South Tees Hospitals
NHS Foundation Trust

Quality Account 2023/2024

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1. Statement on quality from the chief executive of the NHS foundation trust DRAFTED. NEEDS APPROVAL BY SH

I am pleased to introduce the 2023/24 Quality Account as Chief Executive of South Tees Hospitals NHS Foundation Trust.

As a clinically led organisation the safety and wellbeing of our patients, service users and colleagues - underpinned by our commitment to clinical research, innovation and training - is at the heart of our mission. Our clinicians lead by the way they manage our resources and deliver safe, quality care across our hospitals and services – aided by the experience, professionalism and skills that exist across our clinical and support areas.

It has been another challenging year for the NHS as we continue our recovery from the COVID-19 pandemic while also putting contingency plans in place for ongoing periods of industrial action. With this in mind, I would like to make a special point of thanking all our amazing clinical and non-clinical teams for their continued support, dedication and professionalism.

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

When the CQC inspects hospital trusts, the care regulator also reviews whether they are safe, caring, effective and responsive to people's needs, and the trust achieved an overall 'Good' rating in each area. Over the last four years, our experienced clinicians have laid the foundations of a trust where safety and quality are put first, where colleagues feel empowered to make improvements for their patients and service users, where funding is used to invest in the things that experienced clinicians agree will make the biggest difference for the people we serve, and where influence to make positive changes beyond hospital walls is being exercised.

This has only been strengthened further by the formation of our hospital group with North Tees and Hartlepool NHS Foundation Trust in 2024 which will support both organisations' shared goals for our patients, service users and colleagues by formalising the way we already work together in the interests of the people and communities we have the privilege to serve.

The group model means that the two organisations remain separate, so they can represent their communities really effectively, but it has the flexibility to enable the trusts to work at scale to take strategic decisions which benefit the group as a whole and the patients we serve.

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

Stacey Hunter

Group Chief Executive Officer
South Tees Hospitals NHS Foundation Trust and North Tees and Hartlepool NHS Foundation Trust

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

2.1 Priorities for improvement

a. Review of progress with the quality priorities defined for improvement in 2023/24

The Quality Account provides an opportunity for the Trust to reflect on its achievements over the last 12 months. This includes a look back at the progress made against the quality priorities for 2023/24 that were defined in the 2022/23 Quality Account and are summarised in the table below.

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

Our ambition for improvement, agreed actions, aims and progress at the end of 2023/24 for each quality priority are detailed below.

Patient safety quality priorities

1. Positive safety culture. COMPLETE

It is widely recognised that staff need to feel psychologically safe to proactively raise and discuss patient safety issues, knowing that they and everyone involved will be treated fairly. They need to feel supported in a restorative way and empowered to learn when things do not go as expected, rather than feeling blamed, to ensure effective organisational learning and prevention of future incidents of avoidable harm.
A restorative, just and learning culture is a learning approach to dealing with adverse events, which focuses on harm done rather than blame. The approach recognises that people make mistakes, while ensuring people are held accountable for their decisions. It aims to repair trust and relationships damaged after an incident. It allows all parties to discuss how they have been affected and collaboratively decide what should be done to repair the harm.

The aim of this work was to continue to develop a positive safety culture in which openness, fairness and accountability is expected.

Aims

We planned to:

- Embed a restorative, just and learning culture across the organisation.

- Train 50 key staff in restorative practice.
- Develop a new process and documentation for 'The South Tees Resolution Pathway' to support consistent, constructive, and fair evaluation of the actions of staff involved in incidents.

We aimed to achieve the following measures of success:

- An increase in the percentage of staff agreeing with the question "I would feel secure raising concerns about unsafe clinical practice" in the annual NHS staff survey to above 74%.
- 50 Trust staff completing the restorative practice training during 2023/24.

Progress

Since April 2023, 75 Trust staff have attended Restorative Practice Facilitator 3-day training programme, which has been evaluated very positively. There is a further cohort planned for September 2024. Elements of this training have also been added to the Trust's Manager's Essentials programme to continue to raise awareness of the importance and benefit of an organisational restorative and just culture. In addition, STRIVE colleagues have used their expertise in learning and education to run patient safety learning days, demonstrating an appropriate organisational response to safety events, supporting a positive reporting culture, and building safety learning into leadership development.

Work to embed a restorative, just and learning culture continues within the organisation. The South Tees Way Resolution Pathway has been developed to support staff following any adverse event, including patient safety incidents. The pathway supports the development of a proportionate outcome through open, constructive, and restorative conversations and has now been implemented into practice.

The percentage of staff agreeing with the question "I would feel secure raising concerns about unsafe clinical practice" decreased in the 2023 staff survey results to 71%. Whilst this remained above the national average the result was disappointing, although at the time of the staff survey (October 2023) this work was still in its early stages. Reassuringly, Trust incident reporting figures have remained consistent from 2022/23 (29,318) and 2023/24 (29,278). Analysis of the data showed many areas within the Trust scored well above 74%, with a small number scoring below which has reduced the overall Trust score. This suggests opportunities for targeted work during 2024 and this work will continue into 2024/25.

Summary and plans for ongoing work

There has been considerable good work done during 2023/24 with increasing staff awareness of the importance of an organisational restorative, just and learning culture. We have also implemented resources to support staff and facilitate a proportionate outcome following an adverse event through open, constructive, and restorative conversations.

There is more work to be done to embed this work throughout the organisation and to develop a positive safety culture in which people feel confident that openness, fairness, and accountability is expected.

2. Learning from incidents, claims and inquests. COMPLETE

The NHS Patient Safety Strategy (2019) describes how the NHS will continuously improve patient safety, building on the foundations of a safer culture and safer systems. It notes that an organisation that identifies, contains, and recovers from errors as quickly as possible will be alert to the possibilities of learning and continuous improvement.

It introduced the Patient Safety Incident Response Framework (PSIRF) to replace the previous Serious Incident Framework. This sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Through the implementation of the PSIRF, we will improve our ability to triangulate learning from a range of sources, ensuring the Trust has the appropriate skills, experience, and knowledge to undertake system based and proportionate learning responses and sufficient quality improvement (QI) resource to ensure changes are embedded into practice and sustained. This will continue to optimise the Trust's ability to learn from incidents, claims, and inquests to improve outcomes for our patients.

Aims

We planned to:

- Continue our PSIRF implementation journey.
- Ensure proactive management of incidents across the Trust.
- Expand our mediums for sharing learning across the Trust, including examples of learning from good practice.

We aimed to achieve the following measures of success:

- A sustained reduction in the number of incidents logged on the Datix incident management system that remain open, which means that actions and learning have not been completed.
- Improvements in practice following patient safety incidents that can be demonstrated by audit.
- An increase in staff agreeing with the question "I am confident that my organisation would address my concern" in the annual NHS staff survey above 58%.

Progress

The Trust successfully implemented PSIRF on 29 January 2024, with colleagues engaging positively in relevant education and training as set out within national standards. The Trust also went live with the national Learning from Patient Safety Events (LFPSE) reporting platform on 20 November 2023 and incident reporting levels have remained consistent.

Work is ongoing to meet the training requirements of PSIRF and the National Patient Safety Syllabus. Oversight training for senior leaders and the Board has been arranged and plans are in place to introduce Level 1 Patient Safety Training to all staff as part of an e-learning mandatory training course. Accredited external investigation training was arranged for key colleagues to attend in March 2024.

There has been focused work throughout the year to reduce the number of historical open incidents held on Datix and to ensure that new incidents reported are reviewed, actioned and closed in a timely way. Approximately 2500 incidents are reported monthly within the Trust, and at the beginning of 2023 there were 2655 incidents open on the system, indicating that the management of incidents was not always timely. At the end of March 2024, this has reduced to 1537 open incidents (see figure 1). Work continues to ensure effective incident management processes within the organisation.

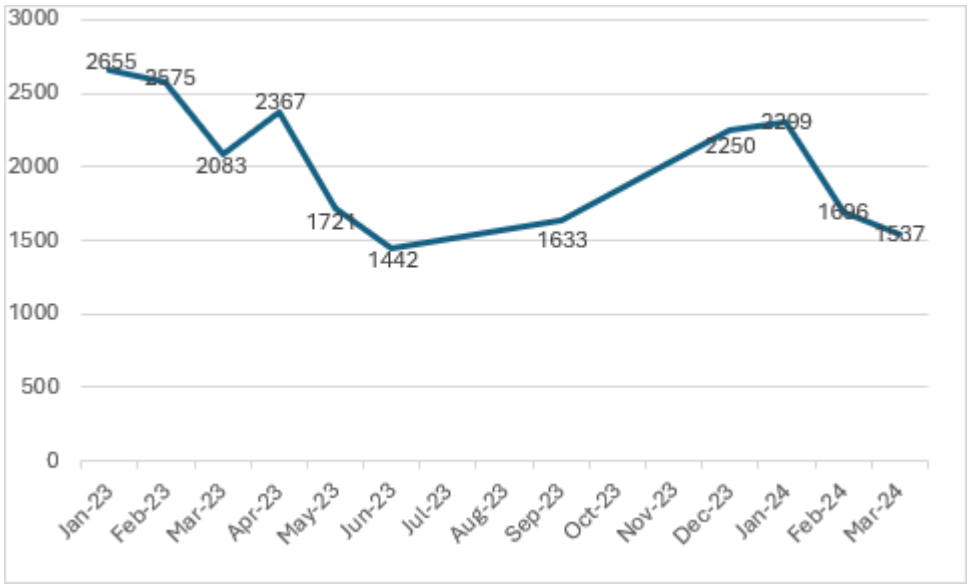


Figure 1: Number of open incidents on Datix January 2023 – March 2024.

Work is planned to produce quarterly reports from patient safety, patient experience, and clinical effectiveness data to triangulate information and identify themes to influence local and Trust wide actions and learning. The Trust Patient Safety Partners are to assist in an audit programme of key safety metrics. Demonstrating improvements in practice following safety incidents using audit is a key part of ensuring learning has been embedded.

There is ongoing work to develop new ways to share the learning from incidents but in the last 12 months:

- A library of completed serious incidents and significant learning events has been developed and is now available on the intranet for all staff. The library enables staff to review incidents and associated learning across the organisation.
- Multidisciplinary team learning events have been introduced that focus on an incident or series of incidents where significant learning has been identified. They provide a facilitated arena for discussion and sharing of learning between different professionals and teams.

The percentage of staff agreeing with the question “I am confident that my organisation would address my concern” decreased in the 2023 staff survey to 54%, which was disappointing. Data analysis confirms many areas within the Trust scored well above 58%, with a small number scoring below which has reduced the overall Trust score. This suggests opportunities for targeted work during 2024.

Summary and plans for ongoing work

There has been good progress with the aims of this work but there is more to do to embed PSIRF in the organisation, to achieve all the measures of success, and to demonstrate quality improvement outcomes. This work will continue as a quality priority into 2024/25.

We are planning to develop learning videos arising from safety events which will be linked to role specific training and monitored on ESR. We will be developing joint work with North Tees to share experience and align the adoption of the PSIRF model and will reflect on the internal reporting of PSIRF outcomes including to the Board.

3. Medication safety and optimising the benefits of ePMA. COMPLETE

There are an estimated 237 million medication errors per year in the NHS in England, with 66 million of these potentially being clinically significant. These errors are estimated to cost the NHS at least £98 million and contribute to the loss of more than 1700 lives annually. NHS England maintains that increased uptake of electronic prescribing and medicines administration (ePMA) systems by trusts would correspond with a

30% reduction in medication errors compared to traditional methods, and a similar reduction in patient adverse drug events.

We are working to increase medication safety and optimise the benefits of ePMA. The implementation of ePMA in the Trust commenced in June 2022, starting on the Older Persons Medicine Ward and since then it has been gradually rolled out more widely, engaging with each of the clinical teams along the way to ensure patient safety (see figure 2). ePMA is currently live using the Better Meds system on 51 inpatient wards and clinical areas, with work ongoing to implement this within Outpatients and the Neonatal Unit. Theatres have also gone live with the CHA-A system which is also due to be implemented in Critical Care for infusion medication in 2024/25.

Aims

At the beginning of 2023/24 we planned to:

- Reduce the numbers of omitted doses of prescribed medications. These are prescribed doses of medicine that are not given. The aim was to ensure the reason for omission was recorded, and the reason for omission was addressed quickly and appropriately, e.g. when a drug was not available on the ward, this was sourced from the emergency drug store or Pharmacy, particularly in relation to critical medicines.
- Improve antimicrobial stewardship across the organisational to promote and monitor the judicious use of antimicrobials to preserve their future effectiveness. Antibiotic stewardship is the effort to measure and improve how antibiotics are prescribed by clinicians and used by patients.
- Improve the quality of prescribing medications.
- Reduce allergy related incidents.
- Improve the recording of venous thromboembolism (VTE) risk assessments and appropriate prescribing of medication to address the identified risk. See section 2.3 for further information about VTE risk assessments.
- Increase compliance with prescribing based on the Trust formulary.
- Improve the standardisation of prescribing.
- Improve cost-effective prescribing.
- Improve medicines reconciliation by prioritising patients at highest risk. This is the process undertaken by pharmacists to compare a patient's medications prescribed in hospital to the medications that the patient has been taking prior to admission. This is to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions.

Progress was to be monitored by:

- Regular audits including the monthly omitted doses audit, antimicrobial prescribing audit, prescribing audit (including insulin), allergy status review, and the Clinical Pharmacy intervention audit.
- Compliance with the Commissioning for Quality and Innovation (CQUIN) indicators for 2023/24.
- Evaluating prescribing and administration incidents recorded in the Datix incident management system.
- Reviewing VTE assessment dashboards.
- Reviewing the contract variance report which monitors compliance with national medicines contracts and enables oversight to ensure prescribing practices are within the Trust formulary.
- Reviewing progress with achieving cost improvement schemes by optimising the benefits of ePMA to monitor prescribing practices.

Progress

Achievements have been reported quarterly to the Trust's Safe and Effective Care Strategic Group and the Quality Assurance Committee, and have included the following headlines:

- 100% compliance with documentation of allergy status.
- Zero transcribing errors on discharge for ePMA wards. This was previously 24% when medications had to be transcribed from a paper chart to the electronic discharge system.

- Improvement in VTE prescribing from >1% non-compliance to <0.2% non-compliance.
- 17% reduction in prescribing errors in the following domains: incorrect time or frequency, incorrect dose, and incorrect route of administration.
- Improvement in prescribing in line with clinical guidelines.
- Reduction in drug interaction interventions.
- Improvement in antimicrobial stewardship indication documented from 82% to 94%.
- Improvement in antimicrobial review date documented from 76% to 100%.
- Improvement in insulin prescribing compliance with policy from 25% to 100%.

Figure 2: Ward 11 ePMA Go-Live Day

Further achievements include an interactive dashboard that shows omitted doses of medications has been developed, implemented, and presented at the senior nursing forums. It empowers staff to review their own areas, take actions to address the reasons recorded for the omitted doses, and therefore to improve compliance with the administration of prescribed medication. There has been some targeted work to ensure the reason for the omission is documented. A reduction in critical omitted doses was seen from 4.7% in July 2023 to 3.6% in August 2023 and this has been maintained.

Utilising an antimicrobial dashboard has helped South Tees achieve the quarter 1 CQUIN target of <40% for switching intravenous antibiotics to oral formulations when this is appropriate for the patient, and a further significant improvement to 9% for quarter 3.

A Parkinson's disease medicines dashboard has been developed and is currently being validated before sharing with wider organisation.

There has been a cost saving of £182,000 from reduction in waste, and duplication of prescribing and ordering, and a further saving of £149,000 for IV to oral antimicrobial switch.

Work has also been focused on developing, configuring, and implementing ePMA in some areas of the Trust that require specific solutions e.g. Critical Care and the Neonatal Unit.

Summary and plans for ongoing work

There has been significant progress with the work on medication safety and optimising the benefits of ePMA during 2023/24 which will continue to provide benefits to patients and the Trust. The senior pharmacy team are continuing to optimise the benefits of ePMA, working with the supplier to develop the system and visiting other organisations to ensure maximum utilisation of the system dashboards.

Other ongoing work includes:

- Development of an audit report of VTE prophylaxis assessments compared with prescribing practices.
- The informatics team working with the supplier to purchase an additional package which will improve the reporting between e-prescribing and electronic noting.
- Testing of the new version of Better Meds which will improve oxygen prescribing and provide further improvements for the clinical pharmacy team including a pharmacist task list which will improve pharmacist efficiency.
- Further improvements in medicines reconciliation documentation which will be implemented after MIYA noting is implemented across the organisation.
- Ongoing discussion with Critical Care to implement Better Meds for non-infusion medication.

Clinical effectiveness quality priorities

1. Learning from GIRFT and clinical audits COMPLETE

This quality priority aimed to improve internal clinical effectiveness processes to ensure effective and continuous learning, particularly from Getting It Right First Time (GIRFT) and clinical audits, to provide patients with the best possible clinical outcomes.

GIRFT is a national programme designed to improve the treatment and care of patients through in-depth reviews of services, benchmarking, and a data-driven evidence base to support change. GIRFT is part of an aligned set of programmes within NHS England and has the backing of the Royal Colleges and professional associations. The reviews of specialties are clinically-led, combining wide-ranging data analysis with the input and professional knowledge of senior clinicians, who examine current practice and suggest recommendations for improvement. The clinicians carrying out the reviews are peers of those delivering the service within the Trust. This mutual understanding helps to ensure achievable recommendations that reflect the unique circumstances of the speciality.

Clinical audit is a quality improvement tool for evaluating and improving patient care and outcomes. This is achieved by systematically reviewing current practices against specific criteria and measuring the impact of changes introduced to generate improvement.

Whilst we have been using GIRFT and clinical audit to identify compliance with best practice, areas for improvement, and actions to deliver positive change, it is challenging to do this efficiently and effectively across a large and complex healthcare organisation like South Tees Trust. To develop and improve these processes the Trust began implementing a software platform called InPhase from late 2022. InPhase is an assurance system that integrates information from different sources and is in use across many Trusts and other agencies including local government and community organisations. We wanted to implement InPhase to enable an integrated view of all relevant clinical effectiveness data and actions for each speciality that would support continuous learning and improved patient care.

Aims

We planned to:

- Develop our software platform InPhase and other digital systems (e.g. electronic patient records) to make the collection of data seamless and visible, to enable benchmarking, interpretation of data at source, identification of learning, and monitoring of the completion of actions to deliver improvement.
- Undertake a gap analysis against the Healthcare Quality Improvement Partnership (HQIP) Best Practice in Clinical Audit to identify areas for improvement in our clinical audit systems and processes. HQIP is the UK's largest clinical audit commissioner, enabling those who commission, deliver and receive healthcare to measure and improve healthcare services.
- Participate in all applicable national clinical audits to ensure we use all these valuable opportunities to benchmark our clinical practice and outcomes and identify any areas for improvement.

We aimed to achieve the following measures of success:

1. Quarterly reports that include relevant clinical effectiveness data for directorate meetings, which will inform and support improvement plans.
2. Revision of clinical audit training and an increase in the number of staff trained in clinical audit to support the on-going evaluation and improvement in clinical care and outcomes for patients.

Progress

Ongoing focus on developing and implementing InPhase.

- InPhase is a platform that can be customised and as experience with it grows, more features and applications can be built, enhanced, and tailored to fit the Trust's range of users.
- In the initial phases the Clinical Effectiveness team worked closely with two specialties to undertake user testing of InPhase and feedback on the clinical audit process including live audit data collection and analysis. During this exercise we identified further development that was needed to enhance the audit collection tool.
- We used InPhase to collect data for several infection prevention and control (IPC) audits which enabled us to develop the data analysis tool.
- More testers were engaged in late 2023. In December 2023 a Trust-wide roll out of InPhase for audit registrations was initiated with processes for user registrations, workflow, audit authorisation and approval testing. This enabled direct registration of audits and service evaluations by specialty audit leads rather than via the Clinical Audit Team.
- We have engaged several clinical teams to test and support the building and further development of the application to record and monitor GIRFT recommendations within InPhase.
- The decision was taken to end the contract with our previous audit system provider in February 2024 which has resulted in a substantial cost-saving to the Trust. As a result, over 100 existing audits have had to be re-created and uploaded to InPhase. During this development phase we have taken the opportunity to review the content of each audit and check if it is still needed or should be revised.
- There has been development of InPhase for actions related to CQC compliance, mortality review process, and for the STAQC team.

Gap analysis against HQIP Best Practice in Clinical Audit

- The gap analysis has been completed. 49 actions have been identified, and implementation of actions is progressing. Currently 53% have been completed.
- The Trust's internal audit provider PricewaterhouseCoopers LLP completed a related audit in August 2023 and identified five areas for action with 13 recommendations. These areas and recommendations mirrored those already identified during the gap analysis and have now all been implemented.

Participation in National Audits

- We participated in 60/65 (92.3%) of national clinical audits we were eligible for with any audits identified as being 'at risk' or with any 'concern' flagged being reported internally. There is increased direct engagement between Clinical Effectiveness (Audit Facilitators) and audit leads or coordinators within the clinical teams. This enables any support needs or potential issues to be identified and actions taken to support the teams.
- During 2023/24 we have analysed our benchmarked performance against 28 published reports of national clinical audits.

Measures of Success

1. New reporting templates for sharing all clinical effectiveness data with directorates and specialties has been developed and includes information on clinical audits, service evaluations, compliance with NICE guidance, GIRFT, metrics for specialised services and registers of external visits. Initial feedback on this has been very positive and indicates improved and increased awareness and engagement with clinical effectiveness and quality data.
2. Initial audit training for Clinical Effectiveness staff was delivered internally, with external training delivered in January 2024 to key Clinical Effectiveness and Patient Safety personnel. Trust-wide audit training material is now being updated and will be published on the intranet as well as delivered in regular training sessions to be organised.

Summary and plans for ongoing work

There will be continued focus and delivery of InPhase including the uploading of all current GIRFT recommendations (over 1800) which will facilitate access for the clinical teams and action owners. There will be continued work on the implementation of the mortality review and CQC app.

We will collate clinical effectiveness data (e.g. audit, NICE guidance, GIRFT, Specialised Services Quality Dashboard) and develop better systems to triangulate information to support clinical teams. Data will be made available for specialties and Directorates at their quality or governance meetings.

Materials and tools for training in clinical audit will be finalised and rolled out via the intranet and training sessions will also be planned. Most of the in-person training on InPhase has been delivered. Clinical Directors have been invited to contact the Clinical Effectiveness team to arrange any local demonstrations or training as needed.

Work continues to implement the actions identified in the gap analysis against HQIP's Best Practice in Clinical Audit.

We will use InPhase to bring together the analysis by the Benchmarking Analyst, information gathered from our audits and GIRFT reviews to assess how we are performing against national standards, what we do well and what we can work on to improve.

2. Mortality review processes and learning from deaths. COMPLETE EXCEPT DATA CHECK

Learning from the deaths of people in their care can help providers improve the quality of the care they provide to patients and their families and identify where they could do more. Clinical mortality review is the process by which medical and other disciplinary experts review the circumstances of an individual death in order to learn and improve care processes. It may identify potential problems in care and in some cases, it may be judged that there is a greater than 50:50 chance that the death could have been prevented. It is important to realise that these judgements based on the records of care, are designed to identify opportunities to learning and cannot replace other legal processes. Medical examiners (MEs) are senior medical doctors who are contracted for a number of sessions a week outside their usual clinical duties to provide independent scrutiny of the causes of death. They are trained in the legal and clinical elements of death certification processes.

Medical examiners (MEs) currently scrutinise all inpatient deaths in the Trust at the time of issue of the medical certification of cause of death or referral to the Coroner. ME scrutiny includes talking to the bereaved family, discussion with the attending team that cared for the patient at the time of death and a proportionate review of the medical records. If during the scrutiny process any concerns are detected, MEs refer for Trust or speciality level mortality review of the care records. Some deaths are recommended by MEs for automatic review for a variety of pre-determined reasons e.g. after elective surgery, patients with learning disabilities etc., and some random cases are also selected for mortality review.

Despite our MEs scrutinising 98% of deaths and the Trust or specialities reviewing in detail 20% of deaths, evidence of learning and change was difficult to assemble. We wanted to improve the reporting of learning from the mortality review process, triangulate themes with other sources of learning and align learning from deaths with the Patient Safety Incident Response Framework (PSIRF) and the Learn from Patient Safety Events (LFPSE) service being introduced in the NHS following the publication of the NHS Patient Safety Strategy (2019). We also wanted to support staff to use InPhase to record specialty mortality review. InPhase is our assurance system that integrates quality, compliance, assurance, and performance information. This work will strengthen the mortality review processes, ensuring learning from deaths is triangulated and shared.

Aims

We planned to:

- Identify and triangulate themes from learning from patient deaths with other sources of learning.
- Support specialties to use InPhase to record specialty mortality review.

