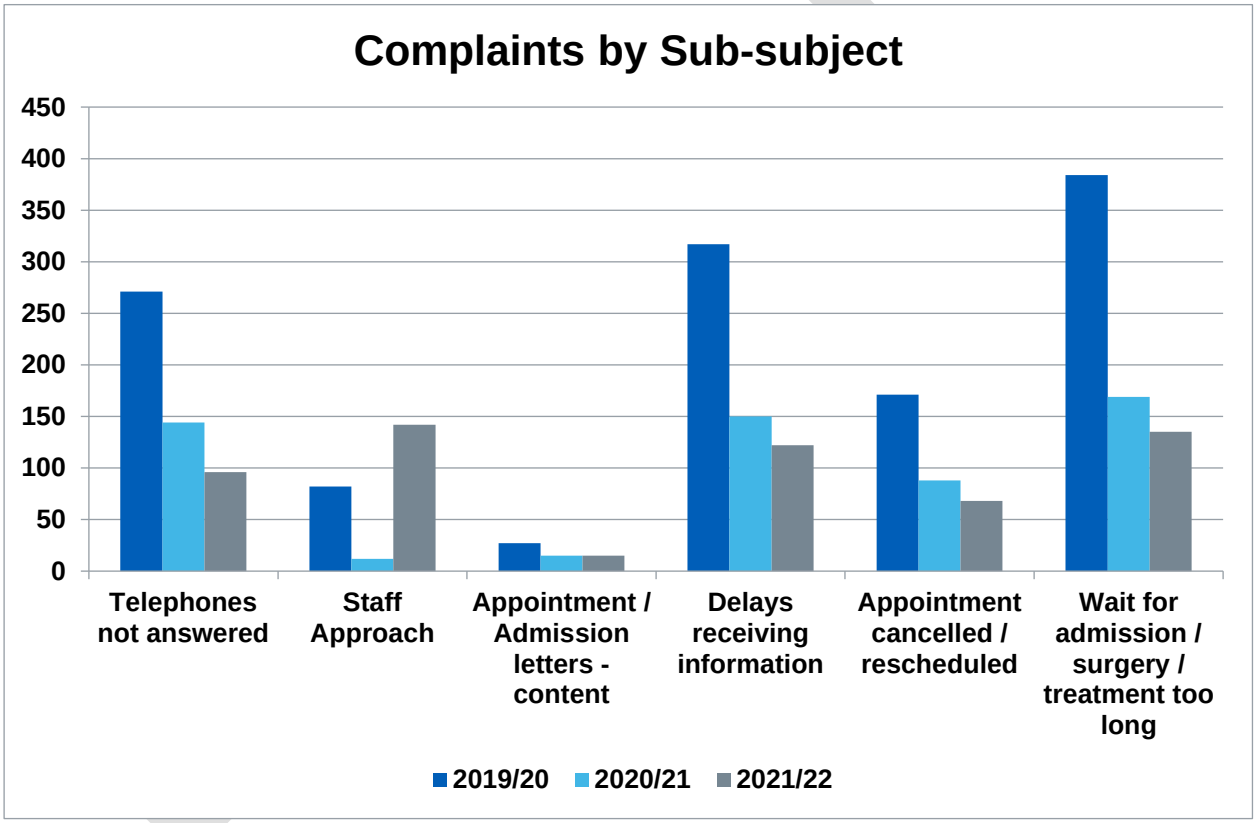


Figure 5: Number of Complaints over the Last 3 Financial Years

2022/23 Quality Priorities

The Trust has agreed the following priorities for 2022/23 following a consultation process. The agreed priorities are areas of importance that will make a difference to our patients. Some of our priorities are new, whilst others have been revised and carried over from last year. Agreed actions will be delivered and monitored during a 12-month period from the 1st April 2022 to the 31st March 2023, with regular updates provided through the year via our quality governance structure.

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

DOMAIN – Patient Safety
Quality Priority
We will continue to build on the positive safety culture within the organisation in which openness, fairness, accountability and learning from high levels of incident reporting is embedded
Rationale
We will implement and embed all elements of the action plan to emerge from the internal Thematic Review of Never Events undertaken at the end of 2021. This will ensure that there are effective and proactive processes and systems in place to facilitate effective system-based learning and improvements across the organisation.

Agreed Actions

How will we do this?

- We will work with our Patient Safety Ambassadors and Patient Safety Specialists to understand current skills, capability and capacity within the organisation
- We will convene a Working Group by the end of Q1 to ensure that all relevant areas of the Trust are involved in the implementation of the action plan
- We will ensure the safety sections of our recently published NHS Staff Survey results are reviewed and discussed, and agree actions needed to improve the patient safety culture

Expected outcome

- The Trust will have compassionate and effective systems in place to enable an optimal safety culture where incidents and actions are reported, responded to and learned from in a timely and effective way
- Learning from incidents will be widely shared and used to improve practice across the whole organisation
- Staff will be empowered to speak up and identify risks to safety without fear of punitive response which will facilitate better outcomes for patients

Measures of Success

- Continued reduction in the number of Never Events occurring within the Trust
- Monitoring of staff survey results and any other safety culture assessment tools
- Q17a Staff Survey – 'I would feel secure raising concerns about unsafe clinical practice' from 76.9% in 2021, to above 80% in 2022/23
- Q17b, - 'I am confident that my organisation would address my concern' from 60.7% in 2021, to above 65% in in 2022/23

DOMAIN – Patient Safety

Quality Priority

We will provide pressure area care to our patients which is safe, and of a high standard by reducing the instances of avoidable category 3 and 4 pressure ulcers

Rationale

It is important that all pressure ulcers are recognised as patient safety incidents and reported accordingly. Any pressure ulcer that meets, or potentially meets, the threshold of a Serious Incident should be thoroughly investigated to ensure any issues in care are identified, understood and resolved to prevent the likelihood of future recurrence.

This requires an assessment of whether any acts of omission or commission may have led to the pressure ulcer developing. It is not acceptable to locally define, in advance, certain types of

pressure ulcer that are 'unavoidable' as long as some routine preventative measures have been undertaken.

Serious Incident investigations which seek to conclude that an incident was either 'avoidable' or 'unavoidable', rather than focusing what could be learned to prevent future harm, are not compliant with Root Cause Analysis (RCA) methodology.

By using a variety of tools and techniques, we will proactively continue to learn and reduce the incidence of avoidable category 3 and 4 pressure ulcers in order to impact on patients who are most at risk.

Agreed Actions

How will we do this?

We will ensure that staff, particularly those working in areas where patients are at an increased risk of pressure damage are appropriately knowledgeable in pressure ulcer prevention

We will continue with the pressure ulcer collaborative to ensure pressure damage can be prevented wherever possible

We will roll out 'Purpose T' as a pressure ulcer risk assessment framework, and audit the impact of this

Expected outcome

We will ensure that appropriate proactive and preventative measures are undertaken in relation to pressure ulcers

We will ensure that at least 90% of the Registered Nurse workforce has received training or an update on the Purpose T pressure ulcer risk assessment tool

We will have no new Trust acquired avoidable category 4 pressure ulcers in the next financial year

We will reduce the number of new Trust acquired avoidable category 3 pressure ulcers by 20% in the next financial year

Increase the quality of any pressure ulcer SI investigation reports and action plans

Measures of Success

How will we get there?

Monitor the frequency of staff training relating to pressure ulcer prevention and increase if necessary

Reduction in category 3 and 4 pressure ulcers. Reductions in Serious Incidents relating to pressure ulcers. Reduction in complaints relating to pressure ulcers. Reduction in inquests/claims relating to pressure ulcers

Gather category 3 and 4 pressure ulcer data by acute and community setting and identify those which are new and avoidable and attributed to the Trust

We will identify learning through an increase in the quality of our SI reports

Number of SI reports signed off at PU Panel and at Tees Valley Clinical Commissioning Group (TVCCG) SI Panel when first presented

Number of SI actions completed with evidence and within agreed timescale

DOMAIN – Patient Safety

Quality Priority

We will reduce instances of Trust-Attributed (TA) and avoidable Clostridium Difficile Infection (CDI) for inpatients

Rationale

We will review, implement and embed all elements of the CDI recovery and action plan learning from the review of 2021/22 in order to improve patient safety and experience

Agreed Actions

How will we do this?

- We will implement and establish the structured review process for all cases of TA CDI by the end of Q1 2022/23
- We will embed the role of dedicated CDI Infection Prevention and Control Nurse (IPCN) and review the outputs by the end of Q2 2022/23
- We will update and implement the CDI toolbox training programme, with a focus on completion in 4 key priority areas by the end of Q1 2022/23 and a full programme will be offered by the end of Q4 2022/23
- We will implement new assurance audits in relation to the 'focus on five' for CDI in addition to current processes by the end of Q1
- We will complete the action plans and CDI recovery plan by the end of Q4 2022/23, ensuring the standards and good practice are embedded across all clinical areas

Expected outcome

- The Trust will have robust and effective systems in place to enable an optimal safety culture where early identification of changes in patient's presentation is responded to and learned from in a timely and effective way
- Learning from the structure review process will be shared with all clinical teams and used to improve practice
- We will have a dedicated drive with a nominated lead for CDI across the organisation

- We will increase staff knowledge and confidence in relation to CDI through education and training and demonstrate improvement

Measures of Success

How will we get there?

- A reduction in the level of Clostridium Difficile infection to below 111 or less, in line with national trajectory

DOMAIN – Clinical Effectiveness

Quality Priority

We will review and revise our processes for Clinical Audit in order to facilitate effective and evidence based clinical care for our patients

Rationale

We will review and implement a Trust-wide approach to Clinical Audit which is embedded in practice and demonstrates improvement and best practice for our staff and our patients

Agreed Actions

How will we do this?

- We will have effective systems in place for all elements of the Clinical Audit and action planning cycle

Expected outcome

- Staff will deliver patient care based on the most up to date evidence and best practice standards
- We will review all level 1, 2, 3 and 4 clinical audits and agree these in the forward plan
- We will have an effective system in place for the reporting and tracking of all Clinical Audit activity

Measures of Success

- 100% of relevant clinical audits completed at levels 1
- 80% of relevant clinical audits completed at levels 2
- An increase in clinical audits completed at level 3 and 4 against 22021/22 levels
- 100% of clinical audit action plans completed at levels 1
- 80% of clinical audit action plans completed at levels 2
- An increase in clinical audit action plans competed at levels 3 and 4 against 2021/22 levels

DOMAIN – Clinical Effectiveness

Quality Priority

We will review and revise our processes for NICE in order to facilitate effective and evidence based clinical care for our patients

Rationale

We will review and implement a Trust-wide approach NICE which is embedded in practice, which demonstrates improvement and best practice for our staff and our patients

Agreed Actions

How will we do this?

- We will have effective systems in place for the tracking of all elements of NICE Guidelines and NICE Quality Standards

Expected outcome

- We will have an effective system in place for the dissemination, reporting and tracking of all NICE activity
- We will review all NICE Quality Standards in order to agree relevance and report on the levels of compliance
- We will review all NICE Guidelines in order to agree relevance and report on the levels of compliance

Measures of Success

- A 10% increase from 2021/22 compliance of NICE Guidelines received, assessed as relevant and disseminated which provide assurance of compliance with supporting evidence
- A 10% increase from 2021/22 compliance of NICE Quality Standards received, assessed as relevant and disseminated which provide assurance of compliance with supporting evidence

DOMAIN – Patient Experience

Quality Priority

We will ensure that patients, their relatives and carers have the best experience possible in relation to a planned, safe and effective discharge from our hospitals

Rationale

Using various methods, we will undertake improvement work in relation to discharge on a selection of pilot wards across Trust sites, to facilitate an effective, co-designed and patient centred process.

Agreed Actions

How will we do this?

- We will establish a training programme, with at least 20 members of discharge staff trained by the end of Q1 2022/23
- We will identify wards or departments to implement new ways of working, as identified in the discharge action plan by the end of Q2 2022/23.
- We will work with patients, relatives and carers to understand what matters to them in relation to planning a safe and effective discharge and develop an action plan around these standards by the end of Q3 2022/23.
- We will complete the action plans by the end of Q4 2022/23 and ensure the standards and good practice are fully embedded and disseminated to other clinical areas.

Expected outcome

- Patients, relatives and carers can expect consistently high standards of care in relation to their discharge, based on co-designed pathways and initiatives, as set out in the Trusts improvement plan.

Measures of Success

How will we get there?

- Numbers of staff trained in Always Events® methodology
- A reduction in the number of concerns and complaints raised in the areas where Always Events® discharge projects have been implemented
- A reduction in the number of incidents involving safeguarding concerns where unsafe discharges have been identified
- An increase in the number of compliments and appreciations received raised in the areas where Always Events® projects have been implemented
- Evidence of learning/change in practice from patient feedback and incidents
- Feedback from the Patient Experience Discharge Survey
- At least 95% of patients over the age of 65 leaving hospital and going straight home / usual place of residence either on discharge pathway 0 or pathway 1
- 70% of patients not meeting the criteria to reside will be discharged by 5pm
- A reduction in the % of patients re-admitted as an emergency admission within 30 days of a discharge

DOMAIN – Patient Experience

Quality Priority

We will ensure all patients have their nutrition and hydration needs met

Rationale

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

Agreed Actions

How will we do this?

- Ensure that patients' nutrition and hydration needs are assessed on admission and reassessed weekly (if LOS>7 days), and have a care plan in place
- Ensure that clear processes and systems are in place to ensure that patients receive the best mealtime experience
- Ensure that we can capture patient experience in relation to nutrition and hydration and be responsive to feedback
- Implement electronic Malnutrition Universal Screening Tool (MUST – On PatientTrack).
- Establish a Nutrition Link Nurse network across the Trust and programme of education.
- Conduct a Quality Improvement review of the mealtime process
- Develop mechanisms to obtain feedback regarding nutrition and hydration, specifically in relation to vulnerable groups of patients
- Develop a Nutrition and Hydration Strategy

Expected outcome

- Patients, relatives and carers can expect consistently high standards of care in relation to nutrition and hydration, based on co-designed pathways and initiatives
- There is timely visibility of data, with appropriate action taken relating to nutrition and hydration

Measures of Success

How will we get there?

- Minimum of 80% clinical ward staff will receive training on MUST screening as part of PatientTrack implementation
- MUST audit compliance > 90% achieved for all inpatient areas
- Each ward will have at least one identified Nutrition Link Nurse

- Nutrition Link Nurse will attend a minimum of 2 Nutrition & Hydration Education Sessions per annum
- Increased support available for patients who require assistance with eating and drinking
- Reduction in complaints in relation to nutrition and hydration

DOMAIN – Patient Experience

Quality Priority

We will ensure that we have effective ways of receiving feedback from our patients, their relatives and carers which will lead to demonstrable improvements in practice

Rationale

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

Agreed Actions

How will we do this?

- Establish a Patient Participation Group by end of Q2 2022/23
- Recruit patients to initiatives across the organisation
- Maintain or increase annual PLACE Scores and benchmark to other local and national Trusts
- Carry out monthly PLACE lite assessments focusing on different areas every month and benchmark to other local and national Trusts
- Review of current estate provision for patient, relative and carer contacts and feedback

Expected outcome

- Quality improvement activity will be used to inform what matters to patients, relatives and carers

Measures of Success

How will we get there?

- Increased number of Patient Experience contacts by at least 10% on the previous year
- Examples of improvements in practice informed by patient/relative/carer feedback and participation
- Demonstrable improvement in environment for the provision of Patient Experience activity
- PLACE lite benchmarking data and local action plans

Statements of Assurance from the Board

Review of services

During 2021/22, South Tees Hospitals NHS Foundation Trust provided and/or sub-contracted 91 relevant health services. South Tees Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 91 of these relevant health services.

The income generated by the relevant health services reviewed in 2021/22 represents 93**%** of the total income generated from the provision of relevant health services by the South Tees Hospitals NHS Foundation Trust for 2021/22.

Clinical Audit

South Tees Hospitals NHS Foundation Trust is committed to undertaking effective clinical audit across our clinical services and recognises that this is a key element for providing high quality care. Clinical audit enhances patient care and safety, provides assurance of continuous quality improvement and developing and maintaining high quality patient-centred services. The Trust has a well-structured clinical audit programme which is regularly reviewed to ensure it reflects the needs of our acute and community services.

During 2021/22, 57 national clinical audits and 2 national confidential enquiries covered relevant health services that South Tees Hospitals NHS Foundation Trust provides.

During 2021/22, South Tees Hospitals NHS Foundation Trust participated in 84.2% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in. (Eligibility, for the purpose of this report, is defined as those national audits that the Trust could participate in that were not suspended due to the COVID-19 pandemic).

The national clinical audits and national confidential enquiries that the South Tees Hospitals NHS Foundation Trust was eligible to participate in, and for which data collection was completed during 2021/22 are listed below in Table 3, alongside the number of cases submitted to each audit or enquiry as a number or percentage of the number of registered cases required by the terms of that audit or enquiry:

Title	Eligible	Participated	% Cases
Case Mix Programme (CMP) Also includes Cardiac Intensive Care (Intensive Care National Audit & Research Centre (ICNARC) data)	✓	✓	100%

Title	Eligible	Participated	% Cases
Child Health Clinical Outcome Review Programme- National Confidential Enquiries into Patient Outcome and Deaths (NCEPOD) Transition from child to adult health services	✓	✓	Ongoing
Chronic Kidney Disease registry	✓	✓	100%
Elective Surgery - National PROMs Programme (Patient Reported Outcomes Measure)	✓	✓	69%
Emergency Medicine QIP - Pain in Children (care in Emergency Departments)	✓	✓	Ongoing
Emergency Medicine QIP – Infection Control (care in Emergency Departments)	✓	✓	Ongoing
The Falls and Fragility Fracture Audit Programme (FFFAP) The Fracture Liaison Service Audit (FLS-DB)	✓	✓	100%
Falls and Fragility Fractures Audit programme (FFFAP): National Audit Inpatient Falls	✓	✓	Partial participation n=30
Falls and Fragility Fractures Audit programme (FFFAP): National Hip Fracture Database	✓	✓	N=529
Inflammatory Bowel Disease Audit	✓	X	0%
Learning Disabilities Mortality Review Programme (LeDeR)	✓	✓	100%
Maternal, New-born and Infant Clinical Outcome Review Programme	✓	✓	100%
Medical and Surgical Clinical Outcome Review Programme (National Confidential Enquiry into Patient Outcome and Death, NCEPOD)- Epilepsy	✓	✓	80% (4/5)
National Adult Diabetes Audit – National Diabetes Core Audit	✓	X	0%
National Adult Diabetes Audit –National Pregnancy in Diabetes Audit	✓	✓	100%
National Adult Diabetes Audit –National Diabetes Foot Care Audit	✓	✓	100%
National Diabetes Audit – Adults: NaDIA-Harms - reporting on diabetic inpatient harms in England	✓	X	0%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Adult Asthma Secondary Care	✓	✓	Partial participation N=60
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	✓	✓	Partial participation N=209
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Paediatric Asthma Secondary Care	✓	✓	100%

Title	Eligible	Participated	% Cases
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Pulmonary Rehabilitation-Organisational and Clinical Audit	✓	✓	100%
National Audit of Breast Cancer in Older People (NABCOP)	✓	✓	100%
National Audit of Cardiac Rehabilitation (NACR)	✓	✓	100%
National Audit of Care at the End of Life (NACEL) 1	✓	✓	100%
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	✓	✓	62%
National Cardiac Arrest Audit (NCAA)	✓	✓	100%
National Cardiac Audit Programme (NCAP) – Cardiac Rhythm Management	✓	✓	100%
National Cardiac Audit Programme (NCAP) - Myocardial Ischaemia National Audit Project MINAP	✓	✓	100%
National Cardiac Audit Programme (NCAP) - National Adult Cardiac Surgery Audit	✓	✓	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 Comparative Audit of Blood Transfusion programme - 2021 Audit of Patient Blood Management & NICE Guidelines	✓	X	0%
National Early Inflammatory Arthritis Audit (NEIAA)	✓	✓	100%
National Emergency Laparotomy Audit (NELA)	✓	✓	100%
National Gastro-intestinal Cancer Programme: National Oesophago-gastric Cancer (NOGCA)	✓	✓	100%
National Gastro-intestinal Cancer Programme: National Bowel Cancer Audit (NBOCA)	✓	✓	100%
National Joint Registry (NJR)	✓	✓	97%
National Lung Cancer Audit (NLCA)	✓	✓	100%
National Lung Cancer Audit (NLCA)/Adult Thoracic Surgery with SCTS	✓	✓	100%
National Maternity and Perinatal Audit (NMPA)	✓	✓	100%
National Neonatal Audit Programme	✓	✓	100%
National Paediatric Diabetes Audit (NPDA)	✓	✓	100%
National Perinatal Mortality Review Tool	✓	✓	100%
National Prostate Cancer Audit	✓	✓	100%
National Vascular Registry	✓	✓	100%
Neurosurgical National Audit Programme	✓	✓	100%
Paediatric Intensive Care Audit Network (PICANet)	✓	✓	100%
Respiratory Audits - National Outpatient Management of Pulmonary Embolism	✓	✓	100%

Title	Eligible	Participated	% Cases
Respiratory Audits - National Smoking Cessation 2021 Audit	✓	✓	100%
Sentinel Stroke National Audit Programme (SSNAP)	✓	✓	100%
Serious Hazards of Transfusion Scheme (SHOT)	✓	✓	100%
Society for Acute Medicine Benchmarking Audit	✓	✓	100%
Transurethral Resection and Single Instillation Mitomycin C Evaluation in Bladder Cancer Treatment	✓	✓	100%
The Trauma Audit & Research Network (TARN)	✓	✓	100%
UK Cystic Fibrosis Registry	✓	✓	100%
Urology Audit - Cytoreductive Radical Nephrectomy Audit	✓	X	0%
Urology Audit - Management of the Lower Ureter in Nephroureterectomy Audit (BAUS Lower NU Audit)	✓	X	0%

Table 3: National Clinical Audits

The reports of 4 national clinical audits were reviewed by the provider in 2021/22 and South Tees Hospitals Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Title of Audit	Actions
NCEPOD Pulmonary Embolism	• Give an interim dose of anticoagulant to patients suspected of having an acute pulmonary embolism (unless contraindicated) when confirmation of the diagnosis is expected to be delayed by more than one hour. • The anticoagulant selected, and its dose, should be personalised to the patient. This timing is in line with NICE QS29 2013. • Document the severity of acute pulmonary embolism immediately after the confirmation of diagnosis. Severity should be assessed using a validated standardised tool, such as 'PESI' or 'sPESI.' This score should then be considered when deciding on the level of inpatient or ambulatory care. • Standardise CT pulmonary angiogram reporting.

