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Part 1
Statement on quality from the Chief Executive
I am delighted to introduce the 2017/2018 Quality Report as Chief Executive of South Tees Hospitals NHS Foundation Trust.

With patient safety and quality at the heart of everything we do, we are committed to ensuring our resources are used effectively in order to provide safe services and the very highest standards of care for our patients. This report outlines achievements and successes against our quality priorities over the past 12 months and our priorities for 2018/19.

For the second consecutive year the Trust has been below the threshold for Trust attributed cases of Clostridium difficile, with 48 cases against an upper threshold of 55 in 2017/18. In addition a reduction of 15% in staphylococcus aureus bacteraemia was achieved in the same year. This reflects the significant amount of work undertaken both in the organisation and in collaboration with our commissioners in tackling health care associated infection.

With a focus on improving medication safety, the organisation has achieved a reduction in omitted doses, and in particular for critical medicines.

Our 1000 voices real time patient experience programme has been fully implemented across all inpatient areas, for the first time giving consistent quantitative and qualitative feedback to our clinical teams. The use of verbatim patient comments has meant that the voice of the patient has been clearly heard in real time at ward level. Staff have been able to act to make the small changes which make a big difference to our patients.

Operationally, our other three key quality measures, which directly link to the outcomes and experience of our patients, were:

- **Four-hour accident and emergency waiting time target** - our year-end performance was 95.68% against a target of 95%. We are incredibly proud of this performance particularly given levels of activity and patient acuity over the winter period;
- **62-day cancer wait target for first definitive treatment for all cancers** – our year-end performance was 85.44% against a target of 85%. This demonstrates considerable improvement with sustained compliance since November 2017;
- **Referral to Treatment (RTT) 18-week target** – our year-end performance was 91.45% against a national target of 92%. Although this is disappointing there are clear plans in place in 2018/19 to secure improvements.

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

We continue to promote a quality focused culture throughout our organisation to ensure we deliver excellence in both patient outcome and experience.

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

Signed:

Siobhan McArdle

Date: 24 May 2018
Siobhan McArdle
Part 2
Priorities for improvement and statements of assurance from the board
Priorities for improvement

Review of progress with the 2017/18 quality priorities
In last year’s quality account we identified the following as our quality priorities:

- Reducing harm from healthcare associated infection
- Reducing the harm from pressure ulcers and falls
- Improving medication safety
- Improving the response to the deteriorating patient
- Improving the mortality review process
- Ensuring patients receive care in the right place at the right time

Supported by our clinical strategy

The following section summarises the progress made against the goals identified for each priority.
Safety @ South Tees

Reducing harm from Health Care Acquired Infections (HCAI)

Our goals:

- To reduce the incidence of clostridium difficile infections;
- To reduce the incidence of staphylococcus aureus infections.

Progress to date:

There has been significant progress in reducing clostridium difficile infections in the Trust in 2017/18. The threshold was to have no more than 55 cases; this was achieved with a total of 48 Trust attributed cases for the year. Although this is a slight increase from the previous year (48 vs 43) the overall number of clostridium difficile infections in the Trust reduced by 9%. This demonstrates that the actions implemented through the HCAI annual plan and clostridium difficile action tracker have been effective. There has been 1 case of Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia and 34 cases of Methicillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia in 2017/18 which is a 15% reduction in Staphylococcus Aureus infections compared to 2016/17. Work to reduce infection in patients with invasive devices in situ was part of the infection prevention action plan for 2017/18 and will continue to be part of the Infection Prevention and Control (IPC) team’s focus for 2018 /19 as we acknowledge that there are still many infections such as MSSA that are associated with the insertion and subsequent management of an invasive device.

Several initiatives have been introduced by the Trust in order to improve performance on HCAI, these include:

Improving surveillance for Escherichia coli (E. coli)

Reducing infections such as E. coli is a national priority with the stated aim of a 50% reduction in gram negative bacteraemia by 2021. Acknowledging that the majority of these infections have a community onset we have contributed to and submitted a health–economy wide action plan in conjunction with our two Clinical Commissioning Groups (CCGs).

Resource has been deployed from the current IPC team from January 2018 to facilitate a more in-depth analysis of cases which will then inform future practice and policy and drive reductions for these infections.
The Trust is continuing to actively participate in the newly formed Tees-wide Health and Social Care Infection Prevention and Control Collaborative (TIPCC). The overall purpose of this group is to develop and deliver local strategies to ensure that no person is harmed by a preventable infection. This aim will be enacted through the delivery of the agreed health economy action plan for the reduction of E. coli in the first instance, but also to look for further opportunities to work across the health economy in other aspects of infection prevention in the wider public.

The Trust has participated in a number of national and regional workshops facilitated by the Academic Health Science Network (AHSN) and NHS Improvement (NHS I) to advance the current local action plans into a more cohesive plan for the region in terms of commonality where there are opportunities to develop solutions together.

Dedicated IPC post for care homes

The Trust hosted an Infection, Prevention and Control (IPC) Nurse post to facilitate education and training to care home staff as well as support the management of patients with infection within these environments. This post is funded by both the Tees Clinical Commissioning Group and the Local Authority through the Better Care Fund (BCF). The post has been highly successful in acting as a conduit across the health economy and has gained further funding for 2018/19.

Refresh and re-launch of High Impact Interventions

The national High Impact Interventions known as the Saving Lives programme was refreshed and relaunched in April 2017. This audit programme along with a monthly return of numbers of patients with invasive devices has facilitated targeted interventions to improve assurance of standardised practice in relation to peripheral cannula and urinary catheters.

Reducing antimicrobial prescribing

The Trust has continued reducing its antibiotic consumption as part of the national Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis) Commissioning for Quality and Innovation (CQUIN) scheme. Once again in 2017/18, the aim was to decrease overall antibiotic prescribing by 1%, as well as lowering the amount used of two specific antibiotic groups; the baseline for all three arms was the 2016 calendar year. The antibiotic pharmacist has continued to support this initiative through regular audits and education regarding appropriate antibiotic prescribing. The Trust achieved the reduction in the use of the two specific antibiotic groups but narrowly missed the overall reduction of antibiotic prescribing target.

The Trust was the first pilot site for the national Antibiotic Review Kit (ARK) trial looking to improve antibiotic review outcomes. Following on from this, a further revision to the short stay inpatient drug chart has been made to support the ARK antibiotic review concepts. Also, helping the reductions within the two specific antibiotic categories was the introduction of prescribing flowcharts for their use alongside giving them both “protected antimicrobial” status within the Trust, which meant that they are only used when absolutely appropriate.
**Diarrhoea management**

Weekly audits of patient records are completed to ensure appropriate management of patients who present with diarrhoea the results of which are shared with clinical matrons and ward managers. A service review of the Infection Prevention and Control (IPC) team has afforded the opportunity for a dedicated Infection Prevention and Control Nurse (IPCN) to be based with the Emergency Department and admission units. This provides visible support for risk assessment, clinical management of patients presenting with diarrhoea, use of isolation facilities as well as bed occupancy. This, along with an IPC Nurse being on duty 7 days per week has facilitated the early identification and timely management of patients who may have an infection. Further iterations of the Diarrhoea Assessment Tool have been piloted to reflect the unique risk factors in a number of specialties.

**Cleaning monitoring meetings**

These meetings take place monthly with our Private Finance Initiative (PFI) partners, who manage the cleaning services, to ensure agreed actions are delivered. The delivery of consistently high cleaning standards requires constant purpose so joint monitoring by the Trust and the PFI partner takes place on a weekly basis and is reported to the monthly cleaning standards meeting and the Infection Prevention Action Group (IPAG).

A new process of screening requests for enhanced cleaning has been introduced within the Infection Prevention and Control (IPC) team. This has resulted in a significant reduction of inappropriate requests and facilitates cleaning resources to be directed appropriately which has had a positive impact in patient flow.

**Deep clean programme**

During the bed re-configuration on the James Cook site there was the opportunity to deep clean 5 ward areas during 2017/18. A refurbishment of ward 4, the renal ward, has also seen an improvement in the bathroom facilities for our patients on this ward.
Progress to date:
The rate of falls across 2017/18 is 5.4 falls per 1000 bed days. This exceeds the goal of 5 per 1000 bed days for the year.

Rate of falls per 1000 bed days

Source: CBIS

The graph above shows a sustained increase in the rate of falls in 2017/18 with the rate increasing above the target of 5 per 1000 bed days in October 2017 and continuing to the year end.

This is disappointing, but we know that harm predominantly occurs to frail older adults and this is a group that is increasing within our population. Wards that admit older, more frail individuals, often with multiple risk factors including a history of previous falls, faints, or dizziness, cognitive or sensory impairment, impaired gait, muscle strength and balance problems, and an acute illness are more likely to have higher than average falls rates.

A number of wards with a high fall rate, high acuity and level of frailty are working with the corporate nursing team to test quality improvement initiatives using service improvement methodology, Plan Do Study Act cycles (PDSA). These interventions and actions are aimed at risk reduction and include improving continence care, use of safety huddles and deployment of staff during times of heightened risk (staff change over and breaks). A trial of movement sensors was carried out in community hospitals. It was found that the use of the sensors did not lead to a reduction in falls and therefore the use of such aids needs to be patient specific rather than routine.

The reduction target has been met in respect of falls resulting in fracture with a 14% reduction, as shown in the next table.

Number of falls resulting in a fracture

<table>
<thead>
<tr>
<th>16/17</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>17/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>38</td>
<td></td>
</tr>
</tbody>
</table>

Data source: Datix
The falls strategy was launched in 2017/18. The strategy focuses on interventions and action across the 7 domains as shown in the diagram below:

**Aim:** To consistently achieve less than 5.0 rate per 1000 bed days
Through analysis of incident data it has been identified that continence issues are often contributory factors in a patient fall. This has led to an increased focus on continence with a pilot of a continence assessment, care plan and catheterisation pathway completed at the Friarage Hospital. The pilot ended in March 2018 and once evaluation has been completed this will be rolled out across the organisation.

Pressure ulcers

The Trust changed the reporting of pressure ulcers in April 2017. This meant that pressure ulcers were classed as Trust attributed if they occurred after the patient had been in our care for 72 hours or received 3 or more visits per week from the community nursing team. This has meant that comparison with 2016/17 data is not possible, therefore a quarter on quarter reduction of category 2 pressure ulcers in 2017/18 was set along with zero tolerance of category 3 and 4 pressure ulcers (the most serious). The quarter on quarter reduction was achieved in quarter 3 and a reduction in the most serious category 3 and 4 pressure ulcers can be seen.

<table>
<thead>
<tr>
<th>Category</th>
<th>16/17</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>17/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1</td>
<td>301</td>
<td>51</td>
<td>51</td>
<td>42</td>
<td>33</td>
<td>177</td>
</tr>
<tr>
<td>Category 2</td>
<td>1150</td>
<td>112</td>
<td>133</td>
<td>110</td>
<td>144</td>
<td>499</td>
</tr>
<tr>
<td>Category 3 (avoidable)</td>
<td>46</td>
<td>16</td>
<td>13</td>
<td>5</td>
<td>9</td>
<td>43</td>
</tr>
<tr>
<td>Category 4 (avoidable)</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

A revised intentional rounding chart has been implemented and is currently being evaluated. However it has been noted that the compliance with completion of the rounding chart can be inconsistent. Our aim is to improve compliance and achieve further reduction in pressure ulcers. There is continued focus on the use of this chart with monthly audit and actions at ward and centre level.
The Tissue Viability ‘strategy on a page’ was launched in 2017. This demonstrates the vision and direction for tissue viability, with effective domains against which to report progress in education and practice for clinical teams and for the tissue viability service itself.

**Aim:**
Zero tolerance to Trust acquired category 3 & 4 pressure ulcers. 20% year on year reduction of category 2 pressure ulcers

**Excellence in Patient Outcome and Experience**
Progress to date:

The governance of medication safety has changed this year with it being a key focus for the organisation. The Safer Medication Practice Group now directly reports into the Quality Assurance Committee so that there is a greater oversight of medicines management at a high level. This is now chaired by the Director of Nursing and has improved the learning from medication errors across the organisation.

Significant progress has been made over the last year on the audit of medicines security within the Pharmacy department which has reduced the risk, with most areas scoring as low risk. Further work is ongoing with regards to ward based medicines security, and the pharmacy team is currently working with the clinical matrons to implement an action plan.

In June 2017 the main Pharmacy department was inspected by its regulatory body the General Pharmaceutical Council (GPhC). This inspection covered all of the standards a registered pharmacy is expected to achieve which fall into 5 main principles:

- Governance;
- Staff;
- Premises;
- Services including Medicines Management;
- Equipment and Facilities.

The overall rating for the organisation was ‘Good’. This is the first time this style of inspection has occurred so there is no comparable rating. This provides assurance to the organisation that the Pharmacy department is compliant with GPhC standards.

The lack of a clinical pharmacy service at weekends and vacant posts has meant that the level 2 medicines reconciliation rate within 24 hours has not exceeded over 60% this year, with some months figures falling below 40%. A small weekend Clinical Pharmacy Service based front of house will be implemented following recruitment to vacancies as well as a restructure of the management team to ensure pharmacists are focused on delivering a clinical service.

A key focus across the organisation has been omitted doses, particularly for critical medicines. Audit data has shown a reduction in both omitted doses and omitted critical doses this year. January 2018 figures included the lowest overall percentage of critical omitted doses to date at 1.64%. The percentage of all omitted doses in the prior year was 4.54%.
Further work is ongoing to target specific areas that consistently have a high number of omitted doses, and a medicines management dashboard has now been launched across all wards to show the visibility of the pharmacy audit results to the ward staff.