We aimed to achieve the following measures of success:

- A reduction in the backlog of Trust mortality reviews. A backlog of approximately 160 cases were awaiting mortality review in April 2023, after the process was paused from March 2020 to September 2021 because of the pandemic.
- The development of key performance indicators (KPIs) in relation to the time to undertake Trust mortality reviews in line with National Quality Board Guidance, and then to meet the KPIs to ensure patient deaths are reviewed in a robust and timely way to optimise learning opportunities.
- The completion of at least one 'deep dive' learning summit per quarter to provide an in-depth analysis of learning.

Progress

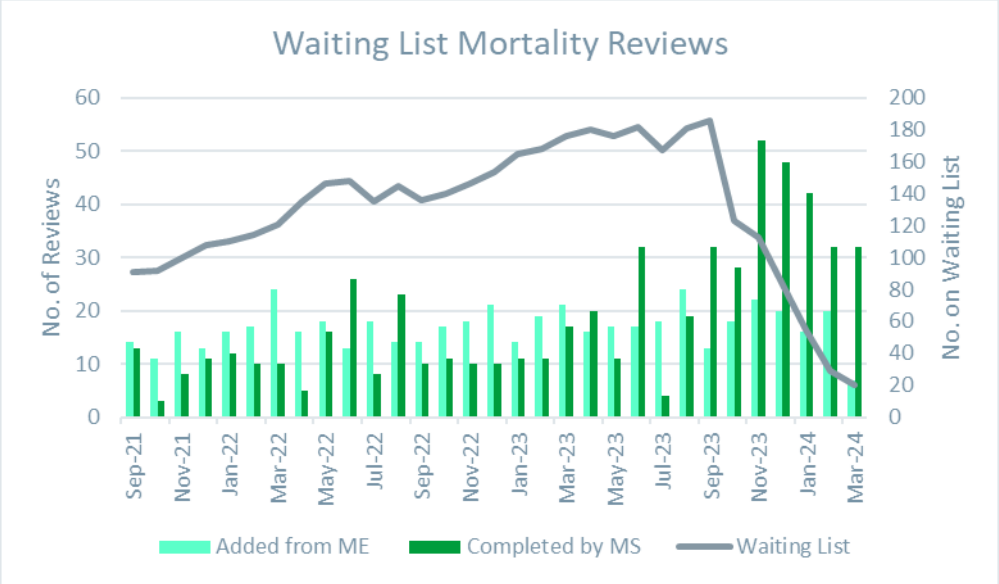


Figure 3: Waiting List – Mortality Surveillance Reviews. (Data s*ource: South Tees Hospitals NHS Foundation Trust Mortality Surveillance Database.) ME = Medical Examiner. MS = Mortality Surveillance Team.*

Figure 3 shows the number of deaths recommended for Trust mortality review. An average of 16 new cases per month are recommended for review. The waiting list at the end of quarter 4 was 20 which is an improvement on the 55 reported in quarter 3 and the 171 reported in quarter 2.

<u>Backlog of Trust Mortality Reviews in April 2023.</u>

In April 2023 there were approximately 160 cases that were awaiting a Trust mortality review. Most of the cases in the backlog were not originally recommended for review by the ME service. They were identified for review prior to this process being introduced for reasons such as the death of a patient admitted for elective surgery, an associated Datix incident rated moderate harm or greater, hospital acquired COVID, tertiary referrals from other trusts, mental health concerns etc.

In May 2023 the Trust commenced a 3-month redeployment of a Band 5 Nurse to support the mortality review process, initially screening the backlog cases into those requiring full review and those that could be closed. Nursing input into mortality reviews has been very positive and has been key to reforming both review processes and increasing the feedback of learning into the Trust. Figure 2 below shows the impact on capacity of adding nurse led reviews. The Trust was able to extend this arrangement until March 2024 and is planning to advertise a permanent role during quarter 1 2024/25.

Access to patient records has also improved with a positive impact on the timeliness of reviews. Mediviewer is a resource for reviewing older (pre-2023) scanned records. The availability of this, and the passing on of records from the Medical Examiner office directly to the Mortality Surveillance Team before they are redirected elsewhere has meant that the waiting list has been greatly reduced. Processes are in place to maintain that level of responsiveness.

Since April 2023 we have completed 710 reviews, 469 consultant led reviews and an additional 241 which were undertaken by the nurse reviewer. 97% of the historic backlog of cases predating April 2023, and 93% of the cases recommended for review (204 out of 217) since April 2023 have been completed. **DATA BEING CHECKED**

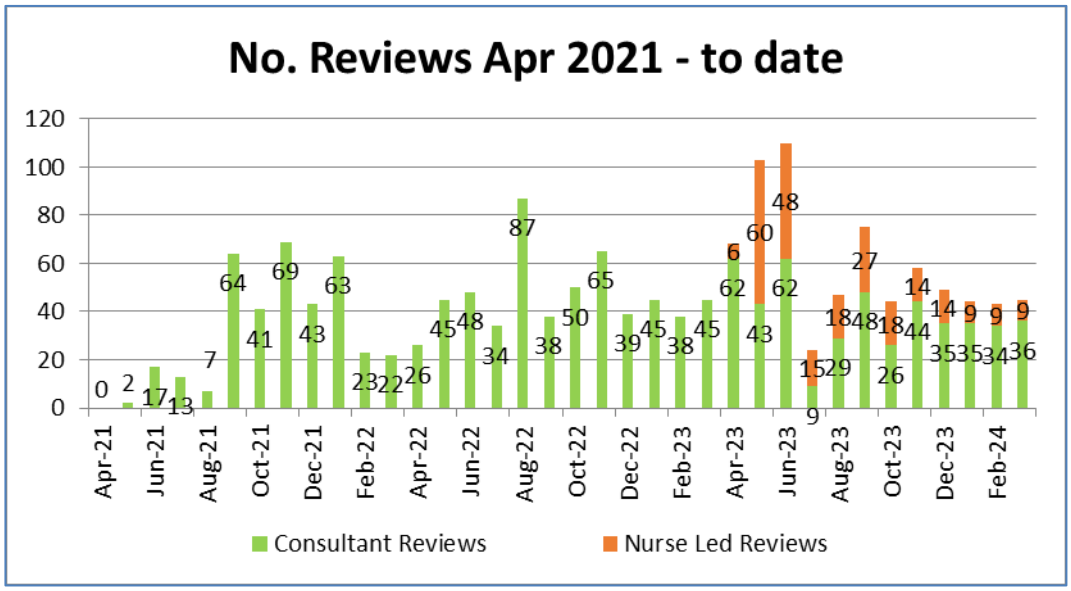


Figure 4: Mortality surveillance reviews from April 2021 to March 2024. (Data source: South Tees Hospitals NHS Foundation Trust Mortality Surveillance Database.)

Integration of Learning from other Safety Events.

Integration with learning from other safety events is progressing. Implementation of Learn from Patient Safety Events (LFPSE) commenced in quarter 3 and implementation of the Patient Safety Incident Response Framework (PSIRF) took place in quarter 4. A series of workshops to review how the Trust can integrate mortality review, PSIRF and LFPSE processes have been held since May 2023 with facilitation by the STRIVE Quality Improvement Team, and this has been very valuable. This work is on-going with further workshops held in quarter 4.

The Trust adopted the Structured Judgement Review Plus (SJR+) methodology and has developed this into InPhase which will replace the current Trust mortality review database. This is facilitating preparations for integration with the changes in learning from other patient safety events and will allow speciality mortality reviews to move into the system during 2024-25.

Deep Dive Learning Events.

The first deep dive learning event held on 27 April 2023 involved presentation of a case involving three surgical specialties and it was attended by a wide audience who discussed the management of a complex patient involving several teams of clinicians. The second event was held on 5 October 2023 and involved the presentation and discussion of four cases. Two involved deaths that were investigated by the Coroner and all involved issues with medications. Learning was discussed and shared with an audience of doctors from across the Trust and involved clinical pharmacist and electronic Prescribing Management and Administration (ePMA) educator support. The third event was held on 21 March 2024 and included 2 cases where nutrition and hydration issues were identified. This was presented to a multi-disciplinary audience with good feedback. A further event was planned for April but has been deferred until June 2024. The cases discussed will highlight concerns related to care at the end of life.

Key Performance Indicators (KPIs).

The Mortality Surveillance Team have developed their reporting to include new KPIs relating to the number of patients requiring and receiving reviews, and the time to review. The time to review usually starts from the time of referral for Trust mortality review by MEs or the Patient Safety Team, but where cases are

selected for other reasons the date of death may be used. Now that the backlog is almost cleared, the Mortality Surveillance Team have agreed to review cases referred by the MEs because of potential concerns within 2 weeks for urgent cases and 4 weeks for less urgent cases. The intention is to monitor the speed of review against these challenging targets during 2024/25.

As of end of March 2024 48% of required cases were being reviewed within 2 weeks of death and 59% within a month.

Summary and plans for ongoing work

The Trust can demonstrate significant progress against the original aims and measures of success. Mortality review processes have been adapted to use scanned medical records and the MIYA Electronic Patient Record and the waiting list has been reduced to 20 cases. The implementation and embedding of PSIRF and LFPSE is on-going, but the development of the SJR+ tool in InPhase will facilitate integration with the learning from other patient safety events, enabling the triangulation of learning to evolve.

Patient experience quality priorities

1. Implementation of the Patient Experience Strategy. COMPLETE

This work was focused on implementing the Patient Experience and Involvement Strategy, developed in collaboration with our patients, carers and Healthwatch. The strategy set out to:

- Recognise the individual needs of patients, carers, and their families, ensuring they are provided with equal opportunities to be heard as partners in their health care.
- Ensure services meet the needs of the community.
- Ensure all patients, carers and their families feel encouraged to be involved in their care and treatment as much they wish to be.
- Improve communication about health conditions and treatment plans to ensure they are understood be those receiving them.

Aims

We planned to:

- Form a patient participation group.
- Ensure a patient representative on all key meetings across the organisation.
- Identify areas of good practice and share across the organisation.
- Ensure verbal and written information about health conditions and treatment plans is provided in a format that the patient and carer understand.

We aimed to achieve the following measures of success:

- Delivery of the actions specified within the strategy for years 1-3.
- Increased deployment of the Family Liaison Officer service to patients and families.

Progress

Working with people

We have formed links with community groups and charities to ensure groups seldom heard from are given the opportunity to feed back. These include groups and charities for people with dementia, Parkinson's disease, epilepsy, stroke, acquired brain injuries, substance misuse. There are also groups for people who have left intensive care, to provide ongoing support after critical illness to them and their families and friends, people who are carers, young carers, deaf and blind, and people who identify as Black, Asian or

minority ethnic (BAME), or neurodivergent. Further links are being developed with Healthwatch North Yorkshire and other community groups. We have also:

- Recruited to the patient involvement bank which will enable patient involvement in key meetings and service development. Recruitment to the children and young persons (CYP) involvement bank and CYP involvement activities will commence in 2024.
- Co-created a leaflet with patients and Healthwatch South Tees to inform patients, carers, families and staff of the Patient Experience and Involvement Strategy.
- Developed a poster to be displayed in Emergency Department (ED) waiting areas to inform other patients and visitors about the reasons for substance misuse, to support an improvement in attitude towards those attending ED. This was suggested by service users and volunteers at North Yorkshire Horizons. An addiction awareness video has also been created to share with staff in the organisation to support with training.
- Shared different designs for the new Urgent Treatment Centre (UTC) at James Cook University Hospital (JCUH) with 25 patients in Redcar UTC and used their feedback to select the designs.
- Engaged with patients regarding research and innovation. Patients have reviewed materials ahead of ovarian cancer research projects, giving feedback and suggesting changes. The Research and Innovations Team have also worked with patients regarding lost property in hospital and the use of patient property boxes to reduce this. A pilot of boxes on three wards is starting on 1 April 2024.
- Started to review complaints to identify if a Family Liaison Officer would be appropriate to support patients, carers, and families through an investigation, and ensure they are kept updated and involved.

Internal Groups and Meetings

Patient stories continue to be presented at Trust Board, Patient Experience Steering Group, and Council of Governor meetings highlighting the impact the stories have had on the Trust and the changes made.

Colleagues leading work on patient experience and involvement and bereavement services now attend Collaborative Board meetings to inform staff of the Patient Experience and Involvement Strategy and how to involve patients in developing services. They also attend internal group meetings such as the Veterans, Nutrition and Hydration, End of Life Care, Health Inequalities Steering Group and Fairer Access Working Group to provide patient feedback. Work continues to support the Maternity and Neonatal Voices Partnership Black and Asian Minority Ethnic Group in conjunction with Teesside University to give feedback on maternity services.

Strategy, Policy and Patient Information

Work has included:

- Four focus groups with patients, carers, and relatives to support the production of a Mental Health Strategy for the Trust.
- Development of a Patient Participation Reimbursement Policy that is awaiting review by the Finance Team.
- Development and publication of an Accessible Information Standards policy to ensure we communicate with patients, carers, and their families based on their identified needs.
- Review of the Patient Information Policy to ensure the process of creating patient information is easy to follow, and that patients and carers can review information being produced.
- Development of internal and external web pages regarding patient involvement to inform staff and the public about our work.
- Creation of a newsletter to share with patients who have signed up to the Involvement Bank to update them about what has happened in the Trust to involve patients and to share new opportunities.

Summary and plans for ongoing work

There has been good work done to prepare start our work on patient engagement and involvement, with new resources developed from patient feedback, and good practice shared through patient stories. We are planning ongoing work to:

- Form a patient participation group and use the patient involvement bank to enable representation from patients on groups within the Trust.
- Progress health literacy for patient leaflets to ensure readability for patients, carers, and families.
- Gain patient, carer, and family feedback ahead of the Translation and Interpretation Service tender process to ensure the services meet their needs.

2. Development and implementation of a Mental Health Strategy. COMPLETE EXCEPT DATA UPDATE

There is increasing evidence that trauma-informed approaches can reduce the negative impact of trauma experiences and support mental and physical health outcomes. Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as harmful or life threatening. Trauma-informed practice aims to increase practitioners' awareness of how trauma can negatively impact on individuals and communities, and their ability to feel safe or develop trusting relationships with health and care services and their staff.

We recognise the impact of mental health, mental ill health, and trauma on people presenting to the Trust and wanted to identify appropriate strategies to ensure this is understood and that it informs our assessments, interventions, and treatments. This work was therefore focused on the development and implementation of a Mental Health Strategy to improve care and share learning, especially for our patients who have mental ill health. In addition, we wanted to recognise the impact of our work on staff and to develop a culture which is trauma reducing, staff focused, and wellbeing driven.

Aims

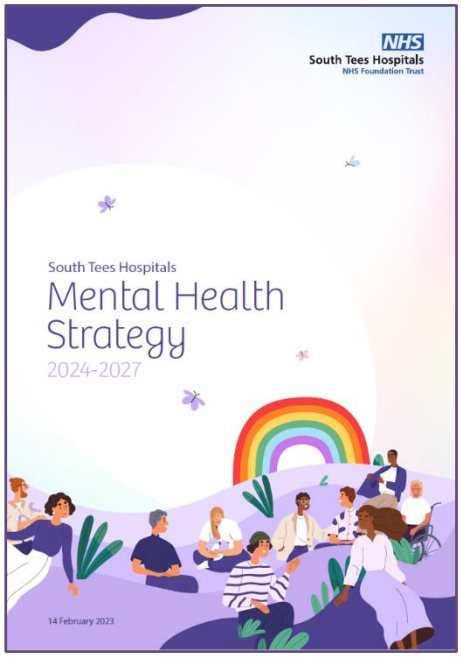
We planned to:

- Introduce a mental health strategic group to provide operational and strategic insight into addressing the mental health needs of our staff and patient community.
- Undertake a needs analysis of our current approach to mental health, identifying what works, what is needed now, and use this to build an implementation plan.
- Implement reporting structures where our mental health strategy journey, plans and outcomes are reported, governed, and agreed.
- Identify key stakeholders, internal and external, including people with lived experience to form our strategic group.
- Develop a staff survey, seeking clarity on the key mental health experiences of staff that need attention.
- Conduct focus groups with people who have lived experience of mental health needs and treatment within our Trust.

We aimed to achieve the following measures of success:

- To increase the percentage of patients attending the Emergency Department (ED) at James Cook University Hospital (JCUH) and the Clinical Decisions Unit (CDU) at Friarage Hospital (FHN) who receive a completed mental health triage following the Royal College of Emergency Medicine 'Mental Health in Emergency Departments' guidance.
- To increase the number of staff working in ED at JCUH and the Acute Medical Unit at FHN who have received mental health training.

Progress



The Mental Health Strategy has been developed, approved and published on the intranet. The focus is to develop, improve, learn from, and enhance the provision of mental health care for our patients, alongside their physical health needs.

The Strategic Mental Health Group is established with agreed terms of reference and membership. Oversight and governance is via the Health Inequalities Steering Group. The Mental Health Strategy Group brings together colleagues from clinical services and subject matter experts regarding safeguarding, the Mental Capacity Act and Deprivation of Liberty safeguards, and patient safety.

Further actions undertaken include identifying a range of organisational mental health assessment tools, to facilitate the identification of individual priorities within clinical services which will be governed by the Mental Health Strategy Group.

Together with the Patient Experience Team we have organised a questionnaire for patients, asking how best to support their mental health when in hospital. We also organised focus groups at James Cook University Hospital, Friarage Hospital and Redcar Community Hospital to further explore patients' needs and perspectives on better integrated mental health and physical health care across the Trust.

We continue to meet with colleagues within the Tees, Esk and Wear Valleys Mental Health Trust to explore care pathways and trauma informed care, and to continue work concerning the connection between mental health and physical health.

Within ED, regular audits of compliance with documenting mental health risk using a paper-based mental health risk assessment tool showed significant improvement over time (see table 1). The aim was to audit at least 15 patients within each audit cycle:

Audit cycle	All patients presenting to ED with mental ill health, self-harm or overdose have a fully completed mental health risk assessment.	The mental health risk assessment will be repeated 4 hourly.	All patients at medium or high risk will have a ligature risk assessment completed.
1	6/18 (33%)	1/18 (6%)	1/18 (6%)
2	10/14 (71%)	4/18 (22%)	7/20 (35%)
3	19/20 (95%)	9/15 (60%)	18/20 (90%)

Table 1: Audit results of compliance with paper-based mental health risk assessment

To improve compliance and patient care, the risk assessment tool was implemented on Symphony, the clinical digital system in use in ED on 15 April 2024. A pre and post implementation audit shows…. **RESULTS AWAITED**

The team are also participating in the Royal College of Emergency Medicine (RCEM) national mental health audit focused on triage and mental health risk assessment. This is a two-year audit with expected completion October 2024.

CDU at FHN have achieved the target of 90% for mental health training compliance whilst ED at JCUH have not achieved this since July 2023 (see table 2). This will continue to be monitored and progressed next year.

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
ED Compliant		91.57%	91.57%									
ED Non-Compliant	81.36%			85.38%	80.67%	81.97%	80.97%	82.99%	84.23%	81.93%	79.03%	74.05%
AMU FHN (CDU) Compliant				90.48%	94.87%	95.00%	97.50%	95.12%	92.86%	95.12%	97.50%	92.68%
AMU FHN (CDU) Non-Compliant	75.56%	85.71%	85.71%									

Table 2: Mental health training compliance CDU and ED April 2023 – March 2024.

Summary and plans for ongoing work

There has been good progress with the initial work and we have published our Mental Health Strategy. We have established a Strategic Mental Health Group to provide strategic and operational leadership as we implement the strategy and mental health improvement plan. There has been demonstrable improvement in mental health risk assessments in ED. To further improve the care of patients in ED, Psychiatry Liaison are planning to review how many patients with a mental health presentation abscond or leave before they have completed a mental health assessment. The purpose is to develop and provide a booklet, as recommended by RCEM, to patients at triage about the Psychiatry Liaison role and what they can do to help. It will provide useful contact numbers in the event they still do not wish to stay in the department and have the mental capacity to decide to leave.

Key next steps are to:

- Continue to monitor our measures of success regarding appropriate mental health triage in ED and CDU, and the training of staff in these areas in mental health.
- Develop a staff survey.
- Enhance patient involvement.
- Continue to review mental health assessment tools and other documents to ensure these contribute to safe and effective care.
- Improve mental health training compliance in ED.

3. Shared decision making and goals of care. COMPLETE

People want to be more involved in decisions about their health and care. Shared decision making ensures that people are supported to be as involved in the decision-making process as they would wish.

Shared decision-making means people are supported to understand the care, treatment, and support options available and the risks, benefits, and consequences of those options, in addition to making decisions about a preferred choice of action, based on evidence based, good quality information and their personal preferences. Goals of care describe what a patient wants to achieve during an episode of care, within the context of their clinical situation. They are the clinical and personal goals that are determined through a shared decision-making process.

We wanted to review best practice and explore how patients are currently involved in shared decision making and agreeing goals of care, before implementing actions to improve by focusing on key services and key clinical situations e.g. when patients face end of life care, increasing frailty, and cardio-pulmonary resuscitation decisions.

NICE guideline (NG197) Shared decision making Overview | Shared decision making | Guidance | NICE covers how to make shared decision-making part of everyday care in healthcare settings. It promotes ways for healthcare professionals and people using services to work together to make decisions about treatment and care. It includes recommendations on training, communicating risks, benefits, and consequences, and how to embed shared decision making in organisational culture and practices.

The Trust has an indicator within the 2023/24 Commissioning for Quality and Innovation (CQUIN) Scheme related to achieving high quality shared decision-making conversations in specific specialised pathways to support recovery.

Aims

We planned to:

- Undertake a gap analysis against recommendations within NICE guideline (NG197) Shared decision making and then to develop a Trust wide improvement plan to put shared decision making into practice.
- Engage with clinical teams regarding the development of procedure specific consent forms, ensuring that information on risks, benefits and consequences is personalised and supported by good quality patient decision aids.
- Facilitate early identification of frailty in patients attending specific clinical areas within the Trust to enable patient centred decisions and joint care planning.

We aimed to achieve the following measures of success:

- An increase in the number of staff trained in end-of-life care. This training includes a focus on shared decision-making and enabling people to be involved in agreeing goals of care at end of life.
- Undertaking a quarterly 'do not attempt cardio-pulmonary resuscitation' (DNACPR) audit and ensuring this drives improvement in end-of-life care planning.
- An increase in the percentage of older people attending CDU and Older Person's Medicine who are clinically assessed to determine their degree of frailty, which will in turn identify their needs and direct a focused care plan based on shared decision making, including those admitted with major trauma.
- Achieving the CQUIN indicator related to shared decision making.

Progress

The Lead Nurse for Cancer and Palliative Care and the Consultant in Palliative Medicine developed a programme of training for staff providing end of life care. This commenced in September 2023 with the first cohort of senior nurses receiving training. By the end of 2023/24 over 500 colleagues had received training. A full time Palliative Care Educator has been recruited and commences in post on 1 May 2024 which will enable the development and delivery of a formal education programme. Role specific training has been mapped to consultants and other relevant groups of staff to ensure this delivers appropriate skills, knowledge, and abilities.

The Lead Nurse for Cancer and Palliative Care has developed a DNACPR audit tool. The first quarterly audit has been undertaken by the Safe & Effective Care Leads and was focused on the health records of deceased patients. The audit report has been presented to the Morbidity and Mortality Review Group and the End-of-Life Steering Group. Following some revision to the audit tool, future audits will be undertaken in clinical areas, using the paper-based and electronic health records of current patients, which will facilitate immediate feedback to improve discussions and documentation in relation to DNACPR shared decision making.

Work has been undertaken with the Clinical Directors of Older Person's Medicine and the Clinical Decisions Unit at FHN to review approaches to increase the number of clinical frailty assessments undertaken with older people attending specific clinical areas within the Trust. A benchmarking exercise of existing frailty data on clinical IT systems was undertaken during quarter 3, with the data suggesting a decrease at both JCUH and FHN sites in the number of assessments undertaken. This is likely to have been impacted by the implementation of the MIYA clinical system for frailty assessments as this data was previously on a different clinical system. The aim is to ensure our digital platforms enable staff to improve the assessment and identification of clinical frailty in patients and to ensure their needs are met via a focused care plan.

In relation to the CQUIN indicator on shared decision making, following discussion and engagement with senior clinicians within the Trust, speciality pathways were identified where patients will receive the shared decision-making questionnaire when they attend clinic appointments. Patients on care pathways for palliative chemotherapy, early-stage lung cancer or renal disease were given a nine-item questionnaire about shared decision-making discussions with their doctor. 51 responses from each pathway were collected in each audit period, and results showed an average score of 89% in quarter 2 and 87% in quarter 4 against a target of 65%. Analysis of the data is underway to identify opportunities to improve the quality of the shared decision-making discussions within each pathway.

Summary and plans for ongoing work

There has been good progress with staff training in end-of-life care to improve shared decision-making and to enable people to be involved in agreeing goals of care at end of life. Quarterly audits of DNACPR discussions and documentation have started and future audits in clinical areas will facilitate immediate feedback to staff to improve DNACPR shared decision making with patients in those areas.