	• Look for indicators of massive (high risk) or sub-massive (intermediate risk) pulmonary embolism, in addition to calculating the severity of acute pulmonary embolism • Escalate promptly based on local guidance and document in the case notes. • Assess patients suspected of having an acute pulmonary embolism for their suitability for ambulatory care and document the rationale for selecting or excluding it in the clinical notes. • Provide every patient with an acute pulmonary embolism with a follow-up plan, patient information leaflet and, at discharge, a discharge letter
Royal College of Emergency Medicine (RCEM) Vital Signs in Adults	• Delayed data entry into Symphony from staff performing vital sign recording. Action agreed to highlight adjusting times on Symphony to represent the time vital signs recorded rather than the time entered onto computer to Nursing and Health Care Assistant staff at regular daily huddles. • Staff to use Symphony reminders of timings for repeat observations when abnormal VCS identified at triage • Highlight to junior doctors at induction to document acknowledgement of vital sign recording in clinical notes. • A more in-depth audit to be performed looking at elevated NEWS Scores.
National Neonatal Audit Programme	• Education of all staff on the NICU regarding data input • Employ specific personnel for data entry and data cleansing • Liaison with the ophthalmologists to undertake the examination at the optimal time • Ensuring that babies who have been seen as an outpatient have a robust method of data input following their results
SSNAP Stroke Audit	• Ensure as many patients who are admitted directly to stroke ward as possible are scanned within 1 hr of arrival • Recommend Stroke Nurse Practitioners have greater involvement with stroke admissions that present to A+E earlier • Recommend direct admissions stroke to unit (currently only “in hours”). Key to this is 24/7 Stroke Nurse Practitioner

	Cover and robust medical cover onsite to support the SNPs when required

Table 4: National Clinical Audit Reports

Local Clinical Audits

Local clinical audits undertaken by South Tees NHS Hospitals Foundation Trust in 2021/22 are shown below.

Title of Local Clinical Audits
Hyperglycaemia in Very Low Birth Weight Infants & <= 28 weeks Gestation
LocSSIP Endovenous Checklist LS01
To Compare the Practice of use of Sildenafil in Neonatal Unit
LocSSIP Regional Block Undertaken Outside the Theatre Environment LS04
Appendicectomy Audit
Identification and Initial Management of Obesity in Secondary Care in Paediatrics
Audit of Care for Pregnant Women with Epilepsy
Complex Endometriosis Audit
Management of Decompensated Liver Disease
Management of Pregnancy of Unknown Location (PUL)
Mental Health Audit in Obstetrics against NICE guidance
Audit on the use of Shoulder Dystocia Information Provided to Antenatal Diabetic Patients
Antenatal Multiple Pregnancy Audit
Cochlear Implants During Covid-19
LocSSIP EYLEA Intra-Vitreal Injection Safety Checklist LS16
LocSSIP LUCENTIS Intra-Vitreal Injection Safety Checklist LS17
Evaluation of the Short-term Impact of COVID-19 on General Surgical Services for Colorectal Cancer in our Hospital.
LocSSIP Imaging Under General Anaesthesia or Sedation Checklist LS27
5 Day COVID Swab Audit
LocSSIP Dermatology Minor Skin Surgery LS41
LocSSIP Ascitic Tap - Drain Insertion LS62
Evaluation of our Practice Regarding Sodium-glucose co-transporter-2 (SGLT 2) Inhibitors in Patients with Type 2 Diabetes Mellitus and Coronary Artery Disease
LocSSIP IVF Surgical Safety LS70
Antibiotic Prescribing in Acute Medicine
2-year audit of NICE TA573: Daratumumab with Bortezomib and Dexamethasone for Previously Treated Multiple Myeloma

An Audit to Assess Knowledge of Nickel Allergy Management by Orthodontic Clinicians
Audit of Turn-round Time in Neuropathology
Medical Neglect Audit - Paediatrics
Use Of Clinical Frailty Scales by Community Therapy Teams
The Level of Adherence to the Trust Antimicrobial Policy in Prescribing Antibiotic Across the Orthopaedic & Vascular Wards
Re-audit of Recording of x-ray interpretation in patients' notes: urgent and emergency cases
Chest X-ray Audit
Management of Babies Born to Mothers with Grave's Disease
ENT Results Management Pathway
A Retrospective Clinical Audit to Compare the Effectiveness of Providing Bowel and Bladder Information to Patients Referred for Radiotherapy for Cervix or Uterine Cancer in Advance of Radiotherapy CT Planning Appointments
2-Year Audit of NICE TA573: Daratumumab with Bortezomib and Dexamethasone for Previously Treated Multiple Myeloma
Head Injury (HI) in Children - Are we following NICE Guidelines (CG176)
Audit of Referrals in the Major Trauma Psychology Service
VTE Risk Re-assessment in Urgent and Emergency care
Adequacy of Ankle Radiographs in Trauma Audit
Correct Patient Identification on ECGs in the Emergency Department
Urinary Catheter Audit – Older Person's Medicine
Audit of Revision Total Knee Replacement Surgical Practice Against BOA Surgical Practice Standards
Compliance of Non-invasive ventilation Prescription in Acute Respiratory Failure
Group B Strep Audit - Obstetrics
Inpatient Oxygen Prescription Audit in Acute Medicine
Assessing Analgesia for Patients Presenting to the Emergency Department with Fractured Neck of Femur
Sarilumab eligibility compliance among COVID 19 patients in Ward 9 JCUH
Insulin Prescription in Acute Admission
Community Prevalence and Management of Vitamin D Deficiency (Hypovitaminosis D)
Were the Haematology MDT Outcomes Followed Up by the Treating Consultants?
LocSSIP ERCP Safer Endoscopy Checklist LS09

Table 5: Local Clinical Audits

GETTING IT RIGHT FIRST TIME PROGRAMME (GIRFT)

Getting It Right First Time (GIRFT) is a national programme designed to improve medical care within the NHS by reducing unwarranted variations. By tackling variations in the way services are delivered across the NHS, and by sharing best practice between Trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies, such as the reduction of unnecessary procedures, and cost savings.

GIRFT collaborates and works in genuine partnership with NHS Trusts, specialist clinical professional bodies (Royal Colleges and societies), and its partner NHS organisations in collating, scrutinising and sharing data, highlighting both underperformance and excellence. This evidence has had a major impact in identifying variation in clinical outcomes and has provided the focus for hospital teams, departments and clinical networks to tackle unwarranted variation, where it exists, through benchmarking and adopting best practice.

The NHS benefits through improved productivity, efficiency and capacity, which in turn benefits patients, who can receive treatments quicker, have more equity of access to high quality care, and have better outcomes.

South Tees Hospitals NHS Foundation Trust (STHFT) has established a central support function to facilitate and co-ordinate the GIRFT programme on behalf of the organisation via the corporate quality surveillance team with support from the operational administration staff from the service specialty teams in its Collaboratives and linking with operational colleagues and clinical leads from the organisation.

During 2021/2022 seven virtual GIRFT deep dive visits have been undertaken; six initial visits to Emergency Medicine, Geriatric Medicine, Neonatology, Oral and Maxillo-facial Surgery, Paediatric Critical Care (operational delivery network review), Rheumatology, and one re-visit to Urology services. Further deep dive visits are planned in 2022.

Observation notes have been received identifying recommendations for improvement as well as notable good practice for each of the specialties. The potential improvement opportunities (main cross-cutting themes) include coding, specifically relating to more accurate coding of specialty and treatment function codes. A coding review is now currently underway at the Trust and specialties are meeting with colleagues in coding on a regular basis to ensure accurate recording of specific clinical information. Specialities are also working to ensure implementation of GIRFT's 5-point plan for

reducing litigation costs as this has also been a cross-cutting theme for potential improvement. Each specialty has its own further areas for improvement noted within action plans.

At Trust level the recommendations found in the specialties are collated and developed into a single implementation action plan. Monitoring the delivery of implementation action plans is undertaken by the Corporate Quality Surveillance Team with progress reported through the Trusts governance structure.

In 2021/2022 a total of 27 specialty implementation plans have been reviewed and updated following GIRFT deep dives. The table below illustrates the Trusts participation in the GIRFT national programme:

Work Stream Specialties	Initial Visit Date	Re-visit Date
Acute & General Medicine	23/09/2019	Planned for 2021 – delayed due to Covid
Anaesthetics & Peri-operative Medicine	19/12/2018	
Breast Surgery	13/02/2020 postponed	
Cardiology	25/09/2019	
Cardiothoracic Surgery	31/08/2017	19/05/2022
Cranial Neurosurgery	29/09/2016	31/07/2020
Dermatology	27/03/2019	
Diabetes	22/05/2020 postponed	
ENT	08/01/2018	
Endocrinology	01/10/2019	
Emergency Medicine	11/05/2021	
Gastroenterology	30/08/2019	
General Surgery	03/12/2018	
Geriatric Medicine	12/10/2021	
Hospital Dentistry	01/09/2018	03/07/2019
Imaging & Radiology	11/03/2019	
Intensive & Critical Care	18/07/2018	
Lung Cancer	28/09/2020	
Neonatology	17/02/2022	
Neurology	15/05/2019	22/01/2021
Obstetrics & Gynaecology	17/07/2017	
Orthopaedic Surgery	31/01/2014	01/10/2018
Orthopaedic Trauma Surgery (adult)	09/05/2022	
Ophthalmology	10/05/2017	Planned for 2021 – delayed due to Covid
Oral & Maxillo-Facial Surgery	05/08/2021	
Outpatients	TBC	

Work Stream Specialties	Initial Visit Date	Re-visit Date
Pathology	07/09/2021	
Paediatric Critical Care (ODN)	10/06/2021	
Paediatric General Surgery	01/02/2018	
Paediatric Ortho (Trauma & Elective)	20/10/2020	
Plastics/Burns/Hand Surgery	05/10/2020	
Renal	06/03/2019	
Respiratory	TBC	
Rheumatology	29/10/2021	
Spinal Surgery	05/07/2017	Planned for 2021 – delayed due to Covid
Stroke	15/03/2019	
Urology	15/03/2017	01/10/2021
Vascular	05/10/2016	12/10/2018

Table 6: GIRFT Deep Dives

The GIRFT team is working with local systems to help the NHS with post-COVID-19 elective recovery and restoration of services, aiming to reduce the backlog of patients waiting for operations and improve outcomes and access to care. Up to 60% of people on waiting lists need high-volume surgery, such as cataract removal, hernia repairs or joint replacement operations. The Trust is now engaging with GIRFT's High Volume Low Complexity (HVLC) programme which is focusing initially on driving improvement in six high-volume specialties – ophthalmology, general surgery, trauma and orthopaedics (including spinal surgery), gynaecology, ENT and urology and will support with other surgical and medical specialties going forwards to agree standardised pathways and adopt best practice, as well as pooling capacity and resources, to deliver excellent clinical outcomes and equity of access to care for its population.

ANNUAL QUALITY SURVEILLANCE PROGRAMME

Annual Assessment Outcomes

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 and the submission deadline is set to 30 June each 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).

Due to the Covid-19 pandemic the annual self-declaration process for 2021/2022 was paused and the QSIS portal did not open for submission on 1 April 2021. The specialised and cancer peer review routine programme visits for 2021/2022 also remained paused. However, the Trust continued to monitor progress against those services that were deemed non-compliant in 2019/20 following annual assessments, via a Service Development Improvement Plan (SDIP). The SDIP is now well embedded within the Trusts governance structure with reporting on a quarterly basis. Workforce issues remain the main theme of non-compliance hampered by challenges due to Covid related staffing absences, with some specialties being able to recruit into positions where previously this has been a struggle, e.g., restorative dentistry.

Specialised Services Quality Dashboards

During 2021/2022 the Specialised Services Quality Dashboard (SSQD) submission process has continued on a voluntary basis and the Trust has maintained 90% of its data submissions.

The table below lists the Trusts specialised services that required submission of data against a set of metrics for 2021/22:

Specialised Service	Internal/External Source Requirements	Comments
Adult Critical Care: • General Critical Care	External Source Data (Intensive Care and National Audit & Research Centre (ICNARC) Required quarterly	Populated via ICNARC and validated by Trust
Adult 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 Chemotherapy (Adult)	External and Provider data Required quarterly	New requirement from Q2 2020/21 only
Cancer Malignant Mesothelioma	Provider data Required quarterly	New requirement for 2020/21 Provider data populated and validated by Trust

Cardiac Surgery (Adults)	External Source Data (Hospital Episode Statistics (HES) Required quarterly	Data populated from external source and validated by Trust
Cardiology: • Cardiac Magnetic Resonance Imaging (Adult)	Provider data Required quarterly	New requirement for 2019/2020 Provider data populated and validated by Trust
Cardiology: • Electrophysiology & Ablation Services	External source data Required quarterly	Data populated from external source and validated by Trust
Cardiology: • Implantable Cardioverter Defibrillator and Cardiac Resynchronisation Therapy (Adult)	Provider data Required quarterly	Provider data populated and validated by Trust
Cardiology: • Primary Percutaneous Coronary Intervention (Adult)	Provider data Required quarterly	Provider data populated and validated by Trust
Colorectal: • Faecal Incontinence (Adult)	Provider data Required quarterly	Provider data populated and validated by Trust
Complex Disability Equipment – Prosthetic Specialised Services for people of all ages with limb loss	Provider data Required annually	Provider data populated and validated by Trust
Cystic Fibrosis (Children)	Provider and external source data requirement quarterly	Provider data populated and validated by Trust
Adult 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 (with provider data required for Q4)
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	Provider data populated and validated by Trust
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 Q3 only
Specialised Burn Care: • Adults • Paediatrics	External Source Data International Burn Injury Database (IBID) Required quarterly	Data populated from external source and validated by Trust
Specialised Complex Surgery for Urinary Incontinence and Vaginal and Uterine Prolapse (16 years and above)	Provider data Required quarterly	New requirement for 2020/21 Provider data populated and validated by Trust
Specialised Endocrinology Services (Adult)	Provider data Required quarterly	Provider data populated and validated by Trust
Specialised Human Immunodeficiency Virus (HIV) Services (Adult)	External Source Data HIV and AIDS Reporting System (HARS) Required annually	Data populated from external source and validated by Trust. Annual submission in Q3
Specialised Immunology (All Ages)	External Source Data (MDAS) Required quarterly	Data populated from external source and validated by Trust
Specialised Kidney, bladder and prostate Cancer Services (Adult)	Provider data Required quarterly	Provider data populated and validated by Trust
Specialised Vascular Services (Adult): Arterial	Provider data Required quarterly	Data not yet submitted by the Trust for 2019/2020

Spinal Cord Injuries (All ages)	External Source Data National Spinal Cord Injury Database (NSCID) Rolling annual requirement/quarterly	Data populated from external source and validated by Trust
Thoracic Surgery (Adult)	Provider data	New requirement for 2019/2020 Provider data populated and validated by Trust

Table 7: Specialised Services Submission Data

MANAGEMENT OF COMPLIANCE AND REGULATORY VISITS, INSPECTIONS AND ACCREDITATION

During 2021/2022 work was undertaken on strengthening the process for the management of compliance and regulatory visits, inspections and accreditation to ensure a robust register of external visits. This has included: -

- Review of a proforma to report details of visits to ensure all requirements are met
- Update of Corporate Register with alert and flagging rules to indicate when reports are due and completed
- Regular monthly briefings via the Trust briefing, with follow-up emails/calls made to departments by the quality surveillance team
- Work with public relations to highlight process and provide relevant information on a quality surveillance page held on the Trust intranet site.

Clinical Research

Clinical research is a national and Trust priority. The 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 subcontracted by

South Tees NHS Foundation Trust in 2021/22 that were recruited during that period to participate in research approved by a research ethics committee is 3421 (across 129 studies).This number does not include participants recruited into the NOVAVAX COVID vaccine trial at University Hospital of Hartlepool, which was delivered by R&D staff from across the whole Durham Tees Valley Research Alliance (DTVRA) including from this Trust.

By way of comparison the Trust recruited 3196 patients enrolled in 162 different research studies in 2019/20 and 4651 patients in 80 studies in 2020/21. While the number of recruits decreased year-on-year, 2020/21 was a typical year dominated by Covid research activity and the increased number of recruiting studies is a positive sign in terms of subsequent efforts to re-open and increase non-Covid research.

74% of studies met the National Institute for Health Research (NIHR) advisory target (40 days from receiving a complete research application) for setting up new trials; staff capacity and external delays contributed to this lower % but the Research and Development Team have appointed new team members and implemented several new measures to improve this figure in 2022/23.

The Trust continued its formal research alliance with two other local 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). This restructure created 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 was awarded 3 NIHR grants, a European Commission grant and other commercial and charity 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. Feedback from patients who have participated in NIHR studies within the Trust is sought via the NIHR “Patient Research Experience Survey” with feedback reviewed at our monthly Research and Development Team Directorate meetings.

Goals Agreed with Commissioners – use of the CQUIN Payment Framework

During 2021/22 block payments were made to NHS Providers and were deemed to include CQUIN, there were no separate CQUIN schemes nor was there a separate allocation of funding.

Care Quality Commission (CQC) Compliance

South Tees Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is unconditional.

South Tees Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during 2021/22.

The overall rating for the Trust is 'requires improvement" following an inspection in 2019/20. The CQC conducted a focused inspection on a small number of wards at The James Cook University Hospital and Friarage Hospital on 9-10 February 2022. As this was not a full inspection, it did not look at all the improvements the Trust has made since 2019 and the Trust's overall 'requires improvement' rating has not changed. During their visit, the CQC recognised the enormous efforts of colleagues in the face of unprecedented Omicron winter pressure on services at the time of their inspection and issued a Section 29A warning notice identifying improvements to take place over the coming months on ward-based documentation, nutrition and hydration, MCA/DOLS and discharge. The trust was already acting on these areas as part of its clinically led recovery from the winter Omicron surge, which at its peak saw more than 500 COVID-related staff absences and has now made additional changes following feedback from inspectors.

A CQC Project Team has supported a weekly meeting to review evidence of progress with embedding actions from the 2019 inspection, and evidence of compliance with standards and key lines of enquiry. The Trust continues to work as part of its recovery from COVID-19 to ensure robust evidence of compliance. Progress updates were provided to the CQC Compliance Group, Quality Assurance Committee and the Trust Board and continues to work as part of its recovery from COVID-19 to ensure robust evidence of compliance on the necessary changes, learning and improvement. The Trust is fully compliant with the registration requirements of the Care Quality Commission.

Ward Accreditation

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 of Quality and Care (STAQC) programme has been aligned with the CQC fundamental standards and key lines of enquiry, the integrated performance report and the Trusts objectives. The programme compliments and enhances professional knowledge and empowers staff and teams to make the changes they want to make. STAQC celebrates the positive

impact of strong multi-disciplinary partnership working and allows a culture of continuous improvements to deliver safe, effective, compassionate care to patients.

The STAQC team have assessed 34 areas for accreditation since March 2021; 18 areas have achieved diamond accreditation on the first attempt, 15 areas have achieved gold accreditation on the first attempt and one area has been awarded silver after assessment.

NHS Number and General Medical Practice Code Validity

South Tees Hospitals NHS Foundation Trust submitted records during 2021/22 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 latest published data for December 2021 data which:

Included the patient's valid NHS number was:

- 99.8% for admitted patient care;
- 99.9% for outpatient care; and
- 98.6% for accident and emergency care

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

- 100% for admitted patient care;
- 100% for outpatient care; and
- 100% for accident and emergency care

Data Security & Protection Toolkit Compliance

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

The 2021/22 DSPT submission is assessed against compliance with 38 assertion areas which are comprised of over 149 pieces of evidence, 110 of these are mandatory.

Due to the impact of COVID-19 the submission dates have been moved to the 30th June 2022. The Trust maintains an action plan regarding compliance which is monitored at the bi-monthly Information Governance Steering Group and reported to the Trusts Senior Information Risk Owner (SIRO) as well

as being reviewed by the annual DSPT Internal audit review. This year the review has been performed by Klynveld, Peat, Marwick, Goerdele, (KPMG) as part of a national standardisation exercise, the findings of which are monitored and discussed at the Trusts Audit and Risk Committee.

Last year's submission (2020/21) was confirmed as "Standards Not Met – Plan Agreed" with 4 outstanding items of the 110 requirements – although compliance was not ultimately achieved during the year (and these areas remain non-compliant in the 2021/22 submission) the plan was regularly updated and submitted as approved by NHS Digital.

Currently 92 of the 110 requirements have been met and the action plan will be submitted to NHS digital to update the trusts compliance which will be "Standards Not Fully Met - Plan Agreed". Information on the final submission due in June 2022 will be included in next year's Quality Accounts.

Additionally, with the raised awareness regarding cyber security risks due to the Ukraine conflict, NHS organisations where required to provide an update on six key areas of cyber security compliance within the DSPT as part of an immediate follow up process with NHSE/I once baseline DSPT submissions where made. The Trust provided assurance that 2 of 6 areas were implemented and the remaining four partially compliant with action plans in place to implement prior to the 2021/22 DSPT final submission deadline (30/06/2022).