<table>
<thead>
<tr>
<th>Centre Ward</th>
<th>March to May 2017</th>
<th>July 2017</th>
<th>August 2018</th>
<th>September 2018</th>
<th>October 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRUST</td>
<td>5.58%</td>
<td>4.14%</td>
<td>4.84%</td>
<td>2.71%</td>
<td>4.97%</td>
</tr>
<tr>
<td></td>
<td>3.26%</td>
<td>5.38%</td>
<td>3.80%</td>
<td>6.07%</td>
<td>4.11%</td>
</tr>
<tr>
<td>Community Care</td>
<td>7.22%</td>
<td>5.79%</td>
<td>6.27%</td>
<td>2.95%</td>
<td>5.27%</td>
</tr>
<tr>
<td></td>
<td>3.72%</td>
<td>6.81%</td>
<td>7.04%</td>
<td>7.12%</td>
<td>4.53%</td>
</tr>
<tr>
<td>Specialist &amp; Planned Care</td>
<td>5.22%</td>
<td>3.62%</td>
<td>3.85%</td>
<td>2.68%</td>
<td>4.56%</td>
</tr>
<tr>
<td></td>
<td>2.87%</td>
<td>4.24%</td>
<td>2.07%</td>
<td>5.77%</td>
<td>4.26%</td>
</tr>
<tr>
<td>Urgent &amp; Emergency Care</td>
<td>4.90%</td>
<td>3.97%</td>
<td>6.02%</td>
<td>2.03%</td>
<td>6.59%</td>
</tr>
<tr>
<td></td>
<td>4.35%</td>
<td>4.53%</td>
<td>2.53%</td>
<td>3.69%</td>
<td>0.52%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Centre Ward</th>
<th>November 2017</th>
<th>December 2017</th>
<th>January 2018</th>
<th>February 2018</th>
<th>March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRUST</td>
<td>4.22%</td>
<td>2.15%</td>
<td>4.65%</td>
<td>2.78%</td>
<td>4.54%</td>
</tr>
<tr>
<td></td>
<td>1.64%</td>
<td>5.49%</td>
<td>2.73%</td>
<td>5.35%</td>
<td>4.10%</td>
</tr>
<tr>
<td>Community Care</td>
<td>3.19%</td>
<td>1.36%</td>
<td>5.44%</td>
<td>3.12%</td>
<td>4.70%</td>
</tr>
<tr>
<td></td>
<td>3.42%</td>
<td>7.47%</td>
<td>3.08%</td>
<td>5.10%</td>
<td>2.76%</td>
</tr>
<tr>
<td>Specialist &amp; Planned Care</td>
<td>4.86%</td>
<td>2.53%</td>
<td>4.62%</td>
<td>2.62%</td>
<td>4.44%</td>
</tr>
<tr>
<td></td>
<td>1.17%</td>
<td>4.35%</td>
<td>2.57%</td>
<td>5.51%</td>
<td>4.37%</td>
</tr>
<tr>
<td>Specialist &amp; Planned Care</td>
<td>2.74%</td>
<td>0.85%</td>
<td>3.01%</td>
<td>3.10%</td>
<td>4.93%</td>
</tr>
<tr>
<td></td>
<td>3.50%</td>
<td>9.74%</td>
<td>3.46%</td>
<td>5.23%</td>
<td>5.59%</td>
</tr>
</tbody>
</table>
During 2017/18 the Trust had CQUIN targets that required sepsis screening in the Emergency Department (ED) and inpatient areas to reach 90% of eligible patients. This was already being achieved in the Emergency Department as they use an electronic patient record which makes this mandatory. As can be seen in the table that follows, it was not being achieved in the inpatient areas at the start of the year. The Trust invested in an additional module for the Vitalpac system (an electronic tool for recording physiological observations such as blood pressure and temperature), that identifies patients at risk of sepsis and ensures that the screen takes place.

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of patients that are screened for sepsis in the ED department that trigger for screening</td>
<td>93%</td>
<td>94%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>% of patients that are screened for sepsis in inpatient areas that trigger for screening</td>
<td>61%</td>
<td>69%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

The second part of the CQUIN scheme was for 90% of patients with a diagnosis of sepsis to received appropriate antibiotics within 1 hour. The table below demonstrates that there was an improved performance in Q2 and Q3. Operational pressures in Q4 are thought to have been a contributory factor in the reduced compliance. Intensive work to raise awareness is in place to ensure sustained compliance at all times of the year.

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of patients with sepsis that received antibiotics within 1 hour in the ED department.</td>
<td>72%</td>
<td>81%</td>
<td>84%</td>
<td>61%</td>
</tr>
<tr>
<td>% of patients with sepsis that received antibiotics within 1 hour in inpatient areas.</td>
<td>78%</td>
<td>97%</td>
<td>93%</td>
<td>76%</td>
</tr>
</tbody>
</table>
Since the implementation of the Vitalpac system in 2014 there has been 100% compliance with the taking of a full set of observations. This is instrumental in the early recognition of the deteriorating patient. In order to build on this work the Trust also monitors the percentage of observations that are taken on time. Observations should be taken at prescribed intervals depending on how poorly the patient is, this ensures that patients are observed frequently enough when poorly and not disturbed unnecessarily when they are not. It is expected that 95% of observations will be taken on time. The following table shows that there is still considerable variation across the organisation and this remains a priority moving into 2018/19.

<table>
<thead>
<tr>
<th></th>
<th>Average % taken on time</th>
<th>Min % taken on time</th>
<th>Max % taken on time</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>82</td>
<td>72</td>
<td>95</td>
</tr>
<tr>
<td>May</td>
<td>81</td>
<td>67</td>
<td>96</td>
</tr>
<tr>
<td>June</td>
<td>82</td>
<td>70</td>
<td>94</td>
</tr>
<tr>
<td>July</td>
<td>82</td>
<td>62</td>
<td>94</td>
</tr>
<tr>
<td>August</td>
<td>82</td>
<td>67</td>
<td>93</td>
</tr>
<tr>
<td>September</td>
<td>82</td>
<td>68</td>
<td>94</td>
</tr>
<tr>
<td>October</td>
<td>82</td>
<td>67</td>
<td>94</td>
</tr>
<tr>
<td>November</td>
<td>82</td>
<td>67</td>
<td>92</td>
</tr>
<tr>
<td>December</td>
<td>81</td>
<td>67</td>
<td>93</td>
</tr>
<tr>
<td>January</td>
<td>79</td>
<td>65</td>
<td>91</td>
</tr>
<tr>
<td>February</td>
<td>81</td>
<td>67</td>
<td>92</td>
</tr>
<tr>
<td>March</td>
<td>81</td>
<td>64</td>
<td>94</td>
</tr>
</tbody>
</table>

Data source: Vitalpac performance
A further measure is that 18-22% of observations are taken at night, ensuring that the patient is monitored adequately throughout a 24 hour period. The table below shows that there has been a small improvement in the number of wards that are compliant with this through the year but this also continues to be a focus for the coming year.

<table>
<thead>
<tr>
<th></th>
<th>% taken at night</th>
<th>Min % taken at night</th>
<th>Max % taken at night</th>
<th>Number of wards compliant with 18-22% at night</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>16</td>
<td>2.1</td>
<td>27</td>
<td>7</td>
</tr>
<tr>
<td>May</td>
<td>17</td>
<td>2.5</td>
<td>26</td>
<td>8</td>
</tr>
<tr>
<td>June</td>
<td>16</td>
<td>2.4</td>
<td>26</td>
<td>7</td>
</tr>
<tr>
<td>July</td>
<td>16</td>
<td>4.5</td>
<td>26</td>
<td>7</td>
</tr>
<tr>
<td>August</td>
<td>16</td>
<td>2.2</td>
<td>27</td>
<td>6</td>
</tr>
<tr>
<td>September</td>
<td>16</td>
<td>1.7</td>
<td>27</td>
<td>6</td>
</tr>
<tr>
<td>October</td>
<td>16</td>
<td>1.3</td>
<td>26</td>
<td>10</td>
</tr>
<tr>
<td>November</td>
<td>17</td>
<td>1.7</td>
<td>27</td>
<td>6</td>
</tr>
<tr>
<td>December</td>
<td>17</td>
<td>4</td>
<td>27</td>
<td>9</td>
</tr>
<tr>
<td>January</td>
<td>17</td>
<td>2.5</td>
<td>27</td>
<td>9</td>
</tr>
<tr>
<td>February</td>
<td>17</td>
<td>5.3</td>
<td>33</td>
<td>9</td>
</tr>
<tr>
<td>March</td>
<td>17</td>
<td>2.3</td>
<td>27</td>
<td>10</td>
</tr>
</tbody>
</table>

Data source: Vitalpac performance

Once the patient has been triggered as deteriorating there is an escalation process for staff to follow. The critical care outreach team conducted a review each year to understand how well this process is followed. The results below show that performance has stayed about the same as the previous year.

<table>
<thead>
<tr>
<th></th>
<th>2016/17</th>
<th>2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>No</td>
</tr>
<tr>
<td>Total number of patients that triggered</td>
<td>75</td>
<td>108</td>
</tr>
<tr>
<td>No action taken</td>
<td>35%</td>
<td>26</td>
</tr>
<tr>
<td>Action taken but not documented</td>
<td>15%</td>
<td>11</td>
</tr>
<tr>
<td>Action taken and documented</td>
<td>51%</td>
<td>38</td>
</tr>
</tbody>
</table>

Data source: Local audit
This could be further supported with an additional module in the Vitalpac system which would allow recording of the action taken in response to the patient triggering. This is currently monitored through monthly case note audits by the ward managers. The Trust also holds panel reviews for unexpected deaths and recognition of the deteriorating patient.

Forty eight acutely ill panel reviews have been conducted with ward based teams; these are identified through the following mechanisms:

- Cardiac arrests;
- Incidents related to recognition and response;
- Local morbidity and mortality meetings;
- Unplanned admission to critical care;
- Learning Disability Mortality Review (LeDeR) programme;
- Peri-arrest patients

Analysis of the contributory factors for the incident occurring is supported by the Yorkshire Contributory Factors Framework. Examples of emerging themes have been highlighted as:

- Normalisation of the ‘sick’ patient;
- Lack of recognition – single parameter triggers;
- Lack of recognition – altered mental state;
- Patients in incorrect location;
- Transfers of care;
- Lack of comprehensive handover;
- Non-compliance with escalation pathway;
- Potential to make earlier decisions – escalation plans;
- Reluctance to escalate to senior medics.

Learning from incidents is strongly supported by engagement from ward teams during the investigation process which is shared to a wider audience through various forums. Examples of initiatives that have been developed as a result of learning are an enhanced structured Hospital at Night (H@N) handover and the introduction of a ‘safe patient transfer bundle’.

In summary, there have been some significant improvements made during the year, particularly in relation to the identification and treatment of sepsis. There are however, still a number of opportunities to improve the care we provide to patients and as we move into 2018/19 we need to identify how we can better report and act on the data available to us.
The National Quality Board published Learning from Deaths guidance in March 2017 and a suggested dashboard for publication of information on avoidable deaths on a quarterly basis in 2017/18 by all NHS Trusts and Foundation Trusts. The guidance comes in response to the Care Quality Commission’s (CQC) report Learning, Candour and Accountability published in December 2016. The guidance required each Trust to publish an updated policy by the end of September 2017 on how it responds to, and learns from, deaths of patients who die under its management and care. There are three levels of scrutiny that a provider can apply to the care provided to someone who dies: (i) death certification (ii) case record review and (iii) investigation. The policy should set out how the Trust manages each of these steps.

The regional Mortality Group continues to support the development of case record review across the North East and North Cumbria including the need to work across the system particularly with the mental health providers. The Trust has published its Responding to Deaths policy and the dashboard for deaths has been presented to Board of Directors and published on the website quarterly from Quarter 2.

The Trust was one of four Trusts that contributed to the regional project that published results in September 2017. The Mortality Group was established in January 2012, chaired by Dr Diane Monkhouse, Consultant in Anaesthesia and Critical Care to coordinate mortality reporting on a Trust wide basis. The review of deaths began in October 2013 and has continued on a weekly basis. The reports are circulated to clinical directors, mortality leads and other interested parties.

The group has taken on the responsibilities as set out in the Learning from Deaths guidance. The Trust has been collaborating with the Academic Health Science Network (AHSN) regional pilot that is developing a standardised approach to mortality review. The on-line tool for capturing reviews has been used for both Trust level and specialty reviews since January 2017. So far 714 Trust level reviews and 373 specialty reviews covering seven specialties have been entered onto the system. Discussions have recently been held with Specialist and Planned Care Centre with a view to getting more of their 22 specialties to use the on-line tool in 2018/19.

Currently only about 40% of deaths receive a case record review. The review process will be strengthened by the introduction of medical examiners in 2018/19. This role will review the death including contact with the team that cared for the patient at the time of death, a review of case records and making contact with the family to see if they have any questions or concerns. If any issues are identified, this will trigger a more detailed review. The team have been recruited and started in April 2018. This will mean that all deaths in acute hospitals in the Trust will receive a review.

Improving the mortality review process

Our goals:

- Quarterly publication of findings from Quarter 2 onwards;
- More than 60% of deaths receive case record review by Quarter 4.
In 2017/18 there was a CQUIN scheme to support proactive discharge which involved mapping existing discharge pathways and identifying improvements to be made. The overall aim of the scheme was to increase the proportion of patients admitted via a non-elective route to their usual place of residence within 7 days of admission by 2.5%. This exercise was completed and a number of projects were identified. Through the implementation of these projects patients have been able to return home more quickly with a 2.5% (44.49% vs 47.08%) point increase in discharges in the identified patient group.

The Trust identified the Specialist Weight Management Team to implement personalised care and support planning. In this year they have trained the team in motivational interviewing which enables them to have a supportive conversation with patients to identify a care plan that is relevant to them and covers all of the conditions that they may be suffering from.

The Trust planned to implement Clinical Noting, which is an electronic system for capturing the clinical information about a patient, replacing the need for paper notes. This would have allowed a review of the discharge information and the process for ensuring that it is collated and sent to GPs in a timely way. It has been used in Paediatrics, however it was hoped that this would be rolled out more widely across the organisation. Due to some technical issues this has not been possible and the Trust is exploring options for a more comprehensive electronic patient record in the coming year.

Our goals:

- To achieve the Commissioning for Quality and Innovation (CQUIN) milestones for supporting proactive discharge;
- To achieve the CQUIN milestones for personalised care support planning and support in long term conditions;
- To reduce delayed transfers of care;
- To improve the quality and timeliness of discharge information.

