Our mission is to deliver world-class outcomes, dependable safety and an outstanding experience for patients, their families and carers.
South Tees Hospitals NHS Foundation Trust

Annual report and Accounts

1 April 2011 to 31 March 2012

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) of the National Health Service Act
“Without the TAVI, Eric could have suffered life-threatening heart failure but just look at him now”
- Margaret Leeper, Eric’s wife
About the trust

South Tees Hospitals NHS Foundation Trust is the largest hospital trust in the Tees Valley, serving the people of Middlesbrough, Redcar and Cleveland, Hambleton and Richmondshire and beyond.

We pride ourselves on patients receiving high quality, safe and efficient healthcare thanks to the hard work and dedication of our staff.

The trust runs The James Cook University Hospital in Middlesbrough and the Friarage Hospital in Northallerton providing district general hospital services for the local population.

We also provide community services from Hambleton, Richmondshire, Middlesbrough and Redcar and Cleveland including services at:

- Redcar Primary Care Hospital
- Guisborough Primary Care Hospital
- Carter Bequest Hospital in Middlesbrough
- East Cleveland Primary Care Hospital in Brotton
- The Rutson Rehabilitation Unit in Northallerton
- Friary Community Hospital in Richmond
- Lambert Memorial Community Hospital in Thirsk

Our workforce of almost 9,000 also provides a range of specialist regional services to 1.5 million people in the Tees Valley and parts of Durham, North Yorkshire and Cumbria, with a particular expertise in heart disease, trauma, neurosciences, renal services, cancer services and spinal injuries, and are also the major trauma centre for the Southern part of the Northern region.

We are continuing to build on our links with the Universities of Teesside, Durham and Newcastle and have a purpose-built academic centre with medical students and nursing and midwifery students doing their clinical placements on site.

The trust is also the host site for the County Durham and Tees Valley Local Clinical Research Network and a host site for the North East Research Design Service, reaffirming our commitment to training, life-long learning and research.

At the Friarage Hospital we also host the Ministry of Defence Hospital Unit.

“Very helpful staff, friendly and willing to help. I enjoyed my time there”
The specialist birthmark clinic celebrated treating its 250th patient with a leading-edge procedure to treat vascular birthmarks using bleomycin - an injectable drug.
Chairman and chief executive’s statement

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There is no doubt 2011/2012 has been a challenging year for us and for the NHS as a whole, which is going through considerable reform and facing an unprecedented financial challenge of saving £20 billion by 2015.

As a trust our priority, as always, is to deliver outstanding services for patients and while we have to address the savings required, our focus remains on maintaining high quality, safe care.

We do not underestimate the pressure placed on staff and thank them for their efforts, skill and fortitude which will be needed again over the coming years. As teams and individuals we really have a lot to be proud of and this is an opportunity to reflect on our successes and the positive aspects of our work.

The organisation is right at the forefront of the patient safety agenda, earning national recognition (and awards) for our work around a number of initiatives such as work on readmissions, patient safety express and the patient safety thermometer, Time to Care and how we work with and support teams that are encountering problems.

In July, the trust’s patient safety strategy was launched, which sets out our aspirations and vision for harm free care for patients. Sustained efforts - in both acute and community settings - to further reduce infection rates saw a 67% drop in MRSA bacteraemia (with two cases recorded) and a 46% decrease in Clostridium difficile, where we reported 67 cases in-year.

Clearly we can never stand still in this important area and our vision of ‘no avoidable deaths and no avoidable harm’ means we must always be looking for ways to improve what we do and how we do it.

Once again, South Tees was named a ‘Top 40’ Hospital by CHKS and was also rated highly for patient experience, which was reflected by patients’ and relatives complimentary views to the Care Quality Commission who carried out an unannounced inspection at a time when the organisation was very busy.

In April, we welcomed our colleagues from Middlesbrough, Redcar and Cleveland and Hambleton and Richmondshire community services into the trust and are already exploring the opportunities this partnership brings to make continuous clinical improvements and bring healthcare closer to home.

The new Endeavour Unit on the James Cook site, which was part of our £35 million plans to develop cancer services, is now complete and we continue to invest in major new schemes we know will make a difference to patient care - notably a generic 16-bed high dependency unit and a fourth catheter lab.

We have achieved major trauma centre status for the southern part of the northern region, which ensures that in partnership with the local trauma network, patients with serious and life-threatening injuries are treated quickly in a specialist hospital with expert staff available round the clock, and were one of only a small number of hospitals to be approached by the Department of Health to provide care for civilian patients from Libya.

Partnership working and meaningful engagement is essential to our work in delivering and designing safe healthcare services around the needs of patients and carers.

Working with Hambleton, Richmondshire and Whitby Clinical Commissioning Group, our clinicians began a three-month period of wider engagement with the public in the spring around children’s and maternity services at the Friarage Hospital, following concerns about their future sustainability and safety issues.

“It was all very straight forward and the care I received was outstanding”
This will continue in 2012/2013 alongside developing a long-term service model for the hospital that meets the needs of the local population.

We also thank our military and Carillion colleague and volunteers and fundraisers for their continued support throughout the year.

As the whole country is in a very difficult financial time, the scale of the financial challenge we continue to face cannot be underestimated but we did deliver a £2.9 million trading surplus in-year.

In 2012/2013, we must continue to focus on delivering all our financial plans and productivity and efficiency (P & E) schemes if we want to protect local services, jobs and the future of the organisation and this needs staff involvement in every area. We also recognise that improving the working lives of our workforce is essential if real improvements in patient care are to be achieved.

As you read this report and the quality account, I hope our commitment to quality of care led by the Board of Directors and the Council of Governors, and our willingness to listen and learn, is well demonstrated.

Deborah Jenkins - chairman

Simon Pleydell – chief executive
Trust structure

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Board of Directors

Provides strategic direction to the trust to meet health and healthcare needs within the framework of Government policy. Has overall accountability for delivery of patient care, statutory function and NHS executive requirements.

Management Group

- Responsible for overall management of the trust
- Chaired by the chief executive
- Membership includes the chief of each clinical division, chairman of the senior medical staff committee and the directors of support directorates

Clinical Divisions

**ACADEMIC**

- Allied Health Professionals Education; Courses and Conferences Services; Academic Centre; Library Services; Nursing Education; Postgraduate Education; Research and Development; Academic Department of Anaesthesia and Critical Care; Undergraduate Education; Resuscitation Training; Country Durham & Tees Valley Comprehensive Local Research Network; North of England Cancer Research Network - South; Academic Emergency Medicine.

**ANAESTHESIA & THEATRES**

- Anaesthesia (adult and paediatric); Operating Theatres (day surgery and inpatient); Day of Surgery Admission Units; Acute and Chronic Pain Services; Sleep Medicine; Academic Anaesthesia (education and research).

**CARDIOTHORACIC SERVICES**

- Cardiology; Cardiothoracic Anaesthesia and Intensive Care; Cardiothoracic Surgery.

**COMMUNITY SERVICES**

- Cardiovascular Primary Prevention, Community Nursing, Community Matrons, Community Rehabilitation, Community Hospitals, Specialist Palliative Care in the Community, Continence, Dietetic and Nutrition, Falls, Fast Response Teams, Osteoporosis, Middlesbrough Medical Centre, Resolution Health Centre, Health Improvement, Health Visiting, Heart Function Clinic, Infection Prevention and Control, Intensive Home Support, Intermediate Care, Lymphodema, Minor Injuries, Podiatry, Pulmonary Rehabilitation, School Nursing, Specialist Musculoskeletal Service, Specialist Nursing, Specialist Skin Service, Stop Smoking Service, Specialist Weight Management Service, Stroke Rehabilitation.

**ACUTE MEDICINE**

- Accident and Emergency; Acute Medicine; Chest Medicine; Care of the Elderly; Critical Care; Gastroenterology; Clinical Infection; Diabetes/Endocrinology; Acute Medicine - Friarage.

**SPECIALITY MEDICINE**

- Dermatology; Haematology; Radiotherapy and Oncology; Nephrology; Rheumatology; Specialist Palliative Care.

**NEUROSCIENCES**

- Neurology; Neurophysiology; Neurosurgery; Neuroradiology; Disablility Service Centre; Rehabilitation Medicine; Disablility Services Centre.

**CLINICAL SUPPORT SERVICES**

- Cancer Family History; Clinical Psychology; Medical Illustration; Medical Physics; Nutrition and Dietetics; Occupational Therapy; Orthotics; Pharmacy; Physiotherapy; Speech and Language Therapy.

**PATHOLOGY**

- Cellular Pathology; Clinical Chemistry; Haematology and Blood Transfusion; Immunology; Microbiology (including Virology and Mycology).

**RADIOLOGY**

- Plain Film Imaging, CT, MRI, Ultrasound, Fluoroscopy and Interventional Radiology.

**SURGERY**

- Ear, Nose and Throat; General and Vascular Surgery; Ophthalmology; Oral and Maxillofacial Surgery; Orthodontics; Plastic Surgery; Urology.

**TRAUMA**

- Orthopaedics and Spinal Injuries

**WOMEN & CHILDREN**

- Community Paediatricians; Gynaecology; Neonatology; Obstetrics; Paediatrics.

The divisions are divided into specialities, each led by a consultant (clinical director) working in the field.
“It has made a massive amount of difference - he’s like any other normal little boy of his age,” Joanne Feather, mum of Thomas Meadows, who had a Montgomery hip screw fitted.
Highlights of the year

From starting the year giving a warm welcome to community services staff to finishing it with the completion of our £35 million cancer redevelopment, the trust has had a busy 12 months. Here is a snapshot of some of the highlights in 2011/2012.

**Time to win**

The Time to Care team (TtC) receive national acclaim - and a Lean Healthcare Academy Award - for their innovative work on the productive ward, which aims to release nurses’ time to care for patients.

The team won the ‘Productive Series’ award for their programme which is changing the culture of service improvement at ward level, enabling staff to lead and manage change in their own areas, resulting in improvements in the environment and the way teams communicate.

**Warm welcome to community services staff**

As part of the Government’s Transforming Community Services agenda, community services staff from Middlesbrough, Redcar and Cleveland and Hambleton and Richmondshire joined the trust in April.

**In memory of Shelly**

Daren Watson sets up The Michelle Parker Charity in memory of his partner, who died of a brain tumour to raise funds for the neurosurgery team who treated the Darlington mum.

**Cancer service redevelopment**

Cancer patients officially opened the new chemotherapy day unit at The James Cook University Hospital in June, which was transformed as part of the trust’s multi-million pound plans to develop cancer services, while the first outpatient clinics were run from the new Endeavour Unit - a stand-alone radiotherapy centre.
Surgeon celebrates 5,000th operation

Cardiothoracic surgeon Simon Kendall carried out his 5,000th cardiac operation in August and celebrated with his team by sharing a huge chocolate cake after the procedure.

Specialist weight management service expands to Stockton

A newly commissioned specialist weight management service was launched in Stockton in October by the community services team to help clients, who have already accessed all other weight management options without success, make sustainable behavioural changes and lose weight.

The new service complements the existing community service, which has been a great success in the Middlesbrough and Redcar and Cleveland area.