Clinical Coding

South Tees Hospitals NHS Foundation Trust was not subject to a Payment by Results clinical coding audit during 2021/22 by the Audit Commission.

Learning from Deaths

During 2021/22, 1,940 patients of South Tees Hospitals NHS Foundation Trust died. This comprised the number of deaths which occurred in each quarter of that reporting period:

425 in the first quarter;
485 in the second quarter;
508 in the third quarter;
522 in the fourth quarter.

By 31st March 2022, 1,934 case record reviews and 27 investigations have been carried out in relation to 1,940 deaths above. In 27 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:

4 in the first quarter;
10 in the second quarter;
10 in the third quarter;
3 in the fourth quarter

There were 3 deaths, representing 0.2% of the patient deaths during the reporting period, that were 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;
2, representing 0.4% for the second quarter;
0, representing 0% for the third quarter;
0, representing 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 of 6 consultants with expertise across many specialties. Each review results in 2 grades, one for quality of care and one for preventability of the death. Particularly complex cases are further reviewed by a cross-specialty panel of senior medical and nursing staff.

117 case record reviews and 27 investigations were completed after 31/03/2021 which related to deaths which took place before the start of this reporting period.

Staff who 'Speak Up' (Including Whistle-blowers)

As part of the adoption of the new model, significant investment was made in Freedom to Speak up (FTSU). The goal of this investment was to continue to change and improve the culture across the organisation. Senior leaders, the Board, Chair and Chief Executive have been proactive in ensuring the service was strengthened and that the Guardians had access to senior leaders when needed.

Following an open recruitment and selection process, a team of Guardians were appointed with ring-fenced time dedicated to raising awareness of FTSU and dealing with issues raised. In the last twelve months the model has seen a significant shift in the way the model was implemented and the views of the 9,300 colleagues the Guardians work with.

The increased visibility, awareness and accessibility to the Guardians and their increased profile have assisted the Trust to answer concerns raised in a timely manner. This has been met with positive outcomes recorded for many concerns raised.

A wide range of data is collected by the FTSU Guardians. The information collected and collated in the last twelve months reflects the significant positive impact the model for speaking up has had for staff and patients between April 2021 and March 2022.

A total of 107 issues were raised with the FTSU Guardians during this time, compared to 57 reported during 2020 to 2021, an increase of just over 100%.

42% per cent of colleagues chose to raise issues anonymously, 26% were raised openly and 32% were raised confidentially.

The Freedom to Speak up ethos and message is being introduced across the Trust in all induction and preceptorship programmes. We have recently linked with the clinical educators for newly appointed Health Care Assistants to ensure FTSU is included as part of their care certificate when joining the Trust. The Guardians have also forged excellent links with the University of Teesside and regularly delivering sessions to healthcare students across the board.

We were delighted to be finalists in the HSJ awards 2021 as the Freedom to Speak up organisation of the year. Though we did not win, the recognition we received for being the most improved acute Trust in the Freedom to Speak up index 2020-2021 is a testament to the hard work the team has put in and the investment from the Trust to ensure speak up is business as usual at South Tees.

We have re-established our network of 24 Freedom to Speak up champions from across the organisation. Our champions range from administrative and clerical staff to consultant and military colleagues. We have ensured we have FTSU champions in our satellite sites and within the community setting.

The FTSU Guardians have undertaken a gap analysis based on 8 National Guardians Office (NGO) case reviews to ensure the Trust is benchmarked against these. We are pleased to report there are no outstanding recommendations rated red, with the gap analysis nearing completion with all actions being achieved by the end of the financial year. The Guardians will continue to perform gap analysis on any further case reviews published by the NGO.

The Guardians have developed guidance for investigators, as well as a report template to ensure consistency and a unified approach when concerns are being investigated and fed back to the team which has been well received by appointed investigators.

The Guardians have also developed a Standard Operating Procedure (SOP) to allow Freedom to Speak Up Guardians to perform high level peer sampling on a quarterly basis to ensure that all required evidence is being maintained for cases and that the correct process is being followed.

Feedback to Staff

Colleagues continue to 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.

Feedback is important to ensure cases are closed and any learning is identified. It also provides staff with reassurance their concerns are taken seriously and investigated. A section on the report template is provided to investigators to detail how feedback was assimilated. Staff are also encouraged to report detriment to the Guardians, and this is monitored and reported back to the National Guardians Office.

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 which are grouped together measures and 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

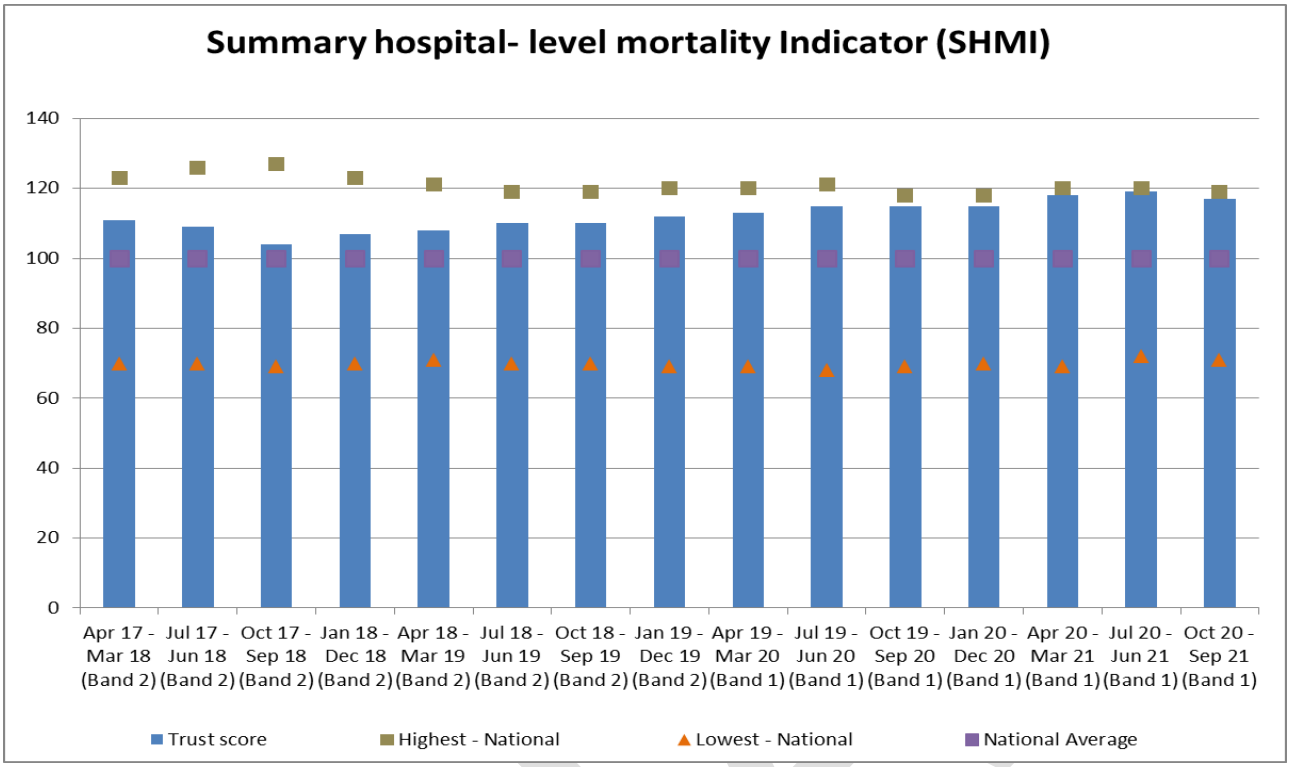


Figure 6: Summary Hospital Level Mortality Indicator (SHMI) (Data source: NHS Digital)

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

1. The SHMI is not designed to account for the COVID-19 pandemic and although spells coded for COVID-19 have been removed by NHS Digital from the indicator calculation, the large reduction in the number of admissions to hospital, particularly during wave 1, has had a substantial impact on the expected number of deaths. Therefore, although the number of observed deaths has fallen compared to previous years, the expected number of hospital deaths has fallen by a greater number due to reduction in the number of admissions. The fall in the number of admissions has not been experienced evenly across the country, with areas with high levels of COVID-19, such as the North-East, experiencing a greater impact.

2. Despite the high level of need in the population the Trust serves, the organisation has historically fallen behind other Trusts in recording the number of other medical conditions patients have, alongside the main illnesses being treated. The Trust is in the process of implementing electronic records systems which are expected to address this comorbidity recording anomaly.

3. Patients who are treated within a single day for unplanned care without the need for admission are currently moved from the dataset, which is used to calculate SHMI, to another emergency

care dataset and this therefore removes low-risk patients from the dataset's calculation. This change in the way patients who are treated within a single day for unplanned care without the need for admission are recorded, has taken place earlier than in other Trusts.

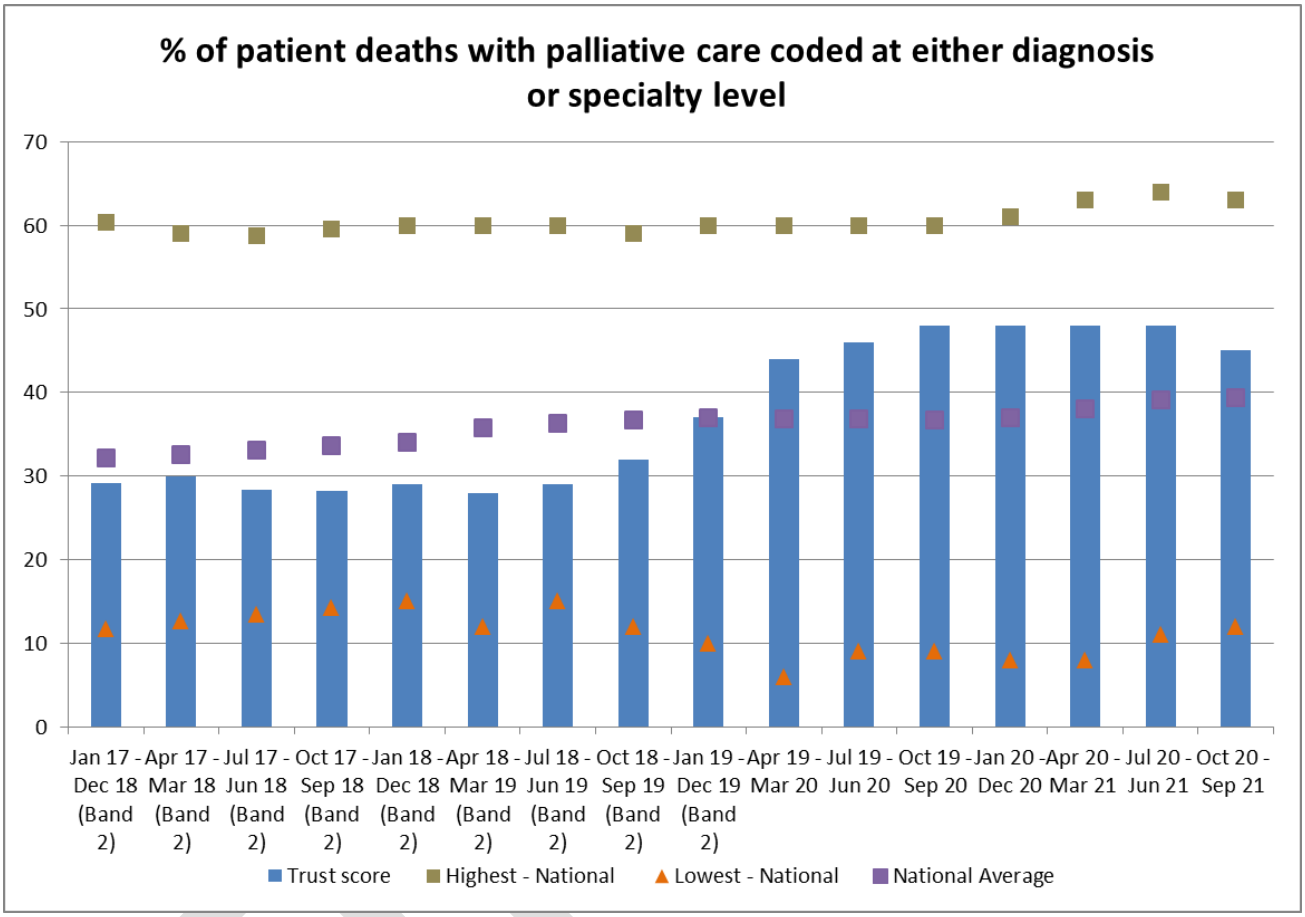


Figure 7: Percentage of Patient Deaths with Palliative Care Coded (Data source: NHS Digital)

The percentage of patient deaths with specialist palliative care coding has been higher than the national average in the last seven reporting periods. There has been a small fall in the last reporting period as the number of spells rises after the pandemic, but this indicator is stable at above 45%. This reflects the work that was done to ensure that all the specialist palliative care provided to patients was captured in the coding used to calculate SHMI. This involved a comparison between two digital systems used to record the care provided.

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

- The Trust has governance committees which monitor and respond to mortality information and the Quality Assurance Committee in particular coordinates hospital safety and improvement activity.

- The Trust regularly reviews the range of statistics available to monitor hospital mortality, establishing the Medical Examiner Service in May 2018 (the first in the North-East), overseeing trust and specialty level case note reviews of hospital deaths so that common themes can be identified, and lessons can be learnt to improve the quality of its services.

The number of deaths in the Trust is variable from year to year, depending on the severity of respiratory and other seasonal infections each year and the pattern during the COVID-19 pandemic has been unlike any previous year in the Trusts' history. However, the trend outside the seasonal variations and the pandemic years has remained stable over a long period of time, despite an aging population and increasing complexity of the condition's 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.

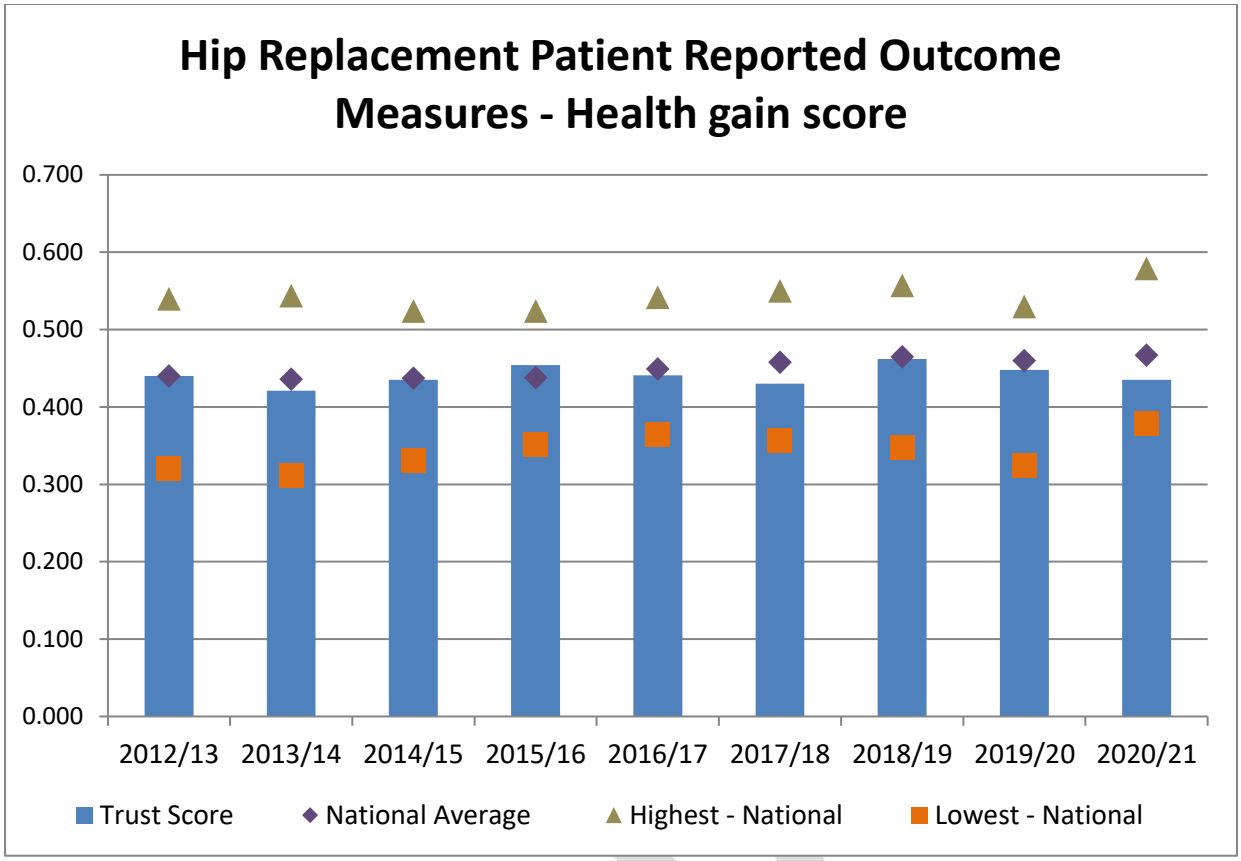


Figure 8: Hip Replacement PROMS

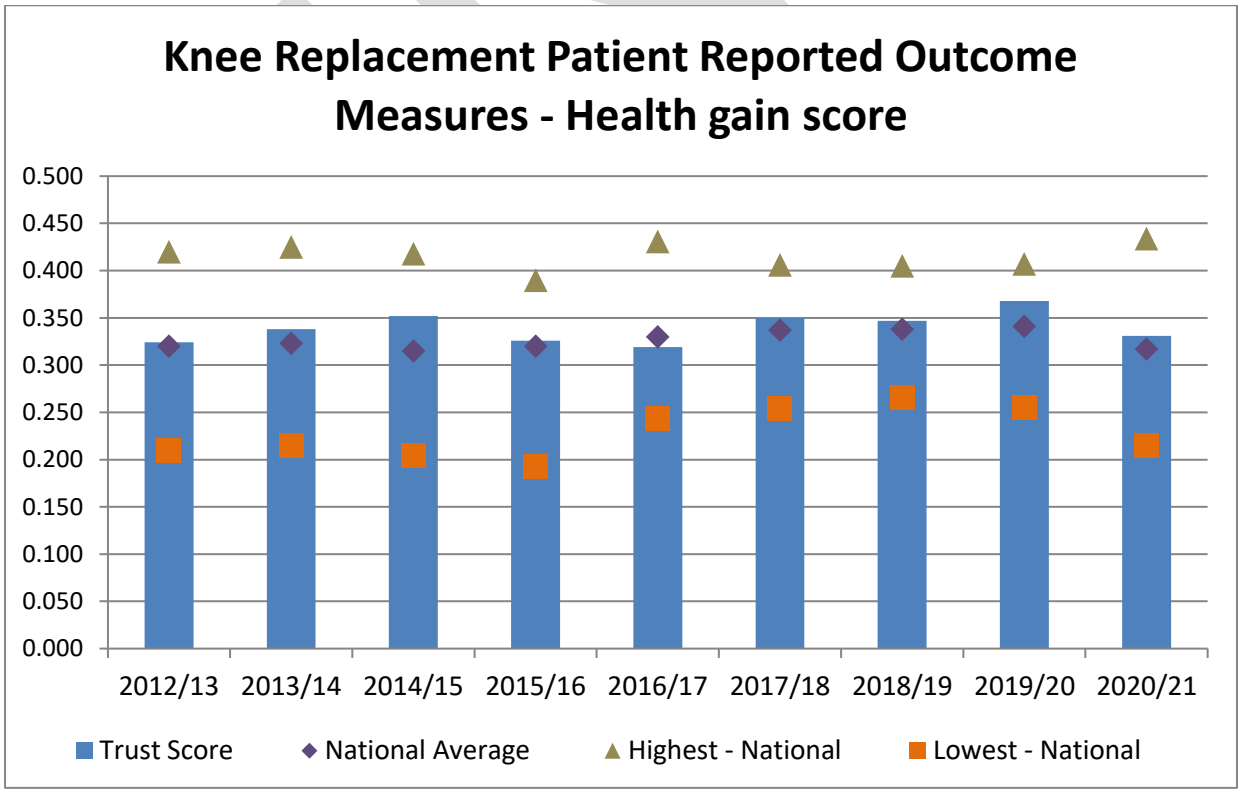


Figure 9: Knee Replacement PROMS (Data source: NHS Digital)

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.

Production of data has been disrupted by the COVID-19 pandemic.