Ensuring patients receive care in the Right Place, at the Right Time
Project | Details
--- | ---
**Referrals** | Work has been ongoing with wards and Social Care to identify patients who are not yet medically fit, but it is known they will likely require social care input. Notifications are sent to Social Care to allow for preliminary work and preparation in an attempt to reduce length of stay once the patient is medically fit.

**Discharge to Assess** | Discharge to assess pilot was ongoing in Tees between January and March 18.

**Trusted Assessor** | Trusted assessor model is embedded in the Hambleton Richmond and Whitby CCG area for commissioned beds (not private care home providers) which are managed by the organisation’s Single Point Of Referral (SPOR) team. In the South Tees CCG area the trusted assessor post is currently out to advertisement.

**Care Home Selection (CHS)** | Currently the organisation has a ‘Care Home Selection’ service based on site supporting with complex placements to care homes.

**Medipack** | Increased awareness of medipacks, expanding opportunity to community hospitals.

**Pneumatic Tube** | Implementation of pneumatic tube, re focused approach and awareness campaign raised through the intranet and communications portal throughout March 18.

**Pharmacy Availability** | Pharmacy availability to be reviewed in relation to closing times, including weekends. The information from the Medworxx system was utilised to allocate effective additional pharmacy resource over the recent Easter Bank Holiday and will similarly be used for forthcoming Bank Holidays and winter pressures planning.
The Trust implemented real time data collection of patient feedback in January 2017. A team of Patient Experience Facilitators visits every ward each month and using a structured questionnaire (based on the National Inpatient Survey) talks to patients about their experience in hospital. They capture the survey responses and the patient’s comments and this is used to feedback any immediate issues to senior staff on the ward. This is then followed by a report within 24 hours of the visit. By July 2017 all inpatient wards were on the programme and receiving monthly reports. A questionnaire that can be completed by relatives has been developed for critical care areas and the neonatal unit so that these areas are able to receive relevant feedback.

The questionnaire provides feedback across 10 domains as well as an overall score.

1. Consistency and Co-ordination
2. Doctors
3. Nurses
4. Cleanliness
5. Medication
6. Kindness and Compassion
7. Dignity
8. Involvement
9. Pain Control
10. Noise at Night

The feedback is provided at ward, clinical centre and Trust level to allow comparisons across wards and also trends over time.

Listening and Improving

1000 Voices Patient Experience Programme

Our goals:

• To complete full rollout of inpatient real time data collection and develop mechanisms to share and utilise at centre and organisational level;
• To further develop data collection and implement improvements for patients with dementia / frailty and their carers;
• Implement the birth reflection pathway in maternity services;
• Develop feedback mechanisms into outpatient departments;
• Further develop feedback mechanisms in care closer to home project.
Comments are individually themed using a set framework and this is presented graphically to allow the identification of trends and themes at ward, centre and Trust level.

The programme has provided the wards with information that was previously not available, and receiving comments verbatim in real time has really allowed staff to understand the impact of their actions. It also allows them to receive positive feedback immediately.

Alongside this, the Trust has developed a governor ‘drop in’ programme for the outpatients department. During the visit the governors will talk to staff and patients as well as making general observations. This is fed back to the department manager and followed up with a report.

The Patient Experience Team continues to work with the strategic lead and lead nurse for frailty / dementia to further develop the way in which we collate the experiences of these patients. This work will continue into 2018/19 as the strategy is rolled out across the organisation.

The team from the Real Time Patient Experience Programme has spoken with 4661 patients in 2017/18 and has seen an increase in the overall domain scores in this period.

The domains of consistency and co-ordination, noise at night and cleanliness have scored below nine across the year. The information from these surveys is now presented alongside data about pressure ulcer, falls and Health Care Acquired Infections (HCAIs) at senior meetings so that a more complete picture including patient observations is included. There are two main issues identified in the consistency and co-ordination domain: a) lack of understanding or confusion about their care b) patients not understanding what they are told by the doctors because too much medical jargon is used. A quality priority for 2018/19 has been established to address these concerns.

A second quality priority is the further development and implementation of the Patient Experience Strategy which will build on the work completed in this year and pick up the elements that have not been completed this year.

The graph shows the Domain Score over the year.

Source: Real Time patient experience database
The Quality Account Priorities are a sub-set of the Quality Improvement Objectives within the Trust’s annual plan. In order to select priorities for 2018/19 a full review of trends in incidents, complaints, the Patient Advice and Liaison Service (PALS), claims and patient feedback was conducted. In addition to this a review of national requirements, Care Quality Commission (CQC) concerns, Clinical Commissioning Group (CCG) concerns and contractual requirements identified further areas of concern. Staff were also asked about their priorities for Quality Improvement in the coming year. The Board of Directors has agreed the following as Quality Priorities for 2018/19 in the Quality Account.
Quality Priorities 2018-2019

Safety
- Improving medication safety
- Improving incident reporting (to drive safety culture)
- Reducing harm from HCAI with a focus on E-coli

Outcomes
- Strengthening mortality process
- Improving early review of emergency patients by a consultant across the week
- Ensuring safe and effective discharge

Patient Experience
- Develop and implement the patient experience strategy
- Improving the care of patients with mental health concerns and those in vulnerable groups through a holistic and collaborative approach
- Improving communication with our patients and particularly focusing on reducing the amount of conflicting information patients receive
WELCOME TO THE JAMES COOK UNIVERSITY HOSPITAL
Safety

Priority Improving medication safety

Executive lead: Gill Hunt  Operational Lead: Julie Swaddle

Why we chose this priority:
The organisation continued to make progress against this priority in 2017/18 but recognises that there are further improvements that can be made particularly around medicines reconciliation including improving the productivity and efficiency of staff as well as continuing the work to keep omitted doses to a minimum. It is therefore felt that this is an important priority to continue into 2018/19.

Goals:
- To increase the percentage of medicines reconciliation within 24 hours
- To continue to ensure the omitted doses of the Trust remain below 5% consistently including that of critical medicines

How will we do this?
Implement medication safety dashboards in all inpatient areas in Q1. Provide education and training to ensure staff are aware of metrics on a monthly basis. Ensure performance and learning is embedded in multi-professional ward safety huddles.

- Review the pharmacy workforce model to improve the productivity and efficiency of staffing levels to increase medicines reconciliation, a restructure of staff to allow more medicines management technicians has occurred and will go live in Q2. A weekend service will be implemented in the acute admission units in Q2

- Implement a pilot of automated medicines cabinets in the Emergency Department and Critical Care areas at the James Cook University Hospital, if successful to create a business case for further areas with high omitted doses

- Ambition to procure and implement an Electronic Prescribing System during 2018/19 (as part of an Electronic Patient Record) as a key enabler to improving medication safety

How will we know how we have done?
- Increase medicines reconciliation to 70% by Q4
- Maintain omitted doses of all medicines at less than 5%
- Maintain omitted doses of critical medicines below 3%

Who will this be reported to?
Safer Medication Practice Group
Quality Assurance Committee
Priority  Improving incident reporting to drive a safety culture

Why we chose this priority:
The Trust has identified a reduction in the number of incidents and near misses reported and has been flagged as a potential under reporter of incidents by the CQC. The reporting of incidents and the lessons learnt from this is a key element of driving a high performing safety culture.

Goals:
- To improve the safety culture within the organisation by encouraging staff to report incidents and near misses and improve feedback of lessons learnt

How will we do this?
- Education and awareness training
- Survey of staff to identify barriers to reporting
- Improve near miss reporting
- Review incident reporting form
- Review feedback process to reporters of incidents
- Streamline final approval process
- Streamline root cause analysis process for falls and pressure ulcers

How will we know how we have done?
- Quarter on quarter increase in incident reporting
- Increased feedback of lessons learnt at ward, centre and Trust level

Who will this be reported to?
Quality Assurance Committee
Safety

Priority Reducing harm from HealthCare Associated Infections (HCAIs) with a focus on gram negative bacteraemia

Executive lead: Gill Hunt  Operational Lead: Judith Connor

Why we chose this priority:
Consolidating our performance in achieving our HCAI reductions, the organisation is seeking to further improve its infection prevention and control working with the centres to support the national ambition of reducing all gram negative blood stream infection by 50% by 2021.

Goals:
- To reduce the incidence of E. coli blood stream infections
- To improve continence care within the acute hospital for frail / older people
- Reduce the number of urinary catheters inserted in the hospital setting
- Implement urinary catheter pathway across the hospital and community setting
- Be an active partner in the Tees wide Infection Prevention and Control Collaborative developing and implementing strategies to improve hydration in older people.

How will we know how we have done?
- Number of Trust assigned E. coli cases
- Number of urinary catheters inserted
- Number of patients with a urinary catheter who have a pathway in place

How will we do this?
- Review the contributory factors leading to an E-coli blood stream infection by individual case review to inform action planning across the health economy, from Q1.
- Work with local nursing homes to improve education and training in continence management and urinary catheter care.
- Develop and implement guidance for the treatment of urinary tract infection in frail / older people.

Who will this be reported to?
Infection Prevention Action Group
Quality Assurance Committee
Outcomes

Priority Strengthening the mortality review process

Executive lead: Simon Kendall  Operational Lead: Tony Roberts

Why we chose this priority:
Learning from Deaths is a national priority, with guidance provided by the National Quality Board in 2017 and a Trust Responding to Deaths policy published in September 2018 detailing the approach the Trust is taking.

Goals:
- To strengthen arrangements for Learning from Deaths in care in the Trust

How will we do this?
- Establish a Medical Examiner (ME) Service in Q1. This includes discussing all deaths with bereaved families and attending teams, and reviewing healthcare records.
- Review in more detail all deaths identified by medical examiners.
- Where appropriate ensure deaths are investigated thoroughly

How will we know how we have done?
- Medical examiner service implemented and lessons learned and actions taken identified
- Learning from Deaths dashboard published quarterly in public Board papers reporting death, number reviewed or investigated and proportion judged to be due to problems in care. Report themes identified and actions taken to address concerns.
- Audit of the medical examiner processes by Internal Audit team.

Who will this be reported to?
Mortality Surveillance Group
Quality Assurance Committee
Outcomes

Priority  Improving the early review of emergency patients by a consultant across the week

Executive lead: Sath Nag  Operational Lead: Jonathan Kelly

Why we chose this priority:
This remains a national priority and is consistent with organisational focus on the delivery of high quality front of house services. It is important that patients admitted as an emergency are seen by an appropriate consultant in order to receive the right plan of care in a timely manner.

Goals:
To increase the percentage of emergency patients that are seen by an appropriate consultant within 14 hours.

How will we do this?
- Participate in the six monthly national audits
- Develop specialty specific action plans

How will we know how we have done?
- Improved compliance in second audit of 2018/19

Who will this be reported to?
Quality Assurance Committee
Operational Management Board
Priority Ensuring safe and effective discharge

Executive lead: Gill Hunt  Operational Lead: Helen Day

Why we chose this priority:
South Tees has incurred a number of incident reports and feedback from stakeholders that indicate our discharge planning could be improved in terms of safety and patient experience.

Goals:
To ensure safe and effective discharge for our patients

How will we do this?
- By end of Q1 develop and pilot a discharge care plan (currently a checklist on discharge) on five inpatient wards where prevalence of incidents and complaints are higher. This will be rolled out across the organisation by the end of Q3 and evaluated in Q4.
- Ensure all incidents and complaints relating to discharge are reviewed and relevant actions put in place in a new ‘Discharge Working Group’ to commence May 2018.
- In Q1 develop and pilot a ‘criteria led discharge’ tool to enable a safe and efficient process in defined patient groups.

How will we know how we have done?
- Decreasing trend in incidents, complaints, PALS enquiries and GP alerts.
- Improved patient flow measured by increased numbers of patients discharged before 12 with no associated quality concerns.

Who will this be reported to?
Quality Assurance Committee
Operational Management Board
Patient Experience

Priority Develop and implement patient experience strategy

Executive lead: Siobhan McArdle  Operational Lead: Gill Hunt

Why we chose this priority:
This builds on the work completed in 2017/18 setting the strategic direction for patient experience across the organisation, ensuring patient experience is captured across the full patient pathway

How will we do this?
• Launch the Patient Experience Strategy in Q1
• Develop mechanisms for service improvement and organisational learning
• Ensure the patient voice is evident from ‘Ward to Board’

How will we know how we have done?
• Patient experience captured across the full patient pathway
• Strategic and operational groups in place and effective
• Centre governance meeting minutes

Who will this be reported to?
Quality Assurance Committee
Patient Experience

Priority  Improving the care of patients with mental health issues through a holistic and collaborate approach

Executive lead: Gill Hunt  Operational Lead: Helen Day

Why we chose this priority:
Approximately 30% of patients with long term physical health problems have mental health disorders compared with 9% of the general population. Approximately 46% of patients with mental health problems also have a physical health condition. The lifespan of people with severe mental illness (SMI) is shorter compared to the general population.

Mental and physical health needs have traditionally been treated as separate entities leading to fragmented and inconsistent care resulting in poor outcomes and patient experience.

How will we do this?
Develop and initiate a ‘Treat as One’ Trust strategy and progress the following as key priorities:

- Implement a targeted program that ensures all staff have a relevant depth of understanding of mental health dependent on their role.
- Develop and pilot a Mental Health Screening and Intervention Programme. This will be in defined and appropriate inpatient and outpatient groups.
- Develop and pilot a system to ensure collection and utilisation of patient experience data from those patients with mental health disorders.

How will we know how we have done?

- A robust targeted plan will be in place and by April 2018 e-learning Mental Health Awareness’ will be established as a mandatory component of clinical education for all clinical staff that interact with patients. A 40% compliance will be achieved by end of 2018/19 and 95% compliant by 2019/20.
- A minimum of 3 clinical directorates with defined groups of patients will perform mental health screening as part of their clinical assessment processes. In turn we will expect to see an increase in referral to community psychological therapy organisations.
- Completion of a successful pilot and evidence of service improvement initiatives in the pilot areas.