Family’s touching tribute in memory of Lady Crathorne

A touching tribute was paid to the Friarage Hospital in memory of Lady Crathorne - the Deputy Lieutenant of North Yorkshire who died in the hospital following a four-and-a-half year battle against cancer.

As a thank you to the staff who looked after her, the artist Linda Kitson, who is best known for her work as an official war artist during the Falklands conflict, kindly donated eight paintings, in collaboration with the Crathorne family.

Friends support for urology patients

Thanks to the tremendous on-going support of the Friends of the Friarage Hospital volunteers, £120,000 worth of the latest hi-tech equipment now benefits urology patients at the hospital.

The new kit includes flexible video cystoscopes, which are used in theatres to provide higher quality images and improve diagnostic procedures for patients, and a video flexible ureterorenoscope for diagnosing and treating certain types of kidney cancers and kidney stones.
A taste of patient safety
Patients gave staff ‘food for thought’ at the trust’s first patient experience and engagement event, which focussed on compassion in care and hospital food, including a taster session from a selection of hospital meals served.

Taking the leap
Stop smoking advisors held a number of events on ‘No Smoking Day’ to take home the message of the effects of smoking and to encourage people to quit. This year’s theme was ‘take the leap’.

A passport to improved communication and experience
Colourful balloons and passports were presented to wards and departments during learning disabilities awareness week at James Cook and the Friarage. The traffic light coded hospital ‘passports’ have been adopted by the trust to aim to improve the experience of patients who have learning disabilities when they are admitted to hospital.

Unique partnership to improve hospital support for older people
A unique partnership was launched with the WRVS, when volunteers presented £35,000 to part-fund a pilot scheme to help improve hospital support for older patients and the vulnerable.
210 patients were brought into hospital by helicopter.
There is significant evidence that integration is critical to delivering high quality, efficient services and, as a provider of acute and community healthcare, we must be at the forefront of delivering integrated services.

To reflect the importance of focusing on quality and particularly safety - even in difficult financial times - and the opportunities of integration, the trust’s mission is defined as:

To provide high quality, safe and integrated specialised, secondary and community healthcare services for patients, their families and carers

While we are already nationally recognised as one of the leading healthcare providers for the quality of our services, we do recognise the importance of continuous service improvement and development if we are to maintain and improve our status and reputation amongst the other leading providers.

Our vision is for our standards of patient safety, quality and continuous improvement to be recognised as those which others aspire to. We will also focus on how we work together, recognising that everyone employed by or involved with the organisation contributes to our success. However we cannot stand still and must always be looking for ways to improve what we do and how we do it.

The strategy to achieve this is in two parts – our clinical services strategy for the services we provide and the transformational themes which describe how we deliver them.

The basis of the clinical services strategy is to be the specialist services provider for the north of North Yorkshire and the south of the North east, and to provide integrated healthcare for our local communities of Hambleton, Richmondshire and Whitby, and Middlesbrough, Redcar and Cleveland.

Our specialist services provide a strong identity for the trust as having expertise in complex, tertiary care attracts patients from a much wider area than could be achieved with only our secondary services. They have helped establish our reputation as an outstanding provider and attracted highly skilled staff. Our secondary and community services provide a high volume of activity which enables us to achieve the critical mass in our clinical teams which is essential to support the specialised services.

The transformational themes describe the way in which we work as an organisation to deliver, develop and improve our services. The first theme is quality care and patient safety, supported by three others - organisational capability, business sustainability and partnerships and engagement which focuses on developing and maintaining the external relationships which are critical to our success.

We have already established ourselves as a specialised services centre, based on our expertise in five key areas: cancer services, heart services, trauma services, children’s services and neurosciences, examples of which can be found in the annual report and 2012 will also see increased cardiac catheter laboratory capacity coming on line and the generic high dependency unit (HDU).

For our specialised services there is always a risk that patient flows will change as other providers develop services and retention of these in the long term is dependent on maintaining our networks in our catchment area by matching or exceeding developments in other trusts and providers of health to maintain the reputation of our services.
For specific services, particularly community services and some niche acute services, it appears that commissioners are increasingly using competitive tendering processes when seeking to commission new services or to achieve significant service changes in existing services. We see this as an opportunity to develop new services and potentially to expand our catchment area and increase collaboration between NHS providers to offer joint bids.

As with our specialised services, our secondary and community services cannot stand still. To respond to, or ideally anticipate, the demand of commissioners for improved quality at reduced cost, we must continuously evaluate our services to seek opportunities to improve, innovate and, in some cases, develop. There are a wide range of projects planned to develop our services such as the integrated patient care programme which will affect almost every service in the trust.

The integration of secondary and community services in April 2011 presented us with a significant opportunity to transform how many services are delivered to improve quality and efficiency to the benefit of patients, the trust and the overall health system.

This year (2011/2012) was spent understanding the system we have inherited and developing a joint plan with commissioners, GPs and social care, for its transformation through 2012/2013 and beyond. The ultimate aim is for a system that is more effective and maintains the independence of patients, keeping them in the community for longer and significantly reducing the current excessive reliance on emergency admissions to hospital; a system that has fewer delays and shorter lengths of stay and is, overall, more cost effective; releasing resources for reinvestment in new services or increased capacity to match increasing demand.

We will also be a major contributor to the emerging health and well-being boards in each local authority area, which will act as a statutory body to coordinate all local health provision from April 2013, and recognise the key role they play as part of broader plans to modernise the NHS. Through them we hope to ensure stronger democratic legitimacy and involvement, strengthen our working relationships between health and social care, and encourage the development of more integrated commissioning of services.

The trust generated a trading surplus of £2.9million in the year, before allowing for a technical book value impairment of certain properties of £7.9million, resulting in an overall deficit of £5million. The initial surplus was slightly higher than planned, and helped by some over-performance on certain commissioned activity through the year. It was achieved by the maintenance of quality whilst making good progress in bearing down on costs through efficiencies across the divisions and directorates.

The financial environment has not eased, and funding will tighten further over the medium term. The trust has to live within its means, but is determined to generate a surplus, to continue to invest in those services and specialties that enhance its reputation and ability to serve its communities. This requires prudent financial management and strategic planning over the next three to five years to keep within a compliance framework, yet accommodate growth and a progressive agenda.

In the short term, planning for 2012/2013 has built on earlier progress, with even greater focus before the start of the year on identifying improvement and efficiency programmes capable of meeting our tight cash constraints.

No compromise has been allowed in setting the level of care we are capable of giving to our patients, but an imaginative approach has been adopted in building towards best-in-class services and methods of delivery.

Time is being devoted to optimising the patient flow and experience, identifying and satisfying the demand for new and our most sought-after procedures, and we are challenging our supply chain for innovation in all areas of procurement. Throughout the year we will seek the point at which the need to save money can be matched to the overarching desire to provide resilient services and lay the foundations for the longer-term goals.

We want to maintain financial sustainability and create headroom for investment in service and environmental improvements to enhance the quality of care for patients. To do this we need to
generate income and have sound financial control - delivering cost improvements through service redesign, benchmarking and annual planning processes.

Our main risks to the organisation’s financial position are failing to achieve the targeted income position, cost pressures exceeding anticipated levels and not achieving our productivity and efficiency plans. These risks will be managed through the trust’s operational delivery processes.

We recognise that effective leadership and adequate management processes and structures need to be in place to deliver the trust’s strategy and goals. The appointment of a new finance director from the private sector has brought more commercial financial skills and culture to the trust and the new director of human resources has significant experience of supporting staff through major organisational change.

We also recently restructured the senior management of the community services division to support the major programme of service integration and transformation which we will be undertaking in 2012/2013 and beyond.

The organisation, working with GP colleagues, will continue to engage with health colleagues, staff and the wider public about the future sustainability of children’s and maternity services at the Friarage Hospital, while developing a service model for the hospital that is safe and sustainable in the long-term and meets the needs of the local population.

We are also embarking on a major IT project - Transforming the Care we Deliver - to deliver an electronic patient record, electronic document management and an upgraded IT infrastructure.

We will also take into account the views of the Council of Governors in our forward planning. Full details are available in the trust’s forward plan strategy document for 2012/2013.

**Going concern**

After making enquiries, the directors reasonably expect that South Tees Hospitals NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

“I was very nervous about my operation but need not have worried - everyone was fantastic”
“Despite being obviously very busy, we were still made to feel that we were the only people being looked after”
Keeping patients safe and free from harm is our number one priority. We always want to give personal and compassionate care and make people feel as comfortable as possible during their treatment with us.

To do this we will make sure that patients are in clean beds, get the food and hydration they need and the correct treatment and medicine at the right time and place.

Staff have to be our ambassadors - our ‘eyes and ears’ - if we want to continue to embrace - and improve - our patient safety culture, particularly at a time when there are lots of challenges and pressures in healthcare.

Our vision of ‘no avoidable deaths and no avoidable harm’ means everyone has a role to play in safeguarding quality of care to patients and we will continue to review our standards, governance and performance.

As an organisation we remain committed to finding new ways of improving the safety and quality of our healthcare services.

A vision for harm free care - launch of patient safety strategy

In July, the trust’s patient safety strategy was launched which sets out our aspirations and vision for harm free care for patients.

National and international research estimates one in ten patients admitted to hospital will be the victim of an error - ranging from very minor incidents to patient deaths - and that around 50% of these could be avoided if lessons from previous incidents had been learned.

The trust has always placed patient safety central in its aim to provide patients with high quality and safe care but the new strategy ensures that this is applied consistently across the organisation.

It is an underpinning framework that enhances the organisation’s reputation, reduces harm and reduces costs incurred as a result of errors or near misses. To ensure the strategy is rooted in our everyday work, individual clinical leads have been identified to take on responsibility for a key aspect of patient safety.

A patient safety programme board was also set up which oversees and identifies emerging patient safety issues relating to quality of care and monitors progress against any agreed measures.

“I can say with the greatest of sincerity, our lives would have been so very different today if not for your staff”
Reducing infection

The control and prevention of healthcare associated infections (HCAIs) is essential to ensuring safety, clean care and is the responsibility of everyone working in the trust.

As the nature of infections can be very complex, it demands good leadership and systems which are supportive and continually refined. Undertaking clinical procedures such as line insertion or wound or catheter care requires all relevant healthcare professionals to perform evidenced-based practice consistently.

Reducing HCAIs has been a quality improvement priority in each of the trust’s quality accounts and is supported by the continued roll-out and monitoring of the trust’s three-year strategy to tackle infections.

For 2011/2012, our goal (and Department of Health target) was to continue to reduce MRSA bacteraemia and Clostridium difficile cases year-on-year by:

- Having no more than 4 MRSA bacteraemia cases
- Reducing the number of hospital-attributed cases of Clostridium difficile to 112 cases or less (94 for James Cook/Friarage and 18 for the seven primary care hospitals)

Between April 2011 and March 2012, the trust recorded two cases of MRSA bacteraemia - a 67% reduction from 2010/2011. The target we have been set this year is to have no more than three cases.

The other national target was reducing the number of hospital-attributed cases of Clostridium difficile (C. difficile) - an infection caused by antibiotics - and we recorded 67 cases in-year - a 46% reduction. Our target for 2012/2013 is 80.

We also carry out surveillance on other infections including MSSA where we had a total of 19 trust-attributed cases - a 27% drop from the previous year’s total of 26.