Re-admission within 28 days

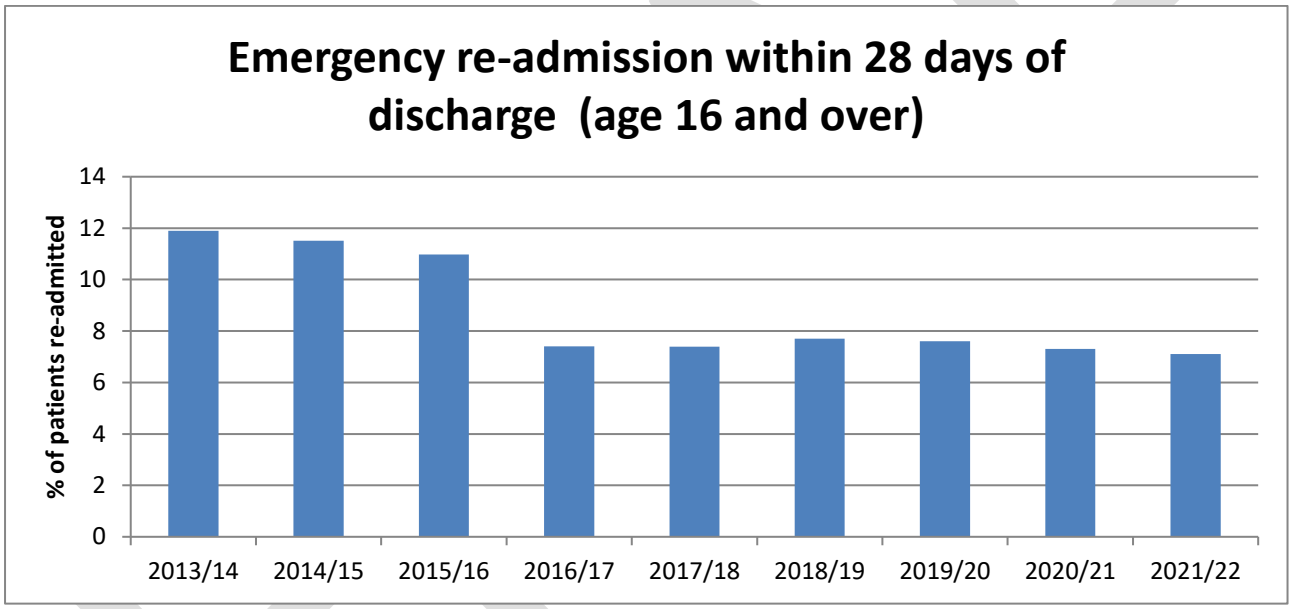


Figure 10: Emergency Readmissions Aged 16 and over (Data source: Local patient administration system)

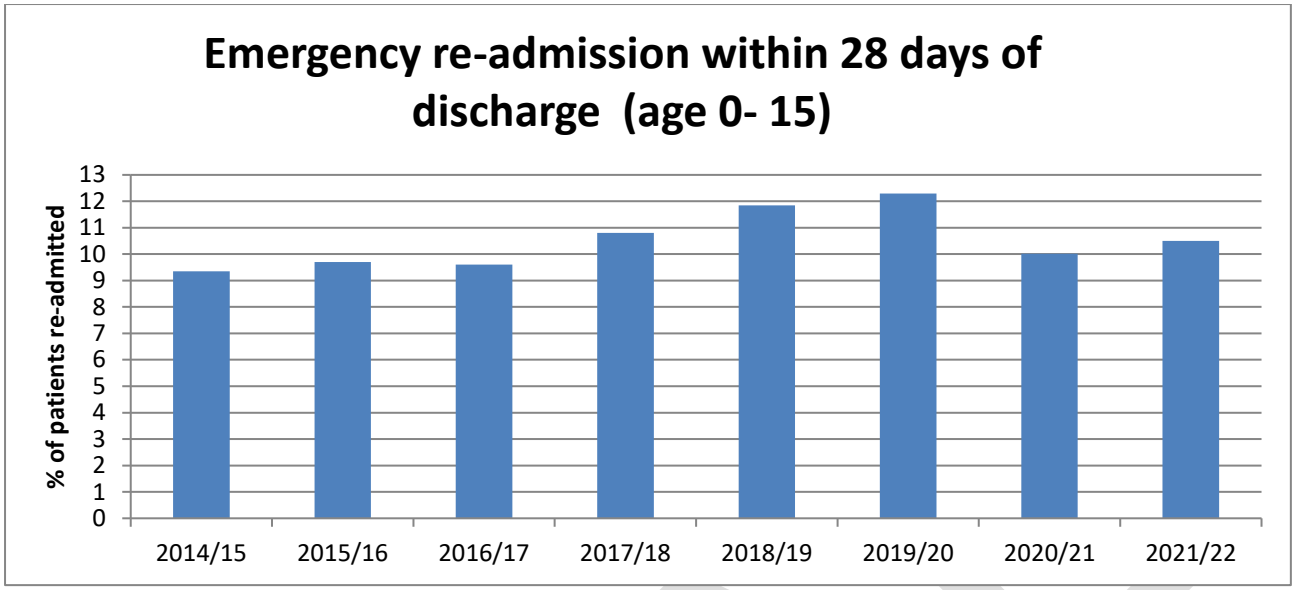


Figure 11: Emergency Readmissions Aged under 16 (Data source: Local patient administration system)

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 decreased from 7.3% in 2020/21 to 7.1% in 2021/22.

Domain 4 - Ensuring people have a positive experience of care

Responsiveness to the personal needs of patients

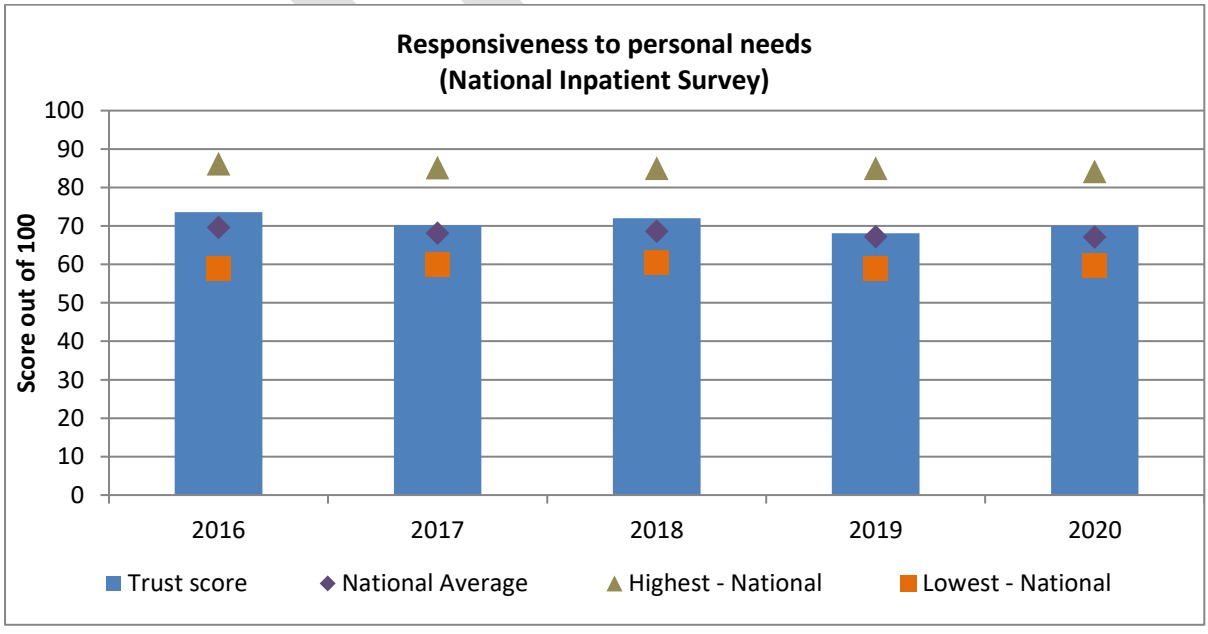


Figure 12: Responsiveness to Personal Needs

South Tees Hospitals NHS Foundation Trust considers that this data shows that the Trust scores above the national average. The Trust intends to continue to capture and analyse patient experience to improve its services.

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

	Apr-21				May-21				Jun-21			
	Response Rate		% Positive Feedback		Response Rate		% Positive Feedback		Response Rate		% Positive Feedback	
	Trust	England	Trust	England	Trust	England	Trust	England	Trust	England	Trust	England
Inpatient	17%	19%	96%	94%	17%	20%	97%	95%	12%	19%	93%	94%
A&E	6%	11%	86%	84%	5%	11%	84%	82%	4%	10%	81%	79%
Antenatal			-	90%			-	92%			89%	90%
Birth	-	12%	*	96%	-	12%	*	95%	-	11%	*	93%
Postnatal ward			91%	94%			99%	94%			97%	91%
Post natal			*	92%			*	94%			100%	92%
Outpatient	1%	7%	96%	94%	8%	7%	96%	93%	2%	7%	97%	93%
Community	1%	3%	100%	95%	1%	4%	97%	96%	2%	3%	96%	95%

	Jul-21				Aug-21				Sep-21			
	Response Rate		% Positive Feedback		Response Rate		% Positive Feedback		Response Rate		% Positive Feedback	
	Trust	England	Trust	England	Trust	England	Trust	England	Trust	England	Trust	England
Inpatient	12%	19%	93%	94%	8%	19%	96%	94%	10%	18%	97%	94%
A&E	5%	10%	80%	76%	6%	10%	81%	77%	4%	10%	80%	75%
Antenatal			89%	90%			93%	90%			93%	87%
Birth	-	11%	*	93%	-	11%	*	93%	-	10%	*	92%
Postnatal ward			97%	91%			96%	92%			100%	91%
Post natal			100%	92%			92%	90%			*	89%
Outpatient	2%	7%	97%	93%	1%	6%	97%	93%	1%	7%	97%	92%
Community	2%	3%	96%	95%	2%	3%	100%	95%	3%	2%	98%	94%

	Oct-21				Nov-21				Dec-21			
	Response Rate		% Positive Feedback		Response Rate		% Positive Feedback		Response Rate		% Positive Feedback	
	Trust	England	Trust	England	Trust	England	Trust	England	Trust	England	Trust	England
Inpatient	11%	18%	97%	94%	11%	18%	97%	94%	9%	17%	98%	94%
A&E	5%	10%	80%	75%	4%	10%	80%	77%	4%	10%	85%	80%
Antenatal			97%	85%			86%	91%			92%	91%
Birth	-	10%	*	93%	-	11%	*	95%	-	9%	*	94%
Postnatal ward			100%	89%			-	92%			98%	91%
Post natal			*	90%			*	89%			*	88%
Outpatient	1%	7%	97%	92%	1%	7%	95%	93%	1%	6%	96%	93%
Community	3%	2%	100%	94%	5%	3%	99%	94%	3%	2%	100%	95%

	Jan-22				Feb-22			
	Response Rate		% Positive Feedback		Response Rate		% Positive Feedback	
	Trust	England	Trust	England	Trust	England	Trust	England
Inpatient	8%	17%	96%	94%	11%	18%	96%	94%
A&E	7%	10%	81%	81%	6%	10%	80%	77%
Antenatal			91%	91%			83%	90%
Birth	-	10%	*	94%	-	11%	*	94%
Postnatal ward			98%	93%			99%	92%
Post natal			*	92%			*	91%
Outpatient	2%	7%	95%	93%	3%	7%	97%	93%
Community	2%	3%	100%	95%	3%	3%	99%	94%

Table 8: Percentage of Staff who would recommend the Trust (Data source: NHS Digital)

The South Tees Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: response rates in some areas are below that of England, however the majority of positive feedback in all areas is at or above that of England.

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 several 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 most recently available national VTE risk assessment data (Q3, 2019-2020) showed that we exceeded the national target of 95% compliance, with a local figure of 95.3%. Since this time VTE data collection and publication has been suspended to release capacity in providers and commissioners to manage the COVID-19 pandemic.

At South Tees Hospitals NHS Foundation Trust, we continue to monitor our own data monthly. We did notice a downward trend in compliance in 2021 to figures as low as ~85%. Looking at the data collection in more detail reveals several concerns about the accuracy of our own data, primarily, inclusion of patients seen in an emergency assessment unit but not admitted to hospital, and patients seen as a day case but not admitted to a hospital bed. There is ongoing work to try and ensure accurate data collection. Where any clinical concerns have been identified these have been addressed with the clinical area.

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

Clostridioides difficile (C. difficile) Infections

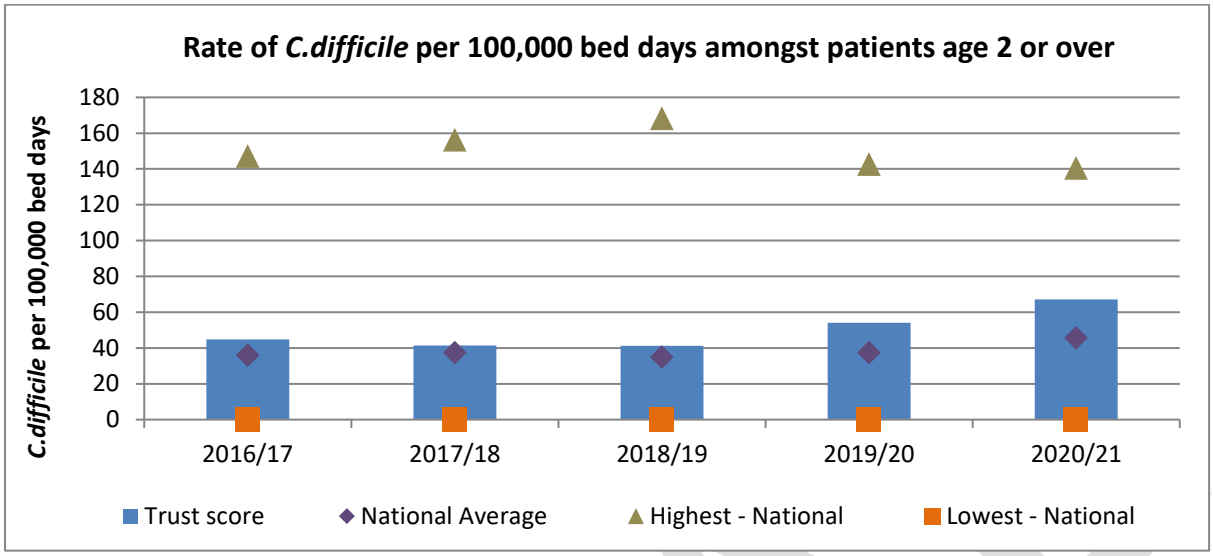


Figure 13: Rate per 100,000 bed days of cases of *C. difficile* infection reported within the Trust amongst patients aged 2 or over. (Data source: NHS Digital)

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 C. *difficile* infections in 2018/19, with a slight increase again in 2019/20 and a further increase in 2020/21 surpassing previous years as indicated in the graph above.

The South Tees Hospitals NHS Foundation Trust has taken actions to improve this rate, and so the quality of its services; the Trust has a comprehensive recovery action plan for the prevention of trust-attributed C. *difficile* infections which is monitored through the Infection Prevention & Control Strategic Group and reported through to the Safe and Effective Care Strategic Group. In addition to this all trust-attributed cases have a Root Cause Analysis (RCA) panel and more recently a Structured Review panel undertaken. Panel reviews are chaired by the Director/Deputy Director of Infection Prevention & Control (DIPC/DDIPC) and attended by CCG colleagues. If the panel agrees that there were no gaps in care, then the case may be discounted from the total for performance measurement purposes. These panels were postponed during COVID-19 but have picked up the trust-attributable cases via internal review and the RCA process from September 2021 onwards, with the introduction of the new structured review process commencing in March 2022.

Identifying a single root cause in cases of C. *difficile* is challenging and is often associated with one or more influencing factors; patient factors e.g., existing long-term conditions, and/or medical factors such as the requirement for antibiotics or laxatives and/or process concerns, e.g., delays in isolation.

Learning from the Structured Review process and aligned to the recovery plan the Trust has implemented a weekly C. *difficile* escalation meeting with the senior nursing team and a Task & Finish group to complete actions reporting into the wider organisation.

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

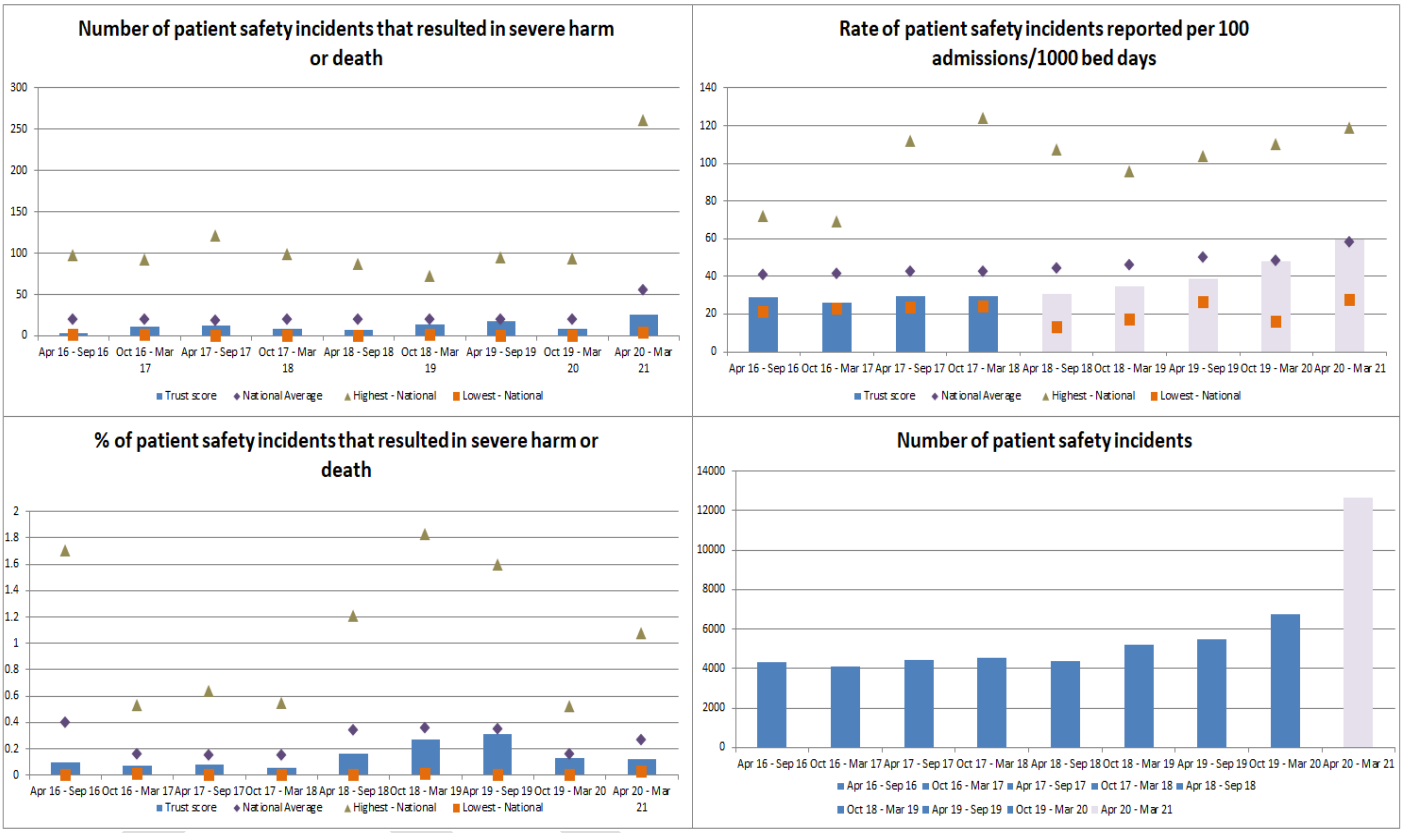


Figure 14: Rate of Patient Safety Incidents Reported* (Data source: NHS Digital)

*Data now provided in annual intervals rather than 6-monthly intervals

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 and the Trust is currently exploring ways of making incident reporting easier.

PART THREE – Other information

An overview of the quality of care based on performance in 2021/22 against indicators

This section of the Quality Account contains a review of our quality performance during 2021/22. 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, directorate and collaborative 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 against key quality indicators.

The following section reviews the work of a range of quality work streams during 2021/22 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 2021/22 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. COVID-19 has been noted as a factor in the increase in the rate of pressure ulcers (particularly in critical care) and has been cited as a factor nationally.

Preventing pressure damage remains a priority. The Trust developed a pressure ulcer collaborative to tackle this increase, and the action plan can be seen below:

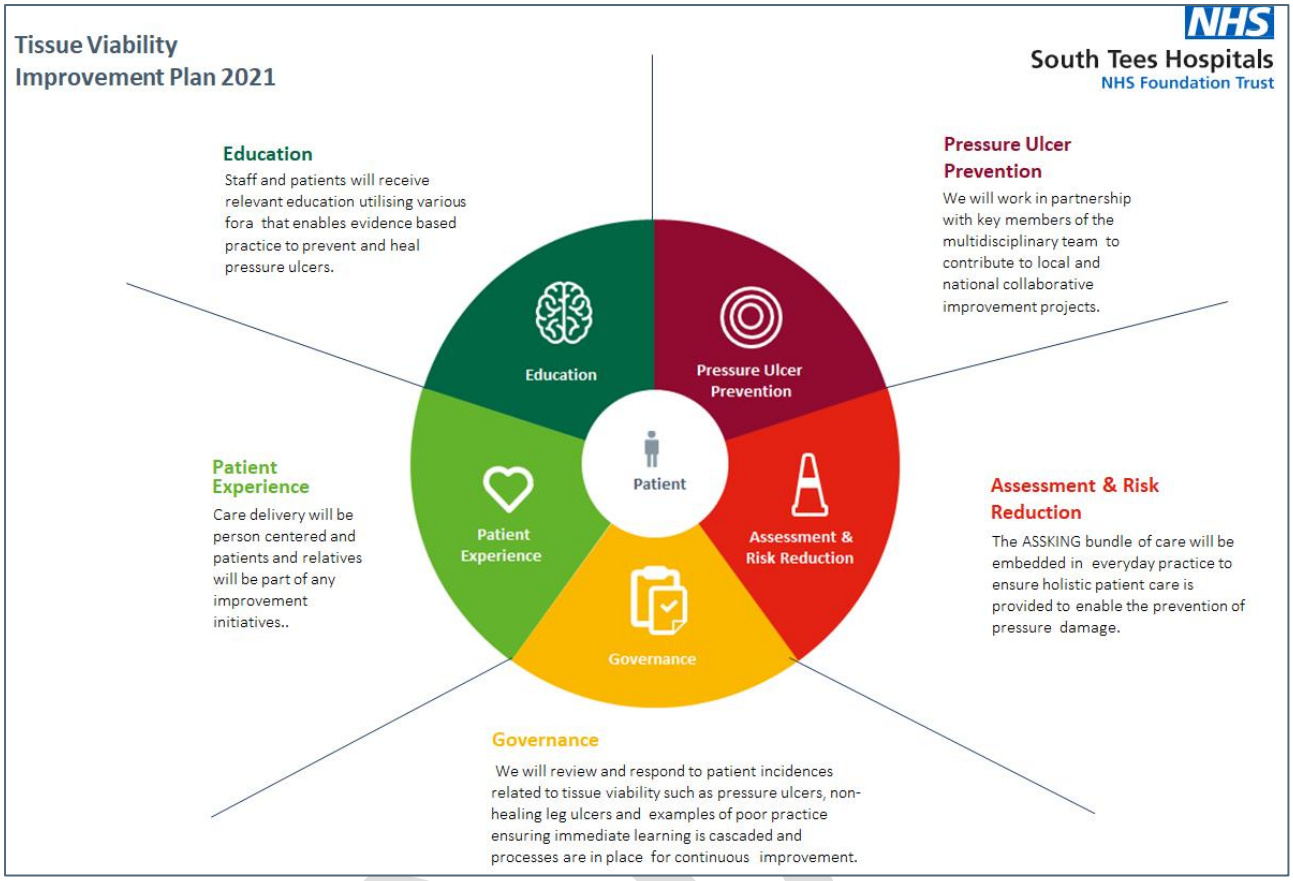


Figure 15: Summary of PU Collaborative approach

Pressure ulcers have been identified as a Quality Priority and further information on the action taken is described in Part 2 of this report.