Work has started to evaluate patient experience of shared decision making on some specialist pathways of care. The data will be used to identify opportunities to improve the quality of the shared decision-making discussions within each pathway, before extending the learning into other areas.

A benchmarking exercise in relation to frailty assessments has identified areas for further work to ensure our digital platforms enable staff to improve the assessment and identification of clinical frailty in patients. This will be progressed during 2024/25. When increasing frailty is identified, the focus will be on ensuring patients are involved in decisions about their care, and that their needs are met via a focused care plan.

During 2024/25, one of our clinical teams Trauma and Orthopaedics is going to develop and pilot the use of good quality surgical risk assessment tools to guide shared decision making, and a gap analysis will be completed against NICE NG197.

b. Quality priorities defined for improvement in 2024/25. FORMAL APPROVAL AWAITED

The Trust has agreed the following group Quality Priorities for 2024/25 following a consultation process with clinical colleagues at both North Tees and South Tees Hospitals NHS Foundation Trusts and the Council of Governors.

Quality Priorities 2024/25		
Patient Safety	**Clinical Effectiveness**	**Patient Experience**
We will continue to embed our Patient Safety Incident Response Plans, developing a positive safety culture in which openness, fairness and accountability are the norm and ensuring that colleagues with the right skills and competencies are involved in all aspects of the patient safety response.	We will ensure continuous learning and improved patient care from GIRFT, NICE and clinical audits.	We will develop and implement a Mental Health Strategy to improve care and share learning for our patients who have mental ill health.
We will continue to optimise the Trust's ability to learn from incidents, claims and inquests to improve outcomes for our patients whilst embedding PSIRF.	We will review and strengthen the mortality review processes, ensuring that learning from deaths is used to improve patient outcomes.	We will proactively seek patient feedback and ensure there is continuous improvement in care and treatment because of the feedback we receive.
We will increase medication safety and continue to optimise the benefits of ePMA and evaluate the impact on learning.	We will develop and implement shared decision making and goals of care.	We will respond in a timely and compassionate way to complaints and implement quality improvements as a result of the learning.

2.2 Statements of assurance from the Board

1. Relevant health services COMPLETE

During 2023/24, 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 2023/24 represents 93.7% of the total income generated from the provision of relevant health services by the South Tees Hospitals NHS Foundation Trust for 2023/24.

2. National clinical audits and national confidential enquiries COMPLETE

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 2023/24, 65 national clinical audits and 4 national confidential enquiries covered relevant health services that South Tees Hospitals NHS Foundation Trust provides.

During 2023/24, South Tees Hospitals NHS Foundation Trust participated in 60/65 (92.3%) 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 2023/24 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
Adult Respiratory Support Audit	Yes	Yes	100%
BAUS Nephrostomy Audit	Yes	Yes	Data submission commenced Feb 2024
Breast & Cosmetic Implant Registry	Yes	Yes	Data collection now underway new platform from 21 March 2024
British Hernia Society Registry	Yes	Yes	Not due to start yet
Case Mix Programme (CMP)	Yes	Yes	100%
Child Health Clinical Outcome Review Programme NCEPOD: Juvenile Idiopathic Arthritis	Yes	Yes	Data collection in progress due 15 April 2024
Child Health Clinical Outcome Review Programme NCEPOD: Testicular Torsion	Yes	Yes	100%
Cleft Registry and Audit Network (CRANE) Database	Yes	Yes	100%
Elective Surgery (National PROMS Programme)	Yes	Yes	100%

Emergency Medicine QIPs a) Care of older people	Yes	Yes	100%
Emergency Medicine QIPs b) Mental Health (Self harm)	Yes	Yes	100%
Emergency Medicine QIPs c) Infection Control	Yes	Yes	100%
Epilepsy 12: National Clinical Audit of Seizures and Epilepsies for Children & Young People	Yes	Yes	100%
Falls and Fragility Fracture Audit Programme (FFAP) a) Fracture Liaison Service Database (FLS-DB)	Yes	Yes	100%
Falls and Fragility Fracture Audit Programme (FFAP) b) National Audit of Inpatient Falls (NAIF)	Yes	Yes	100%
Falls and Fragility Fracture Audit Programme (FFAP) c) National Hip Fracture Database (NHFD)	Yes	Yes	100%
Improving Quality in Crohn's and Colitis (IQICC) (known previously IBD Registry)	Yes	No	0%
Learning from lives and deaths of people with a learning disability and autistic people (LeDer)	Yes	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	Yes	100%
Medical and Surgical Clinical Outcome Review Programme NCEPOD: End of life care	Yes	Yes	Data collection in progress
Medical & Surgical Clinical Outcome Review Programme NCEPOD: Endometriosis	Yes	Yes	86%
National Adult Diabetes Audit (NDA): a) National Diabetes Footcare Audit (NDFA)	Yes	Yes	100%
National Adult Diabetes Audit (NDA): b) National Diabetes inpatient safety audit (NDISA)	Yes	No	0%
National Adult Diabetes Audit (NDA): c) National Pregnancy in Diabetes Audit (NPID)	Yes	Yes	100%
National Adult Diabetes Audit (NDA): d) National Diabetes Core Audit	Yes	No	0%
National Asthma & COPD Audit Programme (NACAP) d) Children & Young People's Asthma Secondary Care	Yes	Yes	100%
National Audit of Cardiac Rehabilitation	Yes	Yes	100% Note: not all data fields due to limited staffing therefore delayed submission of some information.
National Audit of Care at the End of Life (NACEL)	Yes	Yes	Data collection in progress commenced January 2024
National Audit of Dementia (NAD) Round 6	Yes	Yes	100%
National Audit of Pulmonary Hypertension	No	N/A	N/A
National Bariatric Surgery Registry	Yes	Yes	100%

National Cancer Audit Collaborating Centre - National Audit of Metastatic Breast Cancer	Yes	Yes	100%
National Cancer Audit Collaborating Centre - National Audit of Primary Breast Cancer	Yes	Yes	100%
National Cardiac Arrest Audit (NCAA)	Yes	Yes	100%
National Cardiac Audit Programme (NCAP): a) National Adult Cardiac Surgery Audit (NACSA)	Yes	Yes	100%
National Cardiac Audit Programme (NCAP): b) National Congenital Heart Disease Audit (NCHDA)	No	N/A	N/A
National Cardiac Audit Programme (NCAP): c) National Heart Failure Audit (NHFA)	Yes	Yes	100%
National Cardiac Audit Programme (NCAP): d) National Audit of Cardiac Rhythm Management (CRM)	Yes	Yes	100%
National Cardiac Audit Programme (NCAP): e) Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	100%
National Cardiac Audit Programme (NCAP): f) National Audit of Percutaneous Coronary Intervention (NAPCI)	Yes	Yes	100%
National Cardiac Audit Programme (NCAP): g) National Audit of Mitral Valve Leaflet Repairs (MVLR)	Yes	Yes (to related registry)	Specified audit not available for submission on NCAP. 100% of cases involving mitral valve repair have been submitted to the related Transcatheter Mitral and Tricuspid Valve Registry.
National Cardiac Audit Programme (NCAP): h) The UK Transcatheter Aortic Valve Implantation (TAVI) Registry	Yes	Yes	100%
National Child Mortality Database (NCMD)	Yes	Yes	100%
National Comparative Audit of Blood Transfusion a) 2023 Audit of Blood Transfusion against NICE QS 138	Yes	Yes	100%
National Comparative Audit of Blood Transfusion b) 2023 Bedside Transfusion Audit	Yes	Yes	100%
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes	33%
National Emergency Laparotomy Audit (NELA)	Yes	Yes	100%
National Gastro-Intestinal Cancer Audit Programme (GICAP) a) National Bowel Cancer Audit (NBOCA)	Yes	Yes	100%
National Gastro-Intestinal Cancer Audit Programme (GICAP) b) National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	Yes	100%
National Joint Registry	Yes	Yes	100%

National Lung Cancer Audit (NLCA)	Yes	Yes	100%
National Maternity and Perinatal Audit (NMPA)	Yes	Yes	100%
National Neonatal Audit Programme (NNAP)	Yes	Yes	100%
National Obesity Audit (NOA)	Yes	No	0%
National Ophthalmology Database (NOD) Audit National Cataract Audit	Yes	Yes	100%
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	100%
National Prostate Cancer Audit (NPCA)	Yes	Yes	100%
National Respiratory Audit Programme (NRAP) a) COPD Secondary Care	Yes	Yes	100%
National Respiratory Audit Programme (NRAP) b) Pulmonary Rehabilitation	Yes	Yes	100%
National Respiratory Audit Programme (NRAP) c) Adult Asthma Secondary Care	Yes	Yes	100%
National Vascular Registry (NVR)	Yes	Yes	100%
Paediatric Intensive Care Audit Network (PICANet)	Yes	Yes	100%
Perinatal Mortality Review Tool (PMRT)	Yes	Yes	100%
Perioperative Quality Improvement Programme (PQIP)	Yes	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	100%
Serious Hazards of Transfusion UK National Haemovigilance Scheme	Yes	Yes	100%
Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	Yes	100%
The Trauma Audit & Research Network (TARN)	Yes	No	National incident – the submissions platform closed part way through the year. Remains closed but expected to re-open soon.
UK Cystic Fibrosis Registry	Yes	Yes	100%
UK Renal Registry Chronic Kidney Disease Audit	Yes	Yes	Change in submission process by provider from January 2024 -expected to submit full dataset by August 2024
UK Renal Registry National Acute Kidney Injury Audit	Yes	Yes	Change in submission process by provider from January 2024 -expected to submit full dataset by August 2024

Table 3: National Clinical Audits 2023/24 eligibility and participation

The reports of three national clinical audits were reviewed by the provider in 2023/24 and South Tees Hospitals Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

National Bariatric Surgery Registry

Bariatric surgery is a type of operation to help people lose weight for example by making the stomach smaller. The main aim of the registry is to accumulate sufficient data to allow the publication of a comprehensive report on outcomes following bariatric surgery. This will include reporting on weight loss, co-morbidity and improvement of quality of life.

A report of data collected through this registry between April 2018 and March 2022 was analysed and benchmarked against local trusts. The following was noted:

- The emergency re-admission rate within 30 days of surgery is low compared to our neighbouring trusts. This means that fewer patients are having to come back into hospital as an emergency after their surgery. South Tees hospital patients having this type of surgery are staying in longer after their surgery than other trusts which is usually not what we aim for but an increased length of stay can result in better recovery and aftercare of the patient so that their post-surgery diet can be gradually introduced.
- Adverse outcome rates following surgery appeared to be higher than neighbouring trusts. On looking into this further there are small numbers of patients involved (25) therefore the two patients reported to have had an adverse outcome has a big effect on the rate.
- The Bariatric Nurse Specialist has identified an action to reduce waiting times for surgery by introducing a new weight loss injection to help patients lose 10% of their weight more quickly. Staff are being trained in prescribing and administering these injections.

National Lung Cancer Audit

- The standards were within the range with the exception of the proportion of patients seen by a Cancer Nurse Specialist. This has improved a lot from only 13.2% in 2020 (target is 90%) to 87.8% in 2023.
- During this time the team have put in actions to improve the data recording and quality which has also led to this improvement.

National Asthma Audit

- Actions for improvement are to include a request in the discharge letter to GPs that they review the patients two days after their discharge. This will be added to the letter written when a patient is discharged.
- The team are also looking at having later shifts and more staff on shift to capture patients for the asthma audit.

3. Local audit COMPLETE

The reports of three local clinical audits were reviewed by the provider in 2023/24 and South Tees NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Clinical audit of rate of surgical site infection after breast reconstruction

- This was a re-audit to assess the effectiveness of actions identified in previous audit carried out in 2022 which showed a 23% infection rate for patients treated between October 2021 and October 2022.
- Several actions were implemented including ensuring screening for bacteria that are resistant to some antibiotics, full compliance with use of face masks by staff, using an alcohol-based skin preparation and improving the quality of air in the theatres. A checklist to help achieve this was introduced.

- The re-audit was completed in October 2023 and showed a 0% infection rate.

Clinical audit to assess the effectiveness of a procedure called flexor tenotomy to treat diabetic foot ulcers.

- The audit looked at three factors affecting the patients after the procedure and the standards they are aiming for: healing rate (>92%), infection rate (<5%) and healing time (>50% with healing time of 28 days).
- The patients audited were found to have a good healing rate and time but a slightly higher infection rate of 8% compared to <5%.
- The team have looked at when they should consider giving antibiotics after the procedure to help reduce infections.
- An improvement already introduced is to use photography to help document and assess the size of ulcers.

Prompt switching from intravenous to oral antibiotic (CQUIN 03)

The Trust participated in this audit set up by NHS England as part of their work towards reducing the length of hospital stays by ensuring that antibiotics that need to be given in the veins (intravenously) are only used for as long as necessary. Other benefits of switching patients to oral (by mouth) antibiotics from intravenous antibiotics are a reduction in drug costs and the carbon footprint.

The audit is performed every quarter and looks at the proportion of patients who were still having intravenous antibiotics but could have had these orally. The percentages have reduced each quarter of the year; 40% in quarter 1 (April to June), 24% in quarter 2, down to 8.75% in the most recent quarter. The lower this percentage the better as it means less patients are continuing to have the antibiotics in their veins when they could have had them by mouth.

These big improvements have been achieved by using the electronic systems for prescribing medicines, highlighting patients that can change the way they have their medicines, and reviews and advice from specialists during ward rounds. The team also went out to teams with banners and used social media during an antibiotic awareness week in November 2023. The aim was to empower nursing staff to prompt the switching to oral medicines. The team plan to keep up this momentum by further working with matrons and nursing staff from all areas to switch their patients who are improving to oral antibiotics if medically appropriate.

Clinical Research COMPLETE

The number of patients receiving relevant health services provided or subcontracted by South Tees NHS Foundation Trust (STH) in 2023/24 that were recruited during that period to participate in research approved by a research ethics committee was 6504 (across 182 studies and 25 clinical specialties). This is slightly lower than last year (6734) but that was an unusually high recruiting year (see figure 5).

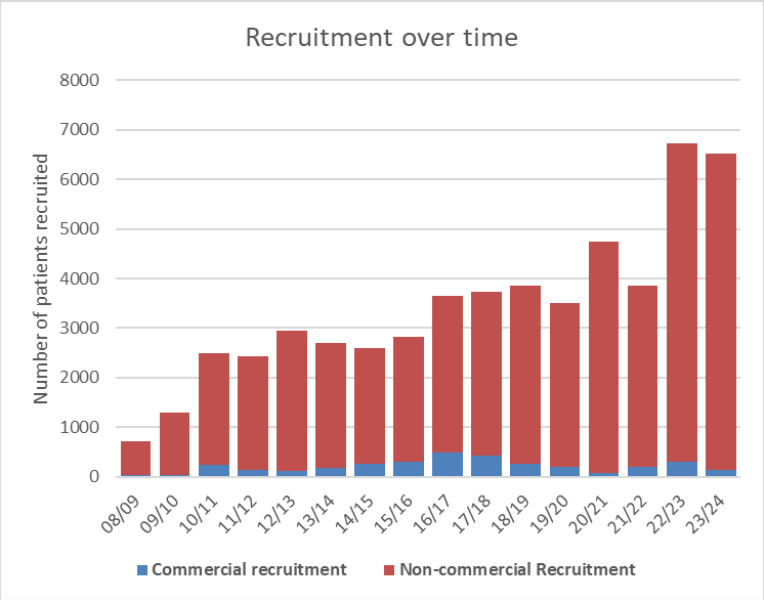


Figure 5: Recruitment to clinical research trials over time.

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

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

A proportion of the South Tees Hospitals NHS Foundation Trust's income in 2023/24 was conditional on achieving quality improvement and innovation goals agreed between South Tees Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2023/24 are available on request from the Quality Assurance Team, South Tees Hospitals NHS Foundation Trust, The James Cook University Hospital, Marton Road Middlesbrough TS4 3BW or via email stees.qualityassurance@nhs.net

5. CQC registration, reviews and investigations COMPLETE

South Tees Hospitals NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is unconditional. South Tees Hospitals NHS Foundation Trust has no conditions on registration. The CQC has not taken enforcement action against South Tees Hospitals NHS Foundation Trust during 2023/24.

South Tees Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during 2023/24.

In August 2023 the CQC carried out a short-notice inspection of maternity services at The James Cook University Hospital and the Friarage Hospital as part of its National Maternity Inspection Programme. The CQC reports published in January 2024 acknowledge a number of areas of outstanding practice including the service's transparency and accountability, and the special support it provides for birth parents and foster carers if a baby is placed into the care of the local authority. Inspectors found leaders were visible and approachable and engaged with people and the community to plan and manage services. Staff were also praised for the way they managed safety, infection prevention, safeguarding and care records. Inspectors identified some areas for improvement which are already being addressed through a comprehensive action plan which includes:

- Ongoing recruitment to support maternity services across James Cook and the Friarage in addition to the successful recruitment of all newly qualified midwives who trained at the trust in 2023.
- Improvements to the building and environment at James Cook, including plans to install a new birthing pool. The trust is continuing to seek investment to improve the environment in maternity services.

Despite many positive findings in the report, maternity services at both hospitals have been rated as "Requires Improvement". However, South Tees Hospitals NHS Foundation Trust's overall CQC rating remains as "Good" (figure 6). The James Cook University Hospital and the Friarage Hospital have a CQC rating of good overall, with both hospitals rated as good in all five key questions of safe, effective, caring, responsive and well-led.

All reports are available at:
South Tees Hospitals NHS Foundation Trust - Overview - Care Quality Commission (cqc.org.uk)

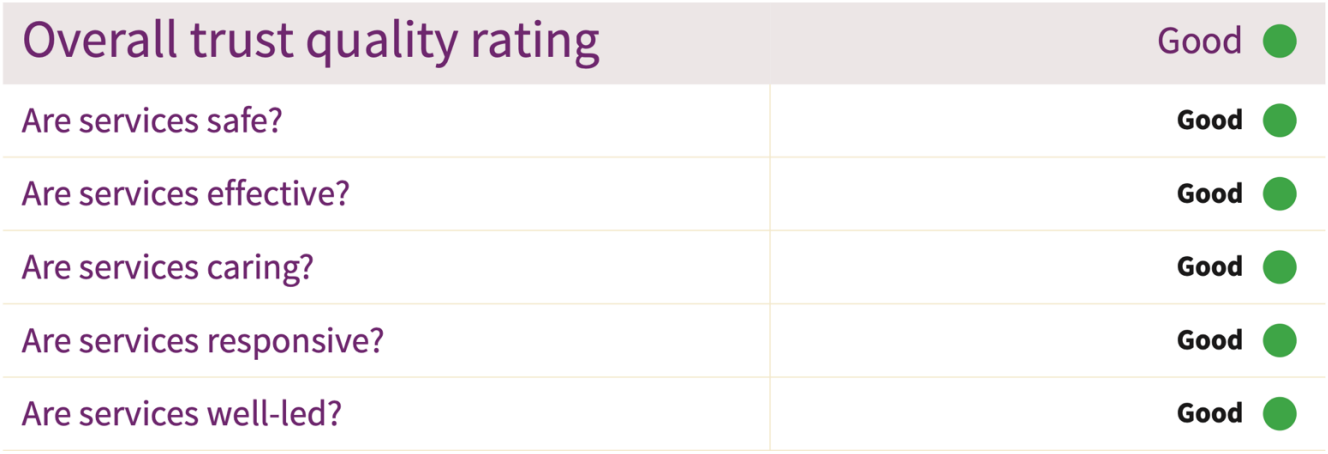


Figure 6: South Tees Hospitals NHS Foundation Trust overall CQC rating

6. Submission of records to the Secondary Uses Service COMPLETE

South Tees Hospitals NHS Foundation Trust submitted records during 2023/24 to the Secondary Uses Service for inclusion in The Data Quality Maturity Index (DQMI). This is a monthly publication intended to highlight the importance of data quality.

The percentage of records in the latest published data for November 2023 which included the patient's valid NHS number was:

- 99.8% for admitted patient care
- 100% for outpatient care, and
- 99.6% for emergency department care.

The percentage of records in the latest published data for November 2023 which included the patient's valid General Medical Practice Code was:

- 99.9% for admitted patient care
- 99.8% for outpatient care, and
- 99.1% for emergency department care.

7. Information Governance grading COMPLETE

Information governance is assessed as part of the mandatory annual national process of submitting compliance with the NHS Data Security and Protection Toolkit (DSPT), which is currently based upon the

National Data Guardian's 10 Data Security Standards. The content of the DSPT is aimed at providing assurance around technical aspects of cyber security, information security and data protection compliance.

The 2022/23 DSPT submission was assessed against compliance with 34 assertion areas which are comprised of 108 mandatory evidence items. South Tees Hospitals NHS Foundation Trust DSPT status for 2022/23 was 'standards met'.

The 2022/23 DSPT review has been performed by PwC (PricewaterhouseCoopers LLP) as part of a national standardisation exercise, the findings of which are monitored and discussed at the Trust Audit and Risk Committee.

At the time of writing, the status of the 2023/24 DSPT is that the Trust has provided 70 of the 108 mandatory evidence items required, and eight of the 34 assertions in this year's toolkit have been completed. The final submission date is 30 June 2024.

8. Clinical coding audit COMPLETE

South Tees Hospitals NHS Foundation Trust was not subject to a Payment by Results clinical coding audit during 2023/24 by the Audit Commission.

9. Data quality COMPLETE

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

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

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

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

data recording standards along with a range of guidance documents which keep members of staff updated on any new or changes to data recording.

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

10. Learning from deaths COMPLETE

During 2023/24, 1,951 patients of South Tees Hospitals NHS Foundation Trust died. This comprised the number of deaths which occurred in each quarter of that reporting period:

- 440 in the first quarter.
- 443 in the second quarter.
- 512 in the third quarter.
- 556 in the fourth quarter.

By 31st March 2024, 469 case record reviews and 28 investigations have been carried out in relation to 1,951 deaths above. In 28 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:

- 167 in the first quarter.
- 86 in the second quarter.
- 105 in the third quarter.
- 111 in the fourth quarter.

2 representing 0.1% of the patient deaths during 2023/24 are judged to be due 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:

- 0 representing 0% of the number of deaths which occurred in the quarter for the first quarter.
- 0 representing 0% of the number of deaths which occurred in the quarter for the second quarter.
- 1 representing 0.2% of the number of deaths which occurred in the quarter for the third quarter.
- 1 representing 0.2% of the number of deaths which occurred in the quarter for the fourth quarter.

These numbers have been estimated using the adapted version of the Structured Judgement Review Plus tool.

The Trust established a Medical Examiner Service in May 2018. Approximately 99% of deaths are scrutinised by Medical Examiners. Any death where there may be a problem in care (or that meets specific criteria) is reviewed by a central team of four consultants with expertise across many specialties. Each review results in two grades, one for quality of care and one for preventability of the death. Particularly complex cases are further reviewed by a cross-specialty panel of senior medical and nursing staff.

Learning and actions resulting from death reviews include:

- **End of Life Care**. Actions are co-ordinated through the End of Life Care (EoLC) Group. The group is overseeing the update of Care in the Last Days of Life and After Death (Adult) Policy to reflect learning. The group is also supporting the implementation of ‘Do Not Attempt Cardiopulmonary Resuscitation’ (DNACPR) and other end of life documentation in the MIYA Electronic Patient Record. This will ensure appropriate steps are taken to enable improved completion of relevant documentation and improved visibility of DNACPR and stratified treatment escalation plans, and to facilitate data collection for ongoing monitoring and learning.

- **Documentation** in the medical records. Electronic prescribing and medicines administration (ePMA), also known as e-prescribing has been made available in the majority of inpatient areas during 2023/24, and along with clinical noting and other modules within the MIYA Electronic Patient Record, and implementation of the Opera system (a scheduling and management tool) in theatres, has changed documentation of clinical care. Medical Examiner scrutiny and Trust Mortality Surveillance Reviews are sources of intelligence used to inform the development and implementation of these systems, meaning that the learning from deaths is being incorporated into future documentation of clinical care.

- **Coordination of care** between specialities. In paper records, coordination of care was not easily identified in medical records as it relied on notes being made of conversations and telephone calls between colleagues. This has improved to some extent with the implementation of MIYA and remains a key topic discussed by both the MIYA Board and the MIYA Clinical Working Group which lead developments in this field.

- **Transfer of patients from other hospitals**. Information about patients prior to and at the time of referral currently relies on the doctor accepting referral to make a summary in the medical record. Newcastle upon Tyne Hospitals NHS FT have led procurement of a single electronic system for all Trusts in the North East & North Cumbria and Patient Pass (https://www.patientpass.co.uk/) has been chosen with completion of contracts in process currently. An implementation plan for cardiac, renal, vascular, orthopaedic and other specialty services will follow. This means that information about transferred patients will be much easier to audit and that may lead to improvements in care for this important group of patients with complex needs.