A range of initiatives were identified at the start of the year to support improvements in this area, some of which are detailed in this section and also in the trust’s quality account (pages 110 to 158). They include:

- Developing a trust-wide decontamination strategy which includes clear roles, responsibilities and monitoring arrangements around patient equipment, cleaning and decontamination (commodes, mattresses etc)
- Rolling out the second year of the infection prevention and control link practitioners’ programme, which encourages local ownership of audits, observations and teaching and reinforces key messages at ward level
- Reinforcing the importance of isolating patients with suspected Clostridium difficile on the basis of symptoms rather than waiting for test results
- Developing patient experience surveys specifically relating to infection so trends can be analysed and lessons shared with clinical teams
- Developing a risk assessment tool for wards and departments, led by the infection prevention and control link practitioners, with on-going work to develop a standard escalation policy

NHS QUEST

As the trust has some of the highest consistent ratings in the country for service and quality, coupled with some of the highest sets of patient and staff satisfaction scores, we were invited to become one of the first members of NHS QUEST in February 2011.

NHS QUEST is a member-convened network for foundation trusts who wish to focus relentlessly on improving quality and safety. Together, with our partners, we want to find the ways of improving more and faster so we can provide the best care possible for patients.

In summary the network:

- Focuses on improving quality and safety
- Aspires to a level of excellence beyond all current expectations
- Builds the capability of our workforce to improve
- Supports its leaders to create the right culture for reliability
- Measures and reports outcomes
- Learns from one another and shares through action-orientated projects
- Believes we can always do better for our patients
During the year we worked with our members on three improvement projects - harm-free care (under the banner of Safety Express), reducing readmissions, and reducing mortality - so we could learn together and from one another. Further information is available in this section and the quality account on pages 110 to 158.

Harm-free care (Safety Express)

The Department of Health Safe Care workstream has established a quality improvement programme - called ‘Safety Express’ - to help the NHS to develop safer systems in hospitals and in community settings. We now work towards the shared aim of dramatically reducing harm from the following conditions in 95% of patients by 2012:

- Hospital and community acquired pressure ulcers
- Blood clots (DVT and pulmonary embolism)
- Urinary tract infections in patients with catheters
- Falls in care settings

The trust was one of the first to pilot the use of a safety thermometer - an instrument to measure prevalence of these various harms at specific times and the proportion of patients who are ‘harm free’ at any given time - on four acute wards at James Cook.

By repeatedly measuring a sample of our patients we can get a picture of their improvement and how rapid this is and we now use the thermometer in 42 clinical inpatient areas, including community hospital wards.

Monthly meetings are held with the project leads in the four areas of harm to discuss the data and how we can improve support to those clinical areas.

Patient safety award

The trust’s patient safety team was presented with a Safety Express award from the Department of Health for piloting a campaign which has helped hospital trusts reduce harm from pressure ulcers, falls, urinary catheters and blood clots (venous thromboembolism or VTE).

The team also initiated the rollout of the safety thermometer, which has helped clinical areas examine their own practices and implement changes in practice, and received the award for sharing best practice in the field of patient safety.

Reducing falls

Fall-related injuries in hospitals and community settings can be some of the most common, disabling and expensive health conditions, especially in older adults. Analysis of our own figures has shown most patient falls occur from the bed or when patients got out of bed without support.

In-year, the trust invested in new adjustable height beds and more bed rails, as well as reviewing the use of sedation at night. ‘Intentional rounding’ - a process where health professionals carry out regular checks with individual patients at set intervals - has also been introduced across all acute and community wards.

A recruitment drive was also launched with the aim of having a falls link nurse in every clinical area to explore new ideas to reduce falls and share good practice across the organisation.

Link nurses are also trained as ‘key trainers’ so they have the skills and knowledge to educate and assess the competency of other staff in their clinical area.

The number of falls incidents reported in our acute hospitals continued to reduce year-on-year from 2,162 to 2,075, although falls resulting in a fracture did increase slightly from 26 to 34.

Our first year reporting figures for community hospitals showed there were 412 falls incidents - equating to 7.8 falls per 1,000 bed days. Further information is available in the trust’s quality account.

Safer Care North East Patient Safety Awards

South Tees falls’ service won first place at the North East Patient Safety Awards in recognition of the work done in primary care hospitals (PCHs) in improving falls management for inpatients. It included review of the falls risk assessment tool, the ‘Prevent Falls’ booklet and the inpatient training.

It also included audits and work-based training carried out by the falls team and governance, along with analysis and standardisation of reporting of falls. New tools were also developed to help reduce falls for patients admitted onto the wards.
Keeping you safe

South Tees Hospitals NHS Foundation Trust Annual Report 2012

Nutrition and hydration

Recent national studies have shown an unacceptable number of people are becoming malnourished when they are in hospital because they do not get the food they need or the help they need to eat it.

Becoming malnourished not only increases the risk of infection but also the length of time it takes patients to recover leading to prolonged hospital admissions.

In our acute hospitals, 88% of patients had a malnutrition risk assessment (MUST) - a screening tool to identify adults who are malnourished, at risk of malnutrition or obese - within 24 hours of being admitted against a local target we have set of 90%.

This tool has since been updated and piloted in three areas, with a view to rolling it out across the trust in 2012, supported by a training programme delivered by the nutrition nurse specialist.

In community nursing services, 99% of patients were screened for malnutrition and this is also being taken up in our community hospitals.

As part of a National Patient Safety Agency (NPSA) and Patient Safety First campaign on nutrition and hydration - a taste of patient safety – staff held a series of activities to raise the profile of this important issue.

All inpatient ward areas at James Cook and the Friarage, plus the trust’s community staff, have signed a pledge to ensure all patients will be screened within 12 hours of admission and their nutrition and hydration needs assessed.

To identify patients who require assistance at mealtimes a red jug/red tray system also operates, which helps staff to recognise those patients who need help with their meals, ensuring they get enough to eat and drink.

An ‘ask for a snack’ campaign was also run to raise awareness of the extra snacks available between meals in hospital and the importance of encouraging patients to take these as part of a high protein calorie diet.

Daily diet sheets have been produced to be used by ward staff and a volunteer/buddy system is underway to help provide assistance with feeding.

Improving end of life care

The trust’s goal is to provide high quality care with dignity and compassion to all patients who are nearing the end of their lives and during the year progress was made in this agenda.

A project to assess the best way of providing palliative care to inpatients with a life limiting illness was launched at the Friarage Hospital by the trust’s specialist palliative care team covering Hambleton and Richmondshire.

The new service builds on the good practice established by the team for in-reach services at the hospital for many years but included a number of new elements to ensure a more integrated approach - both on the ward and once patients were discharged home.

A community specialist nurse is now based in the hospital, ensuring a quicker response and more support to accident and emergency and the admissions ward, to help assess whether a hospital admission is necessary or can be averted by the effective use of resources in the community.

The scheme also helped ensure patients received rapid access to routine tests and treatment, thereby eliminating any delays in getting people back home.

Written guidance has also been produced for staff help improving access to appropriate support at the end of life.

A two-year pilot project which offers dying patients the choice to spend the last few days of their lives at home rather than in hospital has also proved a success for many patients.

James Cook’s specialist palliative care team (SPCT) was awarded £120,000 from Macmillan Cancer Support to pilot an end of life discharge service run by a discharge sister with part-time clerical support.

A strong partnership was formed with Teesside University’s CHASE – Centre for Health and Social Evaluation - who carried out a service user evaluation and since the project began, 205 dying patients have achieved their wishes and been supported out of the hospital setting for their last few days, usually to their own home but sometimes to a community hospital or care home.
Safeguarding adults and children

Safeguarding is a crucial element of providing care for both adults and children and is subject to various and regular external assessment. The trust takes its responsibilities in this area very seriously to ensure effective safeguarding across an entire patient journey.

A new specialist nurse role for safeguarding adults was introduced in June 2011 and all trust staff have been informed of their responsibility in this important area. We also secured funding to increase the safeguarding children team to include a dedicated trainer to deliver an in-house training programme.

Quality account

The quality account, which is part of the annual report, provides information to the public about the quality of services the trust provides and allows leaders, clinicians, governors and staff to demonstrate their commitment to continuous evidence-based quality improvement.

Putting this information into the public domain, puts our approach to quality up for scrutiny, debate and reflection and shows where we are doing well and where improvement is needed.

After consultation with staff, patients and key partners outside the organisation, we have produced our quality account for 2012/2013, which includes a review of quality in-year and a list of priorities for improvement.

These are grouped under three domains of quality - patient safety, clinical effectiveness and patient experience - and include:

- A continued focus on discharging patients from hospital or community health settings to improve care, clinical outcomes and reduce readmissions
- Further reducing healthcare associated infections
- Improving standards and delivery of nutritional care
- Improving communication
- Ensuring patients get the right care in the right place at the right time to reduce delays and cancellations and improve patient flow

A full copy of the trust’s quality account is available on pages 110 to 158.

Green bag campaign

In September, the trust re-launched the green bag campaign which aims to improve patient safety and reduce medicines waste when patients are admitted to hospital.

The initiative encourages patients to bring in the medicines they take on a regular basis (still in their original containers) in a specially branded green re-usable carrier bag which remains with them for their entire hospital stay.

This gives NHS staff an accurate picture of their medication, enabling better diagnosis and quicker treatment when patients are admitted to hospital and ongoing continuity of care during their hospital stay and on discharge.

Medication errors most commonly occur on transfer of patients between care settings and particularly when people are admitted to hospital, so the scheme means doctors, nurses and pharmacy staff will know immediately what medication patients are taking. We hope to gather the support of the local community to embed this as standard practice when patients stay in hospital, as has been achieved in other areas of the country.

Time to Care - Lean Healthcare Academy Award

The Time to Care (TtC) team won a Lean Healthcare Academy Award 2012 for their innovative work on the productive ward - releasing time to care initiative - which aims to release nurses’ time to care for patients.

The team won the productive series award - England - for their programme which is changing the culture of service improvement at ward level. The trust was a pilot for the productive ward programme in 2007 and while 46 wards are currently active - all remaining wards started the programme in 2012.

Savings for time to care currently stand at more than £50,000 with an increase of 19% of registered nurse time being redirected back into patient care.
Keeping you safe

South Tees Hospitals NHS Foundation Trust Annual Report 2012

E. coli O157 outbreak - Playdays nursery

In August, we took the decision to close the day nursery at James Cook after a number of children developed symptoms of gastrointestinal illness. In total, 28 cases were reported from 22 July to 18 August and five of these children, plus a member of staff from the nursery, were confirmed to have the E. coli O157 infection.

The nursery was closed for two weeks to prevent any further spread of infection and to allow us to carry out deep cleaning and the trust, plus nursery staff, worked closely with the hospital’s infection control team, environmental health officers from Middlesbrough Council, the Health Protection Agency and Middlesbrough Primary Care Trust to investigate possible causes of the infection.

Experts in the Health Protection Agency finished their investigation by November and a report concluded that, considering all the information gathered, it was most likely E. coli O157 was introduced into the nursery by a child with the infection, although the possibility of a staff member could not be ruled out.

Nursery settings with many young children in nappies are a particularly risky environment for the transmission of E. coli O157 but the outbreak was identified promptly and investigated as a matter of urgency, reflecting the seriousness of the illness caused by the E. coli O157 infection in young children.