Who will this be reported to?
Quality Assurance Committee
Board of Directors
Patient Experience

Priority Improving communication with our patients particularly focusing on reducing the amount of conflicting information patients receive

Executive lead: David Chadwick  Operational Lead: Judith Connor

Why we chose this priority:
It has been recognised through the analysis of complaints and real time patient experience feedback that there are some occasions where patients do not understand some of the medical information that they have been given or feel that they do not understand their plan of care.

How will we do this?
- Triangulate existing sources of patient feedback to understand where further work is required and the areas of good practice
- Empower patients to seek clarification from medical staff
- Provide education and awareness for medical staff using patient feedback
- Review of communication during ward rounds
- Review of how board round decisions are communicated to patients
- Review of visiting hours
- Pilot ward manager / matron ward rounds

How will we know how we have done?
- Improvement in scores in the Co-ordination and Consistency domain in 1000 voices programme

Who will this be reported to?
Patient Experience Sub Group
Quality Assurance Committee
Statements of Assurance from the Board
# Statements of Assurance from the Board

## Review of services

During 2017/18, the Trust provided and/or sub-contracted 75 relevant health services.

We have reviewed all of the data available on the quality of care of in 75 of these relevant health services.

The income generated by the relevant health services reviewed in 2017/18 represents 100% of the total income generated from the provision of relevant health services by the Trust for 2017/18.

## Participation in Clinical Audit

The Trust has a well-structured Clinical Audit Programme which is regularly reviewed to ensure it reflects the needs of our acute and community services. We know that high quality clinical audit enhances patient care and safety, and provides assurance of continuous quality improvement.

During 2017/18, 39 national clinical audits and seven national confidential enquiries covered relevant health services that the Trust provides.

During 2017/18, we participated in 95% of national clinical audits and 100% of national confidential enquiries we were that we were eligible to participate in.

The national clinical audits and national confidential enquiries that we were eligible to participate in, and for which data collection was completed during 2017/18, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

<table>
<thead>
<tr>
<th>Title</th>
<th>Eligible</th>
<th>Participated</th>
<th>% cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Critical Care (Case mix programme - ICNARC CMP)</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>British Thoracic Society Adult Bronchiectasis Audit</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>British Thoracic Society National Bronchoscopy Audit 2017</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>CEM 2017-2018 Fractured Neck of Femur</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>CEM 2017-2018 Pain in Children</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>CEM 2018-2017- procedural sedation</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Elective Surgery (National PROMs Programme)</td>
<td>✓</td>
<td>✓</td>
<td>63%</td>
</tr>
<tr>
<td>Endocrine and Thyroid National Audit</td>
<td>✓</td>
<td>X</td>
<td>NA</td>
</tr>
<tr>
<td>National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>National Comparative Re-audit of Patient Blood Management in Adults undergoing scheduled surgery</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>National Comparative re-audit of red cell and platelet transfusion in adult haematology patients</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>National Comparative Audit of Transfusion Associated Circulatory Overload (TACO)</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>National Emergency Laparotomy Audit (NELA)</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Title</td>
<td>Eligible</td>
<td>Participated</td>
<td>% cases</td>
</tr>
<tr>
<td>---------------------------------------------------------------------</td>
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</tr>
<tr>
<td>National Joint Registry – JCUH</td>
<td>✓</td>
<td>✓</td>
<td>94%</td>
</tr>
<tr>
<td>National Joint Registry – FHN</td>
<td>✓</td>
<td>✓</td>
<td>97%</td>
</tr>
<tr>
<td>National Neurosurgical Audit Programme</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>National Ophthalmology Audit</td>
<td>✓</td>
<td>✓</td>
<td>42%</td>
</tr>
<tr>
<td>Perioperative Anaphylaxis in the UK - 6th National Audit Project of the Royal College of Anaesthetists</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Severe Trauma (Trauma Audit &amp; Research Network)</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>British Association of Urological Surgeons (Cystectomy)</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>British Association of Urological Surgeons (Nephrectomy)</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>British Association of Urological Surgeons (Prostatectomy)</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>National Bowel Cancer Audit (NBOCAP)</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>National Lung Cancer Audit (NLCA)</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Oesophago-gastric Cancer Audit</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>National Prostate Cancer Audit</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Acute Myocardial Infarction and other Acute Coronary Syndromes (MINAP)</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Adult cardiac surgery (ACS)</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Cardiac Arrhythmia (Heart Rhythm management Audit)</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Coronary Angioplasty (interventions) audit</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Intensive Care National Audit and Research (ICNARC) data - for Cardiothoracic ICU</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>National Heart Failure Audit</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>National Vascular Registry</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Assessment and Management of Psoriasis BAD National Audit</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>National Bariatric Surgery Registry</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme – pulmonary rehabilitation</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme – pulmonary rehabilitation</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Title</td>
<td>Eligible</td>
<td>Participated</td>
<td>% cases</td>
</tr>
<tr>
<td>---------------------------------------------------------------------</td>
<td>----------</td>
<td>--------------</td>
<td>---------</td>
</tr>
<tr>
<td>National Diabetes Footcare Audit (NDFA, part of NDA)</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>National Diabetes Inpatient audit</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Parkinson’s Audit: (incorporating Occupational Therapy)</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Renal Replacement therapy (renal registry)</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit programme (FFFAP), Inpatient falls</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>National audit of breast cancer in older people</td>
<td>✓</td>
<td>X</td>
<td>NA</td>
</tr>
<tr>
<td>National audit of Dementia Delirium spotlight audit</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>National Hip Fracture Database (FFFAP)</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit programme (SSNAP)</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>British Thoracic Society Paediatric Bronchiectasis Audit</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>National Diabetes Audit – Paediatric</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>National Neonatal Audit (NNAP)</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>National Pregnancy in Diabetes audit</td>
<td>✓</td>
<td>✓</td>
<td>90%</td>
</tr>
<tr>
<td>Paediatric Intensive Care (PICANet)</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Learning Disability Mortality Review Programme (LeDeR)</td>
<td>✓</td>
<td>✓</td>
<td>78%</td>
</tr>
<tr>
<td>The National Maternal, New-born and Infant Review Programme</td>
<td>✓</td>
<td>✓</td>
<td>98%</td>
</tr>
<tr>
<td>National Confidential Enquiry into Patient Outcome or Death (NCEPOD Acute Heart Failure)</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>NCEPOD Cancer in Children, Teens and Young Adults</td>
<td>✓</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>NCEPOD Chronic Neurodisability</td>
<td>✓</td>
<td>✓</td>
<td>66%</td>
</tr>
<tr>
<td>NCEPOD Perioperative Diabetes</td>
<td>✓</td>
<td>✓</td>
<td>Ongoing</td>
</tr>
<tr>
<td>NCEPOD Pulmonary Embolism</td>
<td>✓</td>
<td>✓</td>
<td>Ongoing</td>
</tr>
<tr>
<td>NCEPOD Young Peoples Mental Health</td>
<td>✓</td>
<td>✓</td>
<td>81%</td>
</tr>
</tbody>
</table>
The reports of 13 national clinical audits were reviewed by the provider in 2017/18 and we intend to take the following actions:

<table>
<thead>
<tr>
<th>Title of Audit</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Cardiac Surgery (ACS)</td>
<td>No actions required</td>
</tr>
<tr>
<td>Diabetes Foot Care Audit</td>
<td>Patients who are discharged from the secondary care foot service (podiatry or Multidisciplinary Team (MDT) clinic) to be given a ‘Foot Attack’ booklet with contact details and verbal information re self-presentation</td>
</tr>
<tr>
<td>Intensive Care National Audit and Research Centre (ICNARC) Cardiac Intensive Care unit</td>
<td>No actions required</td>
</tr>
<tr>
<td>Learning Disability Mortality Reviews (LeDeR)</td>
<td>Action plan in place to improve documentation around the following areas; death notification, initial review, level of learning disability, past medical history, normal residency, pen portrait, usual medication / at time of death, timeline for circumstances of death, escalation decisions, reasonable adjustments, evidence of mental capacity assessment, requirement for multi-agency review</td>
</tr>
<tr>
<td>National Bariatric Surgery Registry</td>
<td>The Trust has implemented standardised hospital care pathways for all patients with a resultant decrease in readmissions / hospital stay</td>
</tr>
<tr>
<td>2016 National Comparative Audit of Red Cell and Platelet Transfusion</td>
<td>An audit programme was implemented including a. Audit of consent b. Re-audit of red cell use c. Re-audit of platelet use The Trust has participated in the national 2017 audit and is waiting for publication of the results.</td>
</tr>
<tr>
<td>National Diabetes Audit</td>
<td>There were main areas highlighted as requiring improvement which were reducing medication/ insulin errors, reducing frequency of hypoglycaemia, reducing inappropriate use of Intravenous (IV) insulin, including after Diabetic Ketoacidosis (DKA), and improving foot risk assessment. Actions to address these points are education sessions to junior doctors and diabetes training day, increasing consultant and MDT foot clinics</td>
</tr>
<tr>
<td>National Hip Fracture Database (FFAP)</td>
<td>The Trust continued to participate in the “Hip QIP Scaling Up” programme run by the Health Foundation and Northumbria Healthcare NHS Foundation Trust to improve the care of hip fracture patients, part of which has been the employment of a full-time Nutritional Assistant to improve the nutrition of these frail and vulnerable patients. On the back of our Improved Nutritional Programme – it would appear that the rate of pressure sores in this patient group has reduced significantly. Our Physiotherapists trialled the use of Red Zimmer Frames for use by dementia patients and also launched communal exercise classes for the elderly hip fracture patients</td>
</tr>
</tbody>
</table>
### Title of Audit

<table>
<thead>
<tr>
<th>National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – acute non-invasive ventilation (NIV)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The audit showed there was a lack of clinical lead for NIV service – There is an identified lead in most areas that provide NIV outside of critical care, however there is no specific time allocated in the job plan for this. There is also an issue around coding NIV which is being addressed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NCEPOD – Treat as One</th>
</tr>
</thead>
<tbody>
<tr>
<td>A group has been set up to ensure that patients with potential or pre-existing mental health disorders have their holistic health needs appropriately treated and managed whilst under the care of the Trust by appropriately skilled staff. A five year strategy is being rolled out in A&amp;E and the Medical Assessment Unit (MAU).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Royal College of Emergency Medicine (RCEM) Consultant sign off audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>To increase awareness of the audit findings to medical and nursing staff and to use the daily ‘huddle’ when key messages are passed on to staff to ensure that standards are adhered to</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RCEM Moderate and severe asthma audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>To improve Peak Expiratory Flow Rate (PEFR) recordings, educate and reinforce at huddles, improve discharge planning and documentation. Discharge proforma to be generated</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Trauma Audit and Research Network (TARN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No actions required</td>
</tr>
</tbody>
</table>

### Local Clinical Audits

The reports of local clinical audits reviewed Trust in 2017/2018 are shown below, and we intend to take the following actions to improve the quality of healthcare provided.

<table>
<thead>
<tr>
<th>Title of Audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Anaesthetic Record Keeping</td>
</tr>
<tr>
<td>Present audit results to the department to increase awareness and improve quality, reinforce importance of adhering to the national guidelines, adopt a minimum set of cardiac anaesthetic specific data to generate an auditable standard for future record keeping</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hypothermic Babies on Transfer to Postnatal Ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remove risk of maternal and infant separation</td>
</tr>
<tr>
<td>Initiation and maintenance of breastfeeding</td>
</tr>
<tr>
<td>Decrease risk of early onset jaundice and hypoglycaemia</td>
</tr>
<tr>
<td>Prevention of delayed discharge</td>
</tr>
<tr>
<td>Improved bed availability within postnatal area</td>
</tr>
<tr>
<td>Decrease workload amongst postnatal staff and neonatal staff</td>
</tr>
<tr>
<td>Title of Audit</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Mckinley T34 Syringe Pump Audit</td>
</tr>
<tr>
<td>Percutaneous Tibial Nerve Stimulation (PTNS) Audit against National Institute for Health and Care Excellence (NICE) guidelines</td>
</tr>
<tr>
<td>Dialysis catheter insertion practice</td>
</tr>
<tr>
<td>Navigation Audit – A&amp;E</td>
</tr>
<tr>
<td>Neck of Femur Fracture presenting in James Cook A&amp;E</td>
</tr>
<tr>
<td>Compliance with NICE Guidelines of Treatment of Diabetic Retinopathy with Intravitreal Ranibizumab</td>
</tr>
<tr>
<td>Resuscitation Trolley/Equipment</td>
</tr>
<tr>
<td>Review of Care of the Dying Audit</td>
</tr>
<tr>
<td>Audit of Basal Cell Carcinoma Management</td>
</tr>
<tr>
<td>Record Keeping – Specialist Palliative Care Team</td>
</tr>
</tbody>
</table>
Clinical effectiveness

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

The Trust’s active engagement in research is reflected by the high number of research studies being undertaken. In 2016/17 the Trust recruited over 3000 patients to research for the first time since National Institute for Health Research (NIHR) records began, with a final total of 3640 patients enrolled in 205 different research studies. The Trust is ranked in the top 5% of NHS Trusts in the country for the number of actively recruiting studies and top 10% for number of recruited patients.

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2017/18 that were recruited during that period to participate in research approved by a Research Ethics Committee is 3000.

The Trust is routinely meeting the NIHR target deadlines (40 days from receiving a complete research application) for setting up new trials to help ensure that there are minimal avoidable delays to research activity and income. In order to continue improving the support available for clinical research delivery, the Trust has established a new Clinical Research Lead position and individual Research Nurse Team Leads as part of a restructure.

The Trust continues to successfully deliver major NIHR grant funded trials and this year was awarded further NIHR research grants to sponsor and deliver two major Trauma and Orthopaedic Trials, (PROHER 2 and PRESTO) with other grant applications partway through the application process.

The Trust has received accolades from the NIHR for achieving global, European and UK first patient recruits for several high profile commercial trials. Income from participation in research continues to rise despite the challenging financial climate. Total income generated from research in the financial year to date is £862,000.
Patient engagement

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

An appointment has been made to the Research and Development Patient and Public Involvement lead post; the lead is overseeing the appointment of Research Patient Ambassadors for the Trust, who will be asked for their views on the Trust’s research activity and the best way to communicate with and engage patients and the wider public in research. The lead is also overseeing the development of a video about research to be played in clinic waiting areas.