362 case record reviews and 10 investigations were completed after 31 March 2023 which related to deaths which took place before the start of this reporting period.

3 representing 0.1% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Structured Judgement Review Plus tool.

4 representing 0.1% of the patient deaths during 2022/23 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.3 Reporting against core indicators

1. Summary Hospital-level Mortality Indicator (SHMI) and Palliative Care Coding COMPLETE BUT DATA REFRESH AWAITED FROM NHS DIGITAL (DUE 9/05/2024).

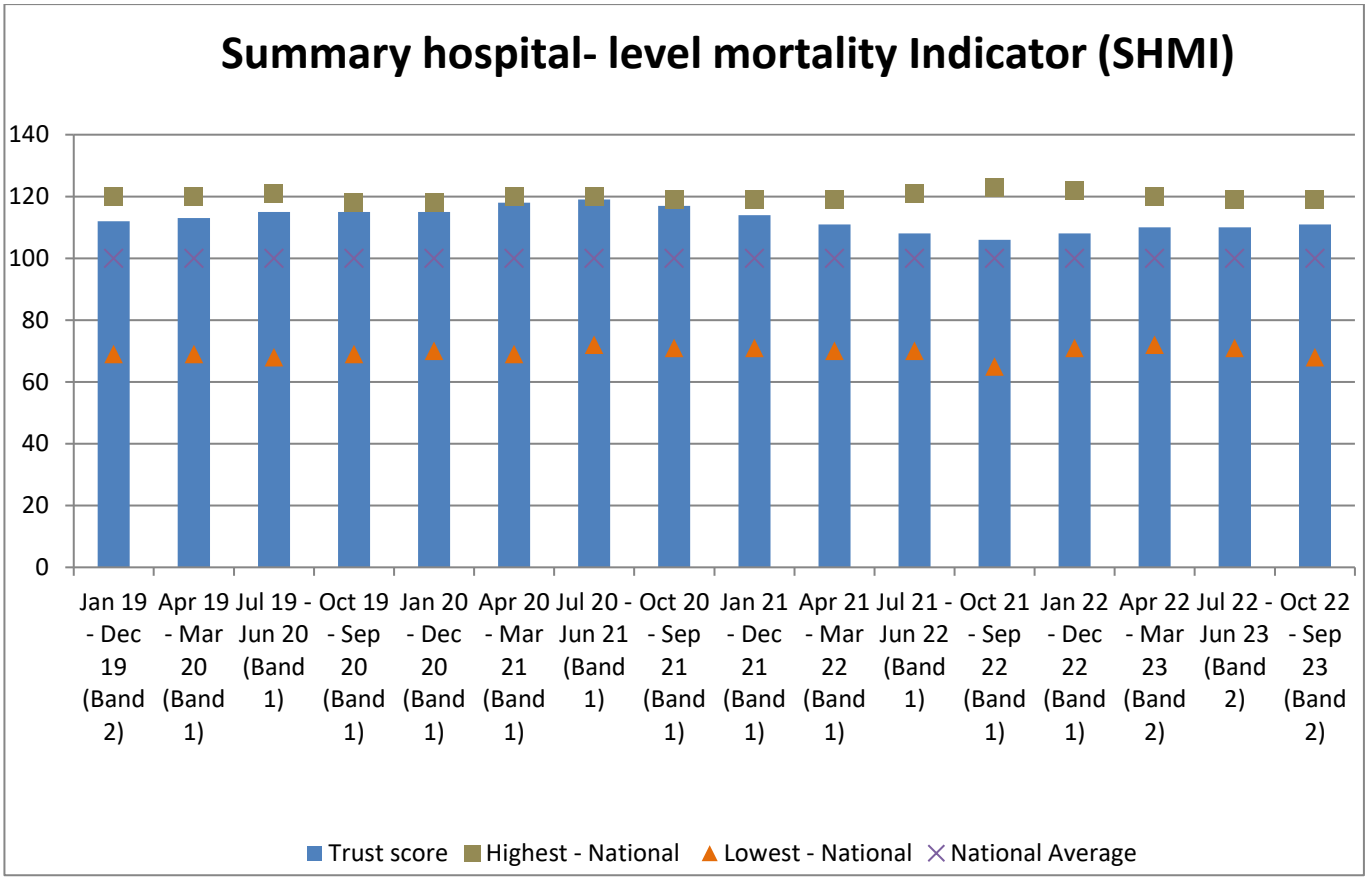


Figure 7: Summary Hospital Level Mortality Indicator (Data source: NHS Digital) To make national average easier to see on graph when data refreshed.

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

1. The SHMI is not designed to account for the COVID-19 pandemic and although spells coded for COVID-19 have been removed by NHS Digital from the indicator calculation, the large reduction in the number of admissions to hospital, particularly during wave 1, has had a substantial impact on the expected number of deaths. For the 12 months January to December 2023 the number of spells included in SHMI is 92% of pre-pandemic levels, partly because 2.5% of spells have been removed by NHS Digital because they contain a spell code for COVID-19. However, SHMI has fallen compared to the pandemic period and is 'as expected' meaning that the number of observed deaths is within the statistical limits, compared to the estimated number of hospital deaths expected given the population of patients cared for in the Trust. The fall in the number of admissions has not been experienced evenly across the country, with areas that had high levels of COVID-19, such as the North-East, experiencing a greater impact.
2. Despite the high level of need in the population the Trust serves, the organisation has historically fallen behind other Trusts in recording the number of other medical conditions patients have, alongside the main illnesses being treated. The Trust is in the process of implementing electronic records systems which are expected to address this comorbidity recording anomaly over time. There may be a short-term reduction as the system is refined and becomes embedded in clinical practice. An improvement has occurred in the 12 months to December 2023 in coding of elective spells and a small fall in non-elective spells, although improvements are expected as electronic records continue to develop.

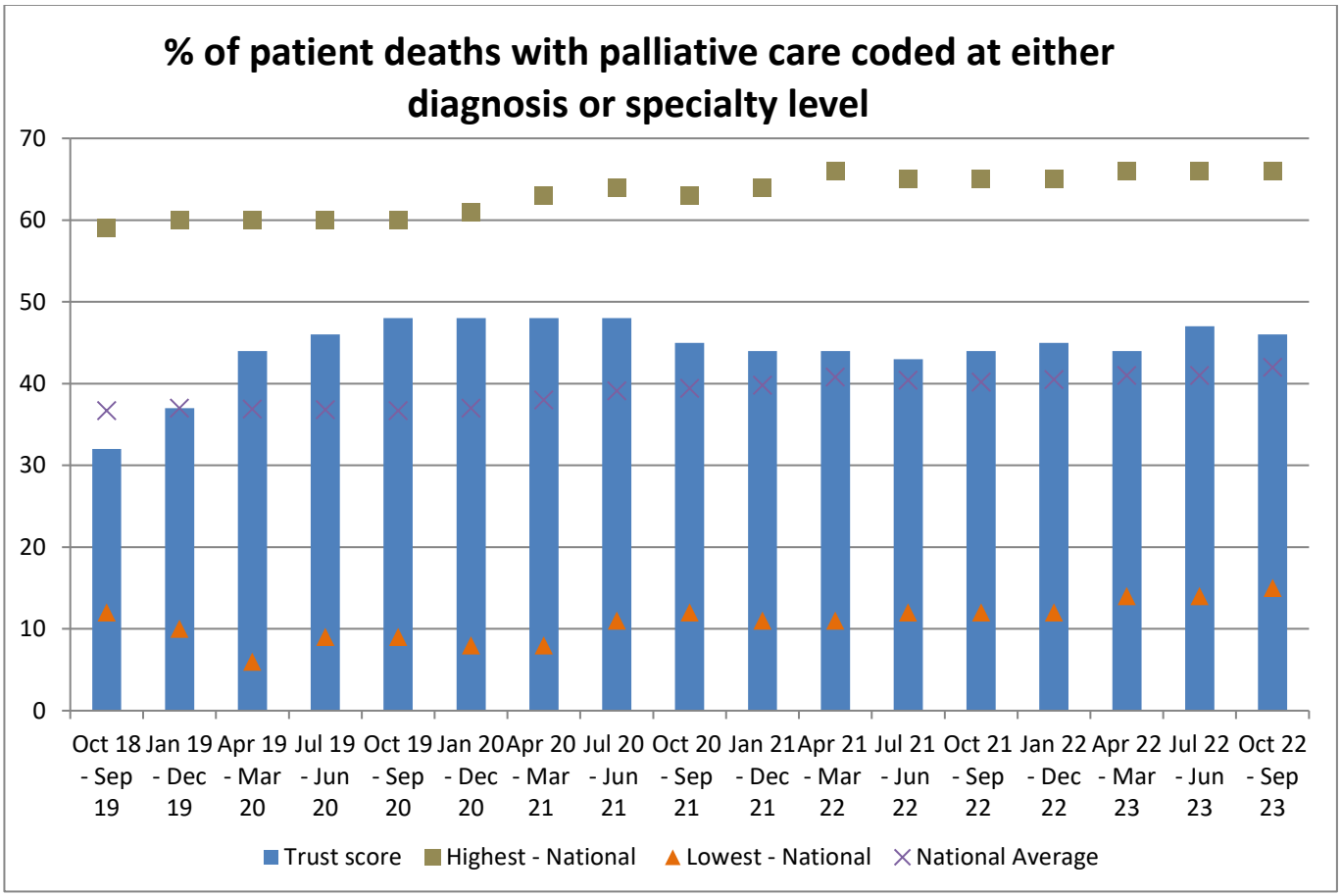


Figure 8: Percentage of Patient Deaths with Palliative Care Coded (Data source: NHS Digital)

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

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

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

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

2. Patient reported outcome measures NO UPDATED DATA AVAILABLE FROM NHSE

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

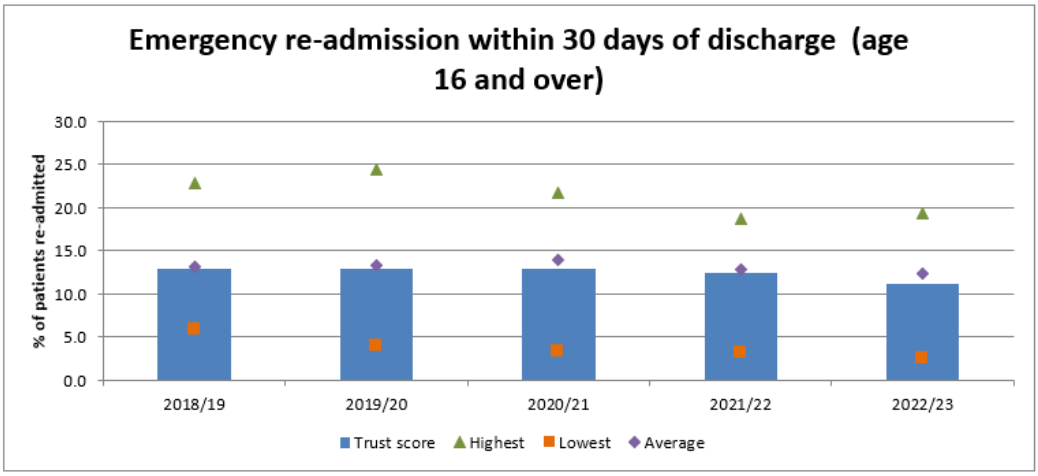
This report would normally include data from NHS Digital in relation to health gain scores for hip and knee replacement patient reported outcome measures.

The North East Quality Observatory Service (NEQOS) have provided a statement:

NHS England have published provisional 2022/23 PROMs data, however due to the earlier publication date there was a significant reduction in the number of PROMs questionnaires received. As a result of this there is insufficient data to make meaningful comparisons and they have not published a score comparison tool. NEQOS analysed and assessed this data, but with all North East and North Cumbria (NENC) Trusts showing fewer than 30 modelled records for both hip and knee replacements NEQOS feel that any reports created using this data would be unrepresentative and not useful. NHS England have not yet confirmed a publication schedule for final 2022/23 data or 2023/24 data.

3. 30-day readmissions COMPLETE

Whilst there will always be some unavoidable reasons for emergency readmission after a patient is discharged, and the relationship between discharge and readmission is complex, a low percentage of patients having emergency readmission is a marker of safe and effective care.



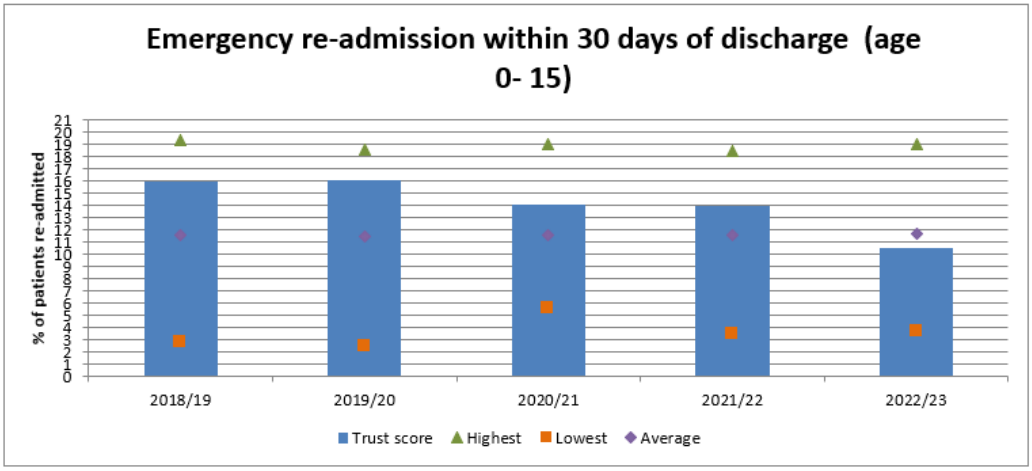


Figure 9: Emergency re-admission data within 30 days of discharge by age category from 2014/15 to 2022/23 (Data source: NHS Digital)

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 12.9% in 2020/21 to 11.2% in 2022/23.
- The percentage of re-admissions for patients aged 0 – 15 decreased from 14.1% in 2020/21 to 10.5% in 2022/23.

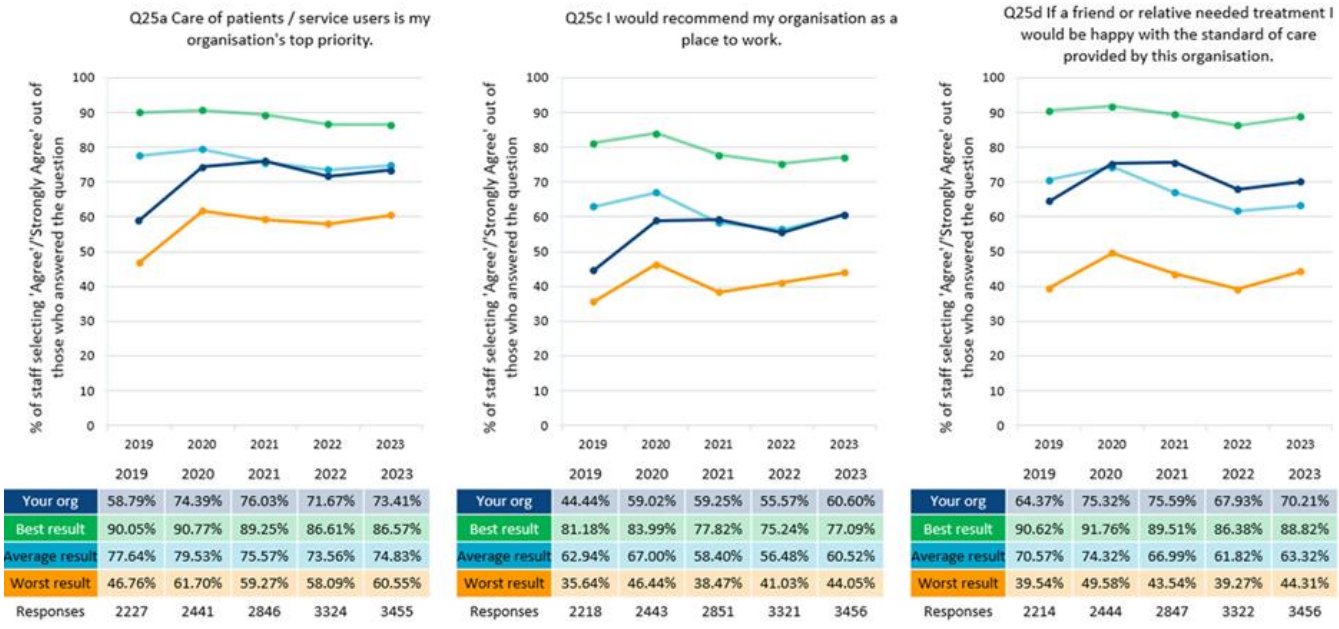
The Trust has taken the following actions to further improve these scores, and therefore the quality of its services:

Whilst the data is a positive reflection of patient care, the Trust continues to be focused on improving patient care and therefore reducing emergency re-admissions. More options for preventing admission and readmission have been developed, for example the establishment of Acute Respiratory Infection Hubs in primary care and increasing use of Same Day Emergency Care, (and this year a new Urgent Treatment Centre at James Cook will open) and this means that children and young people can been seen and treated without inpatient admission.

4. Responsiveness to the personal needs of its patients during the reporting period NO UPDATED DATA ON NHS DIGITAL

NHS Digital has not published any data since the 2021 data included in the last Quality Account.

5. Staff Friends and Family Test COMPLETE



	2019	2020	2021	2022	2023
Your org	58.79%	74.39%	76.03%	71.67%	73.41%
Best result	90.05%	90.77%	89.25%	86.61%	86.57%
Average result	77.64%	79.53%	75.57%	73.56%	74.83%
Worst result	46.76%	61.70%	59.27%	58.09%	60.55%
Responses	2227	2441	2846	3324	3455

	2019	2020	2021	2022	2023
Your org	44.44%	59.02%	59.25%	55.57%	60.60%
Best result	81.18%	83.99%	77.82%	75.24%	77.09%
Average result	62.94%	67.00%	58.40%	56.48%	60.52%
Worst result	35.64%	46.44%	38.47%	41.03%	44.05%
Responses	2218	2443	2851	3321	3456

	2019	2020	2021	2022	2023
Your org	64.37%	75.32%	75.59%	67.93%	70.21%
Best result	90.62%	91.76%	89.51%	86.38%	88.82%
Average result	70.57%	74.32%	66.99%	61.82%	63.32%
Worst result	39.54%	49.58%	43.54%	39.27%	44.31%
Responses	2214	2444	2847	3322	3456

Table 4. NHS Staff Survey results relevant to staff friends and family test (Data source: NHS Staff Survey benchmark report 2023)

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

The Trust has continued to make significant improvements in all areas and is above the sector average for:

- Recommending the organisation as a place to work, and
- if a friend or relative needed treatment, would be happy with the standard of care provided by this organisation.

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

- The Trust will continue to work with staff to improve the quality of care that we provide to patients. The Trust continues to be a clinically led organisation with the Clinical Policy Group making decisions on the best way for the organisation to deliver excellent patient care.
- South Tees Hospitals NHS Foundation Trust and North Tees and Hartlepool NHS Foundation Trust have formed a Hospital Group which will enable the best possible patient care to be delivered across the Tees Valley area. As part of the Hospital Group, we are developing six clinical boards to develop transformation strategies within six key clinical areas.
- The Trust continues to promote the development of the Hospital Group and the exciting opportunities for improving patient care via various briefings, bulletins, and other communications. These also include developments of our staff networks, development opportunities and recognition for the excellent achievements by staff in the form of 'STAR' awards and the annual #LoveAdmin Awards Celebrations.

6. Venous thromboembolism risk assessments COMPLETE

The National Institute for Clinical Excellence (NICE) recommends that all patients in hospital should be assessed for their risk of developing venous thromboembolism (VTE). Patients at higher risk can then be treated with appropriate prophylactic medication to prevent VTE. This measure shows the percentage of eligible inpatients who were risk assessed. A high percentage score is good.

Our most recent internal data regarding VTE risk assessment (February 2024) shows 86.6% compliance against a target of 95%. This is against a background figure of 87.5% for the year 2023 and 88.8% for the year 2022. Data source is e-CAMIS digital administration system.

While we accept that occasional patients do not receive a VTE risk assessment or prophylaxis, we believe that the majority of non-compliances relate to problems with data collection rather than clinical omission. A review of the three clinical areas with the highest numbers of VTE risk assessment non-compliances, accounting for more than half of the non-compliances across the whole Trust, found no clinical concern. Instead there were problems with poor recording of completed risk assessments on the CAMIS digital administration system and inappropriate counting of day patients who do not need routine VTE risk assessment.

Within the past two years many wards have moved from using paper prescriptions to electronic prescriptions, and VTE risk assessments are now being recorded directly on the electronic prescribing system in these areas. When auditing VTE risk assessment on the electronic prescription system, we see that every ward audited had higher levels of completed VTE risk assessments than recorded on CAMIS. This is because we can now directly count all completed VTE risk assessments rather than relying on the completion of the risk assessment then being recorded on the CAMIS system. The data from our electronic prescribing system shows a completed VTE risk assessment figure of 98.0% vs. 86.6% recorded on CAMIS for February 2024. Electronic prescribing has not yet been rolled out to all clinical areas, but going forward we expect this will resolve many of the data collection problems.

VTE continues to be a high clinical priority within South Tees Hospitals NHS Foundation Trust. VTE risk assessment data continues to be reviewed and discussed at quarterly Thrombosis Committee meetings with escalation to the Clinical Effectiveness Steering Group where appropriate. We also all review all cases of hospital acquired VTE, giving feedback to clinical teams where appropriate.

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

Clostridioides difficile infection is caused by a type of bacteria and is an important cause of infectious diarrhoea in healthcare settings and in communities.

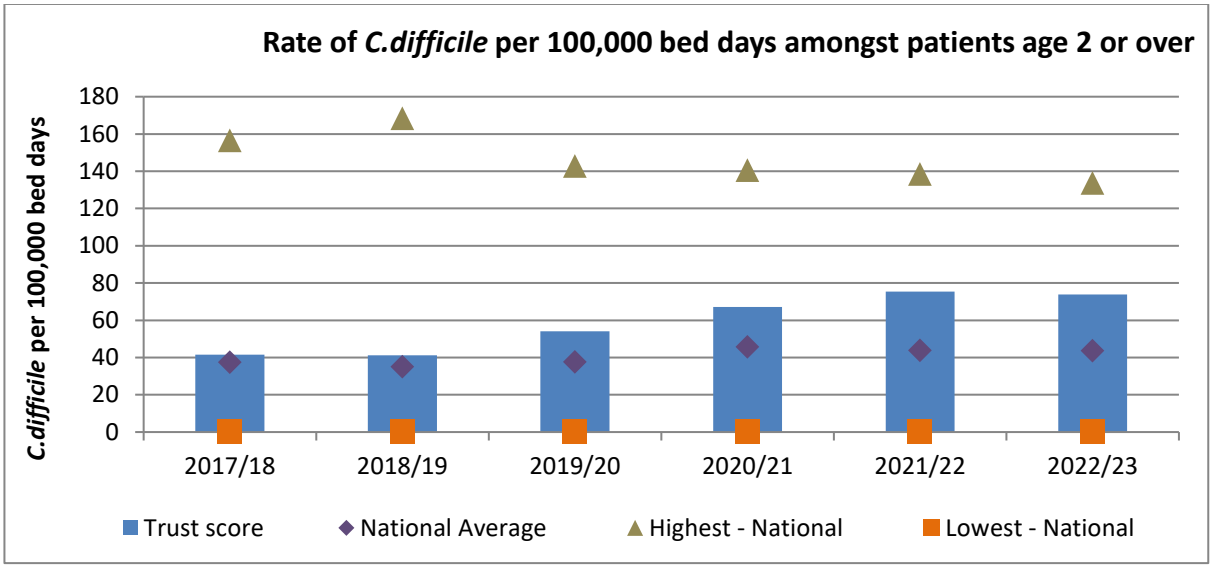


Figure 10: Rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over. (Data source: NHS Digital)

The Trust reports healthcare associated *C. difficile* cases to UK Health Security Agency via the national data capture system against the following categories:

- Hospital onset healthcare associated (HOHA): cases that are detected in the hospital 2 or more days after admission (where day of admission is day 1), and
- Community onset healthcare associated (COHA): cases that occur in the community (or within 2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks.

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

- The Trust is required under the NHS Standard Contract to minimise rates of *C. difficile* infection so that it is no higher than the threshold level set by NHS England.
- The data (figure 10) reflects the ongoing work within the Trust in relation to *C. difficile* infection. More specific information around performance is reported in section 3.2.