Falls

One of the Trust's priorities is to reduce harm in all its forms and improve patient safety. Falls not only cause physical harm but impact patients psychologically, leading to prolonged recovery, prolonged hospital length of stay and a poor experience. Increased deconditioning which is related to reduced levels of activity in the older population during COVID-19, led to a slight increase in the level of harm during the first half of 2021/22, but this reduced significantly over the last quarter with the Trust recording the lowest levels of falls with harm for the past 2 years. There remains a sustained focus on the reduction of falls with active monitoring of the rate of falls and wards receiving bespoke support as needed. The rate of falls remains within the trajectory.

Focused interventions have included partnering with patient interventions, cohort nursing with structured reviews providing opportunities for learning and sharing good practice. Early results have indicated nearly a 50% reduction of falls through the introduction of cohort nursing in some of the high-risk ward areas.

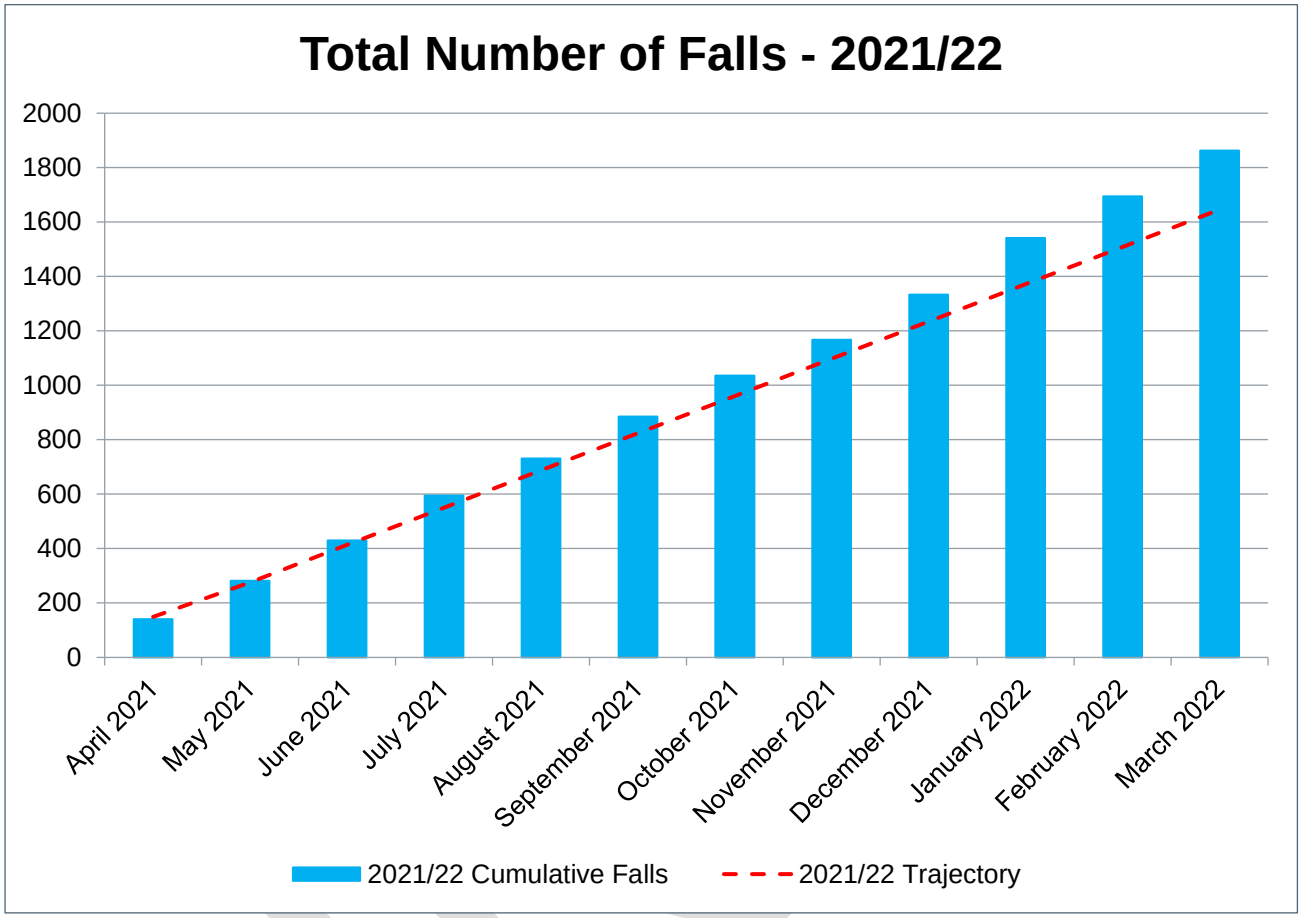


Figure 16: Patient Falls 2021/22

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.
- There is monthly monitoring of the number of falls and level of harm through the integrated performance report, with actions to support findings.
- The organisation continues to participate in the National Audit of Inpatient Falls (NAIF). This has enabled us to benchmark our performance against our peers and learn from recommendations in the audit findings.
- Numbers of falls are monitored and reported through the collaboratives and areas of concern highlighted for additional support. These meetings are also used as a platform for sharing good practice.

- A detailed falls analysis is undertaken twice a year with a report submitted to the Patient Safety Sub-Group (PSSG) and the Safe and Effective Care group.
- On-going interventions include monitoring the completion of the Trusts falls assessment to ensure individual patient's risks are being addressed. Effective handovers between the multidisciplinary teams will strengthen 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.
- The recently appointed Falls Coordinator/Educator will work to support teams and streamline documentation to enable nursing teams to work more efficiently.

Duty of Candour

During 2021/22, the Trust has sought to strengthen the approach to Duty of Candour across the organisation. The Trust policy has been reviewed and revised, and there have been several briefing sessions provided to clinical staff to raise awareness of the regulatory and good practice elements of Duty of Candour and to promote the potential of the process to drive up the quality of care within the organisation.

Compliance with all elements of the Duty of Candour is closely monitored within the Trust, with a monthly compliance report presented at the Patient Safety Steering Group, any exceptions are routinely followed up by the Patient Safety team until there is evidence that Duty of Candour requirements have been fully met.

To enhance the Trusts approach to fulfilling the Duty of Candour, the role of the Family Liaison Officer (FLO) has been implemented during 2021/22. The purpose of the FLO role is to facilitate the delivery of Duty of Candour, engaging with and supporting patients and/or families following the occurrence of a harmful patient safety incident, and enabling the involvement of the patient and/or family in the subsequent patient safety investigation. There are currently 20 trained FLOs within the organisation, and two further training cohorts are planned for 2022.

To further strengthen engagement and support provided to patients and/or families involved in patient safety incidents, the Trust has also recently been accepted as a pilot site to develop a 'Harmed Patient/Family Care Pathway' in collaboration with the Harmed Patient Alliance and the UK charity Action against Medical Accidents (AvMA). The pathway will consist of a range of responses and support that anyone affected by a patient safety incident should be able to expect from the Trust and is in congruence with the principles advocated with Framework for Involving Patients in Patient Safety (NHSE/I, 2021).

Safeguarding

Adult Safeguarding

Safeguarding is a positive duty placed on all staff under Section 42 of the Care Act (2014) to promote the wellbeing of vulnerable people and protect them from harm whether the harm is intentional and irrespective of whoever causes the harm. Safeguarding duties are rooted in law; based around the protection of human rights. As a public authority the Trust must follow the Human Rights Act (1998) in everything it does and treat people in accordance with their rights.

In 21/22 there were 666 safeguarding concerns (which is a 6% increase on the previous year); 167 relating to Trust practice (an increase of 2% in the previous year) and 499 safeguarding concerns reported to the local authority relating to external care and support providers.

There were 18 detentions under the Mental Health Act which is a 30% decrease from 26 the previous year. There have been 670 urgent authorisations / standard applications for patients deprived of their liberty which is 16% increase from 20-21 when 577 applications were made.

The process for raising adult safeguarding concerns within the Trust has been reviewed and the safeguarding adult's team are the single point of contact for all external concerns raised and all internal concerns raised where a referral to the local authority is required. The principles of 'no harm' is applied in tandem with early fact finding to understand the nature of the concern followed by robust investigation to determine learning.

Key areas of learning during 2021-22

- Discharge
- Pressure ulcers
- Medication

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 and the results overall remained stable at 85%.

Children's Safeguarding

The Trust has a statutory, regulatory and contractual requirement to safeguard children and young people, including unborn babies, in accordance with:

- The Children Act 1989 & 2004,
- Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework (NHSE 2015),
- Multi-Agency Risk Assessment Conferences (MARAC) and Domestic Homicide Reviews (Domestic Violence, Crime and Victims Act 2004).
- Counter Terrorism and Security Act 2015 (PREVENT agenda).
- Modern Slavery and Human Trafficking Act (2015).
- Mandatory reporting of Female Genital Mutilation (FGM Act 2003 section 5b).
- NHS Standard Contract Requirements

In 21/22 there have been 4250 enquiries to the Children's Safeguarding Team and the highest number of enquiries related to unborn babies. A total of 175 child protection medicals have been completed which is 52 less than in 20/21 with only 8 completed out of the 24-hour performance target by agreement with the paediatrician and social workers. Safeguarding supervision has continued with 92% - 100% compliance during the Covid pandemic. The Safeguarding Children Team also actively contribute to the multi-agency work across the South Tees Safeguarding Children's Partnership and undertake regular audits to gain assurances around safeguarding practice and participate in multi-agency Child Safeguarding Practice Reviews and Domestic Homicide Reviews.

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, there is a voluntary [Section 20] agreement with the child's parents where children's social care 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 statutory timescales for an initial health assessment to be carried out is within 20 working days.

Following their initial health assessment, each child will have a review health assessment at a statutory interval for their period in care. Children under 5 years have a review health assessment every six months and children over 5 years of age have an annual review health assessment. The review health assessments are co-ordinated, and quality assured by the LAC Team but carried out by other provider Trusts.

The LAC system is complex and highly interdependent on the timely actions of professionals cross a range of agencies. Additionally, a few local children are placed in areas outside of the Trust footprint, and a few children from outside our area are placed here. On that basis, Tees Valley CCG went through a formal procurement process in 2021/22 to develop a Tees wide service. The South Tees LAC Team will transfer to Harrogate District Foundation Trust (HDFT) on 01 April 2022; HDFT will continue to administrate and monitor all health assessments; Trust paediatricians will continue to complete the initial health assessments only.

Where a child is looked after by North Yorkshire County Council their health needs are coordinated by HDFT. Data provided in the report therefore is in relation to South Tees Children. Middlesbrough continues to have some of the highest numbers of children looked after in the country.

Clinical Effectiveness

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 few 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, it 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.

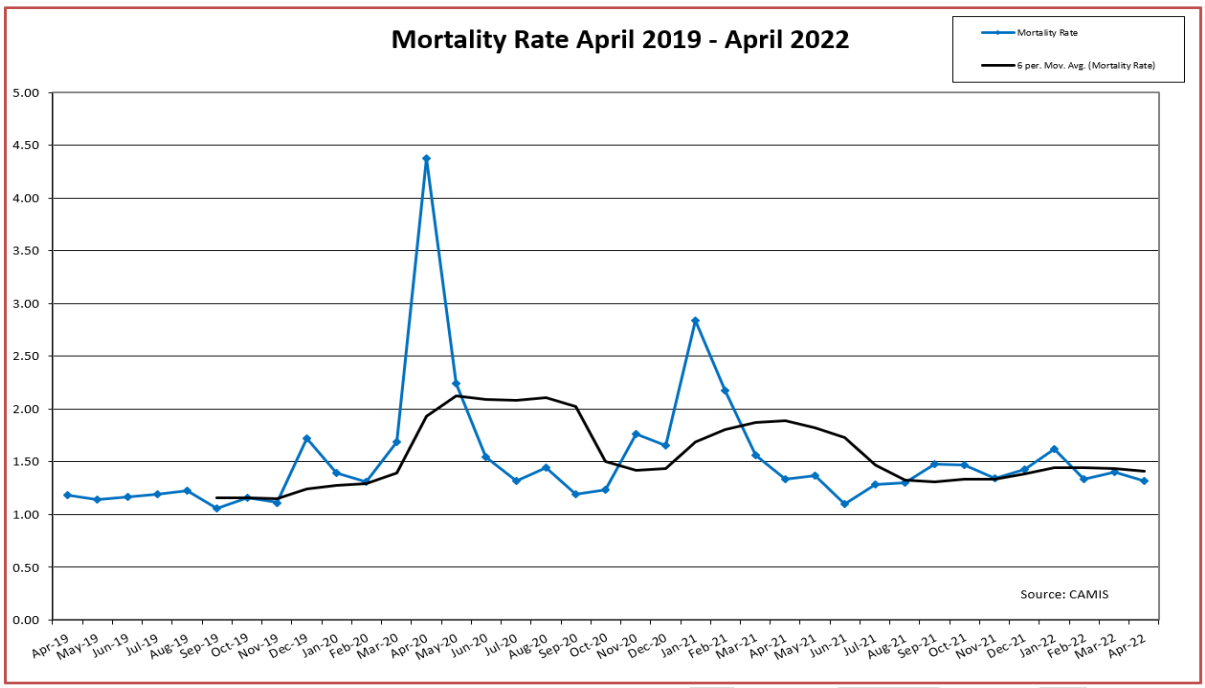


Figure 17: Unadjusted Mortality Rate April 2019 – February 2022 (including rolling 12-month averages) (Source: CAMIS)

Unadjusted mortality measures the number of deaths as a percentage of inpatient and day case spells, excluding infants (less than 28 days old). It is most useful for seeing the pattern of deaths through time. Looking at the trend from April 2019 – April 2022 the peaks caused by the COVID-19 coronavirus pandemic in March-April 2022 and January-February 2021 can clearly be seen with the gradual return to near the normal death rates throughout the rest of 2021 and into 2022.

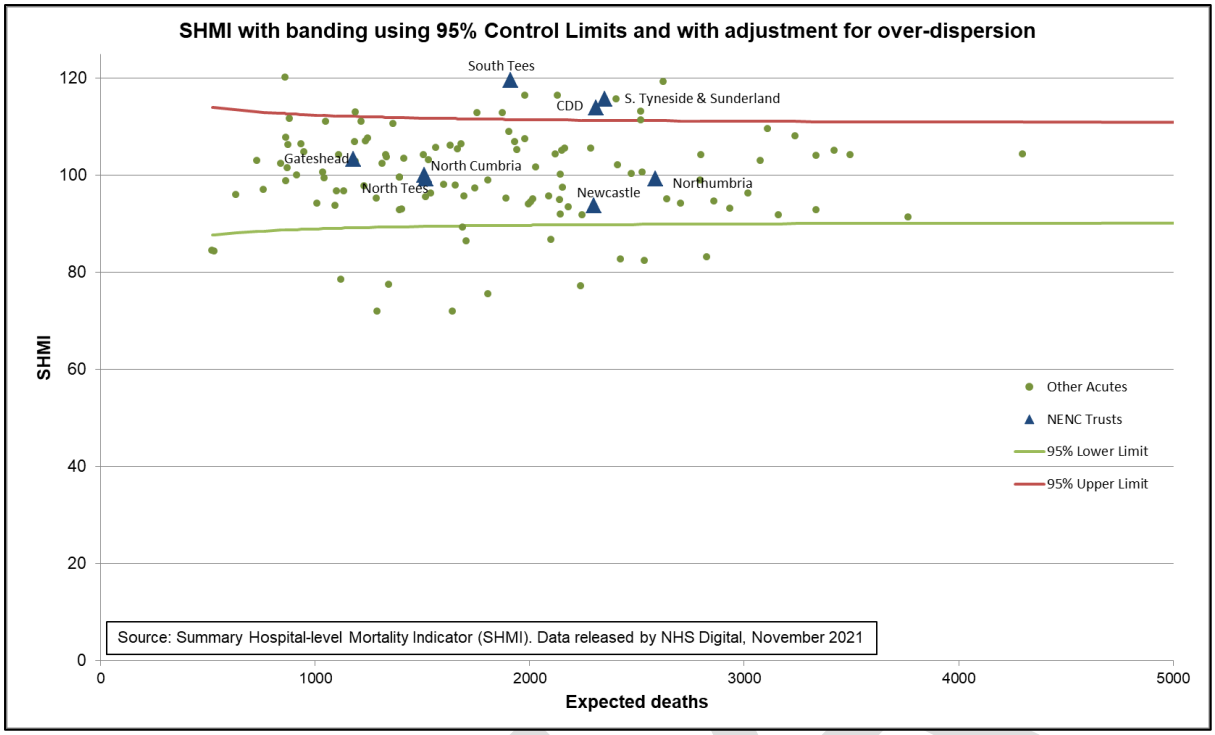


Figure 18: SHMI funnel plot using 95% CLs and adjustment for over-dispersion for July 2020 to June 2021 (Source: SHMI Data Release NHS Digital Nov 2021)

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published monthly as a National Statistic by NHS Digital.

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated there.

The SHMI was not designed to monitor mortality during a pandemic and so NHS Digital remove any hospital spells containing a COVID-19 spell. The number of patients attending hospitals during the pandemic was much lower than would normally be the case (lower by a fifth in this period) and so the number of hospital spells from which an expected number of deaths could be estimated was much lower than usual.

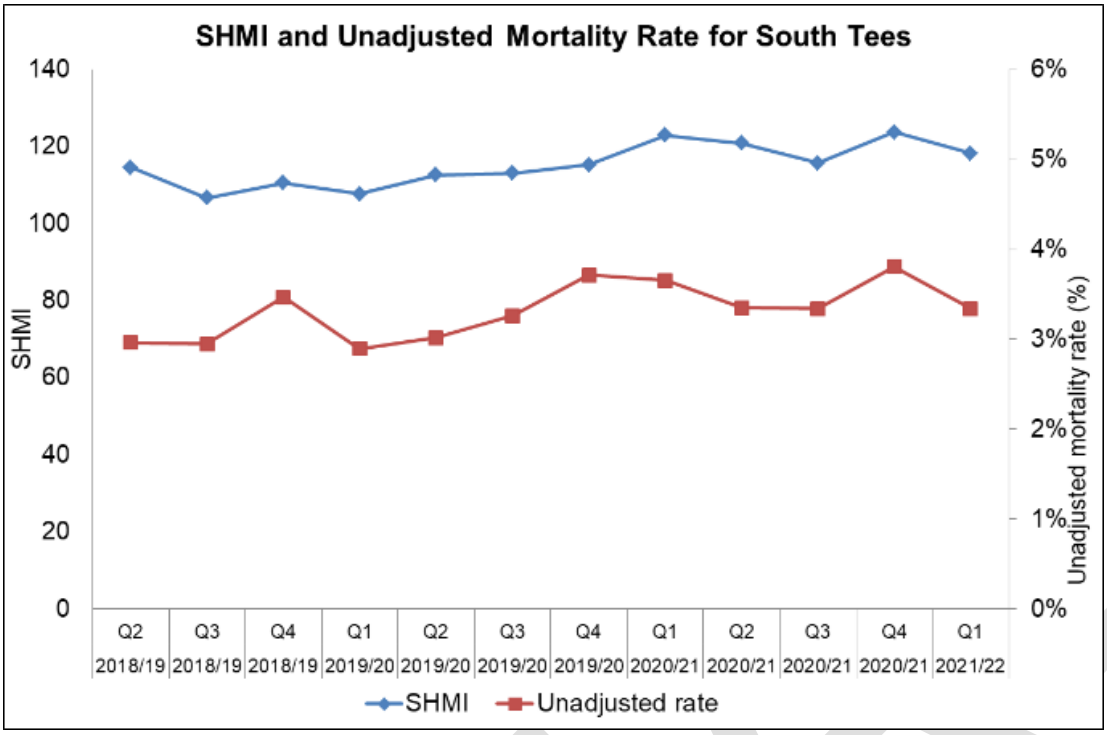


Figure 19: SHMI and Unadjusted Mortality Rate for South Tees (Source: Data extracted from HED Dec 2021)

The SHMI is monitored on a quarterly basis and broadly reflects the unadjusted mortality rate (the number of deaths divided by the population at risk).