Goals agreed with commissioners - use of the Commissioning for Quality and Innovation (CQUIN) payment framework

A proportion of the Trust’s income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body we entered into a contract, agreement or arrangement with for the provision of relevant health services, through the CQUIN payment framework.

Further details of the agreed goals for 2017/18 and for the following 12 month period 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 email quality.assurance@stees.nhs.uk.

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

<table>
<thead>
<tr>
<th>Income conditional upon achievement of the CQUIN measures</th>
<th>Payment received by the Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016/17 £11,134,237</td>
<td>£8,680,911</td>
</tr>
<tr>
<td>*2017/18 £9,292,000</td>
<td>£8,430,000</td>
</tr>
</tbody>
</table>

*Please note that this figure is estimated
Care Quality Commission (CQC) registration

We are required to register with the CQC and our current registration status is ‘registered without conditions’.

The CQC has not taken enforcement action against the Trust during 2017/18.

CQC rating

The CQC inspected the Trust in June 2016 and published its findings in October 2016. The ratings matrix can be found below:

<table>
<thead>
<tr>
<th>Overall</th>
<th>Safe</th>
<th>Good •</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Effective</td>
<td>Good •</td>
</tr>
<tr>
<td></td>
<td>Caring</td>
<td>Good •</td>
</tr>
<tr>
<td></td>
<td>Responsive</td>
<td>Good •</td>
</tr>
<tr>
<td></td>
<td>Well-led</td>
<td>Good •</td>
</tr>
</tbody>
</table>

This inspection was a focused re-inspection and our rating improved from Requires Improvement to Good.

All services and domains were rated as Good, with Maternity and Gynaecology receiving a rating of Outstanding for the well led domain and Community Services receiving an Outstanding rating for the Caring domain. There were no requirement notices issued as a result of this report.

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

NHS number and General Medical Practice Code Validity

The Trust submitted records during 2017/18 to the secondary uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which:

Included the patient’s valid NHS number was:
- 99.8% for admitted patient care;
- 100.0% for outpatient care; and
- 99.4% for accident and emergency care.

Included the patient’s valid General Medical Practice Code was:
- 100% for admitted patient care;
- 100% for outpatient care; and
- 100% for accident and emergency care.

Information Governance (IG) Toolkit attainment levels

The Trust also assesses itself against Department of Health information governance and standards using the IG toolkit – an online system which members of the public can also view.

Using the toolkit, we can develop a strategy and annual work programme to raise our level of compliance year-on-year, and also improve our information risk management process.

The Trust has achieved the required minimum level two standard on all 45 of the 45 standards of the National Information Governance Toolkit.

The Trust’s Information Governance Assessment Report overall score for 2017/18 was 71% and was graded green.
Clinical coding

The Trust was not subject to a Payment by Results Clinical Coding Audit during 2017/18 by the Audit Commission.

Learning from Deaths

During 2017/18, 2,113 patients of the Trust died. This comprised the number of deaths which occurred in each quarter of the reporting period:

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>479</td>
<td>486</td>
<td>583</td>
<td>565</td>
</tr>
</tbody>
</table>

By 31 March 2018, 525 Case Record Reviews and 42 investigations had been carried out in relation to 2,113 deaths above.

In 42 cases, a death was subjected to both a Case Record Review and an investigation. The number of deaths in each quarter for which a Case Record Review or an investigation was carried out was:

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>193</td>
<td>117</td>
<td>114</td>
<td>101</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 (0.2%)</td>
<td>1 (0.2%)</td>
<td>0</td>
<td>1 (0.2%)</td>
</tr>
</tbody>
</table>

The reviews highlighted the following learning points and recommendations:

- **A failure to recognise the deterioration in the patient’s condition**
  This was identified as an individual failure and the individual has reflected on their practice. In a broader context safety huddles have been strengthened to ensure that this is picked up with additional training in caring for the acutely ill patient. The Trust reviews all cases of delays in escalating a deteriorating patient so that lessons learnt can be identified and shared across the organisation

- **Recognition that senior input is required when discussing treatment options with patients.**
  This has been recognised in the Quality Priority for this to ensure that patients receive consistent information to enable them to make informed decisions

- **Delays in accessing appropriate scans for the patient.**
  A process review has been undertaken to ensure that delays are minimised for patients particularly when a transfer to another hospital is required.

399 Case Record Reviews and no investigations were completed after 31/03/2017 which related to patient deaths which took place before the start of the reporting period.

One representing 0.2% of the deaths before the reporting period are judged to be more likely than not to have been due to the problems in the care provided to the patient. This number has been estimated using an adapted version of the Preventable Incident, Survival and Mortality Study (PRISM) methodology. Deaths are reviewed by a central team led by an intensive care consultant. Each review results in two grades, one for quality of care and one for preventability of the death.
In addition to the progress with our locally identified Quality Priorities and our performance against national performance targets, we also monitor measures from the NHS Outcomes Framework. The data reported below is the publicly available data from NHS Digital; we have included benchmarking data where this is available. The most recently available data from the NHS Digital has been used however, it should be noted that due to the nature of some of the measures and the data collection systems, the time period reported for some of the measures may be some time in the past.

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

Reporting against core indicators
Domain 1 - Preventing people from dying prematurely

Summary Hospital Level Mortality Indicator (SHMI)

Data source: NHS Digital

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

% of patient deaths with palliative care coded at either diagnosis or specialty level

Data source: NHS Digital

The percentage of patient deaths with specialist palliative care coding has continued to rise to 23.8% in the latest data release. This is in line with national trends.
The Trust is taking the following actions to improve the indicators and the quality of its services; in 2013 the Trust established a Mortality Surveillance Group to coordinate hospital mortality monitoring and improvement activity. This includes reviewing the range of statistics available to monitor hospital mortality, overseeing a weekly clinical review of hospital deaths so that common themes can be identified and lessons can be learnt to improve the quality of its services. The Specialist Palliative Care Team (SPCT) has reviewed its processes for identifying patients and recording its input into the care of individual patients. This has resulted in more patients being identified by the SPCT. This has required an expansion of the team but is an improvement in the service provided to patients.

The Trust has implemented quality improvements that might reasonably be expected to impact on mortality indicators. These include improving identification and management of deteriorating patients (moving from a paper-based system to an electronically recorded Early Warning Score and use of the Electronic Patient Record in the Emergency Departments and Acute Assessment Units), identifying and managing patients with sepsis, prevention of falls, further reductions in infections and medication errors as well as the implementation of innovations as recommended by Nationa Institute of Care and Excellence (NICE) guidance. The Trust also completed a project focussing on the care of patients with pneumonia (the largest group of deaths included in the SHMI in any acute hospital is patients with pneumonia). This work has made the diagnosis and treatment of these patients faster and may have impacted on mortality in this key group of patients.

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

No applicable indicators
Domain 3 - Helping people to recover from episodes of ill health or following injury

Patient Reported Outcome Measures (PROMs)

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

Data source: NHS Digital
The Trust considers that this data is as described for the following reasons: the specialist review and pre-assessment process ensures that patients are offered the procedure likely to deliver the most benefit and best outcome. In 2017/18 there were not enough returns to allow analysis for groin hernia, a procedure that relatively low numbers of patients undergo (34 eligible in 2017/18). The national requirement to collect PROMs for groin hernia and varicose vein patients ended in September 2017. Data will be completed for all patients already included in the process before this date.

The health gain scores for hip replacements and knee replacements are in line with the national average. No score is reported for varicose veins as the returns from patients have been too low.

We have taken the following action to improve these scores, and the quality of services: providing regular feedback of the scores to clinical teams and benchmarking performance across the NHS and other hospitals in the North East, through a regular report produced by the North East Quality Observatory System (NEQOS), to ensure the quality of services is maintained.

Re-admission within 28 days

The Trust considers that this data is as described for the following reasons: the percentage of re-admissions for patients aged over 16 remained at around 11% between 2013/13 and 2015/16, before falling in 2016/17. The reduced figure has been sustained in 2017/18.

The percentage of re-admission for children aged 0 to 15 years increased slightly year on year % between 2013/13 and 2015/16, before stabilising in 2016/17 and remaining similar in 2017/18. The Paediatric service has an open access day unit facility where children that have had a recent acute admission or a long term chronic condition can return if they deteriorate.

We intend to take the following actions to improve these percentages, and the quality of our services: there has been considerable work undertaken in individual pathways, for example alcohol dependency, pain management and chronic obstructive pulmonary disease (COPD). The Rapid Response service and the Integrated Community Care Team will support those patients at high risk of re-admission.
Domain 4 - Ensuring people have a positive experience of care

Responsiveness to the personal needs of patients (National Inpatient Service)

Data source: NHS Digital

We consider that this data is as described for the following reasons: the Trust clinical standards focus on delivering care in a sensitive and person-centred way.

The Trust intend to take the following actions to improve this data, and the quality of services: the Trust has fully rolled out its Real Time Patient Experience Programme in 2017/18 which uses questions from the National Inpatient Survey. This enables to staff to recognise and respond to patient queries and concerns in real time.
Staff who would recommend the Trust as a provider of care to their family and friends

We consider that this data is as described for the following reasons; the Trust scores have been consistent over the last five years.

The Trust intends to take the following actions to improve this percentage, and so the quality of its services; the Trust continues to work with staff to improve the quality of care provided to patients. In addition, the Trust promotes the achievements of staff in delivering high quality care through regular staff bulletins, staff briefings and offering opportunities for staff feedback.

Data source: NHS Digital
Domain 5 - Treating and caring for people in a safe environment and protecting them from avoidable harm

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

Data source: NHS Digital

We consider that this data is as described for the following reasons; the Trust monitors compliance on a monthly basis and has achieved the required standard.

We have taken the following actions to improve this percentage, and the quality of services; the completion of a VTE risk assessment is monitored monthly through audit to ensure that the actions required following assessment are completed, as well as the recording that the assessment has taken place.
Rate per 100,000 bed days of cases of clostridium difficile (C. difficile) infection reported within the Trust amongst patients aged 2 or over.

Data source: NHS Digital

We consider that this data is as described for the following reasons; the Trust is committed to driving down healthcare acquired infections, and achieved its lowest ever incidence clostridium difficile infections in 16/17. The Trust has taken the following actions to improve this rate, and the quality of services; the Trust has a comprehensive action plan for the prevention of Trust attributed clostridium difficile infections which is monitored through the Infection Prevention Action Group. In addition to this, all Trust attributed cases have a full root cause analysis and are reviewed at a panel chaired by the Consultant in Infectious Diseases.
Rate of patient safety incidents reported within the Trust and the number and percentage of such patient safety incidents that resulted in severe harm or death

Data source: NHS Digital

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

The Trust considers that this data is as described for the following reasons; the Trust has recognised that the rate of incidents and the number of incidents reported has fallen.

We are taking a number of actions to improve this number: this has been identified as a Quality Priority for 2018/19. The actions include providing education and awareness training, a review of the incident reporting form, and streamlining final approval of incidents and root cause analysis for falls and pressure ulcers.
Part 3
Other Information
This section of the Quality Account contains a review of our quality performance during 2017/18. It also includes comments on the development and content of the Quality Account provided by a range of external stakeholders.

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

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

The following section reviews the work of a range of quality work streams during 2017/18: these have been selected as key indicators by the Board that demonstrate the quality of care provided by this organisation.
Pressure ulcers

As reported on page 12 the Trust has continued to focus on the reduction of pressure ulcers in both acute and community settings throughout 2017/18. Along with the launch of the Tissue Viability Strategy, a number of other initiatives have been trialled or implemented throughout the year. The safety@stees collaborative has pressure ulcers and falls as a standing item and this is an opportunity to monitor performance and share good practice.

A poster has been distributed to all clinical areas to provide detail on how to grade and record pressure ulcers. In addition to this clinical areas are displaying the number of days free from pressure ulcers.

It had been identified that there was an increase in heel related pressure ulcers; this led to trials of a hybrid mattress with integral heel support and education on measures that can be taken to prevent these.

Falls

In addition to the work described on page 9, there has been successful collaborative working and targeted interventions in some of our community hospitals that have led to a sustained reduction in falls. This has included interventions such as improvements in way finding, continence and delirium care planning, medication reviews and interventions to prevent de-conditioning.

Through analysis of incident data it was identified that the toilets in some areas were too low and contributing to patients falling. These toilets have been raised by 10cm and a wheelchair / assisted toilet created.

The incident reporting form for falls is being strengthened to enable more detailed reporting and identification of trends and themes to inform further improvement initiatives.

In year there has been a particular focus on the recording of lying and standing blood pressure to identify those patients that are more at risk of falling.

The remit of the Falls Review Panel has been increased to include those patients that have had three or more falls to identify the learning from these cases.

Duty of candour

Central to the Trust’s strategy to improve patient safety is our commitment to improving communication between healthcare professionals and patients and/or carers when a patient is harmed as a result of a patient safety incident. This communication is known as ‘Being Open’. ‘Being Open’ involves apologising and explaining what happened. It ensures communication is open, honest and occurs as soon as possible following an incident. ‘Being Open’ about what happened and discussing incidents promptly, fully and compassionately can help patients cope better with the after-effects. Incidents can incur extra costs through litigation and further treatment; openness and honesty can help prevent such events becoming formal complaints and litigation claims. ‘Being Open’ is a process rather than a one off event. The Duty of Candour is the statutory and regulatory requirement of the ‘Being Open’ process and applies when a patient safety incident results in moderate harm, major (severe) harm or death.
Clinical effectiveness

Dying in hospital – mortality

Hospital mortality rates: how many people die in different hospitals as a proportion of the number of people who are admitted to the hospital, are not easy to compare across the NHS. Simply knowing how many people died at each hospital would be misleading as hospitals see different numbers of patients and provide different services to patients with different levels of risk. However, for an individual hospital or Trust it is important to monitor a number of measures of mortality as collectively they can provide alerts about the quality of care provided in the organisation.

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

Mortality statistics are reported to the Board of Directors on a quarterly basis and have been since 2008. As well as unadjusted mortality, the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) are standard nationally defined measures that are routinely monitored. Although similar in approach, these measures vary in their specifics and so produce different results.