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

- The Trust has a comprehensive recovery action plan for the prevention of Trust-attributed *C. difficile* infections which is monitored through the Infection Prevention and Control Strategic Group and reported through to the Safe and Effective Care Strategic Group.
- Alongside this recovery plan, each of the clinical collaboratives hold their own *C. difficile* action plan relevant to their area of clinical expertise and report on this through the appropriate governance structures.
- All trust-attributed cases have a Rapid Learning Review undertaken in line with PSIRF. These reviews are chaired by the Deputy Director of Infection Prevention and Control (DDIPC) or a senior infection prevention and control (IPC) nurse and have been supported by integrated care board (ICB) colleagues. If the panel agrees that there were no issues in care, then the case may be discounted from the total for internal performance measurement purposes only, as nationally the financial sanctions for C. *difficile* have been removed and the 'appeals' process is no longer in use.

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

- Learning from the Rapid Review process and aligned to the recovery plan the Trust has implemented a monthly C. *difficile* task and finish group with escalation to the senior nursing team meeting to ensure completion of actions across the organisation.
- Continuous update of the C. *difficile* training packages for all staff.
- Membership of the Northeast and North Cumbria ICB 'Deep Dive' around C. *difficile.*
- Membership of NHS England national 'Deep Dive' around C. *difficile.*

8. Patient safety incidents COMPLETE

The NHS England data looks at three measures related to patient safety incidents reported to the National Reporting and Learning System (NRLS):

1. The number and percentage of patient safety incidents reported that resulted in severe harm or death. A low number and percentage are good.
2. The rate of patient safety incidents reported per 100 admissions / 1000 bed days.
3. The total number of patient safety incidents reported.

Data related to 1 and 2 is benchmarked against national data. Please note that the data below (figure 11) is the most recent patient incident data published by NHS England for Quality Accounts.

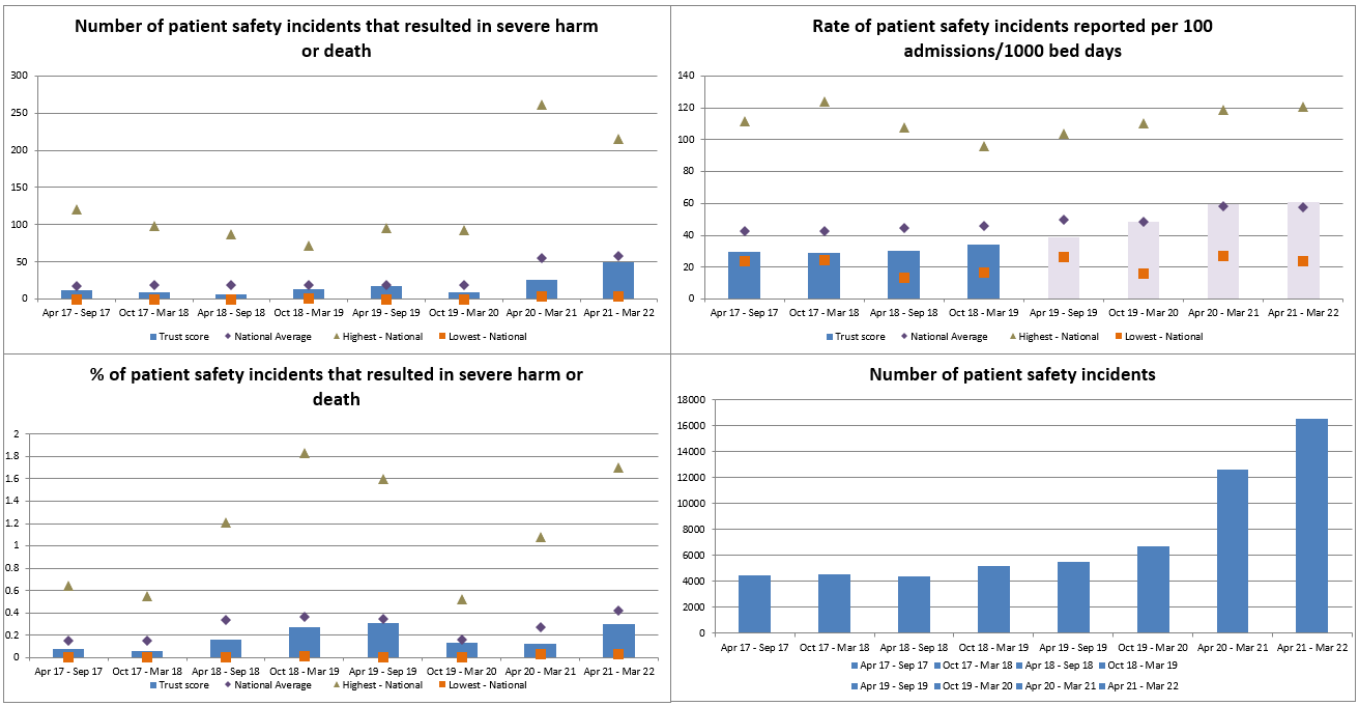


Figure 11: Benchmarked patient safety incident data (Data source NHS England)

We have included some more recent related data from our internal data reporting below (figure 12).

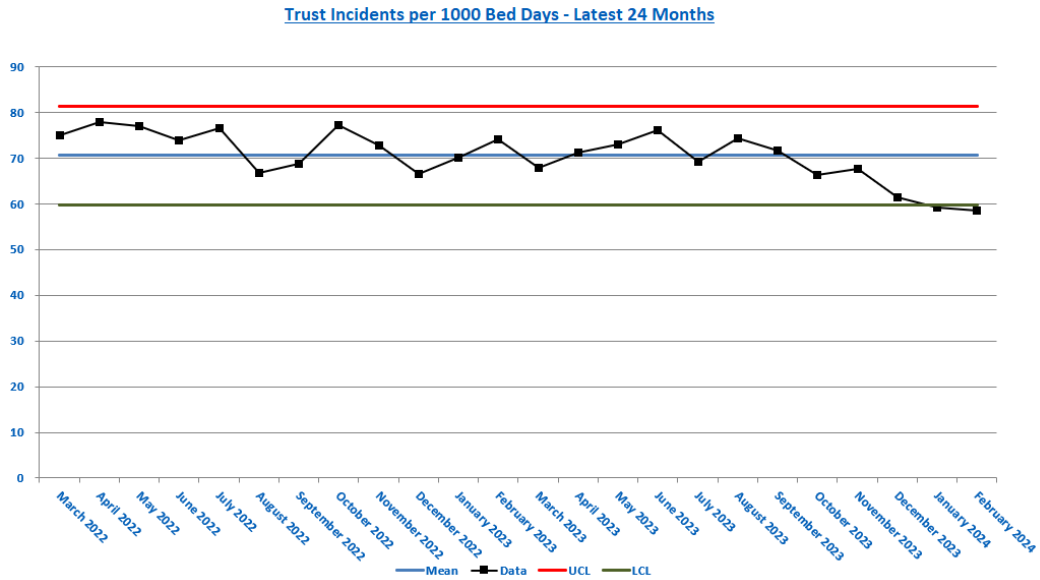


Figure 12: Trust incidents per 1000 bed days March 2022 – February 2024.To refresh with chart from April IPR

As can be seen above (figure 12) there has been a reduction in the number of incidents reported per 1000 bed days despite reporting levels being maintained in line with the expected trajectory. Compared to August 2023, there has been an increase in bed days across the Trust by approximately 3000 which is likely to account for the apparent reduction in associated incidents reported. The number of incidents reported per 1000 bed days increased in March, which may reflect the beginning of the closure of winter beds and therefore a reduction in bed days. The patient safety team will continue to monitor this closely.

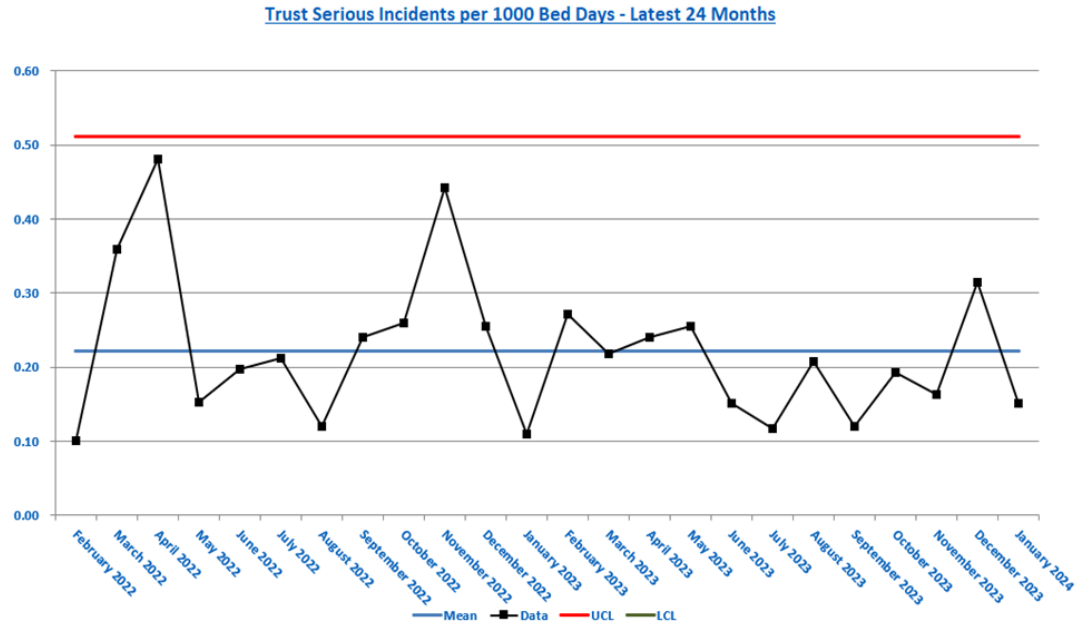


Figure 13: Trust serious incidents per 1000 bed days February 2022 – January 2024

Over the previous 12 months, 92 serious incidents have been reported by the Trust inclusive of never events (figure 13). The average number of serious incidents each month over the last 12 months remained between seven and eight.

The Trust's PSIRF Plan and Policy have been approved by the Trust Board and the ICB and have been implemented since 29 January 2024. Therefore, January will be the last month where incidents will be reported through the serious incident framework.

The Trust reported three Never Events during 2023/24, the lowest number since the national Never Event list was revised in February 2018 (see table 5). This is evidence of the ongoing commitment of all colleagues to provide safe care to our patients. NHSE is currently undertaking a review of the Never Event

list to determine if there are truly strong and systemic barriers in existence to prevent these incidents from occurring. The list is likely to change and therefore future data may not be comparable.

Year	Number of Never Events
2023-24	3
2022-23	7 (1 has since been retracted)
2021-22	4
2020-21	8
2019-20	8
2018-19	5

Table 5: Number of Never Events reported annually since 2018/19

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

- The Trust's incident reporting levels have remained consistent between 2022/23 and 2023/24, however the number of bed days within the Trust has increased by 3000 since August 2023, which has impacted on the data as illustrated in figure 12.

- The number of Never Events occurring within the Trust during 2023/24 is at the lowest since 2018. This could be explained by the enhanced approach to sharing learning across the Trust, the ongoing work to embed Local Safety Standards for Invasive Procedures (LocSSIPs) to ensure consistency in practice in particular clinical situations, and the move to using a systems approach to patient safety investigations to ensure actions are based on strengthening processes rather than focussing on the actions of individuals.

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

- Over the next year, in order to increase incident reporting, the Trust will focus on sharing the improvements undertaken following incidents being reported to demonstrate the outcomes of this process. The Trust will also continue to embed the restorative and just culture approach to patient safety, to enable psychological safety for all staff groups across the organisation.

9. Patient Friends and Family Test COMPLETE

The 2023/24 patient friends and family test (FFT) data is provided in section 3.1 of this report.

3. Overview of quality of care and performance indicators

3.1 Overview of quality of care

Patient Safety

a. Safeguarding, Mental Capacity, Mental Health Legislation, Learning Disabilities and Autism COMPLETE

Within the last year there has been a joint team effort to focus on promotion of our service. This has included:

- The design of a corporate logo to give us an identity.
- Representation and promotion across two safeguarding weeks for North Yorkshire and nationally in collaboration with our partnerships.
- Opening our doors to facilitate student placements.
- Creation of a team film to highlight and promote what we do.
- A safeguarding conference with a focus on various aspects of exploitation and how this impacts on adults and children.
- Refreshing the role of safeguarding champions.

In addition, our popular newsletters and social media posts have continued to cover a wide range of topics and lessons learnt.

There has also been some work undertaken to develop psychological safety and cohesive work with the safeguarding team including restorative training, leadership training and joint whole team civility and insights sessions.

We have created processes for themes which straddle across all our areas of work, but which needed clearer oversight and governance.

- A gap was identified in how allegations against staff are managed which could lead poor decision making and risk. A joint policy was therefore created and ratified in partnership with HR and a training package created and delivered to both teams. This will now be rolled out across the Trust through the Management Essentials programme.
- The team now collate and report on the number of Freedom of Information requests.
- The multi-agency public protection (MAPPA) agenda is co-worked between safeguarding and security management. A policy has been ratified and there is reporting through safeguarding governance.
- The team nave been upskilled on the local PREVENT picture and the relevant Trust staff have received an annual update.
- The new group Board received safeguarding training in March 2024.

Safeguarding training compliance for all staff has been maintained at a high level and the offer has been widened to an interactive session on Microsoft Teams as well as face to face to assist our staff and ease pressure. Figure 14 below relates to staff who require safeguarding training at different levels and highlights the proportion of those staff who have completed the training (compliant), and those who have not (non-compliant).

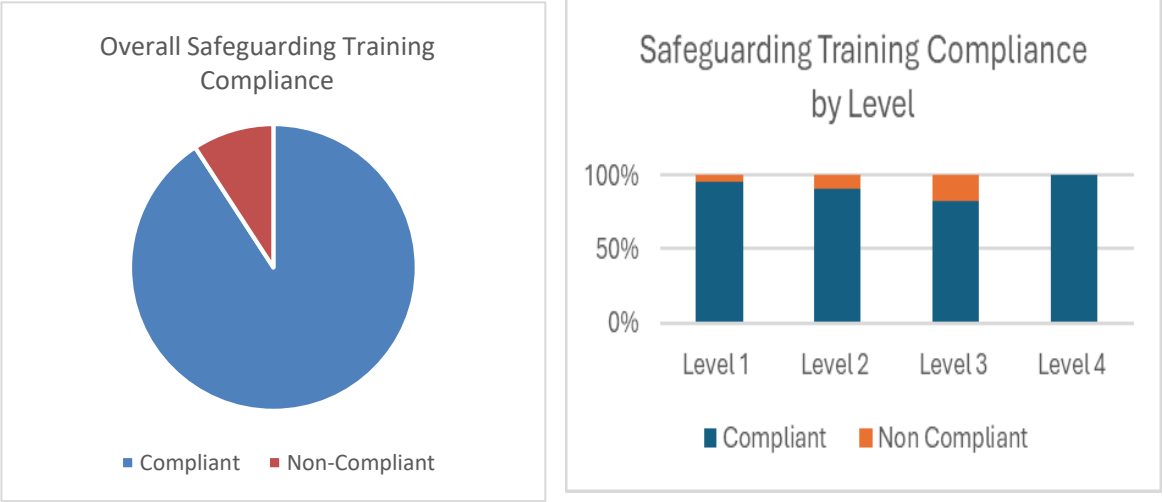


Figure 14: Safeguarding training compliance .

Adult Safeguarding

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

During 2023/24 the team have provided consistent support to our partner agencies within the Teeswide Safeguarding Adult Board (TSAB) and North Yorkshire Safeguarding Adult Board (NYSAB) sub-groups, participating in guidance and policy development, performance reports and multi-agency audits, and engaging with communities during safeguarding weeks. They have developed the quarterly reporting templates to include more core measures and improve data collection.

Key areas of concern have been in relation to discharge, nutrition, and medication. There is now safeguarding representation at both the nutrition and discharge steering groups. Safeguarding support for the new discharge hub at James Cook Hospital including bespoke training and input into discharge documentation saw significant improvement, with discharge dropping from being our number one area of concern, to being outside the top three. The team access the daily patient safety huddles and current cases meetings when needed in order to provide a timely and joined up response to incidents and complaints.

Local partnership learning has identified significant safeguarding risks of self-neglect in people with diabetes. The team now support our diabetic service to reflect and consider how to address challenges such as poor engagement of patients with their diabetic care.

A new Safeguarding Adults Practitioner with experience of mental health practice has begun working with the team. This is very beneficial to managing our complex cases and supporting the development of our Trust mental health strategy.

There has been significant work to promote the role of the Trust Independent Domestic Violence Advisor (IDVA) throughout the Trust with the creation of a promotional poster (figure 15) and an improved referral pathway. Referrals have increased by 55% from last year.

The Mental Health Act (MHA) is the statutory framework used to provide care and treatment for people with mental disorder, which sets out when and how people can be detained for assessment and/or treatment without their consent. The Act provides safeguards designed to protect the rights of the detained person. The Trust may need to detain a small number of patients under the Act on either JCUH or FHN sites where their physical healthcare needs take precedence over their mental healthcare needs. The Trust has a group of staff that carry out the designated staff member (DSM) role and ensure that the rights of the detained person are safeguarded. There is a mandatory annual training programme delivered by the Safeguarding Team for DSMs, and supervision is also available for these staff. Compliance with training is currently 72%, with booked attendance on two further scheduled sessions before 9 April 2024 that will take compliance to 94%.

Figure 15: Poster to highlight the role of the Trust Independent Domestic Violence Advisor (IDVA).

Safeguarding Children and Unborn Babies.

The Safeguarding Children Team are key members of the multi-agency safeguarding systems that are in place to protect unborn babies, children and young people. The role is to ensure staff identify and advocate for vulnerable children, identify safeguarding concerns, and take action in the form of timely referrals to children's social care and specialist support services.

- The Safeguarding Children Team take an average of 1350 calls from Trust staff and partner agencies.
- Trust staff make an average of 495 safeguarding children's referrals per quarter.
- Paediatric consultants carry out an average of 44 child protection medicals per quarter.

The Team continues to represent the Trust at South Tees Safeguarding Partnership meetings and actively contribute to the multi-agency work programme across the Partnership. They contribute to multiagency child safeguarding practice or learning reviews and participate in identifying learning and implementing action plans. The team undertake regular audits to gain assurances around safeguarding practice including:

- Multi-Agency Risk Assessment Conference (MARAC) referral audit
  The audit found that referrals were of good quality and 80% of referrals made were heard at MARAC which is an excellent conversation rate. A recommendation of the audit was to move from handwritten referrals to an electronic referral process and work is ongoing to achieve this.

- Symphony Exploitation Screening tool audit
  An exploitation screening tool is embedded within Symphony (an electronic patient administration system) which encourages staff to consider exploitation risk when a child attends Children and Young People's Emergency Department (CYPED). Following the last audit cycle consideration is being given to different methods of engaging children and young people such as QR code questionnaires.

- Hidden males audit
  This identified that it is still not readily documented who is accompanying a child or birthing person to hospital. This is important to ensure that if a concern arises that it is known who was involved with the child and/or family at that time. The team have designed a poster (figure 16) as part of the actions from this audit which is visible in wards and departments.

Figure 16: Poster to promote recording the name of those accompanying a child or expectant mother to health services.

The Childrens Safeguarding Team and the Children with Complications of Excess Weight (CEW) Team have worked closely since the CEW team was established. The safeguarding support provided has adapted and increased frequency, as the team has grown. The CEW Team report feeling well supported in safeguarding their service users.

The neonatal meetings set up last year have continued to develop. This summer there was a focus on the learning from the Thirlwall inquiry (following the Lucy Letby case) which was shared at the Safeguarding Strategic Group. There has been safeguarding support with the integration and development of user guides for safeguarding documentation on the new maternity and neonatal care record, Badgernet. A pathway assessing bruising in non-mobile babies and children for ED was created and launched.

A Joint Targeted Area Inspection has been anticipated on the subject of serious youth violence. The team have worked with the partnership to prepare for this through looking at cases and scrutinising our practice as individual agencies and collectively.

A new safeguarding specialist practitioner has joined the team with a specific role for young people and transitional safeguarding involving young people moving from children's to adult services.

All Community Midwives are required to have 12 weekly supervision and must attend at least once a quarter. Compliance has consistently remained at over 98% throughout 2023/24. The safeguarding children's team also offer supervision to specialist paediatric staff including:

Safeguarding Supervision – Specialist Paediatric Nurses / AHPs 2023-24	
Neonatal Community Team	Dermatology Nurses
Dieticians	Asthma Nurses
Continence Nurses	Speech and Language Team
Epilepsy Nurses	Cystic Fibrosis Nurses
Enhanced Maternity Practitioners	Therapies Team
Diabetes Nurses	Community Nursing Teams
Enhanced Maternity Support Workers	Complications of Excessive Weight Team

Mental Capacity Act/Deprivation of Liberty Safeguards.

Mental capacity oversight sits within the safeguarding team. The Mental Capacity Act (MCA) Lead post is currently covered by an interim lead due to extended leave.

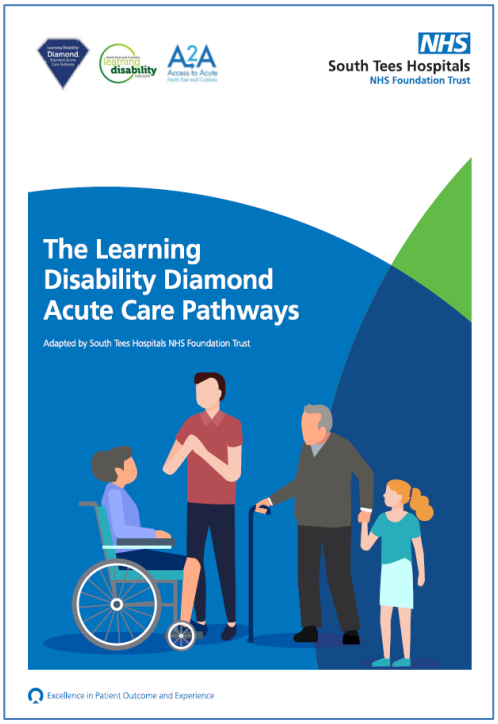
The anticipated Liberty Protection Safeguards legislation to replace Deprivation of Liberty Safeguards (DoLS) has been put on hold by the Government. Waiting for this has given us the opportunity to improve our current MCA and DoLS audit processes to gain better oversight and comparison data. An improved database has been established and the MCA Lead attends regional DoLS forums. Both the permanent and interim MCA Leads have achieved Best Interest Assessor qualifications in the last 12 months.

MCA and DoLS documentation is now integrated into patient records using MIYA Noting which ensures clear records and templates for all staff and a quality standard which can be overseen and reported on remotely.

MCA training currently sits within safeguarding training therefore the compliance levels are the same as those above within figure 14. This training has also been accredited for continuous professional development in the last six months. Bespoke training sessions are provided for staff routinely as well as on request and in response to gaps identified within audits.

Learning Disabilities and Autism.

Over the last year we have significantly increased the number of patients with a learning disability identified on our electronic system. This positive change is a result of a close partnership with our neighbouring mental health and learning disability Trust (Tees Esk and Wear Valley NHS Trust). Due to collaborative working we can identify patients with a learning disability in advance of their involvement with our Trust. In addition, a Learning Disability Liaison Nurse has joined the team to help support people with a learning disability across all areas of patient care, and consequently many more patients than previously have been supported.



There is a national drive to implement training written in conjunction with the family of Oliver McGowan following his death. Mandatory e-learning learning disability training has been implemented for all staff to complete. Meanwhile progress is being made towards an agreed Oliver McGowan regional training model, with the Trust working in partnership with our local ICB on presentation and delivery. The Trust is waiting for the Learning Disability and Autism Training Code of Practice to be published before updating the current training package. However there has been a drive to improve staff knowledge and understanding of reasonable adjustments over the past year, to ensure reasonable adjustments are considered at all points throughout the patient journey.

In conjunction with our Learning Disability Diamond Acute Care Pathways a Maternity Learning Disability Care Pathway has been developed collaboratively with the Northeast and North Cumbria Learning Disability Network, in order that the care received by women with a learning disability accessing maternity care in this Trust is optimal.

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

A gap analysis has taken place in relation to how we support our patients with autism. The Learning Disability Team are progressing this work with a focus on training and care pathway for staff. Most of the team have completed face to face training on neurodiversity in the last six months.

Summary and next steps

Much of the work described will be ongoing, but other work being planned includes:

- Confirmation of the next annual safeguarding audit plan.
- Completion of a harmonisation plan to work cohesively with North Tees Safeguarding Team.
- Further work on the safeguarding content within patient records using MIYA Noting.
- Wide dissemination of the safeguarding film for information.
- Further development of the role of safeguarding champions.
- Agreeing and embedding learning disability and autism training.

b. Nutrition and hydration COMPLETE

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 requirements and best practice. To achieve this there must be effective systems in place to demonstrate this fundamental standard is being achieved. The Trust now has a well-established Nutrition Steering Group, with supporting workstreams (or councils) for Nutrition and Hydration, Children's Nutrition, Enteral Nutrition and Parenteral and Complex Enteral Nutrition.