As with many E. coli outbreaks, it is not always possible to identify the exact source of an infection. The most important factor is to ensure that measures are put in place to reduce the risk of it happening again.

Patient safety walkabouts

As part of the trust’s safety culture, patient safety walkabouts are held throughout the year involving executive and non-executive directors of the Board, who meet staff in wards and departments to listen to their concerns and experiences about patient safety at an informal level.

The meetings are an excellent opportunity for staff to get their message across to the Board and for the Board to get out into clinical settings where the main work of the trust takes place.
“Staff treat you with respect, they close the curtains whenever they attend to you, they are kind and considerate”
We spend more than £1.4 million a day on healthcare
Our performance

South Tees Hospitals NHS Foundation Trust Annual Report 2012

Summary of our performance against Department of Health targets - 2011/12

<table>
<thead>
<tr>
<th>MONITOR Compliance Framework 2011/12</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2011/12 Target</th>
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<tbody>
<tr>
<td><strong>Healthcare associated infections (HCAI)</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Clostridium difficile year on year reduction of infection rates</td>
<td>141</td>
<td>125</td>
<td>67</td>
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<td>Reducing Post 48 hour MRSA Bacteraemia rates</td>
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<tr>
<td><strong>Cancer</strong></td>
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<tr>
<td>Cancer waits 2 week wait target</td>
<td>95.4%</td>
<td>93.3%</td>
<td>94.1%</td>
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<tr>
<td>2 week wait breast symptom referrals - % seen within 2 weeks</td>
<td>96.3%</td>
<td>96.2%</td>
<td>95.9%</td>
<td>93%</td>
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<tr>
<td>Cancer wait 31 day wait for first definitive treatment for all cancers</td>
<td>98.6%</td>
<td>98.1%</td>
<td>98.9%</td>
<td>96%</td>
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<tr>
<td>Cancer wait 31 day wait for subsequent drug treatments for all cancers</td>
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<td>99.9%</td>
<td>100%</td>
<td>98%</td>
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<tr>
<td>Cancer wait 31 day wait for subsequent surgery treatments all cancers</td>
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<td>98.8%</td>
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<td>Cancer wait 31 day wait for subsequent radiotherapy treatments all cancers</td>
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<td>82.5%</td>
<td>87%</td>
<td>85%</td>
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<td>Cancer wait 62 day wait for treatment of all cancers referred from a National screening service.</td>
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<td>94.7%</td>
<td>94.5%</td>
<td>90%</td>
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<tr>
<td><strong>18 weeks referral to treatment time (RTT)</strong></td>
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<tr>
<td>18 Week referral to treatment time (RTT) for admitted patients</td>
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<td>95.4%</td>
<td>92.1%</td>
<td>90%</td>
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<td>18 Week RTT for non-admitted patients</td>
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<td>98.8%</td>
<td>95%</td>
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<td><strong>Accident and emergency</strong></td>
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<td>4 hour maximum wait in A&amp;E from arrival to admission, transfer or discharge</td>
<td>98.9%</td>
<td>98.4%</td>
<td>97.5%</td>
<td>95%</td>
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<tr>
<td>Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability</td>
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</tbody>
</table>
Our performance

South Tees Hospitals NHS Foundation Trust Annual Report 2012

We also continue to see more patients each year and in 2011/2012 saw:

• 2,289 more emergency admissions (from 79,115 to 81,404)
• An inpatient growth of 2,513 (from 178,475 to 180,988)
• 2,055 more patients through accident and emergency (125,726 to 127,781)
• 477,253 outpatient attendances (new and review)

Maternity services receive CNST Level II accreditation

An independent assessment by the CNST - Clinical Negligence Scheme for Trusts - commended the high standard of maternity services after scoring our units in a number of key areas including clinical care, training and competencies and staffing levels.

The results mean the trust was awarded Level 2 accreditation against the CNST Maternity Clinical Risk Management Standards, underlining the dedication of staff to providing mothers and their babies with safe care. The standards and assessment process are designed to:

• Provide a structured framework within which to focus effective risk management activities in order to deliver quality improvements in organisational governance, patient care and the safety of patients
• Increase awareness and encourage implementation of the national agenda for the NHS
• Encourage and support maternity services in taking a proactive approach to improvement
• Reflect risk exposure and empower maternity services to determine how to manage their own risks
• Contribute to embedding risk management into the maternity service’s culture
• Minimise the number and cost of claims by reducing the number and severity of adverse incidents and the likelihood of recurrence
• Assist in the management of adverse incidents and claims
• Provide assurance to the maternity service, other inspecting bodies and stakeholders, including patients.

This was a major achievement and represented a huge amount of work by the maternity services team. Not only does it benefit the trust financially in terms of reducing CNST premiums but also provides external evidence to the standards and policies we have supporting the delivery of our maternity services.

Dr Foster - Good Hospital Guide

The Dr Foster - Good Hospital Guide - was published in The Telegraph, concentrating on hospital mortality (death) rates. South Tees was not an outlier on any of the mortality measures, which included deaths in low risk conditions and deaths after surgery, and performed well on the indicators of good quality stroke care and elective hip and knee replacements.

The only area where we were identified as a high outlier was in the measure of patients with hip fracture who do not receive an operation within two days of admission and internal checking suggests there were differences in way the methodology was calculated. We have now seen major improvements in this area for the benefit of these vulnerable patients.

CHKS Top 40 Hospitals

South Tees was, again, named as one of the 40 top hospitals by CHKS, a leading independent provider of healthcare intelligence and quality improvement services. The awards celebrate excellence amongst CHKS clients across the UK and are based on the evaluation of 21 key performance indicators covering safety, clinical effectiveness, health outcomes, efficiency, patient experience and quality of care.

We carry out around 1,150 heart operations a year
The trust’s risk ratings with Monitor

Monitor – the independent regulator of foundation trusts – asks all foundation trusts to assess their own compliance with the terms of their authorisation, as part of its risk-based approach to regulation.

Each trust has to submit an annual plan, plus quarterly and ad-hoc reports, and Monitor uses this information to assign annual and quarterly risk ratings, review actual performance against plans and identify any steps that need to be taken to address problems.

Each quarter a report is published which covers performance and risk ratings for NHS foundation trusts and gives each NHS organisation the opportunity to understand their own performance compared to other trusts. Two risk ratings are published for each NHS foundation trust on:

- Governance (rated red, amber or green)
- Finance (rated one to five where one represents the highest figure and five the lowest)

<table>
<thead>
<tr>
<th>Annual Plan 2011/2012</th>
<th>Q1 2011/12</th>
<th>Q2 2011/12</th>
<th>Q3 2011/12</th>
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<td>Governance risk rating</td>
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<td>Green</td>
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<tr>
<td>Financial risk rating</td>
<td>3</td>
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</table>

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<th></th>
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<tbody>
<tr>
<td>Governance risk rating</td>
<td>Amber/Red</td>
<td>Amber/Green</td>
<td>Amber/Green</td>
<td>Amber/Red</td>
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<tr>
<td>Financial risk rating</td>
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<td>4</td>
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</tbody>
</table>
Our performance

Information governance

Information governance is the framework by which the NHS handles information about patients and employees, in particular personal and sensitive information. It allows individuals, the NHS and our partners to ensure personal information is dealt with legally, securely, efficiently and effectively in order to deliver the best possible care and provides a framework to bring together all the requirements, standards and best practice that apply to the handling of personal information.

This not only covers personal information, relating to patients/service users and employees, but also corporate information such as financial and accounting records. It also provides a way for employees to deal consistently with the many different rules about how information is handled.

Between April 2011 and March 2012, there were no serious untoward incidents of the severity rating 3-5. Personal data related incidents classified at a severity rating of levels 1 and 2 are shown summarised in the table below.

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

Through 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.

A toolkit score level of 0-1 equates to a grade red and a score level of 2-3 equates to a grade green. In-year, all but two standards achieved a minimum score level of two – those not achieved were:

- **Mandatory IG training for all staff (Requirement 9-112)**
  
  70% of staff had received IG toolkit training against a target of 95%. An action plan is being developed so we can improve on this and attain the required standard during 2012/2013.

- **Using minimum personal data to satisfy a purpose and to strip out information relating to a data subject that is not necessary for the particular processing being undertaken (Requirement 9-324)**
  
  The trust is not currently fully compliant with this requirement and actions we intend to take to address this are changing processes to establish an internal ‘safe haven’ for information exchange and developing a standard operating procedure.

<table>
<thead>
<tr>
<th>Category</th>
<th>Nature of Incident</th>
<th>Total</th>
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<tbody>
<tr>
<td>I</td>
<td>Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises</td>
<td>0</td>
</tr>
<tr>
<td>II</td>
<td>Loss of inadequately protected equipment, devices or paper documents from outside NHS premises</td>
<td>0</td>
</tr>
<tr>
<td>III</td>
<td>Insecure disposal of inadequately protected electronic equipment, devices or paper documents</td>
<td>0</td>
</tr>
<tr>
<td>IV</td>
<td>Unauthorised disclosure</td>
<td>5</td>
</tr>
<tr>
<td>V</td>
<td>Other</td>
<td>0</td>
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</table>
Inpatient workload

Emergency admissions growth over time
Our performance

Activity at clinical divisional level for the last two years

*Activity increases in surgery and a decrease in trauma reflect changes in the trust’s clinical structure when the directorates of reconstructive surgery, plastic surgery, oral maxillofacial surgery and orthodontics joined the division of surgery from trauma.
Switchboard operators at James Cook receive, on average, 408,000 internal and external calls a year.
Our £35million cancer redevelopment now provides the very best facilities and treatment for cancer patients.
Service developments and change

As the needs of the population change, so must NHS services. Patients want more say in their healthcare and how it is provided to them.

Now, there is greater opportunity for patients to be cared for closer to home, or even in their own home, by healthcare professionals supported by medical advances and technology.

At the same time, medical advances mean that there are increasing opportunities and advantages for patients to receive care for more complicated treatment or specialist illness at larger centres.

We will continue to look at ways we can enhance care for patients who use our hospitals and community services.

Major trauma centre

Major trauma means multiple, serious injuries that could result in death or serious disability, including serious head injuries, severe gunshot wounds or road traffic accidents - types of injury which are quite rare.

As major trauma is so uncommon, it is not possible for all hospitals to have the equipment and specialist doctors needed to treat it effectively.

For this reason it is better for patients to be seen in a major trauma centre - a hospital where patients can be operated on immediately, if necessary, and where there is a full range of trauma specialists, including orthopaedics, neurosurgery and radiology teams.

During the year, the Department of Health looked to set up regional trauma networks to ensure patients with serious and life-threatening injuries are treated quickly in a specialist hospital where expert staff are available round the clock.

This programme will make big changes to existing ways of dealing with major trauma and the ways in which patients are admitted to hospital or referred for treatment.

The James Cook University Hospital was formally designated as a major trauma centre for the southern part of the Northern region (effective from 1 April 2012), for an initial period of three years and then subject to reassessment.

We will work in partnership with the local trauma network as this type of care is very important. Many patients will need an appropriate rehabilitation over many months to help them return to an active life – an area that does require increased focus and investment over time at the trust.

Developing cancer services

The new chemotherapy day unit, which was transformed as part of the trust’s multi-million pound plans to develop cancer services, was officially opened by patients at James Cook in June.