Learning Disabilities Mortality Review (LeDeR)

Approximately 2.16% of the adult population in the United Kingdom are believed to have a learning disability, yet only 0.5% are identified on GP learning disability registers. Of the population identified as having a learning disability, 54% also have mental health issues; this is often seen as a behaviour associated with the learning disability / autism cohort and therefore can be significantly underestimated. Middlesbrough has the highest proportion of people with learning disabilities across the North-East & Cumbria with Redcar & Cleveland having the highest number of people with complex and/or profound learning disabilities.

The Trust has completed 19 Structured Judgement Reviews (SJR) for each adult with an identified learning disability who died in the Trust during 2021/22. In addition to this there have been two child deaths reviewed in Child Death Overview Panel (CDOP) and another SJR requested for an adult who died out of hospital who had received a high level of care from the Trust. The table and graph below show the number and causes of death for this patient group.

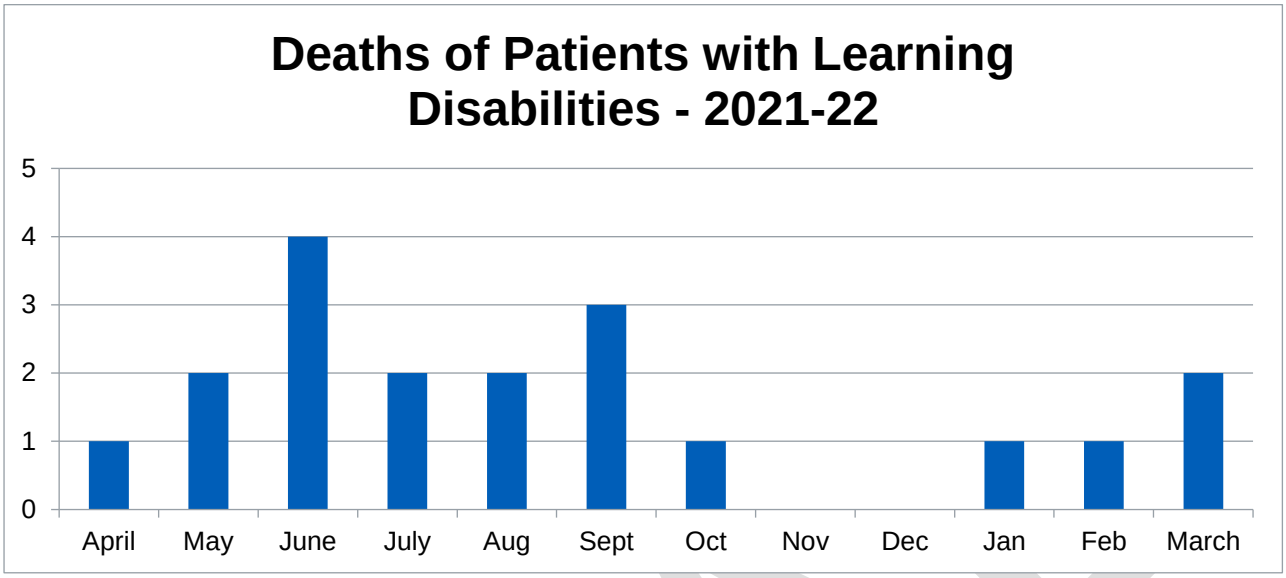


Figure 20: Number of Learning Disability Deaths

Cause Of Death			
Aspiration pneumonia	5	Cancer	2
Pneumonia	2	Urosepsis	1
Covid-19 pneumonitis	1	Other	6
Cause of death still to be confirmed by coroner			2

Table 9: Causes of Learning Disabilities Deaths

Key themes and learning identified from completed reviews by the LeDeR programme include:

- The need for healthcare co-ordination for people who have complex or multiple health conditions
- Assurance that effective reasonable adjustments are being provided
- Learning disability awareness training for all staff supporting people with learning disabilities and or autism

Re-admissions

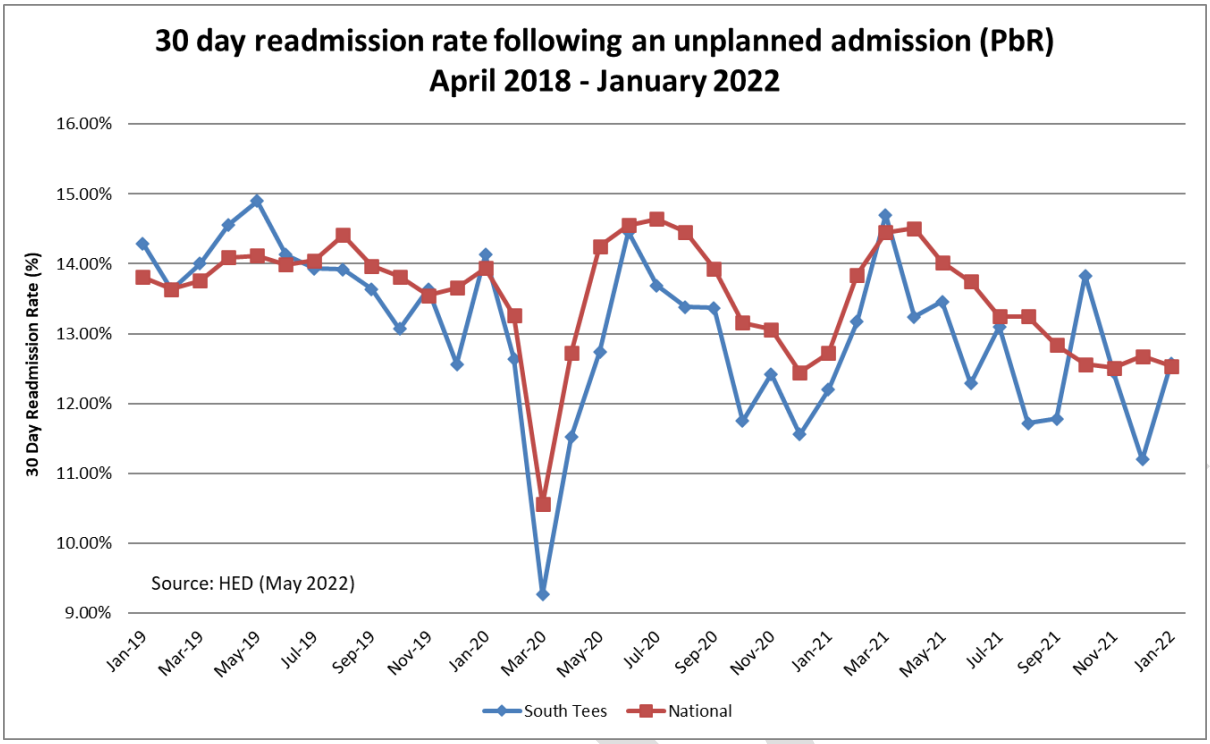


Figure 21: 30-day readmission rate following an unplanned readmission (Payment by Results)

Over the period illustrated, 30-day readmissions for the Trust have averaged 13.2% compared to the national average of 13.6%. 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 was impacted substantially by the pandemic but is currently lower than the national average. This has also resulted in a slight lag in the data, meaning that data is only available up to January 2022.

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.

Nutritional Screening

Patients are assessed on admission using the Malnutrition Universal Screening Tool (MUST), which is a validated screening tool to detect malnutrition in adult patients.

Several initiatives have been introduced to improve compliance of MUST Assessments, including:

- MUST compliance auditing has been increased on all wards across the Trust
- Focussed training has been delivered, with support from Practice Educators, to enable more 'toolbox' training in the ward areas.
- An electronic MUST screening tool has been developed as part of the Trust patientTrack system. This has reached final test stages, with training and implementation commencing in March 2022. This includes a reminder system when re-screening assessments need to be completed. It also includes the nutrition and hydration care plan for the patient, including any special dietary requirements.
- A video resource has been produced to provide training to staff on how to make a nutritional assessment if a patient is unable to be weighed.

Catering and Meal Provision

Infection control restrictions throughout the pandemic have limited some of the activities we would have previously carried out to engage patients, visitors and staff with our hospital menus and food evaluation.

Throughout the year we have reviewed the wide range of menus that we provide to meet the nutritional, cultural, age appropriate and dietary preference choices needed. This also includes ensuring we have a range of food choices or snacks and hot meals that can be ordered outside of the 'routine' meal service times, for example, if a meal has been missed due to being away from the ward to have a procedure, or if a patient has additional nutritional needs.

Posters have been developed which are displayed in ward areas so that patients know what meals, snacks and beverages to expect to be offered during the day, and the time of their meals.
Based on feedback from children and young people and a 'Come dine with me' event, new menus were created working with Children and Young People (CYP) dietitians and SERCO colleagues.

During the pandemic, resident parents of sick children in paediatric inpatients and neonatal areas were unable to purchase meals as the restaurants and coffee shops were closed. The Trust agreed to provide meals free of charge, served with the children's meal delivery. Meeting the nutritional needs of children and young people and their resident parents / carers is an area under National review

currently by NHS E/I, and James Cook CYP dietitians and senior nurses hosted a visit in February 2022 as part of this review. We were identified as an example of good practice based on our menus, staff and patient engagement and the support we offer parents and carers.

We are proud to be members of the National Steering Group, visiting other hospitals to carry out reviews which will contribute to a report for the Secretary of State. We are also continuing the work of the CYP Nutritional Steering Group; with good multi-disciplinary representation from all areas across paediatrics and neonates.

Meal Times

During the year we have reviewed and updated our guidelines and policies including the standard operating procedures that guide on the delivery of food and drinks to our inpatients in the best way we can to ensure that they get the help and assistance they need and that unnecessary disruption at mealtimes is avoided. We will be building on this over the year as it is aligned with one of our quality priorities.

Enteral Feeding

As part of a national safety directive, a multi-disciplinary group has been working on the development of improved documentation to support the safe placement of a nasogastric feeding tube, when patients require a different route to receive their nutrition and hydration due to inability to manage this orally. Referred to as a LocSSIP, the checklists are developed to ensure the correct safety standards are met during invasive procedures. Training resources have been developed to support the implementation of this.

Seven Day Services

Due to the increasing pressures in responding to COVID-19, internal formal monitoring, and subsequent submissions, for FY 2020/2021 regarding the implementation of seven-day standards was deferred.

During this period, the Trust restructured the provision of urgent and emergency care to ensure that patients received safe and effective care. This involved increasing the numbers of consultants being present on wards for early senior review, daily assessments on wards and twice daily in critical care. This was achieved by consultants changing working practice while elective work was reduced.

This approach provided the organisation with confidence that many of the 7-day standards were being met, although there was not a formal audit during this time. As the elective caseload has been re-

established, consultants have returned to their specialist roles. Additional recruitment of consultant staff in the organisation should result in the delivery on the 4 clinical priority standards. The Trust is also making progress on the “consultant of week model” for improved continuity.

We have identified that further focussed work is required to deliver 7-day services in a sustainable way in terms of access to Allied Health Professionals, Diagnostics and Interventional Radiology (IR).

The trust notes the changes to the guidance of February 2022 which will be adopted in future assurance reports to the Board.

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 Trusts Quality Account regarding this.

The vacancy rate greatly improved in 2021/2022 compared to the previous year with the annual vacancy rate dropping from 4.1% to 0.5%. Vacancies have been covered in the main by 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 through the Medical Training Initiative has helped to fill ST3+ level vacancies in a few specialties.

We continue to fill approximately 96% of all locum shifts each month with the majority (approximately 90%) being filled by internal locum cover as opposed to agency. The regional locum bank (FlexiShift) hosted by the North-East Lead Employer Trust (LET) is now well established for all LET employees. The regional bank provides the Trust with access to an additional pool of LET employed doctors who work in other Trusts and GP surgeries.

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 People Committee, and a Junior Doctors’ Forum meeting quarterly.

Patient Experience

Our patients and service users are at the heart of everything we do. We strive to continually provide the highest standard of experience of care to every patient and service users. We proactively seek their feedback to identify good practice and implement improvements where necessary to ensure we

are meeting our patients' expectations and the expectations of their carer or family. The Trust uses several data 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.

The Trust participates in several national patient surveys and has a local patient experience surveys available in all inpatient areas via iPads. Patients attending outpatient appointments or using emergency care services receive a text message or email to provide their feedback. This supports the collection of real-time feedback to improve the patient and service user experience while it is still relevant, or they are still receiving care. This assures patients and service users that their feedback is listened to and acted upon. There is also the opportunity for patients and service users to provide feedback about their care to the Patient Experience Team / Patient Advice and Liaison Service (PALS) who work to support a timely response.

The Trust is also an active participant in the 'Ask Listen Do' campaign, which ensures patients with a learning disability are provided with help and support to raise and concerns and provide feedback.

We invite patients and service users to share their stories at our Trust Board meetings and other internal meetings to allow colleagues to hear their experience first-hand. The benefits of this approach for those providing and receiving care is profound. Patient experience is integral to the multidisciplinary teams across the Trust to facilitate shared learning and improvements.

The Trust works collaboratively with external partners, such as, Tees, Esk and Wear Valleys NHS Foundation Trust, Healthwatch South Tees and Redcar and Cleveland, North East NHS Independent Complaints Advocacy Service, Carers Together, Carers Plus and Age Concern to ensure we hear from all of our patients and service users, particularly those who we do not receive feedback from.

Complaints

In 2021/22 there was 339 formal complaints received by the Trust, an increase of 16% on the previous year, in comparison to the complaint activity in 2020/21, where 291 formal complaints were received. The reduction in the number received in 2020/21 was due to the COVID-19 pandemic, therefore not providing a clear comparison.

Figure 22 shows a downward trend, per spell (hospital provider spell) since June 2021 to March 2022. The average number of formal complaints received each month in 2021/22 was 28: -

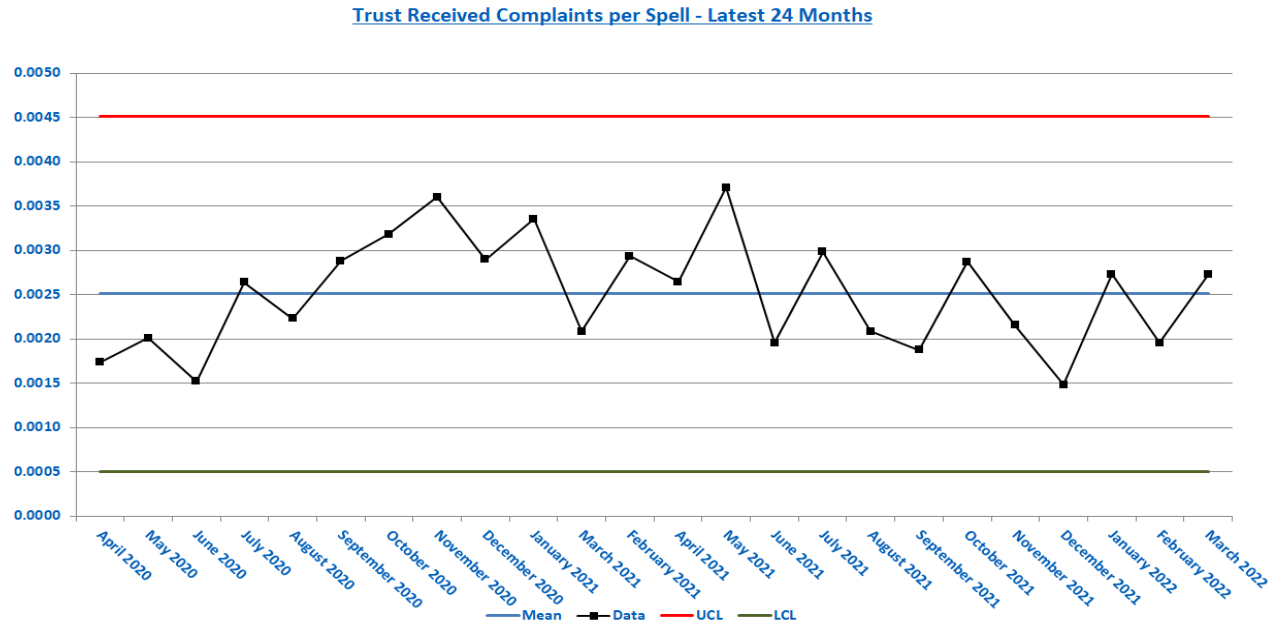


Figure 22 – Formal complaints received by month, per spell - latest 24 months

Regional Comparison

Figure 23 below shows the regional comparison for complaints as per the published data obtained from NHS Digital, per finished consultant episode up to Q2 2021/22: -

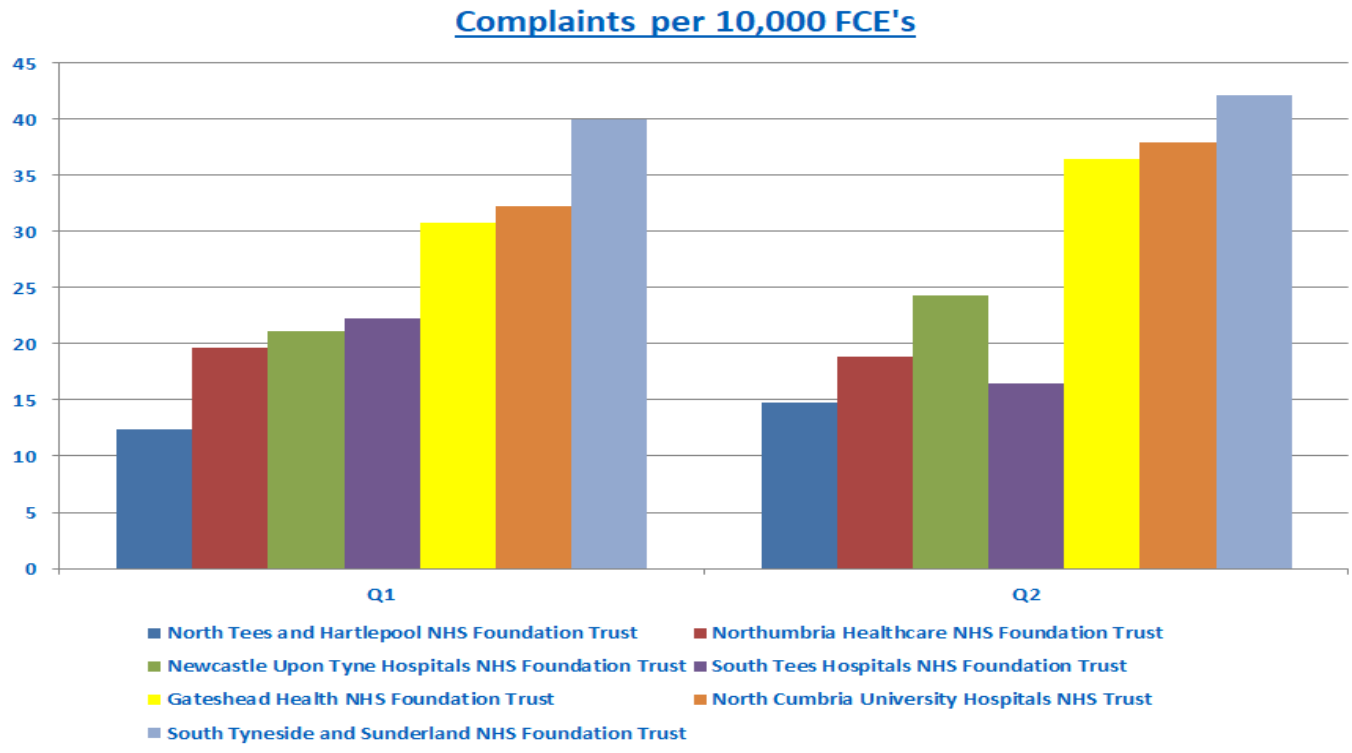


Figure 23: Reginal comparison of complaints per 10,000 FCE

The Trust's rate of complaints per 10,000 finished consultant episodes (FCE) is comparatively lower to neighbouring organisations.