Significant nutrition and hydration improvement activity has continued throughout 2023-24, with examples below:

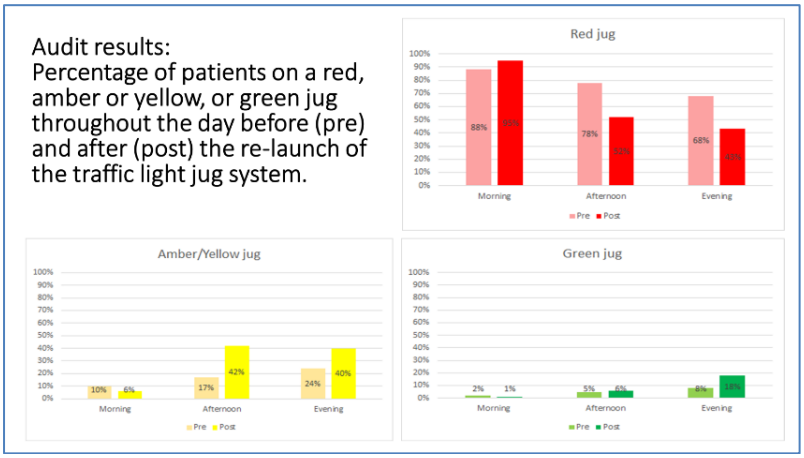
Ward Nutrition Assistants

The role of the ward nutrition assistant has gained an increased profile across the organisation over the last year. We currently have 13 employed as part of ward establishments across the Trust, with additional wards going through the recruitment process. The nutrition assistant is responsible for supporting ward teams by completing food and fluid intake charts, taking patient weights, and monitoring 'traffic light jugs' used to improve patient hydration. They have a key role in assisting ward housekeepers to ensure the correct menu provision for patients with special dietary requirements, to provide extra nourishing drinks and snacks between meals for patients who need them, and to support patients who require assistance with eating and drinking. During the last year work has been undertaken to establish and strengthen their induction programme, and to produce a competency-based training package to support their development. A regular Nutrition Assistant Forum has now been set up to provide ongoing support, engagement, and education.

Improving Hydration

The traffic light water jug system was relaunched across the Trust in September 2023, with support from our ward nutrition assistants and nutrition coordinators, and a greater focus on increasing patient awareness of the importance of good hydration.

Coloured water jug lids are used as a simple visual way of monitoring how much patients are drinking to help minimise their risk of dehydration and acute kidney injury (AKI). Patients are given a water jug with a red lid in the morning. When they have drunk it all (or the equivalent volume of other fluids) the jug is refilled, and the lid is switched to a yellow one. When that is empty it is refilled, and the lid changed to a green one.



Use of the traffic light jug lids was audited before the relaunch in September 2023, and afterwards in November 2023. Results have demonstrated a significant improvement in patients' fluid consumption throughout the day.

Work continues to maintain this positive impact, and the audit will be repeated in 2024 with further local training where it is needed.

Figure 16: Audit results before and after relaunch of the traffic light jug system 2023

Digital Workstream Developments

The nutrition screening tool 'MUST' and nutrition care plans are now on the electronic observations and assessments system Patientrack across the Trust. During 2023-24 the initial phase of the electronic food record chart has also been launched. An evaluation chart has been developed alongside this to prompt staff to review patients' nutrition intake every three days to facilitate timely escalation of patients who may need consideration of additional or artificial nutrition support.

Enteral Tube Feeding Pathways

Some people who cannot get enough nutrients by eating need a feeding tube which is passed through the nose and into the stomach (a nasogastric or NG tube) or into the small bowel (a nasojejunal or NJ tube) for the purpose of enteral feeding. Patients requiring an NJ feeding tube would normally need to have this placed in the Endoscopy or Radiology Department. During the year our nutrition nurse specialists have completed competency training in a new technique of placing NJ feeding tubes called the CORTRAK procedure. This enables safe bedside placement of NJ tubes for patients who meet the criteria, reducing the number of requests for NJ tubes to be placed within Endoscopy or Radiology and facilitating more timely feeding tube placement.

Blended Diet Policy and Toolkit

The Children's Council and Enteral Council have worked together to produce and launch a joint policy on the use of a blended diet via a gastrostomy tube. This provides guidance on how 'home foods' can be safely blended to supplement enteral tube feeding regimens for those requiring long-term feeding and where patients, parents and relatives want to increase involvement in family meals, whilst ensuring this does not compromise nutritional value or nutritional status.

Patient Experience and Catering Surveys

Work continues to evaluate hospital food provision with ongoing collaboration with catering service providers to enhance the mealtime experience.

- The 2023 PLACE audit results for food rated the Trust at 95.34% (national average 90.9%).
- Improved surveys for evaluating hospital catering provision trust-wide were introduced during the latter part of 2022-23 and the overall results for 2023/24 compared to quarter 4 2022/23 show:
    - Overall response rate has increased to 86% from 81%.
    - 76% patients report being provided with a copy of the menu to enable food choice from 55%.
    - 91% of patients report satisfaction with the provision of between meals snacks from 82%.
    - 94% of patients continue to report they were offered meals that met their specific dietary requirements.

Work has also begun to establish more valuable methods of measuring the experience of our vulnerable patients. Close working with the Therapeutic Care Team has captured specific experiences of patients that have enabled a timely response to their individual needs to improve food choice and provision. This has facilitated learning from patient stories that has enhanced training and education of both catering and clinical staff. In addition, the process for identifying and managing adult and child in-patients with known food allergies and intolerances was reviewed and relaunched alongside guidelines for clinical staff.

Nutrition and Hydration Week 2024

The year ends, as always, with the annual national nutrition and hydration campaign. The engagement of clinical teams and wards across the Trust during the 2024 Nutrition and Hydration week (see figure 17) was phenomenal, with activities running daily to promote awareness of the importance of nutrition and hydration amongst our hospital population, and to support our patients with additional requirements. National Swallowing Awareness Day also fell within this week and a range of information resources were shared with staff to enhance their knowledge within this subject area. There was also a focus on nutrition and hydration for our staff.

Figure 17: Photos of activities across the Trust during 2024 Nutrition and Hydration week.

Summary and ongoing work

As part of the Nutrition and Hydration Improvement Plan, ongoing work will include:

- Development of a nutrition and hydration training matrix for all roles.
- Continued collaboration and developments with catering providers to ensure our organisation is compliant with PLACE, National Hospital Food Standards and the British Dietetic Association (BDA) Digest standards for the nutritional quality of food provision.
- Ongoing improvement work on the enteral tube feeding pathways.
- Review and update of the Parenteral Nutrition Pathways for adults and children.
- Completion of the nutrition dashboard to enhance monitoring of data, compliance, quality improvements and patient experience to enable us to be responsive to the needs of patients and the provision of optimal nutritional care.

c. Duty of candour COMPLETE

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

Throughout 2023/24, the Trust has continued to strengthen the approach to duty of candour across the organisation. There have been education sessions provided to clinical staff to increase 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 Trust.

The Trust's CQC inspection report published in May 2023 stated that across the organisation, all staff 'understood and demonstrated an awareness of duty of candour and the importance of being open and honest when delivering care' and that they 'gave patients and families a full explanation when things went wrong'.

Compliance with all elements of the statutory duty of candour is proactively and closely monitored within the Trust, with a bi-monthly 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. Throughout the year, the Trust has monitored all notifiable safety incidents and has confirmed full compliance for each element of the duty of candour at the appropriate stage of the process.

To enhance the Trust's approach to fulfilling the duty of candour, the Family Liaison Officer (FLO) role is now firmly embedded within the organisation. 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 their meaningful involvement in the subsequent patient safety investigation. There are now over 60 trained FLOs within the organisation, with a further training cohort planned in September 2024.

To further strengthen the engagement and support provided to patients and/or families involved in patient safety incidents, the Trust commissioned six cohorts of Restorative Practice Facilitator training throughout 2023/24. The programme studies the ethos of a restorative approach in response to the impact of harmful events and relationship strain within the health setting. This focus explores the needs of impacted individuals and the context for restorative responses to healthcare harm.

During 2023/24, the Trust established a process to provide funding for counselling and therapeutic psychological input for patients and/or families who have been harmed during healthcare. This approach is recommended as best practice within the Harmed Patient Pathway developed by the charitable organisation Action against Medical Accidents (AvMA) and has so far provided timely support to a number of patients and/or their families since being implemented.

In summary, the Trust continues to promote openness and transparency as the default position for working with our patients and their families, with the aim of restoratively meeting the needs of all individuals affected by healthcare harm.

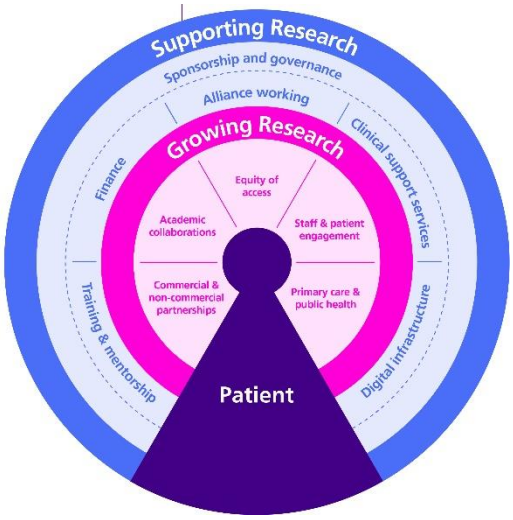
Clinical effectiveness indicators

a. Research and Innovation COMPLETE

Clinical Research

Clinical research helps us to improve patient care. Hospitals that are research active have better patient outcomes. Participation in research can help improve current and future care by finding new ways to diagnose, prevent, treat, or cure disease and disability. All research undertaken in the NHS is rigorously reviewed to ensure it is well designed and there are very clear regulations and guidelines to follow to

ensure that the safety of patients and their data is paramount. We have dedicated clinical and non-clinical staff employed in our trust to ensure that all research receives the relevant reviews and approvals, is conducted exactly as the research protocol directs and that patient safety is monitored throughout. The R&D Department employs over 130 members of staff directly supporting research and offers opportunities to clinical staff to work part-time within research to ensure research is embedded across the organisation. The Trust is a partner organisation within the Clinical Research Network for the North-East and North Cumbria (CRN NENC) and supports the CRN NENC to deliver and lead high quality research as part of the National Institute for Health Research (NIHR) portfolio. In 2019 we joined a strategic alliance with our research and development colleagues in North Tees & Hartlepool NHS Foundation Trust (NTH) to form the Tees Valley Research Alliance (TVRA) to offer an improved, efficient research service that would deliver more research opportunities to the patients of Teesside.



We have refreshed our TVRA Strategy to be delivered across both partner trusts in the Alliance. It is a patient focused strategy to deliver improved outcomes through two main streams 'Growing Research' and 'Supporting Research' (figure 18).

Figure 18: TVRA Strategy 2024

We have established a 'Community of Practice', bringing together researchers with a variety of experience from across the TVRA to support, mentor, learn and develop research collaborations across our two partner Trusts.

Successful contingency funding requests from the CRN NENC have enabled us to fund 12 additional nursing, midwifery and allied health professional (NMAHP) posts (3.15 WTE) in eight clinical areas including peri-operative medicine, renal/urology, critical care, stroke, nuclear medicine and cancer care. These will support existing clinical roles and patient recruitment, creating an embedded research culture within care delivery.

Both TVRA Trusts are now live on the global TriNetX platform (https://trinetx.com). This will allow greater visibility of our trusts to potential commercial research sponsors thus bringing more cutting-edge trials to our populations. It will also allow our own researchers to interrogate our Trust-based patient information systems to support study feasibility reviews.

Trust sponsored studies

The Trust has been successful in being awarded over £13.3 million (M) in grant awards in the last year. £2.5M of this was for general trust sponsored studies, £6.5M for Academic Centre for Surgery (ACeS) led studies and £4.3M for Academic Cardiovascular Unit (ACU) led studies. The recent achievements of the ACU and ACeS highlighted below illustrate the growth in our clinical academic units and how collaboration with external academic partners can attract funding and help secure research appointments into the Trust and lead programmes of impactful research for patient benefit.

Academic Cardiovascular Unit:

The results for a major trial that was recently completed by the cardiovascular research team have been published and presented internationally by Professor Enoch Akowuah. The Mini Mitral trial results can be accessed here (https://jamanetwork.com/journals/jama/article-abstract/2805908). Two MD fellows have been appointed and additional clinical academic fellowships are planned in collaboration with Newcastle

University. Seven applications for research grants led by the unit have been submitted this year and another four submitted as collaborators with other national organisations.

Academic Centre for Surgery:

A joint Senior Lecturer post has been appointed in collaboration with Hull York Medical School in addition to two academic Clinical Fellows. Two associate clinical lead posts will be advertised in 2024/25 to further support their research activity. Seven applications research grants led by ACeS have been submitted this year and another six submitted as collaborators with other national organisations.

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

We have extended the 'Research Support and Best Practice Council' to colleagues from North Tees & Hartlepool Trust. We have increased the number of non-medical Principal Investigators this last year from 24 to 43, with 31 at STH and 12 at NTH.

Patient Engagement

Feedback from patients who have participated in NIHR studies within the Trust is sought via the NIHR Patient Research Experience Survey (PRES) and is reviewed quarterly at our Directorate meetings. Due to high recruitment into trials last year our target for responses to the PRES survey was significantly increased to 644 for this year. Although we have not met the target for responses received, from the 186 responses to date 86% felt their contribution was valued and 89% would take part again if asked.
We have significantly improved the content of staff facing and patient facing internet sites and have developed a patient and staff facing animation to explain the purpose of research and how patients can get involved (https://staffintranet.xstees.nhs.uk/services/academic-centre/research/overview-of-research-at-south-tees-and-how-to-get-involved/).

Innovation

The challenge to improve healthcare delivery creates an environment for healthcare innovation in which we can generate new ways of working, thinking and engaging with healthcare to produce potentially transformative products and services for the benefit of our patients. The Trust is creating a culture of innovation and is committed to supporting our staff to innovate.

During 2023/24 staff made 28 enquiries to the Innovation Team about improving patient care by developing their own ideas or by seeking solutions to address unmet healthcare needs they had identified. Further assessment of 13 of these enquiries is ongoing. Five relate to unmet health needs, five to medical devices and three to non-medical devices. The Trust is reviewing solutions for the unmet healthcare needs which could be in-house software solutions for three, a possible medical device solution is being assessed for one and a non-medical device for another. The medical devices are all under assessment and / or further development. In relation to the non-medical devices, there are two proof of concept prototype devices being evaluated in-house, and another is being assessed as a possible solution may already be available.

Work continues regarding enquiries from 2021/22 and 2022/23. There are three new medical devices being progressed; one has undertaken proof of concept evaluation with the opportunity to evaluate further with medical certification taking place in-house; one has been developed and will undergo proof of concept evaluation; the last is still under development. Two identified unmet healthcare needs are being assessed and the Trust is reviewing opportunities to find solutions. Two software solution ideas have been developed with one undergoing in-house testing with the ambition that this will provide a solution to the wider NHS, and the other is being reviewed to see if it could provide a regional solution.

The Trust is hoping to launch a service for advanced surgical planning in 2024 from an idea raised in 2020. A proof of concept service has received favourable feedback and work continues to look at the opportunities for the Trust to provide this service to the wider NHS. An idea around a novel shoulder stabilisation implant, again raised in 2020, has completed proof of concept evaluation and a wider clinical trial is planned once intellectual property associated with the idea is protected. An agreement with an

industry partner has been completed to provide the Trust with an opportunity for further investment in South Tees Innovation should this lead to commercialisation of the product. An industry partner has also worked with the Trust on an innovative idea with a royalty payment arrangement due to be put in place.

Overall, the Trust continues to develop a culture of innovation and continues the work needed to progress the ideas that staff have raised.

b. STAQC and Endoscopy improvement journey COMPLETE

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

Accreditation is defined as the development of a set of standards so that areas for improvement can be identified and areas for excellence celebrated. Accreditations assess the balance of process and outcome data, environmental impact on care delivery, teamwork, impact on and relationships with relevant services along the patient pathway, staff and patient feedback, evidence of learning and continual improvement. Experience shows accreditation programmes can drive continuous improvement in patient outcomes and increase patient satisfaction and staff experiences at ward/department level. Using a collective sense of purpose teams can support communication, encourage ownership, and achieve a robust programme which measures and influences care delivery.

There are over 200 ward, teams and departments that are eligible for accreditation, which consists of:

1. Pre-assessment review of key outcome data, for example, nurse sensitive indicators, complaints and patient experience, a staff survey, human resources metrics such as sickness and appraisal.
2. An “on the day” assessment. The general assessment tool comprises of 163 items under the key headings of culture of compassionate care, well led, reducing avoidable harm and effective care. These are assessed by undertaking a documentation review, patient interviews, multi-disciplinary team and staff interviews, medical staff interviews and an environmental review.

There are specialist accreditation tools for theatres, paediatrics, maternity, ambulatory departments, critical care, and the emergency department.

There has been a continued focus during 2023/2024 to proceed with embedding the STAQC accreditation programme into all clinical areas. Baseline accreditations have continued as a starting point to the formal process, providing clinical areas with a robust action plan and expected timebound actions required to achieve either a gold or diamond accreditation.

Post accreditation assurance checks continue on a monthly basis to all diamond areas accredited, with a touch point for managers to offer support and guidance if required. This has proved successful in maintaining standards and keeping STAQC at the forefront.

Total achievements at end of year			**Key actions for STAQC team**
	2022/23	**2023/24**	• To maintain a comprehensive work plan, transparent to all teams. • To further refine and develop the programme. • To realign with the CQC quality statements. • To maintain a constant focus on shared ownership. • To undertake research/service evaluation into the impact of the programme.
Diamond accreditations	33	40	
Gold accreditations	31	52	
Silver awards	9	11	
Baseline accreditations	10	17	

Case study on Endoscopy Friarage STAQC journey

The Endoscopy Unit is a department within the Friarage hospital which delivers outpatient diagnostic procedures and surveillance of conditions. The unit performs gastroscopies, colonoscopies, flexible sigmoidoscopies and bronchoscopies serving a patient population from the Yorkshire Dales over to Whitby. The unit sees over 200 patients per week providing procedures seven days a week. The vision of the unit is to become a centre of excellence for training and to provide safe patient-centred care from admission to discharge.

The Endoscopy Department in Friarage hospital started their STAQC journey in December 2021. In July 2022 a new state of the art endoscopy diagnostic hub was opened with the layout of the department conducive to the patients journey and Joint Advisory Group (JAG) requirements. The hub has boosted the number of procedures being able to be performed and provides a one stop shop for patients. It hosts minimally invasive gastrointestinal services which provides an alternative procedure to a conventional endoscopy in selected patients and has access to a cytosponge to aid with the surveillance of patients with Barrett's oesophagus.

Figure 19: Rishi Sunak attending the Endoscopy Diagnostic Hub at Friarage Hospital. Check date / descriptor.

Throughout the STAQC journey, engagement from the team meant they were able to use the accreditation standards to drive and support the development of the unit, investment in the leadership team, training, and development of the staff.

The unit was accredited a diamond STAQC award in January 2024. Some of the areas of excellence seen on the day included:

- The waiting room was bright and welcoming, the team had created a personalised staff wall and patients journey board to inform patients of what to expect within the unit. The team had also added activities such as word searches and puzzles to keep patients occupied.
- A staff member had created a distraction box for patients with additional needs and a picture journey book, this was exceptional.
- Staff spoke of an inclusive, cohesive team, with most of the staff saying it is the best team they have worked in.
- A staff achievement board celebrates staff training accomplishments, with all staff having access to the JETS programme, which ensures excellence and robust endoscopy standards are being met.

- The administration team have created a patient query book for patients requiring advice or follow up phone calls, and the team incorporate this into their daily workload demonstrating their responsiveness to patient's needs.
- Excellent student feedback has led to requests from various medical institutions to support their students.
- Excellent, comprehensive, and personalised documentation throughout the full endoscopy pathway was witnessed.

Well done Friarage Endoscopy!

Summary

It's like a ward managers handbook

An effective and manageable way in which to raise

"STAQC was exciting and valuable platform to showcase amazing leadership, team ethos, patient care and our teach, train & retain philosophy, demonstrating effective

The plan for 2024/2025 is to achieve eight accreditations per quarter. This is based on the STAQC team capacity and redeployment, team preparedness and engagement and operational pressures.

c. Fundamental standards of care AWAITING EXAMPLES / CASE STUDY

The Fundamentals of Practice meetings commenced January 2022 and are chaired by the Deputy Chief Nurse (DCN). The intention of this meeting was to triangulate all nursing and quality data to gain an overall understanding of the clinical safety within wards and departments aligned to the Care Quality Commission (CQC) lines of enquiry; culture of compassion, well led, avoidable harm and effective care.

The meetings are held each month with each collaborative and provide a psychologically safe environment for all teams to highlight key issues and celebrate achievements. It is an opportunity to review quality indicator collection (QIC) audits, quality dashboards, patient experience, and infection prevention and control audits. In month safeguarding and CQC enquiries are highlighted, identifying immediate learning and essential sharing. Alongside this learning from structured reviews and never events are also highlighted, and action plans tracked.

Workforce key performance indicators such as vacancies, skill mix, sickness, turnover and exit interviews are also reviewed in order to contextualise any workforce pressures against quality indicators, highlighting any additional support required from the wider organisation.

Having organisational oversight allows transparency of themes that sometimes are in common with each collaborative. When this occurs the DCN requests the clinical matrons to work in collaboration to address key issues in order to gain traction with improvements that are required. Key learning and sharing of good practice is an agenda item at the at Senior Professional Council.

d. In-situ cardiac arrest simulation COMPLETE

In-hospital cardiac arrests are relatively rare, with an incidence of approximately 1.0 per thousand admissions (National Cardiac Arrest Audit 2021-22). Whilst this is positive from a patient safety perspective, it gives clinical staff limited opportunity to utilise and retain their resuscitation skills. Although staff attend annual resuscitation training updates, this training is typically classroom based with an emphasis on technical skills such as basic life support, airway management and defibrillation, and there is limited training regarding non-technical skills such as multidisciplinary team working and communication.

In 2015, the Resuscitation Department implemented in-situ cardiac arrest simulation training in real clinical areas during normal working hours, with participants acting in their normal roles. It has been reported as an effective way to bridge the gap between classroom based learning and clinical resuscitation attempts, and an effective method of uncovering latent safety threats that can then be rectified before they cause harm to patients. These are the previously unidentified problems in a clinical area that may compromise patient safety e.g. equipment problems (broken or missing), system failures, skills or knowledge deficits, and communication errors.

Since 2015, evaluations have shown that participants found the experience very positive, and numerous latent safety threats have been corrected. The aim of this latest evaluation was to assess the in-situ cardiac arrest simulation training facilitated in 2023 against the following key performance indicators:

1. Improved knowledge and technical skills for staff.
2. Familiarisation of staff with equipment and the clinical environment.
3. Improved non-technical skills, especially teamwork and communication.
4. Identification of latent safety threats.

34 simulations were planned between April and December 2023 with 13 cancelled due to clinical pressures on the day. 21 simulations were facilitated and evaluated.

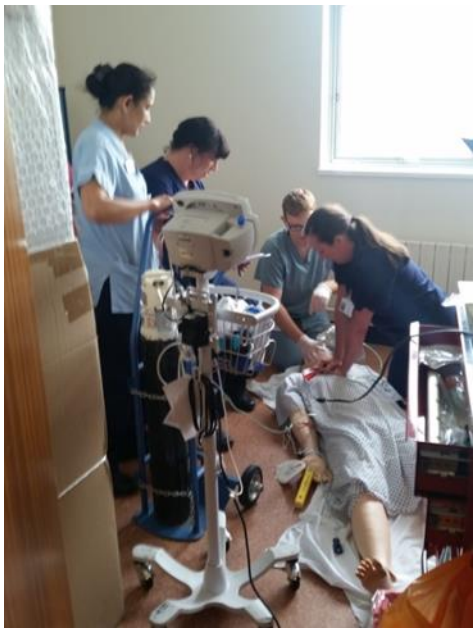


Figure 20: Photo of in-situ cardiac arrest simulation

Areas of good practice.

There were many examples of good practice including:

- Effective A-E assessments from the ward staff (first responders), swift recognition of the deteriorating patient, and prompt response from first responders, confirming cardiac arrest, initiating a 2222 call and prompt starting of high-quality chest compressions.
- Generally good team leadership, and numerous examples of effective, clear communication between ward staff, ward staff and the arrest team and arrest team members**.**
- Consideration to family members.
- Interventions performed effectively by ward staff and the cardiac arrest team.
- Safe defibrillation.

- Prompt arrival of equipment.

Areas identified for improvement.