Before the redevelopment, the ever increasing chemotherapy workload created a situation where staff were being forced to treat patients in an unsatisfactory and overcrowded environment.

“I found it was the small things, over and above the call of duty that made all the difference”
But after a year in temporary accommodation, the new unit is a massive improvement, allowing staff to provide a high quality service in a spacious state-of-the-art facility.

Small rooms have been replaced with lots of space, there is a new consultation room for nurse-led clinics, a small garden area and much more natural light. The revamp also created a new oncology reception which has a waiting area with a drinks kiosk staffed by volunteers.

The chemotherapy day unit is the lead provider of chemotherapy in the southern part of the North of England Cancer Network. Both patients and staff worked with the trust’s building partners Interserve in the design development of the unit.

The unit is part of the trust’s £35million cancer redevelopment which also saw the completion of the Endeavour Unit - a stand-alone radiotherapy centre - in 2012.

It houses three world-class linear accelerators - machines used to give radiation treatment to patients - a CT scanner and a new outpatient suite and from April 2012, James Cook was one of the first hospitals in the world to treat patients with the £1.5million Elekta Agility linear accelerators.

Demand for cancer services is increasing all the time and this expansion gives our patients access to some of the very latest technology and treatment.

Weight loss surgery

Patients can now undergo weight loss surgery at James Cook, which has its own dedicated bariatric team including surgeons, dieticians, nurse specialists, psychologists, allied health professionals and a metabolic physician.

In order to be considered for bariatric surgery patients must have tried to lose weight in other ways and must have weight problems that affect their health or quality of life.

The hospital now offers all types of weight reduction surgery including gastric banding, gastric bypass and sleeve gastrectomy, which are done using key-hole techniques to minimise recovery time.

Bariatric surgery gives another option to patients who have been struggling to lose weight in more conventional ways, offering health and economic benefits which can have a huge impact on a patient’s quality of life.

A specialist weight management service works closely with the bariatric surgery team to support patients who need hospital treatment - an integrated approach unique to James Cook which ensures the patient journey is as smooth as possible.

Simon Brown of Middlesbrough was the first patient to have a gastric bypass in December.

Bariatric surgery has been commissioned by The North-East Specialist Commissioning Group collaboratively across three local health trusts - South Tees Hospitals NHS Foundation Trust, North Tees and Hartlepool NHS Foundation Trust and County Durham and Darlington NHS Foundation Trust.

Together we expect to treat up to 300 patients a year with two surgeons at each site. Patients can be referred for bariatric surgery by their GP or from weight loss programmes but they have to meet strict criteria.

Providing advanced treatment for orthopaedic patients

The Friarage was the first hospital in the country to use a hi-tech OrthoScan C-arm - a small digital x-ray machine - to provide advanced orthopaedic treatment for orthopaedic patients having surgery.

With the compact machine, surgeons can x-ray patients’ hands and feet during an operation quickly and easily without a radiographer being present. Very low doses of radiation are also used to produce clear and sharp images improving safety for both patients and theatre staff.

The equipment was paid for by the Friends of the Friarage Hospital, who have raised several million pounds over the years for local healthcare.
Opening of specialist endovascular theatre

A specialist endovascular theatre - one of the first of its kind in the region - opened at James Cook. This facility makes it possible to combine advanced x-ray imaging with a fully equipped operating theatre.

This means vascular surgeons and radiologists can work together to do highly complex diagnostic procedures and operations including interventional radiology and vascular surgery.

Previously such procedures would have had to be done over two days or started in the main operating theatres upstairs. The new theatre will further improve what are already excellent surgical results for patients.

Clinical teams treat Libyan conflict victims

The trust was one of a small number of hospitals nationally to be approached by the Department of Health after the Libyan Government asked the NHS to provide care for 50 civilian patients who had been injured as a result of conflict.

Four patients, whose injuries included gunshot and shrapnel wounds to the body, were treated by various clinical teams at James Cook after arriving in the UK in October. The full cost of care was met by the Libyan government.

The NHS is renowned worldwide for the expertise and specialist skills of its clinical staff and, as one of the major trauma centres in the Northern region, we were pleased to be able to offer support.

Retinal screening

The South Tees diabetic retinal screening service reached a milestone of screening over 90% of its patients. The aim of the service, which covers Middlesbrough, Redcar and Cleveland and Hartlepool and Richmond, is to reduce the risk of sight loss in its 18,800 patients with diabetes.

Diabetic retinopathy is damage to the retina (the ‘seeing’ part at the back of the eye) and is a complication that can affect anyone who has diabetes.

Over its eight year history, the service has developed strong links with patients, local GP practices and the diabetes care centre and eye department at the hospital. With national averages for patient uptake at around 78%, it is now one of the best in country, ensuring that patients with diabetes in our area are receiving the best possible care for their eyes.

Service improvement for mums-to-be gains national recognition

An innovative scheme designed to promote the one-to-one care of women in labour was shortlisted in the Annual Midwifery Awards from the Royal College of Midwives for promoting natural birth.

The midwifery team trained healthcare assistants to take on a new role of assistant midwifery practitioners, under the supervision of a midwife, as part of a pilot scheme in the low-risk labour suite at James Cook.

A large part of the role involved giving women in labour extra support, encouraging them to use natural methods of pain relief, increasing their mobility and encouraging birth partners to be actively supportive. It has been so successful it is now being rolled out in the hospital permanently.

Pioneering heart treatment benefits patients

More than 80 elderly patients have now benefited from a pioneering heart treatment. TAVI - Transcatheter Aortic Valve Implantation - is an advanced procedure in which a team of specially trained consultants replace narrowed heart valves without the need for open heart surgery.
Service developments and change

South Tees hospitals NHS Foundation Trust Annual Report 2012

It is a much less invasive alternative, where patients are fitted with new heart valves through a small cut which is made in their groin or chest. It also dramatically cuts the length of recovery time.

The specialist technique can only be performed at accredited hospitals and involves up to eight consultants - two cardiologists, two heart surgeons, two cardiac anaesthetists and two imaging cardiologists.

Results from James Cook show the implant has had a 98% success rate with around 60% of patients being discharged within three days of having the procedure.

Specialist weight management service expands to Stockton

A newly commissioned specialist weight management service opened in Stockton for people needing to lose weight to improve their life expectancy.

The service, provided by the trust’s division of community services, aims to help clients aged 16 years and over who have already accessed all other weight management options without success, make sustainable behavioural changes and lose weight.

Rising trends in obesity are one of the biggest threats to the future health of the population of Teeside and approximately 25% of adults are classed as obese. The Stockton service complements the existing community service, which has been run to great success in the Middlesbrough and Redcar and Cleveland area.

Feedback and evaluation from patients across South Tees has been they feel supported by a group of specialist healthcare professionals in the one place, which has given them the knowledge, skills, motivation and confidence to manage their weight in a way that has not happened before.

Children’s spinal service

Children and young people with spinal conditions now have access to a specialist team at James Cook, meaning they no longer have to travel to Leeds or Newcastle for treatment.

The specialised service ensures that all children in the area with back problems are seen by experts and have access to a specialist nurse who provides support and advice.

Teenager Ciaran Jasper was one of the first to benefit locally after she hurt her back in a trampolining accident. On further investigation at the hospital she was subsequently diagnosed with scoliosis.

Ciaran and her family were so impressed with her care they helped the paediatric spine service produce a photographic guide for future patients entitled ‘Scoliosis Surgery - A Patient’s Journey.’ The booklet aims to help children and their families visualise what is involved when surgery is needed to correct a curved spine.

Scarless surgery for urology

Advances in technology have allowed doctors to develop keyhole surgery - thanks to state-of-the-art cameras and instruments. Now things have gone one step further with instruments being miniaturised so they can get through the smallest of holes.

In October, the urology team at James Cook performed its first scarless surgery – a technique which sees surgery performed through an incision in the belly button. Once the belly button is sewn up only a tiny scar remains which is hardly visible.

It can be used to perform various procedures on kidneys and the urinary tract with minimal cosmetic impact. As part of plans to introduce scarless surgery, experts in the field gave a live theatre masterclass. The new procedure causes minimum disruption to the skin and underlying muscles and offers the very best service to our patients.
Non-surgical birthmark treatment helps 250th patient

The specialist birthmark clinic celebrated treating its 250th patient with a leading-edge procedure to treat vascular birthmarks using an injectable drug.

The trust’s birthmark clinic sees more than 100 new patients a year but after becoming the first in Western Europe to introduce bleomycin, many of them no longer have to undergo surgery.

The scarless treatment involves injecting bleomycin through the skin into the strawberry birthmark or vascular malformation (where the veins, arteries or blood vessels are abnormally formed) and can produce dramatic results.

Reconstructive plastic surgeon Mr Tobian Muir holds specialist clinics for adults and children at both James Cook and the Friarage and almost half the patients treated are from other areas of the UK.

Trust results show 93% of patients respond to treatment with the injectable drug, with four out of five showing significant improvement. The recurrence rate is extremely low at just 1%. As well as receiving referrals from other hospitals, Mr Muir has also trained staff at Birmingham Children’s Hospital to set up their own clinic.

Hi-tech computer improves patient care

A cutting-edge computer system - thought to be the first of its kind in the country - is improving patient care in the operating theatre recovery area.

The RADS (recovery arrival departure screen) provides staff with a computerised ‘airport lounge’ view of expected patient arrival and departure times allowing them to better anticipate the workload coming into theatres and avoid patients being held up in recovery.

A colour-coded display highlights the time the patient is expected to arrive in the recovery area and how long their stay is likely to be, based on the surgeon’s estimate of how long their procedure is likely to take and the average length of stay in recovery.

Theatre staff can also alert recovery staff with a 15, 10 or 5 minute warning that the patient’s operation is about to finish, making the predicted times of arrival even more accurate. The software was developed by the trust’s information, communications and technology (ICT) team, based on an idea by theatres’ clinical matron.

Staff can now plan space better, reduce delays in recovery areas and theatre, and avoid keeping people on trolleys any longer than necessary. Estimated times are also becoming more accurate as more data is collated, allowing the theatre teams to plan their working schedule more effectively. The system will be rolled out to the theatres at the Friarage Hospital and linked to wards, so they can see where their patients are and when they can be expected back onto the ward.

Centralising orthodontic services

The trust has centralised its orthodontic service to provide specialist treatment from the James Cook and Friarage hospitals instead of six hospital sites.

As the NHS moves towards providing care closer to patients’ homes, most routine orthodontic treatment can now be done in the community. This has led to a significant drop in the numbers of patients being referred into hospitals as only people with complex needs require that specialist level of treatment.

Patients’ needs can be best met in a specialist centre because of the joint working with other teams such as oral and maxillofacial surgeons. Serious recruitment challenges also prompted us to look at the future viability of the service as we will not have the consultants to run safe services across six hospital sites. The trust discussed the proposal with various groups and the wider public before the changes were made.
Protecting the future

The NHS has an unprecedented financial challenge - to save £20billion at a time when income is largely static and the demand for some health services have increased.

In line with that national picture, the organisation has to save more than £69m over three years. While we aren’t strangers to making efficiency savings, while safeguarding the quality of our services, the scale of the task is huge, particularly as we want to protect local services, jobs and the trust for the future.