Unadjusted Mortality Rate April 2005 – Feb 2018 including rolling 12 month average

[Graph showing mortality rate over time]

Source: CHKS/CAMIS
Unadjusted mortality measures the number of deaths as a percentage of patient inpatient and day case spells, excluding well babies (less than 28 days old). It is most useful for seeing the pattern of deaths through time. Looking at the trend from April 2005 to February 2018 it can be seen that a winter peak is experienced in most years, especially in 2013, 2015 and 2017. The peak in January 2015 in particular was severe but of short duration and reflects the amount of respiratory infections in the community. The peak between October 2017 and January 2018 again reflects the amount and severity of respiratory infections including influenza in the community, as primary causes of death and underlying other conditions such as sepsis, renal failure and other acute medical conditions.

SHMI with 95% Control Limits and with adjustment for over-dispersion for July 2016 – June 2017

The Summary Hospital-level Mortality Indicator is designed to allow comparison between Trusts across the NHS. It includes deaths in hospital as well as deaths within 30 days of discharge from hospital. The SHMI for the Trust has been As Expected (i.e. within the amount of variation that can be anticipated by chance) in all data releases to date and the SHMI is currently 105 (July 2016 to June 2017). This means that the number of deaths in hospital or within 30 days of discharge from hospital is slightly higher than the number expected using a statistical model.
SHMI and Unadjusted Mortality Rate for South Tees


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

An alternative risk adjusted measure which uses around 80% of in-hospital deaths is called the Hospital Standardised Mortality Ratio (HSMR). It uses a more complex risk model which includes adjustment for specialist palliative care (care provided by a specialist team to a small proportion of more complex patients receiving palliative care in the hospital).

HSMR and Palliative Care Coding for South Tees
HSMR for the Trust in the period October 2016 to September 2017 was 105 giving the Trust a rating of As Expected. HSMR adjusts for patients that are coded as receiving specialist palliative care. In the past, the relatively low rate of specialist palliative care coding (the Trust was in lowest fifth of Trusts nationally) adversely affected the HSMR. A review of coding practices to try to ensure that all patients who receive specialist palliative care are included and increased staffing levels within the Specialist Palliative Care Team saw a 15 point decrease in the Trust’s HSMR over the previous year and that improvement is continually monitored.

No mortality alerts have been issued over the year.

Re-admissions

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

Over the period illustrated, 30 day readmissions for the Trust have averaged 12.58% compared to the national average of 12.68%. For some patients this further admission is not linked to their recent hospital stay but for others, they have returned to hospital because of complications after their discharge. These complications may be related to their needs not being adequately established at pre-assessment, through acquiring an infection during their hospital stay or maybe down to their rehabilitation not progressing as planned. The graph demonstrates that the re-admission rate has stayed static over the period reported.

There has been considerable work undertaken in individual pathways, for example alcohol dependency, pain management and COPD. The Rapid Response Service and the Integrated Community Care team will support those patients at high risk of re-admission.
Nutrition and hydration – getting the balance right

It is nationally recognised that today, an unacceptable number of people are becoming malnourished when they are in hospital. They become malnourished because their appetite or food intake is reduced due to their illness, the impact of treatment or interventions that they are receiving, or they don’t get the right food that they can eat or the help they need to eat it.

Being malnourished increases the risk of infection and increases the length of time it will take them to recover.

We have a proactive and organised approach to combating malnutrition, overseen by the Nutrition Steering Committee, and its importance is recognised as a key priority for the organisation.

The Trust aims to:

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

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

Compliance with MUST assessments

Data source: Local audit

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

Nutrition training is now a regular item on the following training programmes:
- Preceptorship – three times a year
- Community Care Centre – monthly
- Frailty Champions – monthly

Nutrition Assistant and Nutrition Pathway on ward 34

Since April 2017 a Nutrition Pathway has been running on ward 34 for patients admitted with a fractured neck of femur. This was introduced as part of the Hip fracture Quality Improvement (HIP QIP) scaling up programme.

This involved:
- Appointing a nutrition assistant to the ward;
- The routine prescription of nutritional supplement to all fractured neck of femur patients;
- More emphasis on the provision of snacks and appropriate meals to this patient group.

Results have been positive:
- Successful implementation of a finger food menu;
- More positive mealtime experience e.g. regular afternoon tea.

Nutrition and Dysphagia training in care homes

Over the past year a significant focus has been on improvement in nutritional screening and management of ‘at risk’ patients in the care home setting: Development and delivery of the nutrition and dysphagia training strand of the Better Care Fund project commenced in April 2017. The main project aim is to reduce the number of acute hospital admissions by upskilling staff in nursing/care homes across South Tees to more effectively identify and manage residents’ nutrition and dysphagia related problems. To date 32 care homes have received nutrition training and 42 have received dysphagia training. The pilot project is due to end in September 2018 dependent on funding, with audit results so far showing positive results. These include, reduction in the number of inappropriate dietetic referrals, increased accuracy of must scoring (59% to 71% post training), increased adherence to local malnutrition pathways, reduction in the cost of inappropriate nutritional supplement prescribing, increased knowledge of safe feeding positions, suitable foods for textured diets, knowledge of correct amount of thickener in stage drinks (49% to 88% post training) and being able to identify the signs of swallowing difficulties.
Seven day services

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

These four standards mean that emergency patients:

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

The Trust is compliant with standards b to c, and is therefore focussing on increasing compliance with the initial consultant review within 14 hours. Following an audit in September 17 that showed 68% compliance with the standard the Trust has:

• Included this standard as one of the Quality Priorities for 2018/19;
• Engaged with Clinical Directors to develop specialty level actions;
• Extended Consultant cover in acute assessment units until 2200 hrs to improve care for patients admitted between 1700 and 2200 hrs;
• Appointed an Operational Lead to drive compliance in the acute assessment units.

Patient experience

The Trust has a number of sources that it can use to understand the patient experience in the organisation, and as discussed on page 15, we have implemented a Real Time Patient Experience Programme across all inpatient wards.

In addition to this, we analyse our complaints, Patient Advice and Liaison (PALs) enquiries and compliments to understand the experience of our patients.

<table>
<thead>
<tr>
<th></th>
<th>2016/17</th>
<th>2017/18</th>
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<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Q1</td>
</tr>
<tr>
<td>Number of Formal Complaints</td>
<td>346 *</td>
<td>115</td>
</tr>
<tr>
<td>Number of PALs</td>
<td>1888</td>
<td>472</td>
</tr>
<tr>
<td>Number of Compliments</td>
<td>423</td>
<td>95</td>
</tr>
</tbody>
</table>

*A revised figure for the number of complaints reported in 2016/17 has now been included. The complaint figure reported in 2016/17 was 256, 90 less than now quoted. Where a complaint had been re-opened during the year, the complaint was excluded from the total figure. However, this also excluded the initial complaint which should have been included in the total figure.

It can be seen that there has been an 11% increase in formal complaints and a 12% increase in PALs enquiries.
In quarter three (October 2017 to December 2017) the published rate for the Trust was 16.5 per 10,000 finished Consultant episodes against the Acute England rate of 37.6 per 10,000 finished consultant episodes.
Friends and Family Test (FFT)

We continue to deliver the Friends and Family Test in line with national guidance. Inpatients or maternity patients will be offered a card before discharge to complete. Patients that attend A&E, outpatients, as a day case and some community services will be sent a text message in the two days following the attendance.

<table>
<thead>
<tr>
<th>APRIL 17</th>
<th>MAY 17</th>
<th>JUNE 17</th>
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<tbody>
<tr>
<td><strong>Response Rate % likely to recommend</strong></td>
<td><strong>Response Rate % likely to recommend</strong></td>
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<td><strong>Trust</strong></td>
<td><strong>England</strong></td>
<td><strong>Trust</strong></td>
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<tr>
<td>Inpatient</td>
<td>13%</td>
<td>25%</td>
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<tr>
<td>A&amp;E</td>
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<tr>
<td>Antenatal</td>
<td>92%</td>
<td>97%</td>
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<tr>
<td>Birth</td>
<td>6%</td>
<td>24%</td>
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<tr>
<td>Postnatal ward</td>
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<tr>
<td>Postnatal</td>
<td>92%</td>
<td>93%</td>
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<tr>
<td>Community</td>
<td>98%</td>
<td>96%</td>
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<th>JULY 17</th>
<th>AUGUST 17</th>
<th>SEPTEMBER 17</th>
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<td>Community</td>
<td>94%</td>
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<th>JANUARY 18</th>
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<tr>
<td><strong>Response Rate % likely to recommend</strong></td>
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<td><strong>Trust</strong></td>
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<td>Postnatal</td>
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<td>Community</td>
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</table>

The Trust performs well against national data with the percentage of patients that are very likely or likely to recommend, with performance generally in line or higher than the national average.

Response rates are lower than the national average and the Trust has tried different methodologies to improve this. In addition to this programme the Trust’s real time programme and postal surveys also capture this information alongside the survey information.
We value all feedback received; negative or positive. The following goals were set in order to improve the experience and satisfaction of service users who provide feedback.

Our goals:

• Map current patient and carer engagement activities and identify gaps to inform the development of a patient and carer engagement strategy;
• Sustain and continue to improve the timeliness of responding to formal complaints, with 80% receiving a response within 25 working days;
• Improve the quality of first responses and the take up of local resolution meetings with the aim of reducing ‘re-opened’ complaints;
• Survey of those who have been involved in the complaint handling process to identify further opportunities for improvement;
• Publish information on complaints and actions taken on the Trust website site;
• Improving the quality of our responses through training in letter writing skills.

Progress to date:

Following a number of changes that were implemented in 2016/17 there has been a sustained improvement from around 70% of complaints responses being issued within the required timeframe at Quarter 4 2017 to 82% by Quarter 4 2018.

We use a web based Datix module to record and track complaints. This provides staff with a single system tracking complaints. It also allows all correspondence to be linked to the complaint record making it easier to advise complainants on current progress / status. The Trust has a standard that complaints will be responded to within 25 days and 40 days if the complaint is particularly complex. The time frame for response is determined by the complexity of the complaint or if a meeting has been arranged outside of the original deadline date.

The Trust offers an ‘Excellence in Patient Outcome and Experience’ initiative, which includes how queries and complaints are handled. An interactive training session has been developed by the corporate training team with the aim of improving complaint responses. This session has been designed to enable reflection on actions that are taken and involvement in achieving our overall goals and vision. The session is open to all staff and four sessions have been held in 2017/18 with further session planned for 2018.

The Independent Complaints Review Panel is a bi-monthly meeting chaired by a patient representative; the panel reviews a sample of complaint responses and ‘re-opened’ complaints to ensure the Trust is meeting the Patients Association Standards. Members have adapted these standards to produce a set of South Tees standards to help focus on what is required. The quality of complaints reviewed by the panel has continued to improve. The terms of reference for the complaints review panel and the complaints leads meetings have been revised and feedback from these meetings is helping in the development of thematic analysis and lessons learned bulletins which will be shared across the organisation in the coming months.

Further actions planned for the coming months include:

• Publish the updated Trust wide Complaints Handling Policy;
• Continue to review ‘re-opened’ complaints to determine a more streamlined approach and ensure we are listening to the views of complainants in respect of the quality of our responses;
• Work to maintain and improve the response rates for formal complaints;
• Attendance at a regional complaints manager’s forum to learn from and share experiences of complaints handling and best practice;
• Work with the communications team and the Complaint Review Panel to determine what information would be useful to display on the Trust’s website;
• Conduct a satisfaction survey for complainants.

Listening to and acting on complaints and concerns
National Patient Surveys

During 2017/8, the Trust has received the report from three national patient surveys, the findings of which is summarised below.

National Cancer Patient Experience Survey 2016

This is the sixth survey and is designed to monitor national progress on cancer care and to provide information to drive local quality improvements.

The Trust received the final report in July 2017. 819 patients responded giving a response rate of 71%, this is higher than the national average of 67%

The organisation scored higher than expected on two of the 59 questions:

• Patient found it easy to contact their Cancer Nurse Specialist;
• Patients can get understandable answers to important questions all or most of the time.

This reflects the impact of the new role of cancer care co-ordinators which support patients through their pathway. The organisation did not score lower than expected on any of the questions

The results from this survey show that the organisation has sustained the good performance achieved in the previous year’s survey, with increases in performance around privacy and dignity as well as the questions highlighted above.

The Trust has focused on the living with and beyond cancer agenda in line with the national agenda. We have been working to promote the Macmillan Cancer Information Centre and ensuring that patients are signposted to appropriate voluntary sector and third sector charities.

National Inpatient Survey

This is the fourteenth survey of adult inpatients. The survey was sent to 1,250 patients that had an overnight inpatient stay who were discharged in July 2016. 548 patients responded giving a response rate of 45% which is in line with the national average. The Trust received the final report in May 2017.

The Trust was better than most Trusts on one question:

• After you used the call bell, how long did it usually take before you got help?

The Trust was “not worse than most Trusts” on any questions.

National Emergency Department Survey

The survey was sent to 1,250 patients that attended the Emergency Department in September 2016. 254 patients responded giving a response rate of 28% which is the same as the national average. The Trust received the final report in October 2017.

The Trust was better than most Trusts on six of the 45 questions:

1. How long did you wait with the ambulance crew before your care was handed over to Emergency Department staff?
2. How long did you wait before being examined by a doctor or a nurse?
3. Were you told how long you would have to wait to be examined?
4. Overall, how long did your visit to the Emergency Department last?
5. If you needed attention, were you able to get a member of medical or nursing staff to help you?
6. Before you left the department did you get the results of your tests?

The Trust was not “worse than most Trusts” on any questions.
National Children and Young People’s Inpatient and Day Case Survey 2016

The survey was sent to 1,250 patients that had an overnight inpatient stay and were discharged in November or December 2016. 262 patients responded giving a response rate of 21% which is slightly below the national average of 26%.

The Trust was better than most Trusts on two questions:

1. Did staff involve you in decisions about your child’s care and treatment?
2. Before the operations or procedures did hospital staff explain to you what would be done?