Things that did not go so well and that might be potential latent safety threats were identified and addressed during the post-simulation debrief. Some examples include:

- The cardiac arrest team were unsure when to administer drugs during a cardiac arrest situation. This is now addressed in cardiac arrest team safety huddles.
- Staff were performing chest compressions for an extended period of time. The importance of staff rotating is reinforced in all resuscitation training sessions.
- Occasionally no clear team leader was identified. The importance of identifying a team leader is discussed at the safety huddle and in both Intermediate Life Support (ILS) and Advanced Life Support (ALS) training.
- Emergency buzzers or pull cords did not work in some areas and on occasions there was difficulty moving the resuscitation trolley due to an uneven floor and ledges. This was escalated to relevant managers to work with the Estates Department.
- Questions were raised and discussed regarding moving heavier patients from the chair to the floor. Advice was given and the team were advised to contact the manual handling team for further advice.
- There were some examples of poor communication. During the debrief the cardiac arrest team were reminded to introduce themselves and use clear closed loop communication (also covered in ILS/ALS training).
- Difficulty was experienced working in a small room. Discussions were held regarding moving the patient where appropriate.

Participant post simulation feedback

The participant evaluation indicated very positive responses regarding improved clinical knowledge in managing emergency events, awareness of the importance of team working and communication in emergency events, and better preparation for a real cardiac arrest event (compared to classroom-based simulation training). Some examples of the feedback:

- “Very well run, good learning opportunity and great debrief and feedback.”
- “It made the situation feel more realistic to be in the real setting using the equipment available on the ward.”
- “I feel the simulation felt very real and I feel it was very beneficial for the whole team to be involved.”

Conclusion

Results of the evaluation confirmed that the key performance indicators continue to be achieved. The recommendations are therefore to:

- Continue classroom-based education to focus upon knowledge and skill acquisition.
- Continue in-situ cardiac arrest simulation training to consolidate classroom-based learning and develop non-technical skills and awareness of the importance of human factors.
- Continue with in-situ cardiac arrest in-situ simulation training to allow for identification and correction of latent safety threats.

Patient experience and involvement indicators

a. Complaints, concerns and compliments COMPLETE EXCEPT DATA UPDATE

South Tees Hospitals NHS Foundation Trust prides itself on delivering seamless high quality, safe healthcare for all. Our vision is to be recognised nationally for excellence in quality, patient safety, patient experience, social engagement, and continuous improvement. However, on occasion some patients,

relatives and carers may not experience the high-quality service we aim to achieve. Where a negative experience has arisen, the Trust seeks to investigate, resolve, and improve using the internal complaints process.

New complaint process

In 2021 the Parliamentary and Health Service Ombudsman (PHSO) released new NHS Complaint Standards, based on best practice in complaints handling and with a focus on early resolution. The PHSO piloted the standards with several NHS organisations and with early adopter sites in 2021-22 to develop supporting materials, training and guidance that would help the NHS embed the standards in its work.

The Trust has experienced ongoing challenges in providing a robust internal complaints process as illustrated in the activity data presented below and is aware of how these impact on patient experience and delays learning. It started the process to adopt the standards during 2023 and is aiming to:

- Effectively resolve all complaints from patients, families, and carers.
- Provide a timely, effective, and proportionate response to complaints.
- Ensure the learning from these improves future practice.

Initial work involved using the PHSO supporting materials to identify key stakeholders and plan the changes needed, including supporting staff within our Clinical Collaboratives who would be involved in the complaint handling process. Following our quality improvement approach, the new process was implemented on 1 January 2024. All patient feedback received by the Patient Experience Team is now initially treated as an enquiry, logged on the Datix Complaint Handling and Management software, and forwarded to appropriate staff in the relevant Clinical Collaborative. Collaborative colleagues contact the enquirer and aim to resolve enquiries at this stage if possible, updating Datix with details of the resolution discussion and any actions and learning arising from the enquiry. If an enquiry can be resolved within 24 hours this will not be counted as a complaint. If it is not possible to resolve within 24 hours, it will be classified as a complaint, escalated to senior staff in the Collaborative, and a timeframe for response agreed with the complainant based on the complexity of the complaint.

Concerns and Complaints Activity

The Patient Advice and Liaison Service (PALS) service has historically offered patients confidential advice, support and information, and has helped to resolve concerns or problems related to NHS care. From 1 January 2024 there are no longer separate PALS and complaints processes, and the data for complaints and enquiries received below (figure 21) reflects this.

The apparent decrease in PALS activity early in 2023 was due in part to a backlog of concerns waiting to be logged by the Patient Experience Team (PET) due to capacity issues. The increase from September to November reflects the recruitment of new staff.

Concerns have been related to all aspects of clinical care and communication. The Patent Experience Team log the concern received and attempt to resolve the concern if they can, for example assisting with appointment issues. Other concerns require appropriate ward or department staff to contact the enquirer and they aim to resolve the concern within the 10-working day timeframe. Overall, aspects of clinical care remain the most complained about subject. The majority relate to the quality of medical care, followed by misdiagnosis or missed diagnosis and clinical opinion being questioned.

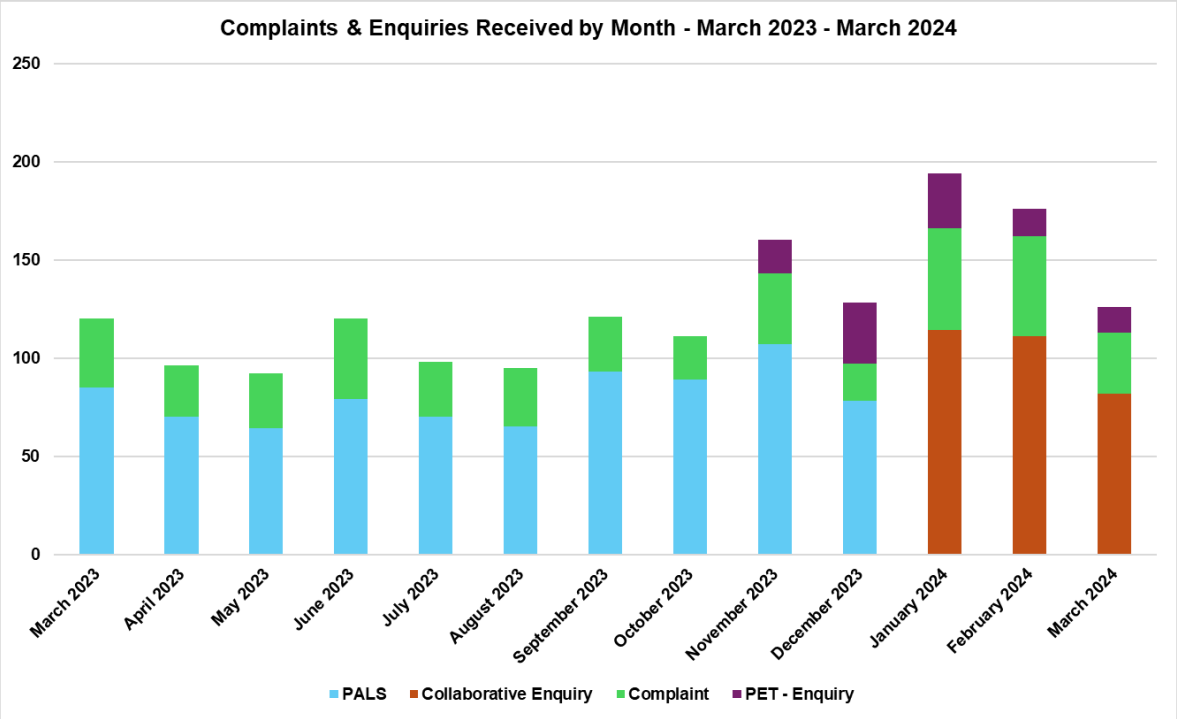


Figure 21: Complaints and enquiries received March 2023 – March 2024.

The closure of informal concerns within 10 working days has consistently fallen below the Trust internal target of 80% (figure 22). The main reasons are late responses from the handler and reflects challenges in locating paper-based healthcare records for review and operational pressures being experienced across the Trust and wider NHS.

96% of complaints received during the last 12 months were acknowledged within three working days. The delays in responding to 14 complaints were due to pressures on the Patient Experience Department. However, the Trust's internal target of closing 80% of complaints within the relevant timeframe has not been achieved during 2023/24 (figure 22). Whilst there was an improvement between July to September, this has not been maintained. Despite monitoring progress with each complaint, and weekly meetings to escalate concerns, completion has been impacted by delays in receiving healthcare records, junior doctors strikes, and the availability of clinical staff to draft responses.

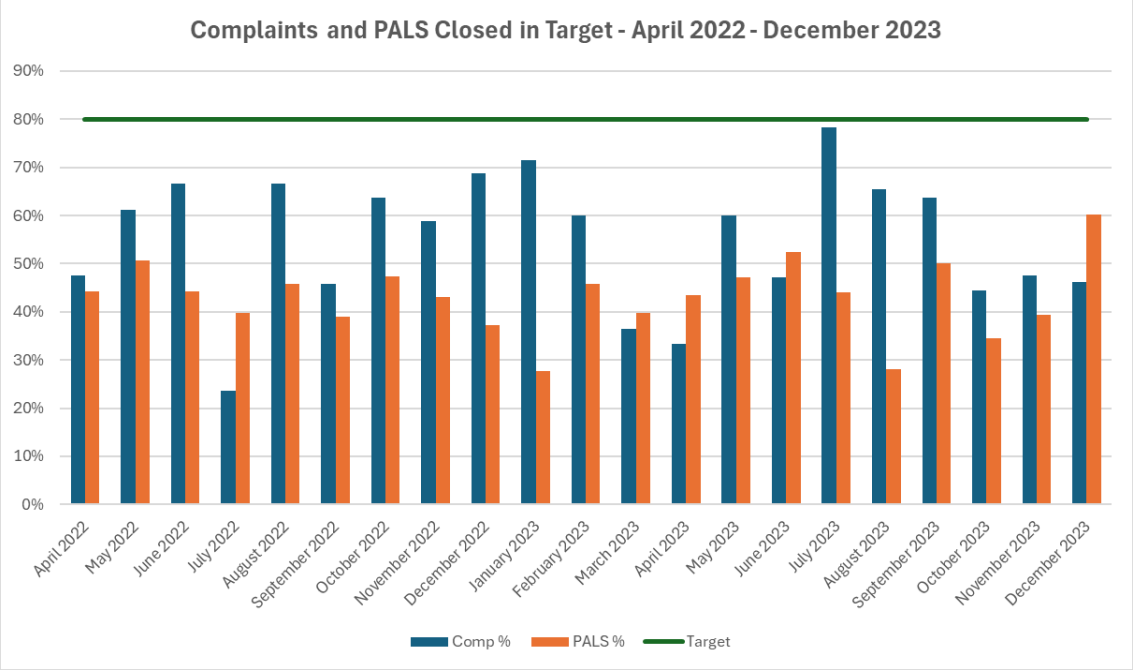


Figure 22: % Complaints and PALS closed within deadline April 2022 – December 2023.

There were 141 complaints closed in quarter 2 and quarter 3 2023/24. Of these, 30 complaints were found to be substantiated, 53 partially substantiated, and 89 unsubstantiated. Awaiting full 2023/24 data

There was a slight decrease in reopened complaints following closure compared to the previous six-month period. See table 6. The main reasons for reopening complaints are new questions relating to the complaint, the recipient disagreeing with the response, new unrelated questions, or a request for a meeting to discuss the complaint response.

January 2023	February 2023	March 2023	April 2023	May 2023	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	Total (Last 12 Months)
3	5	2	1	3	4	0	4	3	2	5	1	33

Table 6: Further contact following receipt of complaint response January – December 2023.

Learning from complaints

Improvements and learning are a key aspect of substantiated complaints. As examples:

- The carer of a patient with Alzheimer's disease raised concerns about staff measuring the patient's medication incorrectly. This was medication brought in with the patient and unfamiliar to the staff. There has been targeted education and training for staff involved in the medication administration process, highlighting the importance of double-checking procedures for all new or unfamiliar medications. The learning has been shared at meetings across the Trust and via a trust-wide safety bulletin.
- Family Liaison Officers supported the family of a patient who deteriorated and died at home from sepsis following surgery. The family felt they could have raised concerns earlier if they had been informed about the signs of sepsis. As a result, a sepsis information card has been developed for post-operative patients.

Compliments Activity

All compliments received by the Trust are uploaded to Datix and shared with the wards and departments (table 7). There is currently a backlog of approximately 125 compliments to be logged for the Collaboratives. Clearing this backlog was part of the patient experience improvement plan and support was provided by the Prospect Placement and the backlog has significantly reduced.

April 2023	May 2023	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	Total
62	20	205	117	18	213	184	247	24	14	11	8	1123

Table 7: Compliments received by Collaborative April 2023 – March 2024 (logged to date).

Summary and ongoing work

The new complaints process will continue to be embedded, and progress with achieving our ambition for timely resolution and responses, and effective learning and improvement will be monitored closely. Following our quality improvement methodology, a follow up workshop to review the ongoing progress with the changes made and to agree any further refinements needed was arranged for early April 2024.

There are also plans to work with the Public Relations Team during 2024 to promote the compliments received by the Trust, ensuring areas of good practice identified by patients, relatives and carers are identified and celebrated.

b. Patient surveys – national and local COMPLETE EXCEPT FFT DATA REFRESH

Examining feedback from patients gives the organisation a direct insight into what is working well – and not so well – in the way we deliver care. We can share across the organisation examples of good practice in order to learn what works well for people, and areas of concern in order that improvements can be made.

Local Trust Surveys and Friends and Family Test (FFT)

There are currently 89 patient surveys utilised in the Trust covering all wards, departments, and community services. Patients can provide comments on all the local Trust surveys. All comments are reviewed by the Patient Experience Team and appropriate sentiment types are added to each. Some comments may receive multiple sentiments. The data for April 2023 – February 2024 shows that overall, 68.1% of comments have been positive and 11.8% negative (figure 23).

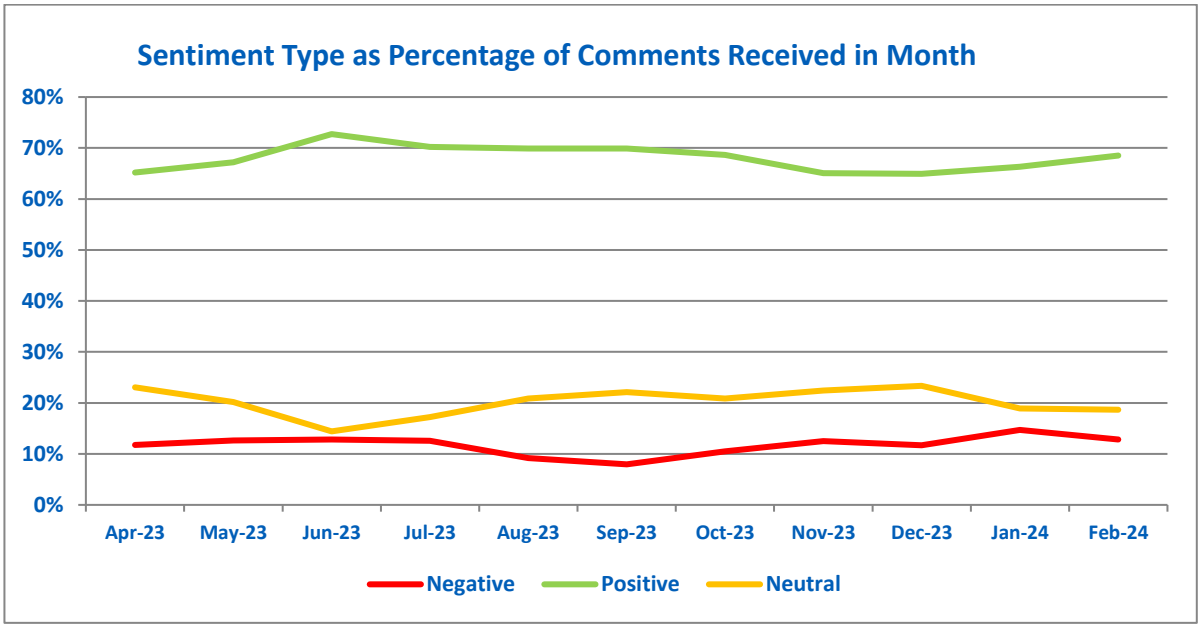


Figure 23 - Patient feedback sentiment analysis by month July – Apr 2023 to Feb 2024

The FFT question is included in most of our local surveys. It invites feedback on the overall experience of using a service and offers a standardised range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience, and results can be compared with other trusts. Data from April 2023 to February 2024 shows the Trust is above national average for percentage likely to recommend services in Inpatient, A&E/UTC, Outpatient and Community (see table 8).

	2023/24			
	Response Rate		% likely to recommend	
	Trust	England	Trust	England
Inpatient	18%	21%	97%	94%
A&E	7%	11%	82%	80%
Antenatal			91%	91%
Birth	16%	13%	88%	94%
Postnatal ward			87%	92%
Post natal			-	92%
Outpatient	4%	4%	97%	94%
Community	6%	4%	98%	95%

Table 8: Inpatient, A&E/UTC, Maternity, Outpatient and Community FFT results benchmarked against national results (April 2023 – February 2024). Awaiting March data and some clarification re missing data.

The Maternity FFT surveys patients at four touchpoints (antenatal, birth, postnatal inpatient, and postnatal community), and overall results for the Trust are above national average for postnatal community care, and below national average for antenatal, birth and postnatal inpatient care (see table 8).

Wards and departments regularly review their patient feedback and display 'You said, we did' notices to highlight improvements made as a result of this.

National Surveys

The Trust participates in several national surveys run by the Care Quality Commission (CQC). The published reports are scrutinised to assess trust performance compared to previous performance, the performance of local trusts, and to national average scores. Action plans are developed to address any areas for improvement, and these are monitored by the Patient Experience Steering Group. The key findings of the most recently published reports are below.

National Adult Inpatient Survey

The last published National Adult Inpatient Survey report in September 2023 was for the survey carried out in November 2022. The survey included patients aged 16 years or over who spent at least one night, during November 2022, in an NHS hospital in England and were not admitted to maternity or psychiatric units. Each NHS trust selected a sample of 1,250 patients by including every consecutive discharge that met the eligibility criteria, counting back from 30 November 2022. Nationally there were 63,224 responses received, with a response rate of 40%. Of the 1,250 patients identified by the STHFT, 507 patients responded to the survey giving a 43% response rate. **Check data.**

In comparison to other Trusts, South Tees scored 'much better than expected' in one question, 'better than expected' in nine questions, 'somewhat better than expected' in four questions, and 'about the same' in thirty-one questions. No questions scored worse than expected. In comparison with results from the 2021 survey, the trust showed a statistically significant increase in two questions, no statistically significant change in forty questions and a statistically significant decrease in one question.

National Urgent and Emergency Care Survey

The latest published National Urgent and Emergency Care Survey report in August 2023 was for the survey carried out in September 2022. This survey looks at the experiences of adults that have used the Emergency Department (ED) or Urgent Treatment Centre (UTC) in an NHS hospital. In total 122 NHS trusts with a Type 1 accident and emergency department took part in the survey. 59 of these trusts also had direct responsibility for running a Type 3 UTC department. Nationally responses were received from 29,357 patients who attended a Type 1 department (response rate 23%), and from 7418 patients who attended a Type 3 department (response rate 22%). South Tees had a response rate of 43% with 1,250 patients invited to take part and 507 patients participating in the survey. **Check data.**

For the ED the Trust scored in the top 20% of trusts for twenty questions, in the middle 60% of trusts for 12 questions and in the bottom 20% of trusts for five questions. In comparison with other NHS trusts in the region the trust's results were better than all trusts in nine questions, somewhat better in six questions, and about the same for 22 questions. No questions scored worse than all trusts. In comparison to the 2020 survey results the trust had a five percent or more increase in five questions and a five percent or more decrease in nine questions.

For the UTC the Trust scored in the top 20% of Trusts for 14 questions, in the middle 60% of trusts for nine questions and in the bottom 20% of trusts for one question. In comparison with other NHS trusts in the region, the Trust's results were better than all trusts in two questions, somewhat better in two questions, and about the same for 26 questions. No questions scored worse than all trusts. In comparison to the 2020 survey results the trust had a five percent or more increase in two questions and a five percent or more decrease in seven questions.

National Cancer Patient Experience Survey

The most recent National Cancer Patient Experience Survey report was published in July 2023 for the survey carried out in April - June 2022. This survey involved 133 NHS Trusts with 61,268 people responding to the survey nationally, yielding a response rate of 53%. For the STHFT 563 patients responded out of a total of 1,076 patients, resulting in a response rate of 52%.

For the four questions relating to overall NHS care, the trust scored equal to or higher than national average across most tumour groups, but lower than national average for skin, head and neck, and urological tumour groups. For overall survey scores in comparison with other NHS trusts in the region, the trust scored above the expected upper range in four questions, and between the expected upper and lower ranges for 57 questions. No questions scored below the expected lower range. In comparison to the 2021 survey the trust scored at least five percent increase in scores for four questions, and at least five percent decrease for seven questions.

National Maternity Survey

The most recent National Maternity Survey report was published in February 2024 for the survey carried out in February – March 2023. The survey asked for feedback from individuals aged 16 years or over at the time of delivery, who had a live birth at the Trust in February 2023 on their experiences of antenatal care, labour and birth, and postnatal care. South Tees and other larger trusts also asked for feedback from all eligible individuals from ethnic minority backgrounds who had a live birth between in January and March 2023. STHFT invited 300 patients to take part in the survey. 127 patients responded giving a 42% response rate, just higher than the national response rate of 41%.
Compared with 121 other NHS Trusts, STHFT scored 'somewhat better than expected' in five questions and 'about the same' in 49 questions. The trust did not score worse than expected in any questions. In comparison to the 2022 survey, the trust showed a statistically significant increase in two questions. There were no questions with a statistically significant decrease.

Summary and ongoing work

This has been a busy year for patient experience activity across the Trust. The Patient Experience Team support colleagues across the organisation to seek patient feedback and then to effectively use the results to ensure learning and improvement. Moving forward the Trust will be using the Friends and Family Test question, as a guide, to identify where a deeper dive is required, either to share good practice or identify areas of learning for improvement.

c. Patient information improvement COMPLETE

Providing good quality information for patients, carers and parents and communicating that effectively is important to ensure good understanding of health and illness, appointments, procedures, and treatments, and for meaningful shared decision making between patients and clinicians.

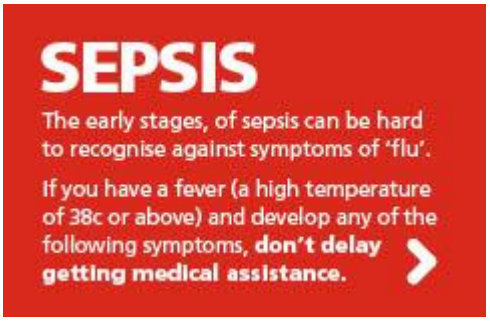
Patient information leaflets

More patient information leaflets have been reviewed and placed on the Trust internet site to be easily accessible by patients and staff. The information is downloadable for printing in the appropriate font size to meet the patient, carer, or parents' requirements. As of March 2024, there were 524 patient information documents available on the South Tees website, and 60 leaflets in draft awaiting approval. Out of date leaflets are removed from the website to ensure they are not accessible, and the archiving of patient information resources that have been replaced with new versions is now more robust.

The Trust continues to promote the use of posters with QR codes to download patient information, to enable people to easily access the up-to-date version of leaflets, and to reduce the amount and cost of paper.

We provide patients or carers who wish to contact our clinical departments for further information with a telephone number and an email address to provide for people who are unable to communicate using a telephone.

We developed new information resources from patient feedback. As referenced in the complaints report, we developed information for patients, carers and relatives about post-operative sepsis following the death of a patient and a complaint. Post-operative patients are given a Sepsis Card with the signs of post-operative sepsis clearly highlighted and instructions about actions to take if this is suspected. This information is also on the Trust website at https://www.southtees.nhs.uk/resources/sepsis/



Interpretation services

In 2022/2023 the average fulfilment rate for face-to-face interpreting services was 69% and for telephone interpreters was 95.9%. Through regular contract and quality monitoring of our interpretation service we have seen a sustained increase in fulfilling requests for interpretation across the Trust, on average 350 per month each for telephone and face-to-face services.

The fulfilment of requests for a face-to-face interpreting service has been above 80% throughout 2023/24 reaching a maximum of 90% in December (see figure 24). The fulfilment of requests for a telephone interpreting service has been above 95% throughout 2023/24 reaching a maximum of 99% in April 2023 and January 2024 (see figure 25).