At the end of 2011 we asked the consultancy firm McKinsey and Company to help us take a fresh look at how we could be more productive and efficient, without affecting the quality of services we provide. They used information about our finances, workforce, quality and operations to compare us to 15 similar trusts across the country.

The outcome of that work was, in many ways, good news and confirmed that we are a high performing trust that can be compared to the best in the country. We are now focussing on four key areas to improve productivity and efficiency:

- Patient flow - looking where there are opportunities to work more efficiently such as daycase rates in surgery, day of procedures admissions, length of stay, outpatient efficiency
- Procurement - buying our consumables more efficiently, particularly high cost items and drug expenditure
- Medical staff productivity - looking at the skill mix of our medical staff and pay arrangements
- Nursing staff productivity - looking at the skill mix of our nursing staff and doing some specific work mapping where all our nurses work and what their primary roles are

Transforming community services

Community services provide essential care to many people, families and local communities, from health promotion to end of life care. This care is provided in many settings, at critical points in people’s lives, and often to those in vulnerable situations.

In April, we welcomed community services staff from Hambleton, Richmondshire, Middlesbrough, Redcar and Cleveland into the trust which has presented us with an excellent opportunity to work closer together to develop smoother and more efficient pathways of care for our patients.

The NHS has recognised for a number of years that improvements needed to be made to community health services. It also faces real challenges from a growing population, increasing demand and the cost of new drugs and technologies that become available.

Plans and strategies for the health service are now focused more than ever on providing care closer to patients’ homes and on making sure the pathway and journey that patients go on through the NHS system is as easy to understand as possible.

That includes making sure that where the responsibility for a patient’s care changes from one organisation to another that this is handled as efficiently as possible.

A key piece of work for the organisation, in partnership with other NHS colleagues and stakeholders, is taking this important agenda forward in 2012/2013.

“You’ve given me a new lease of life”
Training, life-long teaching and research

**New MRI scanner in joint venture with university**

A new £1.5 million MRI scanner is up and running at James Cook as part of a joint venture with Durham University. The new scanner - used to scan people's brains - will be shared between the hospital for clinical work with patients and by the university, for research into the brain.

The partnership approach in sharing the equipment is unique to Tees Valley, and it is the first time Durham University has ever had its own scanner for research purposes.

The MRI scanner is top of the range and compared to existing scanners, provides better and easier access to quality brain and body imaging. It is used by academics from across the university including those from the School for Medicine and Health and the Wolfson Research Institute - both based at the university's Queen's Campus in Stockton.

Research projects include those which investigate autism, the impact of hormones on the brain, and brain function in relation to visual field defects and visuomotor deficits. The whole facility, including the equipment and refurbishment of the space, cost £3 million which was equally shared between Durham University and the trust.

**Clinical trials**

Participation in clinical research demonstrates we are committed to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment options and recognise that active participation in research leads to improved patient outcomes.

The number of patients receiving NHS services provided or sub-contracted by the trust that were recruited during 2011/2012 to participate in research approved by a research ethics committee was 2,500. There are currently 114 portfolio studies reporting recruitment.

**Undergraduate medical education**

The trust is a major teaching hospital and provides teaching to medical students who are at various stages of their medical training.

One of the best ways for students to develop their knowledge and skills is through direct contact with patients in the hospital setting. Geographically we represent a large area, which gives students the opportunity to see patients from a wide range of backgrounds and experience clinical practice in a range of settings.

We are very grateful to the many patients who give up their time to help with teaching. South Tees is the lead trust for Newcastle medical students on placement in the Tees area, with the medical student support office based at James Cook. In July, we had a 100% exam pass rate for our third year medical students.

We are also building an international student appeal with students on placement from Japan, Syria, Germany, Norway and Saint Lucia.

**Video-conferencing**

Cancer clinicians at the Friarage now have a dedicated video-conferencing room in the postgraduate centre, after a £50,000 donation from the Friends of the Friarage Hospital.

The MDT (multi-disciplinary team) room allows more effective communications with colleagues at James Cook and is used mainly by cancer team members who meet regularly to discuss patients diagnosed with cancer and agree their treatment plans.

This includes a PACS (radiology) workstation, two laptops and a computer workstation all linked to LCD display screens configured to project radiology and pathology images allowing all team members to see them.

MDTs are recognised nationally as being an important part of the pathway for cancer patients and bring together professionals from many specialist areas to ensure the diagnostic tests, treatment decisions and care for patients is of the highest standard.
Unique course for custody staff

A unique life support training course for police custody, medical and nursing staff was launched by the trust and Reliance Medical Services.

Believed to be the first of its kind, the Recognition of the Acutely Ill Detainee (RAID) course was specially designed to meet the needs of custody medical teams, taking into account the difficult situations these professionals may face when treating detainees in police cells, such as those under the influence of drink or drugs.

It includes assessment of the acutely ill detainee, managing inebriated people with head injuries, basic life support and dealing with a range of scenarios in a simulated police cell.
“The care is as good as it could be - the staff are lovely”
Care Quality Commission inspection

In January, the Care Quality Commission - the independent regulator of all health and social care services in England - carried out an unannounced inspection of James Cook to check all the essential Government standards on quality and safety were being met.

The team looked at four different clinical areas - accident and emergency, the male and female assessment units (AAU and ward 1) and ward 2 - and also followed a patient pathway from accident and emergency to the radiology department.

Assessors concentrated on privacy and dignity and quality of care; speaking to numerous patients and relatives about their experiences of receiving care, as well as talking to staff and recently published a report on their findings. Comments from patients were particularly positive.

Four key standards were reviewed by the team around dignity and respect, safe and appropriate care and patients being involved in discussions around treatment and all of them were met.

The day the CQC visited us was exceptionally busy across the hospitals and community services so the assessors witnessed the true challenges we face as a large and complex organisation.

Patients rate trust highly in outpatient survey

Patients were satisfied with the high quality care and treatment they received at the trust, according to the Care Quality Commission’s (CQC) 2011 outpatient survey.

Significantly, the trust was placed in the highest scoring 20% of NHS trusts in England by patients when asked about their overall opinion of dignity, respect and care when being examined or treated.

In the survey, patients were asked a series of questions relating to their experience as an outpatient during April or May 2011, including outpatient clinics run with the accident and emergency departments such as fracture clinics.

The trust was in the category of ‘best performing 20 per cent of trusts’ for more than half of all the benchmarked questions asked (23 out of 39) and was not placed as ‘red’ - the 20% of trusts with the lowest scoring threshold - in any category. Our results included:

- Scores of 95 out of 100 for patients being treated with dignity and respect at the outpatients department and given enough privacy when discussing their condition or treatments
- A score of 93 out of 100 for the doctor listening to what they had to say
- A score of 93 out of 100 for having confidence and trust in an NHS professional

Listening to the views and experiences of patients, their carers and families is invaluable in helping to improve the quality of services we provide, so their opinions will always remain one of the most important markers by which we measure our performance.

Areas where improvements could be made were also identified in the survey and include overall communication and patients receiving copies of letters sent between hospital doctors and the family GP. Work has already started to determine the best approach to improve the trust’s performance in these areas.
The report is the fourth national survey of adult outpatients (aged 16 or over) in NHS hospitals in England and almost 73,000 patients who visited one of 163 acute or specialist NHS trusts took part – a national response rate of 53 per cent. At South Tees, 490 patients (58%) responded.

**National inpatient survey**

To improve the quality of services we deliver, it is important to understand what patients think about their care and treatment and during the year the Care Quality Commission carried out the ninth national NHS survey of adult inpatients.

Between October 2011 and January 2012, a questionnaire was sent to 850 recent inpatients aged 16 years or over, who had at least one overnight stay during June, July and August, at South Tees and 488 responses were received.

Overall, results from the survey were around the same as last year so clearly there are improvements we can make. An action plan is being drawn up and the findings will be shared with professional groups and at divisional performance reviews. Full details of the survey can be found on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk).

**Improving the ward environment for dying patients**

A hospital ward refurbishment – including a purpose-built palliative care bay to improve facilities for patients at the end of their lives – has received national praise. Ward 9, which cares for patients with respiratory problems at James Cook, was highly commended in the Building Better Healthcare Awards.

The redevelopment, completed as part of The King’s Fund ‘Enhancing the Healing Environment Programme for End of Life Care’ in partnership with the Department of Health, was runner-up in the estates and facilities category ‘Best Response to DH Policy Award’.

Ward nine had a radical make-over including a new relatives room, palliative care facility (created from a former six bedded bay allowing patients more privacy and dignity) and a modern nurses station. Patients’ relatives and staff were intrinsic to the changes made to the £320,000 refurbishment carried out by company Interserve.

**A passport to improved communication and experience**

Traffic-light coded hospital ‘passports’ devised by a neighbouring mental health trust were adopted by the trust to improve the experience of patients who have learning disabilities when they are admitted to hospital.

The passport enables patients with learning disabilities and their carers to provide staff with important information such as how they prefer to be communicated with, how they prefer to take tablets and medicines, how they may show they are in pain and what level of support they will need.

A copy of the passport is kept in the patient’s hospital records and has three pages:

- A red page for vital information including personal and medical details
- An amber page which contains information on things that are really important to the patient in helping staff care for them
- A green page which contains personal preferences as to what the patient likes and dislikes

The overall aim of the passport is to improve communication between patients with learning disabilities, their carers’ and hospital staff and reduce the frustration patients and carers sometimes find having to keep repeating the same details to different healthcare professionals. This way the patient can hopefully have an improved experience of the hospital while being an inpatient.

**PWLD - do you understand?**

The trust is working hard to improve experience, outcomes and safety of care for people with a learning disability (PWLD) as part of ‘do you understand?’ – a regional campaign which encourages staff to consider whether they are aware of the needs of this vulnerable group and signposts those who are unsure to training resources.

The NHS also has a legal duty to provide ‘reasonable adjustments’ for people with learning disabilities and some improvements we have made in-year include:
• Upgrading bathrooms to accommodate wheelchairs, hoists or changing tables
• Patients with learning disabilities visiting hospital wards or departments before their admission
• Patients/carers staying outside visiting hours to support patients
• Using hospital passports

Further information about the campaign is available at www.pwldnorth.nhs.uk

Listening to concerns and complaints

While the number of complaints is far outstripped by the number of positive comments we receive on the care and services we provide, we do take complaints seriously as they are an important measure of the quality of the care we provide and help us to put in place measures to stop the same mistakes from happening again.

Between 2011/2012, we dealt with 326 formal complaints, which received a written response from the chief executive, compared to 308 in 2010/2011. We also had 2,030 PALS inquiries.

Some of the changes we have made in-year as a result of complaints and concerns include:

• A practical assessment to be considered by division concerned for all candidates for medical posts in the future, to cover language and communication skills and medical skills
• Staff to be more aware of factors which might increase anxiety in elderly dementia patients. Colleagues in older people's services/mental health to deliver awareness sessions to directorate staff
• Producing an information sheet about the different types of dialysers and the fact that patients may be trained on dialysers that differ slightly to the machine they will eventually use at home
• To ensure all clinicians working in urgent care are trained and have had their competencies assessed by an emergency care practitioner - all nurses to attend a university based training programme and in-house training programme
• Women complaining of abdominal pain between 23 and 34 weeks gestation should be observed for a minimum of two hours before being discharged home. Guidelines were also reviewed
• A dedicated member of staff from the division of community services will manage the process of administrating flu vaccines for the team to ensure all patients receive their vaccines in an appropriate time frame

Ombudsman’s review of complaints handling

The health service in the North east recorded the fewest complaints per head of the population of any English region, according to report by the Health Service Ombudsman ‘Listening and Learning: the Ombudsman’s Review of Complaint Handling by the NHS in England 2010-11.’