The results of the above surveys are used in conjunction with the information from the internal postal surveys, Real Time Patient Experience Programme, complaints and PALs enquiries to inform service development.

National Staff Survey

Each year NHS staff are invited to take part in the NHS Staff Survey, the largest survey of staff opinion in the UK. It gathers views on staff experience at work around key areas, which include:

- Appraisal and Development;
- Health and Wellbeing;
- Staff Engagement and Involvement;
- Raising Concerns.

While results are primarily intended for NHS organisations to review and make improvements where necessary, the Care Quality Commission will use them to monitor ongoing compliance with essential standards of quality and safety and the survey also supports accountability to the Secretary of State for Health for the delivery of the NHS Constitution.

In 2017 the survey was carried out between 3 October 2017 and 1 December 2017. The survey was sent to a sample of 1236 staff with a response rate of 33% which is below the national average of 43%. Key findings are as follows.
National Staff Survey

Equality and Diversity

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score 2017</th>
<th>Change since 2016</th>
<th>Ranking, compared with combined acute and community Trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF20 % experiencing discrimination at work in last 12 months</td>
<td>9%</td>
<td>No change</td>
<td>Below (better than average)</td>
</tr>
<tr>
<td>KF21 % believing the organisation provides equal opportunities for career progression / promotion</td>
<td>86%</td>
<td>-1%</td>
<td>Average</td>
</tr>
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</table>

Errors and Incidents

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score 2017</th>
<th>Trust Score 2016</th>
<th>National 2017 average for combined acute and community Trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF 28 Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month</td>
<td>27%</td>
<td>25%</td>
<td>29%</td>
</tr>
<tr>
<td>KF 29 Percentage of staff reporting errors, near misses or incidents witnessed in the last month</td>
<td>80%</td>
<td>87%</td>
<td>91%</td>
</tr>
<tr>
<td>KF 30 Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>3.66</td>
<td>3.70</td>
<td>3.73</td>
</tr>
<tr>
<td>KF31 Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.57</td>
<td>3.69</td>
<td>3.67</td>
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</table>

Violence, Harassment and Bullying

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score 2017</th>
<th>Trust Score 2016</th>
<th>National 2017 average for combined acute and community Trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF 26 - Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>26%</td>
<td>22%</td>
<td>24%</td>
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</table>

Patient Experience Measures

<table>
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<tr>
<th>Key Finding</th>
<th>Trust Score 2017</th>
<th>Trust Score 2016</th>
<th>National 2017 average for combined acute and community Trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF 2 - Staff satisfaction with the quality of work and care they are able to deliver</td>
<td>4.01</td>
<td>3.92</td>
<td>3.90</td>
</tr>
<tr>
<td>KF3 - Percentage of staff agreeing that their role makes a difference to patients/service users</td>
<td>91%</td>
<td>91%</td>
<td>90%</td>
</tr>
<tr>
<td>KF 32 Effective use of patient / service user feedback</td>
<td>3.54</td>
<td>3.65</td>
<td>3.69</td>
</tr>
</tbody>
</table>
In addition to this the Trust is monitored on the following key findings:

**Overall Staff Engagement Indicator**

The Overall Staff Engagement Indicator for the Trust in 2017 is 3.73. This is a slight decrease on the 2016 score (3.76).

The engagement score has been calculated using the questions that make up Key Findings 1, 4 and 7. These Key Findings relate to the following aspects of staff engagement:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Change since 2016</th>
<th>Ranking, compared with combined acute and community Trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF 1 - Staff recommendation of the Trust as a place to work or receive treatment</td>
<td>No change</td>
<td>Below (worse than average)</td>
</tr>
<tr>
<td>KF 4 - Staff motivation at work</td>
<td>No change</td>
<td>Below (worse than average)</td>
</tr>
<tr>
<td>KF 7 - Staff ability to contribute towards improvements at work</td>
<td>Decrease (worse than 16)</td>
<td>Below (worse than average)</td>
</tr>
</tbody>
</table>

**Key areas of focus for 2018**

- Development of an Equality and Diversity Strategy for 2018/19;
- Non-executive Director has been appointed has an Equality and Diversity Lead for the Trust;
- Board to own a detailed Equality and Diversity Plan and delivery against targets;
- Identify clear support pathways for staff who have experienced any harassment, bullying, abuse or violence when undertaking their roles;
- Create an integrated strategy with occupational health to deliver proactive support for employees;
- Develop a training programme for line managers and employees; including spot the signs of bullying and resilience.
## Performance against key national priorities

<table>
<thead>
<tr>
<th></th>
<th>13/14</th>
<th>14/15</th>
<th>15/16</th>
<th>16/17</th>
<th>17/18</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Safety</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clostridium (c.) difficile – meeting the C.difficile objective</td>
<td>57</td>
<td>76</td>
<td>61</td>
<td>43</td>
<td>48</td>
</tr>
<tr>
<td><strong>All cancers: 62 day wait for first treatment from Urgent GP referral for suspected cancer</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent GP referral for suspected cancer</td>
<td>84.70%</td>
<td>85.30%</td>
<td>79.10%</td>
<td>81.10%</td>
<td>85.44%</td>
</tr>
<tr>
<td>NHS Cancer Screening Service Referral</td>
<td>94.80%</td>
<td>92.60%</td>
<td>89.80%</td>
<td>89.00%</td>
<td>94.55%</td>
</tr>
<tr>
<td><strong>18 weeks referral to treatment time (RTT)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incomplete pathways</td>
<td>95.20%</td>
<td>95.70%</td>
<td>93.20%</td>
<td>92.20%</td>
<td>91.45%</td>
</tr>
<tr>
<td><strong>Accident &amp; Emergency</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 hour maximum wait in A&amp;E from arrival to admission, transfer or discharge</td>
<td>96.70%</td>
<td>94.90%</td>
<td>95.80%</td>
<td>95.33%</td>
<td>95.68%</td>
</tr>
<tr>
<td><strong>Diagnostics waits:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% patients waiting 6 weeks or less for a diagnostic test</td>
<td>99.60%</td>
<td>98.70%</td>
<td>98.82%</td>
<td>99.15%</td>
<td>97.46%</td>
</tr>
</tbody>
</table>
Annex 1 - Statements from Clinical Commissioning Groups and Healthwatch

NHS South Tees Clinical Commissioning Group and NHS Hartlepool and Stockton Clinical Commissioning Group (received 9 May 2018)

South Tees Hospitals NHS Foundation Trust Quality Report

NHS South Tees Clinical Commissioning Group (STCCG) is pleased to provide a response to the Trusts Quality Account 2017/18 and would like to thank the Trust for inviting the commissioners to contribute to its development this year. The CCG looks forward to actively engaging with the Trust in future years. The response has been jointly agreed with NHS Hartlepool and Stockton on Tees CCG and is provided as follows:

As commissioners, we are committed to commissioning high quality services from the Trust and take seriously our responsibility to ensure that patients’ needs are met by the provision of safe, high quality services and that the views and expectations of patients and the public are listened to and acted upon.

In so far as we have been able to check the factual details, the CCGs view is that the information provided within the annual quality account is an accurate and fair reflection of the Trust’s performance for 2017/18.

It is recognised that the Trust has worked hard in reducing Clostridium difficile infections (CDI) during 2017/18. Therefore, the results are disappointing by showing a slight increase on the previous year. It is also noted the Trust has achieved a reduction of Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia with 1 case being assigned to the Trust during 2017/18. Alongside Methicillin Sensitive Staphylococcus Aureus (MSSA) this provides an overall reduction of 15% in Staphylococcus infections. Work to reduce infections with patients with invasive devices has improved the MRSA infection rate and needs to be continued.

Understandably both the CCGs and Trust remain concerned about the impact on patient outcomes and quality of care; therefore they will continue to work collaboratively and monitor progress against the planned improvements and the challenging targets for the year ahead. One such target is to meet the national priority of reducing infections such as E Coli bacteraemia by 50% by 2021. The Trust’s proactive work by joining the Tees wide Health and Social Care Infection Prevention and Control Collaborative will hopefully aid in meeting this target. The CCG acknowledge the introduction of a number of IPC initiatives that will aid this work, including basing IPC staff in the emergency department to assist with early identification of potential infections and subsequently supporting frontline staff in managing patients with infections effectively.

Medication safety has been recognised by the Trust as a key risk area, in particular medicines reconciliation and medicines omissions. The ongoing work by the Safer Medication group led by the Director of Nursing, is evidence of the positive work in progress by the Trust. Work within the pharmacy to improve medicine reconciliation requires further investment of time to achieve success and the CCG are supportive of this being a priority for 2018/19.

Encouragingly, the main Pharmacy department was inspected by its regulatory body the General Pharmaceutical Council (GPhC), achieving an overall rating of ‘Good’.

With regards to omitted medications, the CCG recognises the work undertaken to date which has supported improvements in reducing omissions, including critical medicines. It would be useful
to understand why some areas are consistently underperforming in medicines omission compared to others (higher rate in Community Care), although the CCG are pleased to note that the Trust have further work planned to target such areas.

Of concern is the overall reduction in reporting of incidents and near misses, something also flagged by the CQC. The CCG are hopeful that the forthcoming work in this area, will demonstrate an improvement over the next year.

The CCGs wish to acknowledge the continued work that the Trust has undertaken to improve the response to the deteriorating patient with SEPSIS screening in the emergency department and inpatient areas to reach the CQUIN target of 90% of eligible patients. Inpatient areas at the start of the year were not achieving this target, however, with the investment of the Vitalpac system, this has improved significantly. The CCG are pleased to see that both areas in the last 6 months have achieved 100%. Patient observations still show room for improvement and the CCG support the Trust’s acknowledgement of this need and note plans are in place to improve on this over 2018/19 with further investment in additional Vitalpac systems.

The CCG note the Trust’s positive response to the National Quality Boards recommendation for all NHS Trusts to publish a dashboard for information on avoidable deaths on a quarterly basis, which the Trust has achieved. In addition, the CCGs recognise the ambitious aim of the Trust to review all deaths in the acute setting this forthcoming year, by recruitment a team of medical examiners. This is indeed ambitious with 40% of deaths currently receiving a review. This ensures the Trust meets the CQC guidance of report Learning, Candour and Accountability published in December 2016 and demonstrates a clear commitment to learning from deaths.

The CCG is encouraged by the 1,000 voices data collection of patient feedback in that it gives the staff real time feedback and changes can be made if required immediately with the patient satisfaction that their voice is heard and acted on.

The CCG support the Trust’s plan to make these issues a quality priority for 2018/19. There are a number of challenges still facing the Trust. Firstly, the concerning rise in complaints (11%) and PALs (12%) received throughout 17/18. Secondly, staff feedback remains at a similar level to last year, whether staff would recommend the Trust, their response to making improvements or their overall motivation. The responses remain below the national average. Emergency readmission rates were successfully reduced during the 2016/17 period and this reduction was sustained during 2017/18 for the over 16 year old population. However, the CCGs would like to highlight the increasing rate of readmission rates for the 0-15 year population and question what measures the Trust have considered to tackle this?

The Trust has continued to focus on the reduction of pressure ulcers in both acute and community settings throughout 2017/18. Along with the launch of the tissue viability strategy, a number of other initiatives have been trialled or implemented throughout the year. The safety@stees collaborative has pressure ulcers and falls as a standing item and this is an opportunity to monitor performance and share good practice. However, the figures for both falls and pressure ulcers within the Trust, still indicate there is continued work to be done in gaining a sustained reduction/improvement in these areas. The CCG is keen to see the outcome of the initiatives to reduce the number of heel pressure ulcers.

During 2017/18, working in partnership with neighbouring CCGs, the collaborative focus on detailed analysis of specific issues has continued; involving CCG and Trust staff during monthly performance clinical meetings and the refresh of the Clinical Quality Review Group. In addition the CCGs have been asked to join Trust internal assurance committees and commissioner assurance visits to provide insight and assurances of the quality of care being delivered to patients.

Commissioners support the identified quality priorities for 2018/19 and acknowledge that these will underpin continued progress by the Trust in meeting their quality improvement goals. The CCGs look forward to continuing to work in partnership with the Trust to assure the quality of services commissioned on behalf of their population in 2018/19.
NHS Hambleton, Richmondshire and Whitby CCG (received 25 May 2018)

South Tees Hospitals NHS Foundation Trust Quality Report

Thank you for sharing the draft of South Tees Hospital Foundation Trust Quality Account for 2017/18. NHS Hambleton, Richmondshire & Whitby Clinical Commissioning Group (HWCCG) is pleased to receive information about the Trust’s achievements and quality priorities and welcomes the opportunity to provide feedback.

This Quality Account has been reviewed in accordance with the Department of Health and Social Care (Quality Accounts) Amendment Regulations 2017.

We are committed to ensuring the provision of high quality services for our population and take seriously our responsibility to commission services that not only meet quality and safety standards, but also listen and respond to patient feedback to help inform service developments.

Overall HRWCCG considers the Quality Account of 2017/18 to be a fair reflection of the Trust’s performance and acknowledges the progress made to improve patient safety, outcomes and experience.

The key successes and challenges of the 2017/18 quality priorities are clearly reflected in the Quality Account. The CCG particularly notes:

- The reduction in health care associated infection (HCAI) rates, especially the C.diff rates which has delivered under the annual target threshold figure now for the second consecutive year. The CCG is pleased to see actions implemented being reflected in the figures and congratulates the Trust for maintaining improvement through 2017/18. As the focus shifts towards E.coli and GNBSI in 2018/19 we are looking forward to working with the Trust on more focused activity at the interface of secondary, primary and tertiary care settings, to ensure learning is translated across the system.

- The disappointing failure to reduce the rate of falls in line with the Trusts own ambition for 2017/18, although acknowledge the reduction seen in falls with fracture by 14%. However, also note the efforts made towards targeted support to hot spot areas, use of PDSA cycles as an improvement methodology to determine solutions at ward level and exploration of indirect contributory factors such as the use of continence assessments and safety huddles to reduce the risk.

- The development of the falls prevention and tissue viability strategies ‘on a page’ which enables the vision around falls prevention and the reduction of pressure ulcers to be effectively shared with all staff.