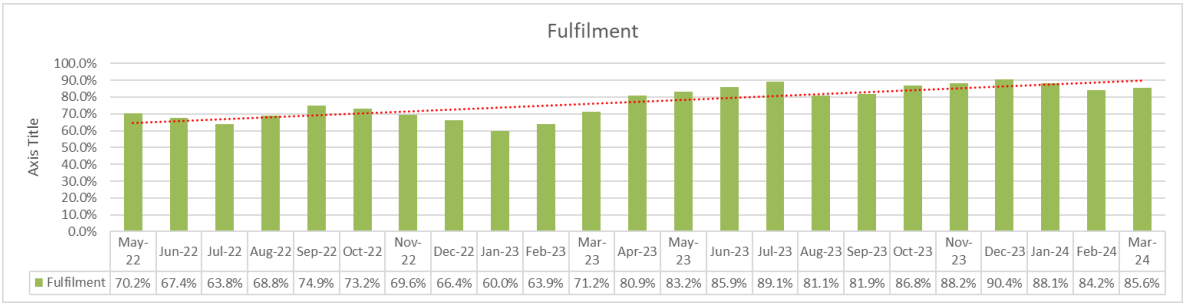


Figure 24: % of requests met by face-to-face interpretation (May 2022 – March 2024).

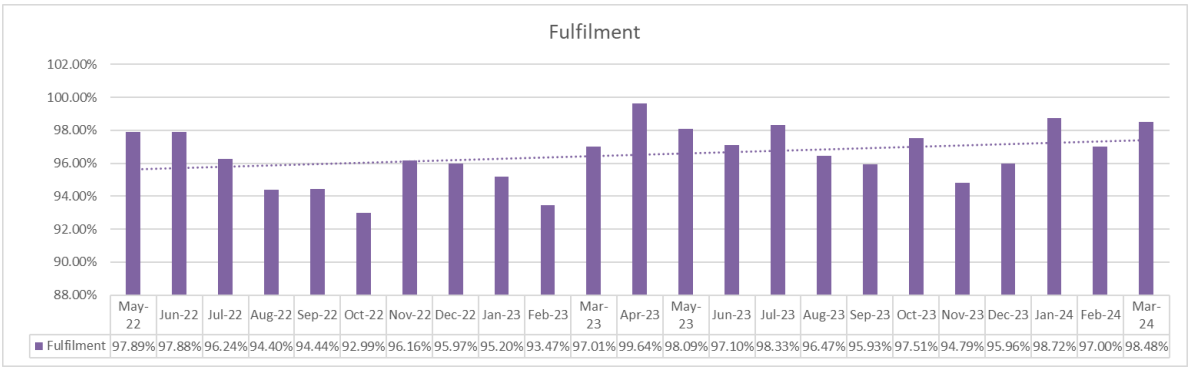


Figure 25: % of requests met by telephone interpretation (May 2022 – March 2024).

The current interpreting and translation service contract is due to expire within the next 12 months. With the support of procurement, and the Service Improvement Team, the Patient Experience Team have commenced a retendering exercise, which will involve key stakeholders and services users in the identification of any future provider.

Specific actions have been taken within Maternity to support interpretation for women whose first language is not English:

- Working with the LMNS the top five languages spoken in Middlesbrough, Redcar & Cleveland were identified, and some patient information leaflets have been made available in all five languages and are available for patients and relatives to download.
- Mobile phones have been made available in clinical areas to assist with telephone interpreting when consent is required for emergency procedures.
- The welcome page on the Badgernet Electronic Patient Record is available in 10 languages and patient leaflets are available in different languages on Badgernet. Badgernet is committed to further translations and there are plans to review this over the current year.

Outpatient Letters Improvement Work

During 2023/24 there has been improvement work to deliver a digital first approach to outpatient communication with patients by delivering outpatient appointment letters and reminders digitally using the DrDoctor Patient Engagement Portal (PEP).

Appropriate outpatient letters and any associated patient information leaflets are sent to the PEP. If we have a mobile number for the patient and they have not opted out, we will send them a text message to notify them that a new letter is available online. Texts will address patients by their first name to avoid confusion about who the appointment is for when several family members use the same mobile number. Patients follow the link and login to view and download their letter. Patients will be sent a reminder after 24 hours if they have not viewed their digital letter, and any patient who does not view their letter online within 48 hours will be sent one by post as usual. When an appointment is within 7 days, patients will be sent their digital letter and paper letter at the same time.

Patients can choose to have all future letters sent by email or to be printed and sent by post. They can also choose to stop receiving text communication about appointments, in which case future letters will be printed and posted. Letters in Braille are currently all sent by post with one side in braille and text on the other side for sighted relatives or carers.

Assuming the patient has not opted out of text communication, outpatient appointment reminders are sent by text 7 days before the appointment. Patients will receive details of their attendance type (face-to-face, video or telephone) and the appropriate appointment booking team telephone number for the clinic they are booked in to. If the appointment is face-to-face, they will receive details of the Outpatient Department, hospital site and nearest entrance where applicable. Patients can also access a map of the location of the hospital and extra information to support a successful outpatient appointment, e.g. to attend 20 minutes early to have blood samples taken, or to bring certain documentation etc.

Summary and ongoing work

There has been important work done during 2023/24 regarding patient information resources, provision of translation services, and the introduction of digital communication for our outpatient services.

Ongoing work will involve reviewing patient information from a health literacy perspective to ensure readability for the communities we service. We will continue to ensure that patient information, about the procedures carried out in the Trust are available in an accessible format to our patients, carers, and relatives to support their care and treatment.

The retendering exercise for translation services will be progressed, and a Trust policy for interpreting will also be developed and implemented.

During 2024/25 the Patient Engagement Portal will start the roll out of:

- Digital letters to the patient and their GP following clinic attendance.
- The opportunity for patients to digitally notify the Trust if they cannot attend their appointment.
- Braille appointment letters sent digitally for the proportion of severely sight impaired people who read braille and have apps to help them read digital communication.

3.2 Performance against key national priorities COMPLETE – AWAITING FULL 23/24 DATA UPDATE. Due 1 MAY 2024.

	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24 YTD	23/24 Targets
Safety										
Clostridioides (C) *difficile* – meeting the C. *difficile* objective	61	43	48	41	89	79	138	140	118	N/a
All cancer – 62 day wait for first treatment from										
Urgent GP referral for suspected cancer	79.10%	81.10%	85.44%	82.65%	77.23%	75.52%	73.83%	60.4%	57.4%	85%
NHS Cancer screening service referral	89.80%	89.00%	94.55%	87.14%	94.41%	62.77%	50.00%	68.71%	63.7%	90%
18 weeks referral to treatment time (RTT)										
Incomplete pathways	93.20%	92.20%	91.45%	89.49%	83.33%	63.20%	65.37%	65.99%	64.09%	92%
Accident & Emergency										
4 hour maximum wait in A&E from arrival to admission, transfer or discharge	95.80%	95.33%	95.68%	95.24%	88.35%	87.25%	75.52%	68.22%	67.10%	95%
Diagnostic Waits										
Patients waiting 6 weeks or less for a diagnostic test	98.82%	99.15%	97.46%	98.26%	94.04%	72.57%	68.71%	77.57%	75.22%	99%

Table 9: Performance against National Priorities

Key findings:

- The Trust recorded 118 cases of C. *difficile* during 2023/24 (YTD). The Trust is committed to driving down healthcare acquired infections and achieved its lowest ever incidence of C. *difficile* infections in 2018/19. However, since this time the Trust has seen increasing numbers year on year, with a slight decrease in 2023/24 on 2022/23 figures. Further narrative can be found in part two of this quality account.

- Our year end performance for the all cancer 62-day wait for first definitive treatment from urgent GP referral for suspected cancer was 57.4% YTD (Apr 23 - Jan 24). The 62-day to first treatment standard is supressed as the longest waiters have treatment. Cancer action plans are reviewed and monitored through the Cancer Delivery Group, informed by a programme of pathway reviews.

- Our year end performance for all cancer 62-day wait for first definitive treatment from NHS cancer screening service referral was 63.7% YTD (Apr 23 - Jan 24). Volumes of patients within this target are low which impacts the overall compliance significantly.

- Our year-end performance for the referral to treatment (RTT) 18-week target was 64.09% YTD (Apr 23 – Jan 24). Referral to treatment within 18 weeks trend is consistent and performs above the national average. Focus on reducing the number of patients waiting more than 65 weeks by March 2024 is demonstrated in the reducing trend for 52-week and 65-week waits.

- Our year-end performance for the 4-hour Accident and Emergency waiting time target was 67.10% YTD (Apr 23 - Jan 24). This target remains a challenge and is impacted by a number of factors such as internal and external patient flows and the demand for acute or urgent care services. Although we have seen an improvement in the number of patients awaiting social care, we have

been impacted by increases in non-elective demand. We are however opening a new facility for urgent care streams of patients alongside the current ED department and will monitor the impact of this.

- Our year-end performance for diagnostic waits (waiting 6 weeks or less) was 75.22% YTD (Apr 23 – Jan 24). General radiology waits for CT, MRI and ultrasound scanning (USS) have improved significantly over the year due to additional capacity being sourced through Community Diagnostic Centre (CDC) funding. Recovery plans are in place and further equipment will be installed over the next 8 months which will further support compliance with the patient tracking list.

- As of the end of the 2023/24 financial year, the Trust has 1 patient who has waited more than 78 weeks from referral to treatment.

3.3 Additional required information

Seven-day services COMPLETE.

Ten NHS Seven Day Hospital Services Clinical Standards were developed in 2013 to support providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency. Providers have been working to achieve all these standards, with a focus on four priority standards identified in 2015 with the support of the Academy of Medical Royal Colleges. The four priority standards were selected to ensure that patients have access to consultant-directed assessment (Clinical Standard 2), diagnostics (Clinical Standard 5), interventions (Clinical Standard 6) and ongoing review (Clinical Standard 8) every day of the week. Full details of all the clinical standards are available at: NHS England Seven-day-services clinical standards. Trust Boards should assess, at least once a year, whether their acute services are meeting the four priority seven-day services clinical standards, using an updated board assurance framework (BAF) and guidance published in February 2022.

After the challenges of the COVID-19 response, the BAF for Seven Day Services re-focuses attention on the four key standards. An assessment against these standards was completed at South Tees in September 2022. The Trust is not comprehensively compliant with Standard 2 for 'consultant review for all new admissions within 14 hours' in every specialty throughout the week. This is due to more limited consultant presence on-site at weekends in specialities with smaller numbers of emergency admissions. The Trust is assured of timely senior clinical assessment for patients admitted as an emergency in all the higher volume specialties and when the patient is unwell or deteriorating. The Trust is also assured that arrangements are in place for daily senior review, and that there is safe access to diagnostic and consultant-led interventional services over the seven-day period, demonstrating compliance with these standards. The Trust is not aware of any issues raised through complaints, serious incidents and staff surveys including the GMC survey of doctors in training that any concerns have been raised in respect of this. The Trust wide roll out of electronic patient records will provide the ability to regularly monitor timely assessment and review of patients.

In addition, the Trust is working with regional provider and commissioning colleagues to develop 7-day access to the mechanical thrombectomy hyper-acute stroke intervention.

Freedom to speak up COMPLETE

'Speaking up is about anything that gets in the way of doing a great job.'[1]

At South Tees Foundation NHS Trust there are now 75 hours dedicated to providing a speak up service to the organisation. It is the responsibility of the Board of Directors to promote and embed an open culture which invites and encourages both positive and negative feedback from all who work within our services. This feedback can then be used to inform future strategies to support our continual learning and improvement.

The Freedom to Speak Up (FTSU) Guardians Team continue to work to improve the speaking up culture throughout the organisation, raising awareness of Freedom to Speak Up and all the routes by which colleagues can raise concerns. This is an evolving service as we align ourselves with changing national guidance, Trust IT systems and the recently adopted Joint Hospital Group Model.

The FTSU model has continued to develop with data collected over the past 12 months and analysed reflecting a positive impact in terms of the numbers of people speaking up, the numbers of people speaking up openly or confidentially and the numbers of people who have accessed the service reporting that they would speak up again.

Figure 26 shows 122 concerns were raised with the guardian team between April 2023 - March 2024 compared to 97 in the previous 12 months. This represents an overall increase of 25.7%.

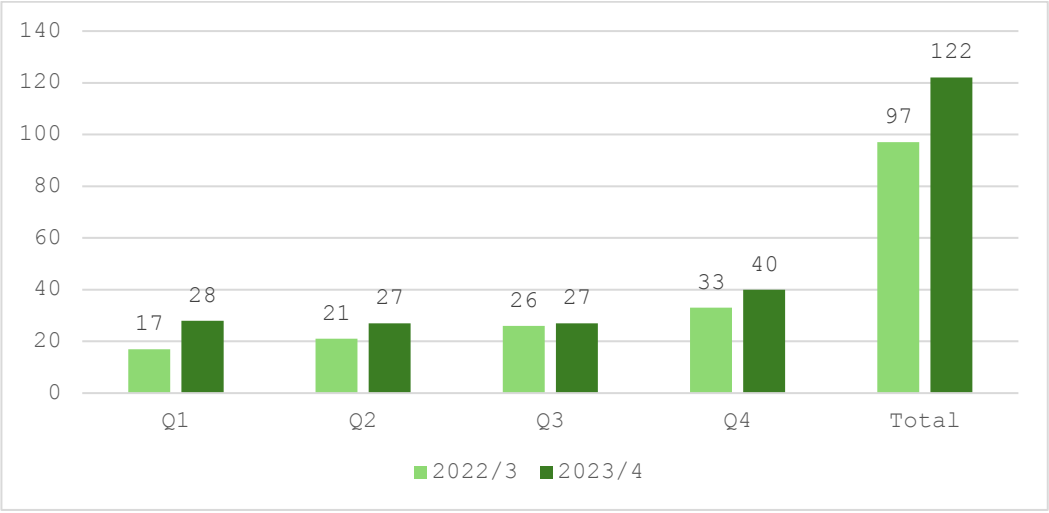


Figure 26: No. of concerns raised with the FTSU Guardians Team 2022/23 and April 2023-March 2024.

Figure 27 below shows the high-level themes recorded against the concerns received in 2023/24. Out of the 122 concerns received, 45.4% were related to inappropriate attitudes or behaviours, 31.1.% were

[1] *https://nationalguardian.org.uk/speaking-up/what-is-speaking-up/*

related to an element of patient safety or quality. 9.3% of concerns featured an element of bullying and harassment, and 14.3% concerns were raised about worker safety or wellbeing.

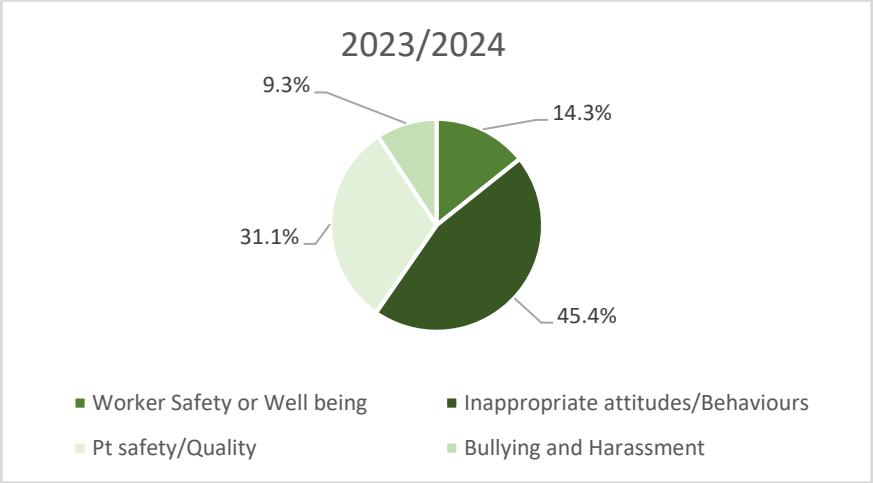


Figure 27: Themes recorded against concerns raised in 2023/24.

2023/24 saw a small positive change in how concerns were raised. 69.9%% of colleagues chose to report their concerns to the FTSU Guardians through an open or confidential route compared to 68.8% last year. And anonymously reported concerns fell slightly from 31.2% in 2022/23 to 30.1% in 2023/24.

Staff Survey and FTSU Questions

The FTSU Guardians use the national NHS Staff Survey data to inform their work. Table 10 shows the recently published results of the FTSU questions asked in the 2023 NHS Staff Survey compared with previous results. Whilst the overall percentages have generally continued to decline this mirrors the national picture, with the Trust remaining above or close to the national benchmarking for three questions, with question Q20b dropping slightly below the national benchmark.

The Guardians will analyse the results further to develop a plan of work for the next 6 months focusing particularly on the areas within the Trust that reported the lowest scores as well as those with the lowest response rate.

Staff Survey Question	2021/22 results	2022/23 results	2023/24 results	2023/24 national benchmarking
Q20a I would feel secure raising concerns about unsafe clinical practice.	76.9%	74.14%	71.05%	70.24%
Q20b I am confident that my organisation would address my concern.	60.7%	58.3%	54.08%	55.90%
Q25e I feel safe to speak up about anything that concerns me in this organisation.	64.62%	63.10%	62.82%	60.89%
Q25f If I spoke up about something that concerned me, I am confident my organisation would address my concern.	49.83%	48.15%	48.69%	48.65%

Table 10: Responses to NHS Staff Survey questions relevant to FTSU 2021/22 to 2023/24.

FTSU Guardian Team work during 2023/24

The FTSU Guardian Team have been working with colleagues in Workforce to make 'Speak up' training mandatory for all staff with plans for 'Listen Up' and 'Follow up' to be developed into workshops delivered across sites. The Guardians continue to share delivery of the FTSU training within induction for new staff and the Care Certificate Programme.

Guardians have built links and work with University of Teesside and the military speak up lead to deliver training to students and military staff.

Local, Regional and National Updates.

As North and South Tees Trusts move into a Group Model, discussions continue between the FTSU Guardians for both trusts around plans for the two services to work more collaboratively and to develop a sustainable plan for proactive and reactive FTSU work.

In November 2023, FTSU services were asked by colleagues at the ICB to provide evidence for their regional audit of the current FTSU procedures in the wake of the Lucy Letby investigation, also known as the Thirlwall inquiry. Each Trust in the region was asked to undertake and submit to the ICB a retrospective audit of two anonymised cases to ensure that correct FTSU processes had been followed. This work was completed by our team in December. The ICB have now spoken with all FTSU Guardians and anticipate sharing their findings and any recommendations over the coming months.

The FTSU Guardians attended the National Guardians conference in Birmingham on 24th of March 2024. Throughout the day attendees explored the barriers to speaking up, with thought-provoking discussion from leaders, experts by experience, professionals from other sectors, and other FTSU Guardians.

Future Plans.

Over the next twelve months the FTSU Guardians have identified several opportunities, including:

- Continuing to embed FTSU model throughout the Trust and implementing of the updated Freedom to Speak Up policy.
- Developing training for staff to clarify what 'detriment' is and how detriment from speaking up can be identified and prevented with the delivery of focused workshops for managers and senior managers.
- Continuing to identify the barriers to speaking up and developing opportunities to overcome these including closer work with equality, diversity and inclusion groups.
- Recruitment and expansion of new and existing FTSU Champions from diverse backgrounds, with regular 'lunch & learn' webinars and meetings, in addition to more formal training twice a year.

Rota gaps for doctors and dentists in training COMPLETE

Organisations are reminded that 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 shall be included in a statement in the Trust's Quality Account".

South Tees NHS Foundation Trust would like to present the following information about rota gaps and other linked work streams.

For the most part, junior doctor medical rotas are managed through a collaboration between the corporate medical rota team and the clinical rota leads in the specific departments of the Trust. We have taken great steps forwards in the electronic rostering of medical staff and have circa 500 junior doctors rostered on this platform2. The full Trust roll out of the system continues and will give the Trust greater insight into the rota gaps that occur and more accurate and contemporaneous data.

In terms of current gaps, we offer the following information from our establishment data. We continue to fill gaps on rotas in line with the management of gaps on junior rotas policy to ensure there is a consistent approach throughout the Trust:

	No of gaps in establishment by tier of rota[3]	**How mitigated**
Medical Rotas	11 gaps general medical T2	Locum cover
	3 gaps neurology T2	Locum or consultants cover
	8 gaps Paeds T2	Paeds – locum cover
	2 gaps Paeds T1	Paeds – locum cover
	Gaps due to maternity cover - respiratory medicine T1	Business case to cover
	1 gap Lab Medicine T1	Lab medicine gap from 3rd April 2024
Surgical Rotas	1 Neurosurgery	Locum cover
	2 T&O	Locum Cover
	1 Breast	Rota reduced over the placement
	2 Colorectal	Rota reduced over the placement
	1 Upper GI	Rota reduced over the placement
	2 Vascular	Rota reduced over the placement
	2 ENT	Rota reduced over the placement
	3 OMFS	Locum cover

In the latter part of this financial year, we have strengthened the process though which a junior doctor or dentist can report on whether they have worked beyond their planned shift timings. This process is called exception reporting. Having a more streamlined process has already resulted in an increase in reporting, which ultimately will help clinical teams identify trends in staff working patterns and hours that may be unsustainable.

Our Guardian of Safe Working (GOSW) along with our corporate medical rota team continue to provide routine reports to the People's Committee, Trust Board, Joint Local Negotiating Committee and Junior Doctor Contract Forum. A consolidated annual report from the GOSW is available for public view. Statutory documentation - South Tees Hospitals NHS Foundation Trust

Over the last year there have been 263 exception reports raised; eight of these had immediate safety concerns associated with them. Out of the 263 exception reports raised, three of these met the threshold to disburse a fine to the Trust.

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[2] *This number includes both doctors/dentists in training and out locally employed doctors.*

[3] *Generally, most departments work on a three tier rota; T1 – FY1-CT2, T2 – CT2+, T3 – Consultant level.*

The GOSW meets regularly with junior British Medical Association (BMA) reps and the Chief Medical Officer's (CMO) office to ensure we are all working towards addressing issues highlighted to the GOSW through exception reports or other avenues of escalation.

The CMO has appointed one of our consultants into the role of rota guardian. In the next financial year, all medical rotas will be reviewed to ensure we have a clear understanding of the number of doctors which should be on each rota to provide excellent clinical care while ensuring maximum training opportunities. Having agreed staffing levels on our rotas will allow us to issue more specific and accurate work schedules to our medical staff4. It will also enable better planning in terms of annual leave and bank holiday cover.

The Trust continues to aspire to triangulate data regarding rota gaps in each department with information on quality and safety incidents, and the number of exception reports raised in each area, giving us rich data about our clinical productivity as well as the safety of our staff and patients.

[4] Accurate work schedules are required to ensure accurate pay.

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

5. Annex 2: Statement of directors responsibilities for the quality report TO BE COMPLETED

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

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the *NHS foundation trust annual reporting manual 2018/19* and supporting guidance *Detailed requirements for quality reports 2018/19*
- the content of the quality report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2023 to March 2024
    - papers relating to quality reported to the board over the period April 2023 to March 2024
    - feedback from commissioners dated x
    - feedback from governors dated x
    - feedback from local Healthwatch organisations dated x
    - feedback from overview and scrutiny committee dated x
    - the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated x
    - the [latest] national patient survey x
    - the [latest] national staff survey x
    - the Head of Internal Audit's annual opinion of the trust's control environment x
    - CQC inspection report dated x
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the board

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

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

6. Annex 3: Glossary of terms FOR FINAL CHECK

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

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

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

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

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

BadgerNet
BadgerNet's Maternity Notes is an online portal.

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

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

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

Clostridioides difficile infections (CDI)
Clostridioides difficile infection (CDI) is caused by a type of bacteria and is an important cause of infectious diarrhoea in healthcare settings and in communities.

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

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

Clinician
Professionally qualified staff providing clinical care to patients.

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

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

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

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

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

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

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

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

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

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

Emergency
An urgent unplanned episode of care.

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

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

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

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

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

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

Inpatient
Patient requiring an overnight stay in hospital.

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

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

Interventional Radiology (IR)
Interventional Radiology" (IR) refers to a range of techniques which rely on the use radiological image guidance (X-ray fluoroscopy, ultrasound, computed tomography [CT] or magnetic resonance imaging [MRI]) to precisely target therapy. Most IR treatments are minimally invasive alternatives to open and laparoscopic (keyhole) surgery. As many IR procedures start with passing a needle through the skin to the target it is sometimes called pinhole surgery.

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

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

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

MIYA Noting Electronic Patient Record
MIYA is a software platform for recording and managing patient information. This aims to be a central record system rather than paper notes or other electronic systems and should improve patient care and safety.

Multidisciplinary Team (MDT)

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

National Institute for Health Research (NIHR)

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

National Institute for Health and Clinical Excellence (NICE)

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

NCEPOD

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

National Patient Survey Programme

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

NHS England (NHSE)

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

NEQOS (North-East Quality Observatory Service)

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

Overview and Scrutiny Committees

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

PALS (Patient Advice and Liaison Service)

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

Patient Reported Outcome Measures (PROMs)

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

Payment by Results

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

Pressure Ulcer

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

Providers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

South Tees Hospitals NHS Foundation Trust

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

TEWV

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