In the region, there were 471 complaints against NHS organisations in 2010-2011, which works out at 18 per 100,000 people, half the figure for the London area which was the most complained about NHS region.

South Tees also recorded the fewest complaints - 23 - followed by Gateshead Health NHS Foundation Trust which recorded 25. Answering and dealing with complaints is a really important part of our business and this is a testament that we take all concerns raised seriously and that people don’t feel compelled to go to the Ombudsman to get an appropriate response

Young people on interview panel

Members of the young persons’ group at James Cook held a focus group as part of the interview process for the post of paediatric intensive care unit manager.

The group visited the unit beforehand and familiarised themselves with the environment before meeting and chatting to prospective candidates in a focus group to gain insight into their ideas and priorities for children and young people who are critically ill.

Using a scoring system, the group then fed back their views to the formal interview panel while a staff focus group was also held so both patients and staff were involved in the recruitment of the new manager.
Patient experience and the environment

South Tees Hospitals NHS Foundation Trust Annual Report 2012

‘You said - we did’

Divisions and directorates constantly encourage feedback from patients and staff to make service improvements. Here are just some examples of ‘you said - we did’ throughout the year.

- As part of the ‘You’re Welcome’ toolkit - Department of Health criteria highlighted in the National Service Framework for Children - a separate teenage friendly area has been created in the children’s surgical day unit in direct response to comments from young people.

- In maternity, patients felt it would be more appropriate to have a bay for breast-feeding ladies so they could give each other support - this has been done.

- A one-stop service was introduced for breast patients who had raised concerns about having to return to hospital for procedures following investigations in clinic.

- A local web-based support group has been set up for testicular cancer patients by the specialist nurse for testicular cancer in response to patient need.

- Seasonal-adjusted visiting times were introduced on a medical ward.

- Food boxes for children have been introduced on the surgical day unit.

- Serene music was introduced in the outpatients department at the Friarage.

- Dignity gowns designed for bariatric patients.

Patient Environment Action Team (PEAT)

PEAT is an annual assessment of inpatient healthcare sites in England that have more than ten beds and is a benchmarking tool to ensure improvements are made in the non-clinical aspects of patient care including environment, food, privacy and dignity.

The assessment results help to highlight areas for improvement and share best practice across healthcare organisations in England. Scores demonstrate how well individual healthcare providers believe they are performing in key areas including food, cleanliness, infection control and patient environment and range from one (unacceptable) to five (excellent).

For the first time, community hospitals were also included in the trust’s PEAT rating and our scores are shown below.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Environment Score</th>
<th>Food Score</th>
<th>Privacy and Dignity Score</th>
</tr>
</thead>
<tbody>
<tr>
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<td>5 Excellent</td>
<td>5 Excellent</td>
<td>5 Excellent</td>
</tr>
<tr>
<td>Friarage Hospital</td>
<td>4 Good</td>
<td>5 Excellent</td>
<td>4 Good</td>
</tr>
<tr>
<td>Redcar Primary Care Hospital</td>
<td>5 Excellent</td>
<td>5 Excellent</td>
<td>5 Excellent</td>
</tr>
<tr>
<td>Carter Bequest Primary Care Hospital</td>
<td>5 Excellent</td>
<td>5 Excellent</td>
<td>5 Excellent</td>
</tr>
<tr>
<td>Lambert Memorial Community Hospital</td>
<td>5 Excellent</td>
<td>5 Excellent</td>
<td>5 Excellent</td>
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<tr>
<td>Friarage Hospital</td>
<td>4 Good</td>
<td>5 Excellent</td>
<td>4 Good</td>
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<tr>
<td>Guisborough Primary Care Hospital</td>
<td>4 Good</td>
<td>5 Excellent</td>
<td>5 Excellent</td>
</tr>
<tr>
<td>The James Cook University Hospital</td>
<td>4 Good</td>
<td>5 Excellent</td>
<td>4 Good</td>
</tr>
</tbody>
</table>
“I was absolutely thrilled to have him home, to have the opportunity was absolutely fantastic and I know my husband appreciated it”
“All of the staff worked with a professional and compassionate approach”
Our staff

We value our staff and are committed to their development, making sure they are properly trained, well supported and are able to balance their home life with their work.

We will always try to fit in with the working preferences of our staff, as long as the needs of each service are met, as research shows supporting a positive and healthy work environment is essential to delivering safe and effective care.

Star Awards

The new Star Awards provided the trust with an opportunity to really showcase the outstanding care and services staff are providing throughout the organisation, both at James Cook and Friarage hospitals and in community services.

In total there were nine categories, while a special merit award was also presented to Margaret Toase, who stepped down as the chairman of staffside, for her significant contribution to the trust over the years.

The winners were:

- **Clinical team of the year - anti-coagulation team.** The team has had a significant impact on services across the trust, including helping to improve risk assessment and reduce the rate of hospital associated venous thromboembolism.

- **Behind the scenes - Time to Care team.** The team has worked tirelessly to embed Time to Care in 46 wards and departments, and has had a huge impact. Saving not only time and money, the programme has more importantly improved staff morale and freed up nursing staff to spend more time with patients.

- **Partnership working - heart failure team.** Working to improve the care of people with chronic heart failure, the team has developed a new pathway of care, increasing early identification, ensuring quicker access to specialist cardiologists and making a significant improvement to the quality of patient care.

- **Learning and development award - cardiothoracic outpatient department.** Since adopting ‘Time to Care’ the team has shown a true commitment not only to improving patient care but also equipped staff with the skills and knowledge to successfully make and embed changes.

- **Innovation award - ward 34.** The ward - one of four areas in the trust chosen to pilot the national Safety Express - embraced the initiative to deliver harm free care across four key areas of patient safety. The pilot was so successful it is now being hailed as a national example of good practice.

- **Unsung hero - Albert Oliver.** Albert has been a porter for 16 years, bringing a smile to every patient that he transports to the neuro x-ray department. Unfailing cheerful, he is punctual, professional and takes pride in providing a high quality service and is known for never turning down any request for help.

- **Together we can - chemotherapy team.** Cancer treatments often have to be made up in advance and sometimes they go unused, resulting in waste of up to £8,000 a month. Clinical and pharmaceutical teams got together, developing a number of initiatives that have reduced the waste to £250 per month.
Our staff

South Tees Hospitals NHS Foundation Trust Annual Report 2012

• Volunteers award - Alice Large and Magda Tinning. Alice was one of the first volunteers to be recruited by our accident and emergency department at James Cook and has made a major contribution to patient care

Magda - or Scotty as she is affectionately known - has given many years of dedicated service to The James Cook University Hospital Voluntary Services which has been established for more than 30 years. It's thanks to people like her the voluntary service has raised over £1m for the hospital

• Chair’s award - mortuary team. Chosen for their commitment to providing a high quality service for families, the team goes about their job professionally, calmly and with real empathy for the families whose lives they touch. They are crucial to the smooth running of our hospitals, and yet they work away quietly, delivering a high quality service that they take real pride in providing

Nightingale Awards

The Nightingale Awards recognise the unique and important contribution nursing and midwifery makes to patients and their families on a day-to-day basis.

This year’s theme was the research contribution that nurses and midwives have made to improving patient care and the national quality, innovation, productivity and prevention (QIPP) agenda.

The overall Nightingale Award winner was Mary Bilous, diabetes specialist nurse, who received three nominations, two by consultant colleagues and one from a midwifery colleague, which reflected her outstanding achievements personally, professionally and above all in the care she gives to patients.

Her commitment to developing services has led to publishing and presenting at national and international level and she is involved in teaching a nationally recognised course in her specialty.

Other winners included:

• Friends of the Friargate award - children’s unit staff, paediatrics
• Matrons’ award - ward 8 staff
• Military award - Kathleen Boon, warrant officer, class 1, Gara ward
• The Debbie Ford memorial award - Dawn McCabe, nursery nurse/play leader, ward 22
• The Elaine Thorpe memorial award - Rachel Lavelle, project midwife, maternity unit
• The McCormack patients award - Mr David Chadwick’s nursing and support team, ward 5

Thank You Awards

In June, the trust held its Thank You Awards, which recognise members of staff or a team who have gone above and beyond the call of duty.

A total of 15 staff awards were handed out for a variety of reasons including an endless search for missing jewellery (which was found), a member of staff looking after a patient’s dog for a month, extraordinary deeds during the severe snowfall in the winter months and outstanding practice at work.

Four ‘star’ plaques were also presented to South Cleveland Heart Fund, The James Cook University Hospital Voluntary Services, The Friends of the Friargate and the WRVS in recognition of the massive contribution they make to the trust.

Anyone who works in the trust’s hospitals or community services can be put forward for a Thank You Award and nominations are looked at by a panel of senior trust staff and governors.

Forms are in the hospital or alternatively you can nominate an individual, or team, by sending details to margaret.blakey@stees.nhs.uk

Staff flu campaign

The trust’s flu campaign began in the autumn with the occupational health team offering all staff the opportunity to be protected against the dominant strains of flu in circulation this year.

As an organisation we do have a duty to ensure all of our staff and volunteers, who have a direct role in caring for patients, are offered this vaccination. By getting the vaccination staff are not only protecting themselves but also their families, patients and the NHS services we provide both in hospitals and the community.

This year the Department of Health set a vaccination target of 60% for trusts and our overall uptake was 50.8% with 4,070 healthcare workers being vaccinated from a potential 8009 (the highest workforce in the region).
This included:

- Doctors - 68.58%
- Nurses, midwives and health visitors - 43.9%
- Professionally qualified staff - 57.2%
- Support to clinical staff - 51.2%

While we did not reach the national target, we did increase our uptake by 4% despite having 2,000 more eligible staff from community services to immunise.

To ensure we delivered an effective, targeted, campaign, the occupational health team first focused on the priority areas most likely to be affected by an outbreak of flu which include critical care, acute medicine, maternity, paediatrics and accident and emergency. Staff working in these areas were also sent a ‘golden ticket’ allowing them priority vaccination in central areas during general drop-in clinics.

A steering group was also set up in January to take forward any lessons learned from the national campaign and to try and improve our uptake rates even further in 2012/2013.

Jane recognised for improving HIV detection rates

Jane Gibson, specialist nurse for HIV and viral hepatitis, had the honour of being named as a finalist in the Nursing Standard Nurse of the Year 2011 Awards. Jane, who is based in the centre for clinical infection at James Cook, was ranked second in the country in the community nursing category earning her an invitation to 10 Downing Street.

The special commendation recognised the work Jane and her team had done to move HIV testing into local communities and make it available in non-clinical settings. Working in partnership with Teesside Positive Action, the project has helped the team reach more vulnerable people, increasing early detection rates.