Patient Advice and Liaison Service (PALS)

There were 1539 advice/enquiry/concerns received by the Trust in 2021/22 which is a decrease from 2020/21 when 1709 were received, a reduction of 11% on the previous year. This is the second consecutive year where a reduction in concerns being logged via the Patient Advice and Liaison Service (PALS) in Figure 24: -

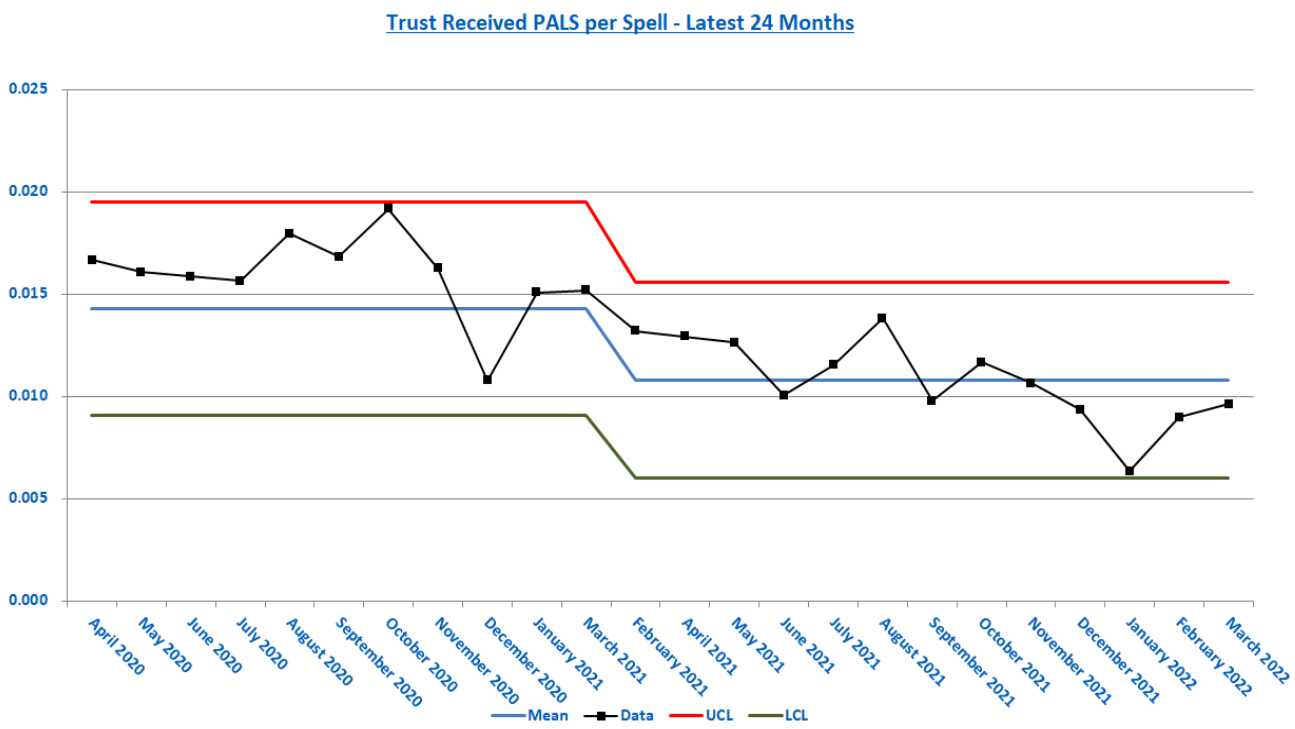


Figure 24: PALS received by month, per spell - latest 24 months

Patient Surveys

Sentiment analysis of patient feedback from surveys

There are currently twenty-five patient surveys utilised in the Trust. These include the adult inpatient, outpatient, A&E, maternity, and community surveys. All patients have the opportunity to provide comments throughout all surveys. Table 10 below provides a monthly summary of this feedback: -

Sentiment Type	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Total (Last 12 Months)
Number of Comments by Sentiment													
Negative	240	272	316	280	297	215	269	232	120	199	96	20	2241
Positive	1043	865	1092	1086	937	843	815	936	665	645	373	54	8282
Neutral	821	848	904	731	771	447	557	424	317	759	148	23	5820
Total	2104	1985	2312	2097	2005	1505	1641	1592	1102	1603	617	97	16343
Sentiment Type as Percentage of Total Comments													
Negative	11.4%	13.7%	13.7%	13.4%	14.8%	14.3%	16.4%	14.6%	10.9%	12.4%	15.6%	20.6%	13.7%
Positive	49.6%	43.6%	47.2%	51.8%	46.7%	56.0%	49.7%	58.8%	60.3%	40.2%	60.5%	55.7%	50.7%
Neutral	39.0%	42.7%	39.1%	34.9%	38.5%	29.7%	33.9%	26.6%	28.8%	47.3%	24.0%	23.7%	35.6%

Table 10: Patient feedback - Sentiment analysis by month

Many comments received from the patient surveys are either positive or neutral. Wards and departments have access to their data to discuss and share at ward/departmental meetings. Any comments which are negative are expected to be actioned in the department and create a 'you said, we did', to share and display at ward/department level.

National Surveys

The National Adult Inpatient Survey

This survey, which was published in January 2022 and consisted of 46 questions, included all patients aged 16 years or over who spent at least one night, during November 2020, in an NHS hospital in England. The trust had 585 participants with a response rate of 49%. This year's survey was conducted using a push-to-web methodology (offering both online and paper completion). The questionnaire was amended significantly, with changes to both question wording and order. Therefore the 2019 results are not comparable with previous years' data and trend data is not available.

The trust scored 'somewhat better' than other trusts in the questions relating to Nurses and in the top four trusts nationally as better than expected for medical care. Table 11 shows how the trust compared with all other trusts: -

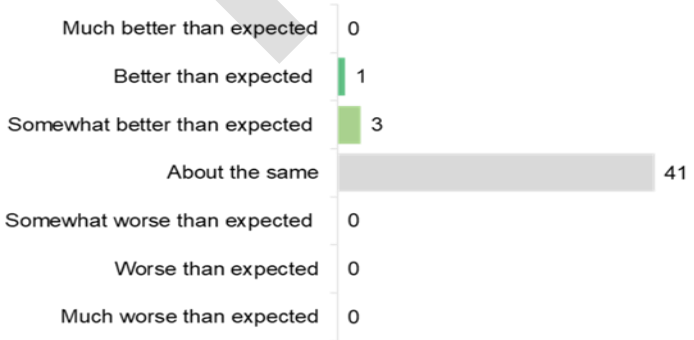


Table 11: National Adult Inpatient Survey - Comparison with other NHS trusts

The Children and Young Person survey

Patients were eligible to participate in the survey if they were aged between 15 days and 15 years old and had been admitted to hospital and discharged between 1 November 2020 and 31 January 2021. Each NHS trust selected a sample of 1,250 patients. The survey was last undertaken in 2018 and the results are comparable to the surveys conducted in 2016 and 2018. The trust had 294 participants with a response rate of 24%.

The results were published in December 2021, with table 12 showing how the trust compared with all other trusts. With the trust scoring better in areas of play and activities, parents and carers feeling that staff played with their child while they were in hospital. Quiet hospital wards and patients feeling it was quiet enough to sleep on the ward, with the choice of admission date being an area that was rated somewhat worse than expected: -

Table 12: Children and Young Person survey - Comparison with other NHS trusts

Urgent and Emergency Care Survey

Published in September 2021, 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 Type 1 services the Trust was in the top 20% of Trusts on 12 questions and the bottom 20% in 4 questions. Areas of strength were doctors and nurses involving patients in discussions about their care, giving enough privacy when being examined or treated. Areas for improvement are waiting times

for ambulance crew handover, side effects of medication and arrangements on leaving the department.

For Type 3 services the Trust was in the top 20% of Trusts on 11 questions and the bottom 20% in 1 question. Areas of strength receiving test results and information on condition after leaving the department, waiting times to be seen, privacy when being examined or treated and the opportunity to discuss the condition with a health care professional. Areas for improvement were access to suitable food or drinks.

Maternity Survey

Published in February 2022, women were eligible to participate in the survey if they gave birth between 1 and 28 February 2021. In England the response rate was 52% with over 23,000 women participating in the survey. The survey is split in to three sections: antenatal care, labour and birth and postnatal care. The results are comparable to the last survey conducted in 2019. The trust had 314 participants with a response rate of 42%, the average trust response was 53%.

Table 13 shows many questions scored about the same as other Trusts, three scored somewhat better and one better than expected. Areas where mother's experiences are best included, during antenatal check-ups, being asked about their mental health, being provided with relevant information, during their pregnancy, about feeding their baby, being able to see or speak to a midwife as much as they wanted during their care after birth. Partner or companion involvement and their attendance at the hospital was identified as an area of improvement: -

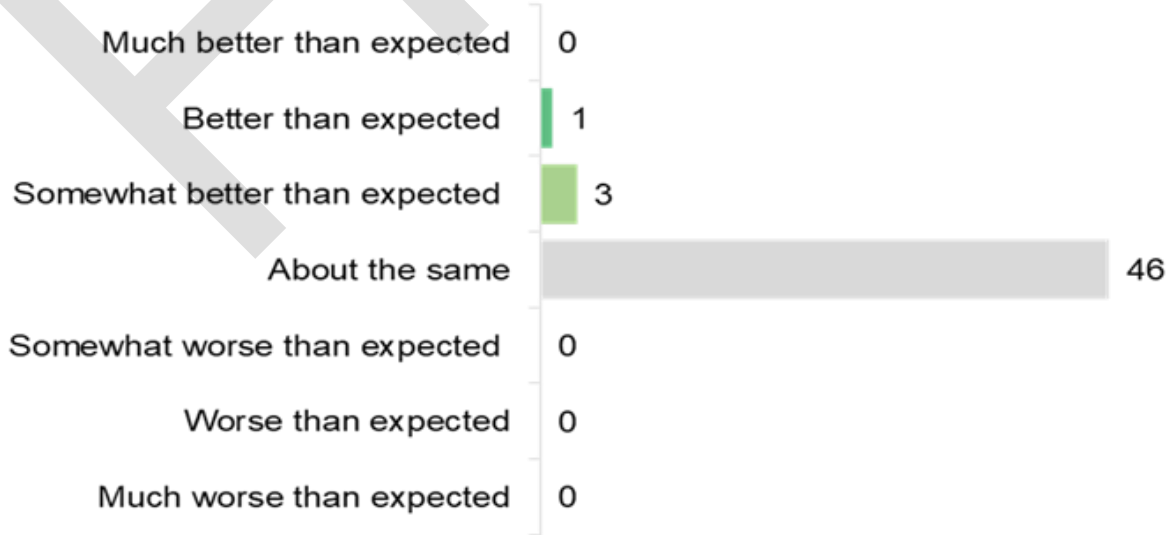


Table 13: Maternity Survey - Comparison with other NHS trusts

National NHS Staff Survey 2021

The NHS annual staff survey was carried out from 4th October to 26th November 2021. The survey mode was mixed, and the sample type was census with a response rate of 31% (2,877 members of staff).

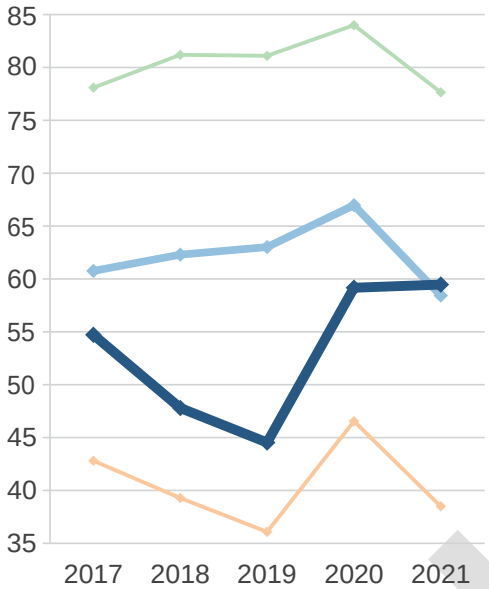
For the 2021 survey onwards the questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements:

Figure 25: People Promise

On the core questions, the Trusts 2021 NHS Staff Survey results are:

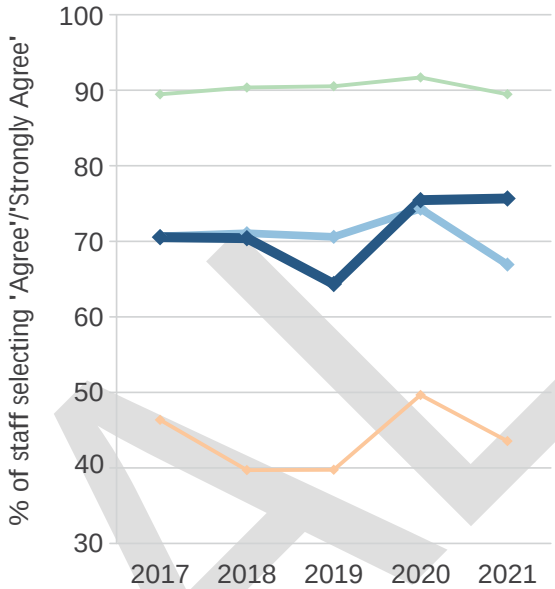
- If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (increase to 75.7 per cent and now above the 66.9 per cent national average).
- Care of patients / service users is my organisation's top priority (increase to 76 per cent and now above the 75.5 per cent national average).
- I would recommend my organisation as a place to work (increase to 59.5 per cent and now above national 58.4 per cent average).

Q21c
I would recommend my organisation as a place to work



	2017	2018	2019	2020	2021
Best	89.5%	90.4%	90.5%	91.7%	89.5%
Your org	70.5%	70.4%	64.4%	75.4%	75.7%
Average	70.7%	71.1%	70.6%	74.3%	66.9%
Worst	46.4%	39.7%	39.8%	49.7%	43.6%

Q21d
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation



	2017	2018	2019	2020	2021
Best	78.1%	81.2%	81.1%	84.0%	77.6%
Your org	54.7%	47.8%	44.5%	59.2%	59.5%
Average	60.8%	62.3%	63.0%	67.0%	58.4%
Worst	42.8%	39.3%	36.1%	46.5%	38.5%

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.3	5.9	6.8	5.9	5.1	5.8	6.7	6.9	5.8
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3

Figure 26: 2021 NHS Staff Survey Results

We are Compassionate and Inclusive

Key indicators in the section relate to care of our patients, raising concerns and recommending the Trust as a place to work. We have improvements in all these areas and now benchmark above the national average.

We are Recognised and Rewarded

This theme includes recognition for good work, feeling values and satisfaction with level of pay. Our results are comparable with last year with no significant deviation.

We each have a Voice That Counts

This theme explores the how colleagues feel about their work environment with opportunities to use initiative, are trusted to do their role and can make suggestions.

Compared to our results from 2020 we have seen an improvement in this theme, with a significant improvement in colleagues being trusted to do their job which has increased from 89.5% in 2020 to 92.0% in 2020. We have also significantly improvement in colleagues feeling secure about raising concerns about unsafe clinical practice which has improved from 67.6% in 2019, to 72.7% in 2020 and 76.9% in 2021.

We are Safe and Healthy

This theme covers staffing, health and wellbeing and bullying and violence.

The survey reports a reduction in musculoskeletal problems and work-related stress against an increase in the national position. Perceived bullying from managers and other colleagues has also reduced.

We are Always Learning

This theme focuses on development opportunities and appraisals. We are in line with the national average for supporting staff to develop and career opportunities. We have improved on our 2020 position for colleagues suggesting the appraisal helped to improve colleagues to do their role and left them feeling valued

In addition, the work the Trust has undertaken over the last 12-months has seen a significant increase in the number of colleagues reporting that the organisation acts fairly regarding career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age (increase to 57.2 per cent and now above the national 55.7 per cent average).

We Work Flexibly

This theme relating to home life balance and flexible working. We have improved our position for opportunities for flexible working patterns.

We are a Team

This theme looks at the support, respect and encouragement from line managers and team working. We have seen an improvement in all questions when benchmarked to our results from 2020. There has been significant improvement in the respect colleagues receive when at work which has increased from 68.5% in 2020 to 72.3% in 2021.

Morale

The themes covered in this section are colleagues' thoughts on leaving the organisation, materials, staffing and relationships.

We have seen an increase in colleagues feeling they get the respect they deserve and encouragement.

Staff Engagement

This theme looks at motivation, enthusiasm and ability to make suggestions and improvements in the role.

Further improvement has been seen in the Trusts overall staff engagement score which is now 6.9 which is above the national average of 6.8.

Staff Engagement – Creating a Sense of Belonging

The Trust is a great place to work and encourages people to develop their career here. It is important for our staff to know that we listen and act on suggestions for improvement.

The Trust's People Plan for 2020/23 articulates how we will deliver on the National People Plan priorities by improving the working experience of our people through five key strategic enablers:

- Addressing workforce shortages
- Improving learning and leadership culture
- Embedding equality, diversity and inclusion
- Creating a sense of belonging
- Improve health and wellbeing

The objective of the strategic enabler – creating a sense of belonging are:

- Actively engage and listen to colleagues so they feel values and respond positively to annual staff survey and regular check in surveys to improve job satisfaction
- Ensure that we have open, honest, transparent and positive channels in which colleagues can raise concerns
- Reward, praise and celebrate colleagues for the contribution they make to the Trust, patients and other colleagues

The following are examples of activities where the Trust has actively sort to engage with its workforce to gain insight and feedback to improve the workplace environment making the Trust a place whereby staff feel involved.

Staff Engagement Network

The Staff Engagement Network which has been in place for 12 months has identified the following 4 key focus areas:

- Recognising and celebrating success
- Employee offer and experience
- Creating a sense of pride and belonging
- Values and behaviours

Staff Recognition

Over the last year we have continued to develop our South Tees Appreciation Reports (STAR) awards to recognise excellence and celebrate success. These are presented by our Executive Director and Non-Executive Director colleagues and published on our social media.

Appraisals

During December 2021 and January 2022, a staff survey link was emailed directly to all 1510 staff within Corporate Services, to evaluate the new values-based appraisal that was rolled out in May 2021. We received 282 responses which equates to an 18.7% return rate. We are now in the process of establishing a small working group to review the feedback and to identify further improvements to the new appraisal process. Our new values, supportive, caring and respectful are at the heart of our appraisal documentation.

A Task and Finish Group has also been established in December that is reviewing and improving the current Management Essentials Programme. Within the programme the module on appraisal is also being reviewed and the feedback from the survey is being incorporated into the redesign of this module.

Value Based Recruitment

Values Based Recruitment is an approach to help attract and select employees whose personal values and behaviours align with the values of the Trust. All successful candidates are provided with the opportunity to have a voice, via a recruitment questionnaire which prompts them to be honest about their recruitment experience. Anyone who wishes to express any comments regarding the recruitment process are provided with direct access to the Recruitment Manager.

Homeworking Forum

A homeworking forum, to reach out to those colleagues who undertake agile working from home, had its first meeting in October 2021. The event was hosted by the Head of HR, Health and Wellbeing Nurse and Staff Side Representatives. Approximately 30 staff attended the event. The event focussed on staff views and feedback on their experiences of remote working, specifically focussed on their relationship with colleagues and managers. A monthly support group has now been established and includes colleagues from Staff Side.

Raising Concerns and Issues

The HR team, in partnership with Staff Side, has developed their engagement relationship by jointly promoting their achievements over the last 12 months and promoting the positive outcomes achieved which have benefited staff within the organisation. By communicating the successful conclusion of several issues that were raised by staff, they can demonstrate that staff have a voice that is listened to and acted upon. Some of the positive outcomes include the following changes:

- Staff who were subject to a change process which resulted in a change of base would receive excess mileage for a total of 4 years.
- Introduction of a robust risk assessment process and review with a total of 98% of the organisation with an up-to-date risk assessment.
- Reviewed the policy and process for suspension of staff because of gross misconduct – adopting a just culture approach.
- Undertook a review of the on-call payments, to ensure consistency across the organisation.
- Promoted redeployment opportunities for staff returning from absence who were not able to return to their substantive duties.

Health and Wellbeing

COVID-19 has heightened our awareness that it is crucial for us to care more about our own and each other's health and wellbeing. Good health and wellbeing of our people is a key focus, and we want to ensure that we provide support for mental, physical, personal and financial wellbeing.

The Trust want a positive wellbeing culture with initiatives that are relevant to our colleagues both now and in the future. We promote our health and wellbeing and engagement initiatives to ensure all colleagues are aware of what is available and that it is embedded across the whole Trust. We support colleagues to enable them to achieve good attendance and we have strengthened our focus specifically on mental health awareness to address identified issues of concern.

Better Health at Work Award

In Dec 2021 the Trust were successful in gaining the bronze level - Better Health at Work Award, overall feedback included:

"This is a sound bronze submission (with some very good aspects) for South Tees and there has clearly been an increased impetus to deliver a meaningful health and wellbeing offer to support staff and ultimately create a healthier, happier, higher-performing workplace over the last 12-18 months, and long may this continue".

Embedding Health & Wellbeing

Health and Wellbeing is included within the new Welcome Induction to new employees. This is a valuable opportunity to showcase how we can support employee's health and wellbeing. The Trust have also now embedded health and wellbeing conversations into our new appraisal processes. This ensures that during appraisal discussions staff can discuss any health and wellbeing related issues and managers can then signpost staff to Health & Wellbeing support services.

Psychological Wellbeing

The Trust has seen a significant increase in demand from across our workforce for access to staff psychological support services especially counselling. Our Wellbeing Guardian, Staff Psychological Wellbeing Advisor and Staff Support Psychologist now also undertake monthly wellbeing walkabouts. During 2021/2022 wards and departments have continued to be visited to ensure staff feel listened to and any concerns are noted and fed back at the Wellbeing Strategy Group for action.

Utilising charitable funds, a project has commenced developing three new 'Wellbeing Pods' which will be located at James Cook Hospital and the Friarage Hospital. This will provide staff with dedicated spaces to take time out in a relaxing purposed built environment. There will also be a specific pod for staff to access wellbeing initiatives and psychological support.

Physical Wellbeing

The Physiotherapy Service continues to be in high demand 97% of staff with work related MSK issues felt that the service helped to keep them at work and avoid sickness absence. 76% of referrals for staff who were absent felt that the service helped them to return to work quicker.

We are committed to support physical wellbeing and have undertaken a wide range of Health & Wellbeing awareness raising campaigns that include interactive events and activities.

Financial Wellbeing

Through partnership working with our staff side colleagues through our Joint Partnership Committee an agreement was reached that we would continue to provide support with our own Hardship Fund provided through the Trusts Charity and provision of Salary Advance through the Trusts finance department.

We are now working with 'The Money and Pensions Service' - an arm's-length body, sponsored by the Department for Work and Pensions, with a joint commitment to ensuring that our colleagues have guidance and access to the information they need to make effective financial decisions over their lifetime, delivered across five core functions: Pension guidance, Debt advice, Money guidance, Consumer protection, strategy.

Occupational Health Services

Our Occupational Health team have continued to provide normal business as usual activities including physiotherapy services, annual health campaigns and roll out of the flu vaccination. Due to Covid restrictions the team have utilised new and creative approaches to deliver their services including the roll out of wellbeing videos and access to online services.

Embedding Equality, Diversity and Inclusion

Through our equality, diversity and inclusion initiatives we continue to promote our values and behaviours at every opportunity and specifically to engender a sense of belonging for all by creating an environment where we value unique differences.