- The work undertaken to strengthen the processes around learning from deaths and adoption of the responsibilities as set out in the Learning from Deaths guidance (and including the LeDeR process). Whilst the Trust’s target of 60% of deaths to undergo a review by Q4 2017/18 was not achieved, the Trust continues to contribute and learn from regional collaboration and the CCG is encouraged by the introduction of the medical examiner role which should see this measure improve in 2018/19.

- The strengthening and embedding of the 1000 voice patient experience programme, ensuring real time patient feedback data is fed back into the system and helping to drive improvements at source.
The work undertaken to improve quality of patient care through the 2017/18 CQUIN, particularly in relation to responding to the needs of the deteriorating patient and identification/timely treatment of sepsis. In addition, the collaborative work undertaken around supporting proactive discharge is encouraging in terms of implementation of the trusted assessor model, discharge to assess and other processes implemented that have helped to expedite timely discharge. However, as stated in our last quality account review, the CCG is keen to ensure quality of patient discharge is not compromised at the expense of ‘the need for speed’ and would have welcomed information on patients (and GP) experience of discharge triangulated from incidents and complaints data to illustrate this.

In relation to the quality priorities identified for 2018/19, the CCG agrees with and supports the improvement ambitions around medication safety, improving incident reporting and continued emphasis on ensuring safe and effective discharge, having particular interest in the activity planned/actioned at the Friarage Hospital. The CCG is also pleased to hear of the work planned to develop the patient experience strategy and improving communication with patients to reduce the amount of conflicting information that is received.

We look forward to working with the Trust in 2018/19 to ensure that despite the challenging financial times ahead there remains a coordinated, collaborative approach towards safeguarding the quality and safety of services provided to our patient population, whilst developing new ways of working to deliver improvements across pathways of care that have local impact.

I hope you find this review helpful. Please do not hesitate to contact me should you have any queries or require any further information.

Gill Collinson
Chief Nurse
Healthwatch Tees (received 21 May 2018)

South Tees Hospitals NHS Foundation Trust Quality Report

Page 5 - Reducing harm from Healthcare Associated Infections (HCAI): staphylococcus aureus bacteraemias are still being associated with the insertion of invasive devices, albeit at an apparently reducing rate. Do all clinical staff receive regular updating of essential Infection Prevention and Control (IPC) skills or does this only take place in those clinical areas following the diagnosis of cases of HCAI?

Healthwatch South Tees welcomes the appointment of a dedicated IPC nurse for community care homes and the basing of an IPC nurse in the Emergency Department and admission units. Are these IPC nurses in addition to existing IPC staff or are they redeployments of existing staff?

Page 25 – Reducing harm from gram negative bacteraemias: this will also require sufficient input from IPC nursing staff in a training capacity to ensure invasive procedures are carried out safely and that there is safe management of urinary catheterisation.

Page 8 – Reducing harm from pressure ulcers and falls: the Trust falls rate exceeded the 2017/18 goal, to what extent might this result have been affected by staff shortages?

Healthwatch South Tees is pleased to note the reduction in prescribing of two specific groups of antibiotics in its bid to reduce antibiotic resistance but disappointed that the Trust failed to achieve an overall reduction of 1% in antibiotic prescribing.

Page 14 – Improving the response to deteriorating patients: has the lack of pharmacists in post been a factor in the failure to achieve appropriate antibiotic cover within one hour in some patients with sepsis?

Page 34 - Healthwatch South Tees is pleased to note the level of the Trusts active involvement in clinical research and its links to clinical effectiveness, not least because this is likely to have a positive impact on quality of care.

Page 43 – Re-admission rates: there is a need to ensure that the Integrated Community Care Team is always directly informed of discharged patients with a high risk of emergency re-admission and that this important communication is not only channelled through the patients discharge letter to their GP.

Page 47 – Quality of Care: maintaining continence, avoiding pressure ulcers and falls associated with toileting are associated with frail elderly patients, an increasing population who are particularly prone to prolonged length of stay. Will the Trust be able to provide the necessary rehabilitation services required by this patient group following their admission?

Page 61 – NHS staff survey: why such a low response rate (33%) which is likely to introduce bias in interpreting the results? It is noted that overall staff engagement indicators are worse than average.

Page 64 – Performance against key national priorities: performance against the urgent GP referral target for suspected cancer is unacceptable.

There is nothing in the report on bed occupancy yet high occupancy rates (<85%) may impact adversely on quality of care. Does the Trust have any comments regarding occupancy rates in South Tees hospitals?

Kind regards

Natasha Judge
Healthwatch South Tees Development & Delivery Manager
Over the past 12 months, the North Yorkshire Scrutiny of Health Committee has continued to liaise with South Tees Hospitals NHS Foundation Trust to better understand some of the pressures that they face.

It is recognised that staff shortages, particularly in emergency medicine, nursing and anaesthesia can have a significant impact upon what services can be delivered from what site and for how long. The Trust contributed to an in-depth investigation into health and social care workforce pressures that were undertaken by the Scrutiny of Health Committee in the autumn of 2017. The information, data and analysis provided helped the committee to appreciate the issue across the whole system and the support of the trust was much appreciated.

It is also recognised that the rural nature of the county and the length of time that it can take to travel to and from appointments can have an impact upon how services are planned and delivered. The committee, however, remains committed to ensuring that people are not excluded from services based upon where they live. The presumption is that you should be able to access the same type and quality of care no matter where you live in North Yorkshire.

The current financial pressures within the health system in North Yorkshire are of great concern. Whilst there are doubts as to whether the funding formula for health is fair and concerns that it disadvantage rural areas, we need to work together to find a way to make the money that we have work the hardest and result in good outcomes across the health and social care system.

The Scrutiny of Health Committee remains committed to a system-wide view of services that helps to ensure that decisions on the planning and delivery of health care are not made in isolation and that the key role that a broad base of community services have to play is not overlooked. This will not be easy going forward as the health commissioners and providers in the county are pulled in three different directions as the new NHS integrated systems for planning and delivery in the West, South and North of the county are put in place.

County Councillor Jim Clark
North Yorkshire Scrutiny of Health Committee
INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF SOUTH TEES HOSPITALS NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of South Tees Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of South Tees Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following two national priority indicators (the indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period;
- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge.

We refer to these national priority indicators collectively as the 'Indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed requirements for quality reports for foundation trusts 2017/18 (the Guidance); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Requirements for external assurance for quality reports for foundation trusts 2017/18.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes and papers for the period April 2017 to May 2018;
- papers relating to quality reported to the board over the period April 2017 to May 2018;
- feedback from commissioners, dated 9 May 2018 and 25 May 2018;
- feedback from governors, dated 8 May 2018;
- feedback from local Healthwatch organisations, dated 21 May 2018;
- feedback from Overview and Scrutiny Committee, dated 15 May 2018;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2006;
• the 2017 national staff survey, dated 6 March 2018;

• Care Quality Commission Inspection, dated October 2018;

• the 2017/18 Head of Internal Audit’s annual opinion over the trust’s control environment, dated 29 May 2018; and

• any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the ‘documents’). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of South Tees Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust’s quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and South Tees Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’, issued by the International Auditing and Assurance Standards Board (‘ISAE 3000’). Our limited assurance procedures included:

• evaluating the design and implementation of the key processes and controls for managing and resourcing the indicator;

• making enquiries of management;

• testing key management controls;

• limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;

• comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and

• reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change
over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by South Tees Hospitals NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP
Chartered Accountants
Quayside House
110 Quayside
Newcastle upon Tyne
NE1 3DX

15 June 2018
Annex 2 - Statement of directors’ responsibilities in respect of the quality report

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

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2017 to May 2018
  - Papers relating to Quality reported to the Board over the period April 2017 to May 2018
  - Feedback from the NHS South Tees and Hartlepool and Stockton Clinical Commissioning Groups dated 9/05/2018
  - Feedback from the NHS Hambleton, Richmond and Whitby Clinical Commissioning Group dated 25/05/2018
  - Feedback from Healthwatch Tees dated 21/05/2018
  - Feedback from North Yorkshire Scrutiny of Health Committee dated 15/05/2018
  - Feedback from the Governors dated
  - The Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 8/5/2018
  - The 2017 national staff survey 06/03/2018
  - The 2016 national patient survey dated 31/05/2017
  - The Head of Internal Audit’s annual opinion over the Trust’s control environment dated 29 May 2018
  - CQC inspection report dated October 2016
  - 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 reviews to confirm that they are working effectively in practice;
  - the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
  - the Quality Report has been prepared in accordance with NHS Improvement’s annual reporting manual (which incorporates the Quality Accounts regulations) (published at www.monitor-hsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board

Signed: Siobhan McArdle
Date: 24 May 2018
Chief Executive & Accounting Officer

Signed: Alan Downey
Date: 24 May 2018
Chairman
Annex 3: How to provide feedback on the account

We welcome feedback on this report and suggestions for the content of future reports. If you wish to comment please go to the Quality Accounts page on the Trust website (www.southtees.nhs.uk).
Annex 4: Glossary of Terms

18 Week RTT
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).

Academic Health Science Network (AHSN)
There are 15 Academic Health Science Networks (AHSNs) across England established by NHS England in 2013 to spread innovation at pace and scale – improving health and generating economic growth.

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

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

Antibiotic Review Kit (ARK)
ARK is developing and testing a bundle of strategies – the ‘Antibiotic Review Kit’ – to help doctors, nurses, pharmacists and patients stop antibiotics in hospital when they are no longer needed.

Better Care Fund (BCF)
The national fund was set up to support moving resources into social care and community services and to support the avoidance of admissions to hospital.

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

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

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

Clinical Commissioning Group (CCG)
These are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. They are clinically led groups that include all of the practitioner groups in their geographical area with the aim of giving GPs and other clinicians the power to influence commissioning decisions for their patients. These organisations are overseen by NHS England.
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 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.

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

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

Diabetic Ketoacidosis (DKA)
This is a potentially fatal condition where a severe lack of insulin means the body cannot use glucose for energy, and the body starts to break down other body tissue as an alternative energy source. Ketones are the by-product of this process. Ketones are poisonous chemicals which build up and, if left unchecked, will cause the body to become acidic – hence the name ‘acidosis’.

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

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

Emergency
An urgent unplanned episode of care.

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

Finished Consultant Episode
An NHS term for a consultant episode which has ended due to discharge, transfer or death. A consultant episode is the time a patient spends in the continuous care of one consultant using hospital site or care home bed(s) of one health care provider or, in the case of shared care, in the care of two or more consultants.
Foundation Trust
A type of NHS Trust in England that has been created to devolve decision-making from central government control to local organisations and communities so they are more responsive to the needs and wishes of their local people. NHS Foundation Trust’s provide and develop healthcare according to core NHS principles – free care, based on need and not on ability to pay. NHS Foundation Trusts have members drawn from patients, the public and staff, and are governed by a Board of Governors comprising people elected from and by the membership base.

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

Health Act
An Act of Parliament is a law, enforced in all areas of the UK where it is applicable. The Health Act 2009 received Royal Assent on 12 November 2009.

Healthcare
Healthcare includes all forms of healthcare provided for individuals, whether relating to physical or mental health, and includes procedures that are similar to forms of medical or surgical care but are not provided in connection with a medical condition, for example cosmetic surgery.

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

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

High Quality Care for All
High Quality Care for All, published in June 2008, was the final report of the NHS Next Stage Review, a year-long process led by Lord Darzi, a respected and renowned surgeon, and around 2000 frontline staff, which involved 60,000 NHS staff, patients, stakeholders and members of the public.

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

Inpatient
Patient requiring at least one overnight stay in hospital.

Malnutrition Universal Screening Tool (MUST)
‘MUST’ is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition (undernutrition), 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.

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 Confidential Enquiry into Patient Outcome and Death (NCEPOD)

National Confidential Enquiry into Patient Outcome and Death. Visit: http://www.ncepod.org.uk/

National Institute for Health Research (NIHR)

The NIHR (National Institute for Health Research) funds health and care research and translates discoveries into practical products, treatments, devices and procedures, involving patients and the public in all work. NIHR ensures the NHS is able to support the research of other funders to encourage broader investment in, and economic growth from, health research. NIHR works 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 Care Excellence (NICE)

The National Institute for Health and Care 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

National Patient Safety Agency

The National Patient Safety Agency is an arm’s-length body of the Department of Health, responsible for promoting patient safety wherever the NHS provides care. Visit: www.npsa.nhs.uk

National patient surveys

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

NHS Improvement (NHSI)

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

Overview and Scrutiny Committees

Since January 2003, every local authority with responsibility 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 ongoing operation and planning of services. They bring democratic accountability into healthcare decisions and make the NHS more publicly accountable and responsive to local communities.

Patient

Those in receipt of health care.

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.

Peripheral Cannula

A peripheral cannula is the catheter placed inside a vein in the arm or hand for intravenous (IV) access to the circulatory system. The purpose of the cannula is to add fluids or medication to the bloodstream, or to remove blood for diagnostic testing.
Plan Do Study Act (PDSA)

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

Private Finance Initiative (PFI) Partnership

The PFI is a way of creating Public-Private Partnerships (PPPs) by funding public infrastructure projects with private capital.

Patient-Led Assessments of the Care Environment (PLACE)

PLACE assessments provide motivation for improvement by providing a clear message, directly from patients, about how the environment or services might be enhanced.

Providers

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

Registration

From April 2009, every NHS Trust that provides healthcare directly to patients must be registered with the Care Quality Commission (CQC). In 2009/10, the CQC is registering Trusts on the basis of their performance in infection control.

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.

Secondary Uses Service (SUS)

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

Service user

An individual who uses a health care service, including those who are not in need of treatment, such as blood donors, carers or those using screening services.
Summary Hospital-level Mortality Index (SHMI)

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

South Tees Hospitals NHS Foundation Trust

Includes the Friarage Hospital (FHN) and James Cook University Hospital (JCUH) and from April 2011, community services in Hambleton, Richmondshire, Middlesbrough, Redcar and Cleveland.

Specialist

Someone devoted to the care of a particular part of the body, or a particular aspect of diagnosis, treatment or care.

Ultrasound

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

Urinary Catheter

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