We strive to ensure our workforce is representative of the communities that we serve and recognise the contribution of all colleagues is supportive, fair and free from discrimination and ensure there is psychological safety for all. The Trust Equality, Diversity and Inclusion (EDI) objectives are:

- Ensure open and transparent opportunities for all
- Review people policies and procedures
- Create diverse and inclusive culture

- To keep our colleagues safe and well at work

Staff Equality and Diversity Information 2022

Below is the current EDI data relating to the workforce at Year Ended 31/03/2022:

Gender	FTE	Headcount
Female	6715.90	7943
Male	1618.89	1847
Total	**8334.80**	**9790**

Ethnicity	FTE	Headcount
BME	891.20	1006
Not Stated	291.99	353
White	7151.62	8431
Total	**8334.80**	**9790**

Sexual Orientation	FTE	Headcount
Bisexual	47.19	53
Do not wish to disclose	1873.60	2307
Gay or Lesbian	120.69	133
Heterosexual or Straight	6260.05	7241
Other sexual orientation not listed	6.20	9
Undecided	2.00	2
Unspecified	25.07	45
Total	**8334.80**	**9790**

Religious Belief	FTE	Headcount
Christianity	3844.79	4499
Atheism	1245.38	1423
Buddhism	27.23	31
Do not wish to disclose	2164.30	2628
Hinduism	106.06	118
Islam	219.55	251
Judaism	2.76	3
Other	685.92	777
Sikhism	12.40	13
Unspecified	26.41	47
Total	**8334.80**	**9790**

Disability	FTE	Headcount
Learning disability/difficulty	64.13	74
Long-standing illness	54.35	64
Mental Health Condition	25.31	29
No	6060.67	7036
Not Declared	1825.14	2184
Other	12.40	14
Physical Impairment	12.67	17
Prefer Not to Answer	15.53	17
Sensory Impairment	14.41	20
Unspecified	180.25	253
Yes - Unspecified	69.95	82
Total	**8334.80**	**9790**

Table 14: Equality and Diversity of Workforce

Equality Delivery System (EDS 2)

Overarching all of the EDI work within the Trust is the Public Sector Equality Duty which is delivered in the NHS through the Equality Delivery System (EDS 2), which supports the following four goals: -

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

Work is currently underway to update the EDS 2 assessment and a new governance structure has been developed to ensure that we are able to demonstrate through an evidence base how we are performing against the EDS 2.

Gender Pay Gap Report

This report details our headline pay gap figures as of 31 March 2022, a brief analysis of why we have a pay gap and an overview of our actions to close the gap. We are committed to ensuring that our pay practices are transparent, fair and equitable. The Trust has adopted and implemented national NHS pay schemes which have undergone an equality analysis.

Our mean gender pay gap is 31.9% and our median gender pay gap is 19.2% which is a marginal improvement of 0.5% for the same period last year. This suggests that our pay gap is impacted by the highest (male) earners in the organisation.

The main reason for the gender pay gap is an in-balance in the numbers of men and women across the whole workforce and a 36% pay gap in the upper quartile. The Medical Consultant workforce predominantly consists of men (71%) and Consultants are the highest paid group of staff - this difference is influencing the gender pay gap.

The progress we have made over the last year has seen an increase % of our female medical staff aged 40 and under is now 51.43% in 2021 versus 48.57% of male medical staff, placing STHFT in a strong position to influence gender ratios at consultant grade in the future.

Equality, Diversity and Inclusion (EDI) Steering Group & Staff Networks

The EDI Steering Group monitors and supports progress against the strategic goal of Embedding EDI, which is within the Trusts People Plan. This group reports to the People Committee which feeds up into the Trust Board providing assurance of progress against the plan.

The EDI Steering Group has representatives from across a range of EDI staff networks and groups, including staff side representatives. The EDI Steering Group meets monthly and includes the Patient

Experience Lead and integrates work from other Trust 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)
- Faith Network
- Menopause Group
- Childless Not by Choice (CNBC) Group

We are currently working to relaunch the Disability and Long-term Health Network group in 2022.

EDI Calendar of Events

From the start of 2022 a new calendar of EDI awareness events has commences including to events linked to Race, Sexual Orientation, Gender Reassignment, Disability, Religion & Belief and Gender. Support to develop a range of initiatives is provided through representatives of the EDI Steering Group as well as the various staff networks and support groups.

The Trusts is committed to EDI education and a range of training is made available to staff, in addition to mandatory EDI training. The training focuses on the Trusts commitment to ensure all staff are free from discrimination and feel equally supported in career progression and opportunities. We introduce all new starters to EDI at the Trust Welcome Induction including an overview of the staff networks.

Workforce Race Equality Scheme and the Workforce Disability Equality Scheme

The trust has reviewed its Workforce Race Equality Scheme (WRES) and Workforce Disability Equality Scheme (WDES) and updated the annual action plans to support further improvements to support the further development of an inclusive culture. The Trusts Workforce Disability Equality Scheme and supporting information is being used to underpin and provide an evidence base in the development of the Health and Wellbeing Strategic Plan, including achieving the Better Health at Work Award at Bronze level.

Reciprocal Mentoring Programme

The Trust has successfully launched a Reciprocal Mentoring Programme. The first cohort on the programme which is planned to last for 2 years is focused on establishing mentoring partnerships with our Black, Asian and Minority Ethnic (BAME) colleagues, who are partnered with members of the Trusts Senior Leaders.

We currently have 23 pairs of mentors who have commenced onto the programme.

Reciprocal Mentoring is a systemic intervention designed to enable change that leads to greater equity of outcomes across the whole organisation. In reciprocal mentoring the mentors are partners developing each other's ability to make significant improvements in equality.

Reciprocal mentoring is a mutually beneficial relationship where each participant learns from each other and improves their professional performance. They hold each other accountable and give each other encouragement and feedback on their goals.

Some key aims of the programme are to create strong partnerships that enable a greater understanding of issues that affect colleagues from different ethnic backgrounds. Together the programme is looking to gain greater insight, which will then enable system change and improvements in equality for staff, patients and service users from across our communities.

Sickness Absence

The Trust remains committed to promoting and maintaining the health and welfare of all staff. We continue to encourage colleagues to have good wellbeing and to achieve a good work life balance. We have focussed on stress and anxiety management and, in partnership with Staff Side and Occupational Health colleagues, have a developed a detailed framework to support both managers and staff.

In 2021/22 the average sickness absence rate for the Trust was 5.26% which exceeded the Trust target of 3.9%. We are confident that the focus on absence management will enable us to better meet 3.9% target within 2022/23.

Developing a Sustainable Workforce

We have some difficulties recruiting to some roles, particularly where there are national shortages such as medical staff, specialist nursing, midwives and some allied health professionals. In addition, in some areas we have high projections for retirements over the next five years.

Our objectives for developing a sustainable workforce are:

- Develop a long-term sustainable workforce planning process to identify workforce needs now and in the future with recruitment plans in place to support them, alongside efficient resourcing plans to ensure that we utilise our people to support our people when and where they are needed
- Establish real time reportable establishment and vacancy rates for our clinical collaborative to support recruitment
- Develop creative and flexible values-based approaches to recruitment, attracting and retaining colleagues who are looking for flexibility throughout their employment
- Overall reduction in agency spends and overtime
- Work with our colleagues and local communities to develop South Tees as the employer of choice

Values Based Recruitment is a recruitment process to help attract and select employees whose personal values and behaviours align with the values of the Trust. Since the beginning of 2022, over 300 interviews have taken place using the values-based recruitment approach.

The new Trust Welcome Induction has been running since July 2021 and provides a comprehensive overview of the organisational priorities and services.

We have developed and implemented a workforce planning model for clinical and non-clinical roles based on capacity and demand to include an action plan to address areas of concern in terms of culture and resourcing and a detailed succession plan.

We continue to build our relationships with higher education and further education sectors which will provide an opportunity for us to develop a talent pipeline and enable our colleagues to develop into new roles.

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 COVID 19 Pandemic.

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 meet 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 interests are mutually compatible with the aim of preserve jobs and the quality of services.

Employment Policies and Partnership Working

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.

Trade Union Facility Time

Time spent on paid trade union activities as a percentage of total paid facility time hours was 4.45% in 2020/21. This figure is based on 26 Trade Union Representatives.

Performance against key national priorities

	15/16	16/17	17/18	18/19	19/20	20/21	21/22	21/22 Target
Safety								
Clostridium (c.) difficile – meeting the C.difficile objective	61	43	48	41	89	79	138	81
All cancers: 62 day wait for first treatment from :								
Urgent GP referral for suspected cancer	79.10%	81.10%	85.44%	82.65%	77.23%	75.52%	73.83%	85%
NHS Cancer Screening Service Referral	89.80%	89.00%	94.55%	87.14%	94.41%	62.77%	50.00%	90%
18 weeks referral to treatment time (RTT)								
Incomplete pathways	93.20%	92.20%	91.45%	89.49%	83.33%	63.20%	65.37%	92%
Accident & Emergency								
4 hour maximum wait in A&E from arrival to admission, transfer or discharge	95.80%	95.33%	95.68%	95.24%	88.35%	83.45%	76.50%	95%
Diagnostic Waits								
Patients waiting 6 weeks or less for a diagnostic test	98.82%	99.15%	97.46%	98.26%	94.04%	72.57%	68.71%	99%

Table 15: Performance against National Priorities

C. difficile – the Trust recorded 138 cases of C. difficile during 2020/21. Further narrative can be found in part 3 of the quality account.

Urgent GP Referral for Suspected Cancer (62-day cancer wait target for first definitive treatment) – our year end performance was 73.83% 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 - year-end performance was 76.50% 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 65.37% 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 68.71% with a target of 99%. Recovery plans and trajectories are in place to address areas of concern.

As of the end of the financial year, the Trust has 1 patient who had waited more than 104 weeks from referral to treatment. The patient had tested positive for COVID-19 and subsequently received his care and treatment early in the new financial year.

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

First floor, 14 Trinity Mews
North Ormesby Health Village
Middlesbrough
TS3 6AL

24th June 2022

Dr. Hilary Lloyd
Director of Nursing & Midwifery
South Tees Hospitals NHS Foundation Trust
The James Cook University Hospital
Marton Road
Middlesbrough
TS4 3BW

Dear Dr Lloyd,

Statement from NHS Tees Valley Clinical Commissioning Group (CCG), County Durham Clinical Commissioning Group and North Yorkshire Clinical Commissioning Group for South Tees Hospitals NHS Foundation Trust (STHFT) Quality Account 2021/22.

NHS Tees Valley CCG, County Durham CCG and North Yorkshire CCG commission healthcare services for the local population. The CCG's take seriously their responsibility to ensure that the needs of patients are met by the provision of safe, high-quality services and therefore welcome the opportunity to submit a statement on the Annual Quality Account for South Tees Hospitals NHS Foundation Trust (STHFT).

The quality of services delivered, and associated performance measures are the subject of discussion and challenge at the Clinical Quality Review Group (CQRG) meetings. The meetings provide an opportunity to gain assurance that there are robust systems in place to support the delivery of safe, effective and high-quality care. The CCGs would like to take this opportunity to thank the Trust for continuing to engage in the CQRG meetings at a time of heightened pressure.

Like many organisations across the country, STHFT faced another challenging year as a result of the COVID-19 pandemic. The CCGs would like to commend the Trust on the commitment and dedication demonstrated during this difficult time, in particular the Trust's achievement in becoming one of the first in our region to offer antibody and antiviral treatments to eligible patients.

The Commissioners are pleased to note that despite the challenges of the pandemic, providing safe and high-quality care has remained a priority for the Trust and progression has been made towards achieving the 2021/22 quality priorities.

Commissioners appreciate the Trust's continued efforts to develop their patient safety culture and approach to incident reporting, including the introduction of 11 Patient Safety Ambassador

roles across the organisation. This has yielded positive results, with the Trust achieving a 15% increase in patient safety incident reporting against the current 10% increase target. The CCGs recognise the positive work undertaken by the Trust which is also reflected within the 2021 Staff Survey Results as 76.9% of staff stated that they would be confident in raising concerns about unsafe clinical practice. The CCGs look forward to learning more about how the Patient Safety Ambassador roles will be developed and embedded throughout 2022/23.

The CCGs acknowledge that the Trust has offered an extensive education and training programme in relation to human factors. This has received positive feedback from staff and the overall number of reported serious incidents have reduced across the organisation. However, the CCGs remain concerned about the impact of Never Events on patient care and it is disappointing to note that Never Event incidents have continued to occur throughout 2021/22. The CCGs support the Trust's plan to continue work to ensure that effective, proactive processes are in place to facilitate system-based learning and improvements across the Trust, specifically the implementation of the action plan to emerge from the internal Thematic Review of Never Events undertaken at the end of 2021.

Despite the challenges presented by the COVID pandemic, the Trust have undertaken extensive work in preparation for the forthcoming Patient Safety Incident Response Framework (PSIRF). Commissioners are pleased to note that the Trust's Quality and Safety Strategy has now been approved, aiming to give all staff personal responsibility for providing quality care within their areas. The Commissioners look forward to working collaboratively with the Trust to ensure the standards are met.

Getting It Right First Time (GIRFT) is a national programme designed to improve the treatment and quality of care offered to patients by reducing the variations in the way in which services are delivered across the NHS. Commissioners recognise and fully support the Trust's participation in the programme. The Trust have participated in 7 virtual deep dive visits across a range of departments during 2021/22 which identified a range of notable practice and some recommendations for improvement. In response to this, the Trust have developed speciality improvement plans and the CCGs look forward to receiving assurance as to how the actions taken improves the quality of care delivered to patients throughout 2022/23.

Commissioners acknowledge the continued work undertaken by the Trust to deliver the End-of-Life Strategy including the implementation of a new leadership team and a refocus of service priorities; the results of which are reflected in the National Audit of Care at the End of Life.

Improving compliance with NICE guidance was identified as a priority for the Trust for 2021/22 and it is evident that extensive work has been undertaken towards achieving this. However, it is recognised that further work is still required to achieve full compliance, and this is reflected in this remaining a continuing priority for the Trust in 2022/23.

Commissioners appreciate the significant amount of improvement work undertaken to support safe, effective and timely discharge from hospital. In particular, the collaborative approach with Local Authorities to introduce a transfer of care hub ensuring that care is available in the right place, and at the right time for all patients. Additional funding has helped to set up a discharge

hub and recruit additional staff including Transfer of Care Coordinators and a System Lead. A single referral form has been trialled and rolled out across the organisation and the CCG look forward to learning more about the outcome of the trial and the results on patient care.

It is reassuring to note that during 2021/22 the Trust have taken steps to reduce the incidence of avoidable category 3 and 4 pressure ulcers in order to positively impact on patients who are most at risk. The Trust have reviewed documentation, assessment tools and introduced Pressure Ulcer Review Panels demonstrating a continued commitment to reduce pressure ulcers and patient harm. The Trust's intention to develop and strengthen this work during 2022/23 with training and education packages and the implementation of new assessment frameworks is welcomed.

It is noted that the Trust's compliance with the nationally assigned Clostridioides Difficiles thresholds have continued to deteriorate and will remain a priority for 2022/2023. The CCGs recognise that compliance with this target have been compounded by system pressures and covid as this can be demonstrated within the contributory factors identified within the investigation reports. The CCGs would like to acknowledge and thank the Trust for the open and honest approach and for the increased surveillance/workstreams that have been put in place.

Unfortunately, due to COVID the Trust's aim to establish a Trust-wide inclusive Patient Experience User Group has not progressed at the planned pace. The CCGs acknowledge that the Trust have made some progress towards this by reviewing letter templates and are pleased to note that the Trust have commenced planning for the implementation of the Patient Participation Group and Conference which will remain a priority for 2022/23.

Commissioners acknowledge the work of the Trust Task and Finish Group to improve patient experience particularly in relation to communication. This is demonstrating a positive reduction in concerns in a number of areas. However, it is concerning that complaints relating to staff approach have increased and the CCGs Are keen to understand what actions the Trust are taking to promptly address this.

Commissioners recognise the Trust's involvement in national clinical audits and National Confidential Enquiries and encourage these contributions in improving the quality of healthcare services at both a local and national level.

Clinical research is both a national and Trust priority and the Commissioners congratulate the Trust on the acquisition of three NIHR grants and supports the Trust with the continuation of research studies to ensure new treatments and therapies are available to the local population.

The Trust was subject to a CQC inspection in February 2022. The enormous efforts of colleagues facing unprecedented winter pressures relating to the COVID 19 Omicron variant were recognised but required improvements were identified in relation to ward-based documentation, nutrition and hydration, MCA/DOLS and discharge. The Commissioners note that requisite improvement work is underway and continue to collaboratively support this as the associated learning and improvements are embedded.

The Commissioners recognise that the Trust continues to report above national average Summary Hospital-level Mortality Indicator (SHMI) mortality values; these are approaching the highest in the national range. The Trust offers mitigating factors to the high values registered including the impact of COVID particularly wave 1 and the effect on hospital admissions as well as recording anomalies. The CCGs will continue to provide robust scrutiny and challenge in relation to mortality outcomes during 2022/23 and will continue working with the Trust to identify opportunities for shared learning across the health economy.

Of particular concern is the continued increase in Safeguarding incidents A total of 167 incidents were reported in 2021/22 relating to Trust practices with key areas of learning identified in relation to discharge, pressure ulcers and medication. CCGs are keen to understand the learning from these incidents and how the Trust will address this.

The CCGs are reassured to note that clinical quality will remain a priority for the Trust in 2021/22 with a focus on the three main areas: Patient Safety, Effectiveness of Care and Patient Experience. Commissioners fully support the identified quality priorities for 2022/23 and acknowledge that these will underpin continued progress by the Trust in meeting their overall quality improvement goals.

The CCGs can confirm that to their best knowledge the information provided within the STHFT 2021/22 Annual Quality Account is an accurate and fair reflection of the Trust's performance. It is clearly presented in the format required and the information it contains accurately represents the Trust's Quality profile.

Commissioners look forward to continuing to work in partnership with the Trust to assure the quality of services commissioned in 2022/23.

Yours sincerely

Jean Golightly
Executive Director of Nursing and Quality
NHS Tees Valley CCG
(Lead Commissioner)

Sue Peckitt
Director of Nursing and Quality
NHS North Yorkshire CCG

Anne Greenley
Director of Nursing and Quality
NHS County Durham CCG

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 2021/22 and supporting guidance published on NHS England's website.
- 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 2021 to May 2022
- Papers relating to Quality reported to the Board over the period April 2021 to May 2022
- Feedback from North Yorkshire CCG received 27/06/2022
- Feedback from Tees Valley CCG received 27/06/2022
- Feedback from County Durham CCG received 27/06/2022
- Feedback from Healthwatch South Tees requested 25/05/2022
- Feedback from Healthwatch North Yorkshire received 22/06/2022 with no comments to add
- Feedback from the Health Scrutiny Panel, Middlesbrough Council requested 25/05/2022
- Feedback from the Governors received 14/06/2022
- The 2021 national staff survey published in March 2022
- The Head of Internal Audit's annual opinion over the Trusts control environment – not required for 2021/22.
- CQC inspection reports dated July 2019 and February 2022
- the Quality Report presents a balanced picture of the NHS foundation Trusts 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 England's annual reporting manual (which incorporates the Quality Accounts regulations) (NHS England » Quality Accounts requirements 2021/22) 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 30.6.2022 Derek Bell, Joint chair

Date 30.6.2022 Sue Page, 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.

Black, Asian and minority ethnic (BAME)

All ethnic groups except White ethnic groups; it does not relate to country origin or affiliation.

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

Care Quality Commission (CQC)

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

Clinical audit

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

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.

Day case

Patient who is admitted to hospital for an elective procedure and 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.

Fall

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

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 Trusts provide and develop healthcare according to core NHS principles – free care, based on need and not on ability to pay. NHS Foundation Trusts have members drawn from patients, the public and staff, and are governed by a Board of Governors comprising people elected from and by the membership base.

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 because of healthcare interventions. There are a number of factors that can increase the risk of acquiring an infection, but high standards of infection control practice minimise the risk of occurrence.

Healthcare Quality Improvement Partnership

The Healthcare Quality Improvement Partnership was established in April 2008 to promote quality in healthcare, and 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.

Medworxx

Patient flow management system used in South Tees

Meridian

IT programme that facilitates Trust-wide data collection via 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 can support the research of other funders to encourage broader investment in, and economic growth from, health research. NIHR work with charities and the life sciences industry to help patients gain earlier access to breakthrough treatments, and train and develop researchers to keep the nation at the forefront of international research.

National Institute for Health and Clinical Excellence (NICE)

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

NCEPOD

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

National Patient Survey Programme

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

NHS 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 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.

NRLS (The National Reporting & Learning System)

The National Reporting and Learning System (NRLS) is a central database of patient safety incident reports. Since the NRLS was set up in 2003, the culture of reporting incidents to improve safety in healthcare has developed substantially.

Overview and Scrutiny Committees

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

PALS (Patient Advice and Liaison Service)

A service that offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.

Patient Reported Outcome Measures (PROMs)

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

Payment by Results

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

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 Trusts and their private or voluntary sector equivalents.

Purpose T (Pressure Ulcer Risk Primary or Secondary Evaluation Tool)

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

Regulations

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

Research

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

Risk

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

Risk Assessment

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

RCA (Root Cause Analysis)

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

Schwartz Rounds

Schwartz Rounds are group reflective practice forums giving staff from all disciplines an opportunity to reflect on the emotional and social aspects of working in healthcare.

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.

SMART (Specific, Measurable, Agreed, Realistic, Time-bound)

Used in objective setting, ensuring objectives are clear and easy to understand, whilst making sure they provide clear goals.

Spell

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

STAQC (South Tees Accreditation for Quality of Care)

STAQC is a ward / department accreditation programme which brings together key measures of nursing and clinical care into one overarching framework.

STRIVE (South Tees Research, innovation and education)

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

Summary Hospital-level Mortality Index (SHMI)

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

South Tees Hospitals NHS Foundation Trust

Includes The Friarage Hospital (FHN) and James Cook University Hospital (JCUH) and community services in Hambleton, Richmondshire, Middlesbrough, Redcar and Cleveland.

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 into the patient's bladder to allow urine to drain freely from the bladder for collection.