Bright Ideas in Health

Staff from the pain directorate won the ‘Bright Ideas in Health Awards 2011’ in the innovative service delivery category for their new technique to help patients control and manage pain effectively during painful treatments such as lithotripsy – a non-invasive procedure to crush kidney stones still in the body.

North east apprentices celebrate success

The region’s NHS recently recognised the outstanding dedication, hard work and enthusiasm of its apprentices at the first ever NHS North East Apprenticeships Celebrating Success Awards.

Twenty apprentices who had excelled in their work were invited to the awards, hosted by NHS North East and supported by Aimhigher, including two from South Tees - Craig Sandwith and Harriet Potter.

Mentoring accolades

Staff nurses Kim Connolly and Sadah Laheji in the Friarage Hospital’s accident and emergency department received the ‘Outstanding Practice Mentor Award’ from the University of Teesside in recognition of their exemplary clinical teaching and mentoring skills for student nurses.

Seven-day service wins national award

The cardiothoracic team of physiotherapists at James Cook won the Chartered Society of Physiotherapists’ (CSP) Service Excellence Awards for introducing a seven-day service based on a new shift pattern.

The new service means patients who had coronary artery bypass surgery have improved access to the intensive rehabilitation services they need, resulting in patients leaving hospital 0.6 days quicker on average and saving the NHS £85,000 over the course of a year.

Across all cardiothoracic surgical conditions, the team has also reduced the length of stay for patients by two bed-days, which helped increase the number of patients that were able to pass through the department.
Our staff

Outstanding medical contribution to heart services

Nurse consultant in cardiac rhythm management, Jayne Mudd, became the first non-doctor to win the prestigious Arrhythmia Alliance award for her ‘Outstanding Medical Contribution to Cardiac Rhythm Management Services.’

Jayne and her team assess, diagnose and treat patients with arrhythmia - a condition whereby the heart beats too slowly, too fast or irregularly. As well as providing this service at James Cook, they have developed outreach clinics in the Middlesbrough, Redcar and Cleveland area. This has improved access for patients and significantly reduced the need for hospital attendance for this group of patients.

Centralised e-rostering

E-rostering can bring together, in one central place, management information on shift patterns (including individuals’ preferred shift patterns), annual leave, sickness absence, staff skill mix and movement of staff between wards.

This enables managers to quickly build rotas to meet patient demand, while staff can access the system to check their rotas and make personal requests.

From October, the trust rolled out a centralised e-rostering process across 65 of the larger wards and departments in the James Cook and Friarage hospitals through a central team.

The system was put in place to help produce more efficient rosters of existing registered and non-registered nursing staff thereby reducing reliance on expensive and higher risk bank and agency staffing. In turn, it also contributes to the patient safety and quality agenda by helping to ensure the appropriate levels of skilled and trained staff are working in the right areas to deliver high standards of patient care.

Following a six-month review in April 2012, the system will now be rolled out for remaining teams, wards and departments in both acute and community settings.

Staff sickness absence

We have a duty to manage employee absence appropriately. To do this, we work with local staff side representatives to develop policies and procedures which reflect best practice, comply with national guidance and terms and conditions of service and legislative requirements, most notably around disability.

The level of sickness absence in 2011/12 was 4.45% - a 0.15% improvement on the previous year’s figures although the trust was behind plan on its locally agreed target.

The management of sickness absence is a key objective for the trust in 2012/2013 and a project group is being set up to review our sickness absence policy, procedures and guidelines.

Staff survey

The ninth annual staff survey was carried out between October and December 2011 and after listening to staff feedback through the chief executive’s blog, it was decided a sample survey would be carried out.

A total of 437 staff completed the questionnaire, including, for the first time, the community services division and the response rate was 52%, which is comparable to the average acute trust return.

The Care Quality Commission’s report on the trust’s results was summarised around 38 key findings and structured around the NHS Constitution under six headings - clear roles, personal development, health and wellbeing, staff engagement, staff satisfaction and equality and diversity.

Questions in the standard questionnaire were broken down into the following areas:

- Work-life balance
- Training, learning and development,
- Your job and your organisation
- Errors, near misses and incidents
- Violence, bullying and harassment
- Occupational health and safety
- Infection control and hygiene
- Health and well-being
Compared against other acute trusts, our results were positive overall. South Tees was in the top 20% for 16 key findings, compared to 21 in the 2010 survey, and better than average for ten key findings.

We were also in the lowest 20% for two of the key findings - staff agreeing their role makes a difference to patients (88% - national average - 90%) and staff motivation at work - 3.75 (based on one to five scale - one being not enthusiastic/absorbed while five is fully enthusiastic/absorbed)

However looking at our 2010 results, there has been no major change in any of the findings which has prompted the trust to ask the question - how do we get some momentum around improvement in this area?

Our top ranking scores were:

**KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months**

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<th>Percentage score</th>
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<tr>
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<tr>
<td>National 2011 average for acute trusts</td>
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**KF38. Percentage of staff experiencing discrimination at work in the last 12 months**

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<td>National 2011 average for acute trusts</td>
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**KF24. Percentage of staff experiencing physical violence from staff in last 12 months**

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<tr>
<td>National 2011 average for acute trusts</td>
<td>1%</td>
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**KF20. Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month**

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<th>Percentage score</th>
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<tbody>
<tr>
<td>Trust score 2011</td>
<td>29%</td>
</tr>
<tr>
<td>National 2011 average for acute trusts</td>
<td>34%</td>
</tr>
</tbody>
</table>
Our staff

South Tees Hospitals NHS Foundation Trust Annual Report 2012

Our least positive scores were:

**KF2. Percentage of staff agreeing that their role makes a difference to patients**

<table>
<thead>
<tr>
<th></th>
<th>Percentage score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2011</td>
<td>88%</td>
</tr>
<tr>
<td>National 2011 average for acute trusts</td>
<td>90%</td>
</tr>
</tbody>
</table>

**KF35. Staff motivation at work**

<table>
<thead>
<tr>
<th></th>
<th>Percentage score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2011</td>
<td>3.75</td>
</tr>
<tr>
<td>National 2011 average for acute trusts</td>
<td>3.82</td>
</tr>
</tbody>
</table>

**KF16. Percentage of staff receiving health and safety training in last 12 months**

<table>
<thead>
<tr>
<th></th>
<th>Percentage score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2011</td>
<td>77%</td>
</tr>
<tr>
<td>National 2011 average for acute trusts</td>
<td>81%</td>
</tr>
</tbody>
</table>

**KF21. Percentage of staff reporting errors, near misses or incidents witnessed in the last month**

<table>
<thead>
<tr>
<th></th>
<th>Percentage score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2011</td>
<td>96%</td>
</tr>
<tr>
<td>National 2011 average for acute trusts</td>
<td>96%</td>
</tr>
</tbody>
</table>
There are improvements in areas such as staff feeling satisfied with the quality of work and patient care they are able to deliver, staff appraisals, perceptions of effective action from their employer towards violence and harassment and staff experiencing discrimination at work.

During the year, divisions and directorates continued to take forward developments from their own staff survey action plans. For example, a divisional day where staff could drop-in, hear about developments and give feedback, was held in specialty medicine.

The Improving Working Lives leads group continues to meet bi-monthly, integrating the various strands such as staff engagement and health and wellbeing, with a nurse representative from occupational health.

Emerging themes from the 2011 staff survey suggest that the trust should focus on the following areas:

- Continued development of strategies for corporate themes, such as staff engagement and motivation
- Sustaining the developments that have been made in key areas such as appraisals and health and wellbeing
- Reinforcement of incident reporting procedures and the benefits of doing so to improve perceptions of staff reporting errors, near misses or incidents witnessed in the last month
- Reviewing organisational frameworks/structures that support the corporate themes
- Further developments in equality and diversity

**Equality and diversity**

As we engage with more staff, patients and service users to develop healthcare, it is important we ensure the needs of everyone in the population are met. From 6 April 2012, the trust is now required to publish equality objectives in response to the Equality Act 2010 (Specific Duties) Regulations 2011.

To help NHS organisations identify objectives, the Department of Health developed the Equality Delivery System (EDS) – a set of 18 outcomes grouped into four goals. These focus on the issues of most concern to patients, carers, communities, NHS staff and Boards with four key goals:

- Better health outcomes for all
- Improved patient access and experience
- Empowered, engaged and included staff
- Inclusive leadership at all levels

The act also includes ‘protected characteristics’ on age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

In order to identify and agree the objectives, a small group of clinical and corporate representatives was set up to gather evidence against the goals and outcomes of the EDS and set the objectives and two focus groups were also held.

The objectives - agreed by the Board of Directors - will be embedded across the whole organisation as part of the trust’s integrated business plan for 2012/2013 and in future, all equality and diversity issues will be considered as part of the annual integrated business planning cycle so that the objectives are reviewed regularly and actions to deliver them identified.

Full details of our objectives are available on the trust’s website at [www.southtees.nhs.uk](http://www.southtees.nhs.uk) but in summary they are:

1. **Information collection for all protected characteristics for patients**

   Currently we do not routinely collect information on all protected characteristics from patients but this is essential if we are to assess our services properly. By April 2013, collection of information on all protected characteristics for patients will be routine.

2. **Objective 2 - Increase the trust’s engagement with patients and the public from all protected characteristics.**

   The trust does not systematically engage with patients and other members of the public from some of the protected characteristics although we do obtain views a variety of ways. By April 2013 we will have established or joined engagement groups focused on the protected characteristics by reviewing what we have already and identifying any gaps.
Our staff

South Tees Hospitals NHS Foundation Trust Annual Report 2012

3. Objective 3 - Improve the experience of older people using our services

A number of high profile reviews and media reporting have highlighted shortcomings in the dignity and care of older people using NHS services. While all the evidence indicates that our services for older people are of good quality, we aspire to provide the highest quality services possible and we recognise that improvement is still possible. By April 2013, we will have set up a trust-wide older people’s strategy and aim to meet the dementia CQUIN goal.

4. Objective 4 - Mandatory equality and diversity training for all staff

We need to make equality and diversity (E&D) training mandatory for all staff, ensuring everyone has clear roles and responsibilities around equality and diversity. By April 2013, this will be part of the trust’s mandatory training requirements and by April 2016 all available staff will be compliant with the E&D mandatory training requirement.

5. Objective 5 - Discrimination, bullying and harassment of staff

By April 2016, to have reduced the incidence of discrimination, bullying and harassment of all staff, and significantly reduced the incidence for staff with a disability, as reported in the NHS staff survey.

Breakdown of workforce statistics

<table>
<thead>
<tr>
<th></th>
<th>Staff 2010/2011</th>
<th>%</th>
<th>Staff 2011/2012</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-16</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>17-21</td>
<td>94</td>
<td>1.3</td>
<td>101</td>
<td>1.14</td>
</tr>
<tr>
<td>22+</td>
<td>7,417</td>
<td>98.7</td>
<td>8,787</td>
<td>98.86</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>6,119</td>
<td>81.5</td>
<td>7,357</td>
<td>82.77</td>
</tr>
<tr>
<td>Mixed</td>
<td>38</td>
<td>0.5</td>
<td>45</td>
<td>0.51</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>278</td>
<td>3.7</td>
<td>286</td>
<td>3.22</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>34</td>
<td>0.5</td>
<td>37</td>
<td>0.42</td>
</tr>
<tr>
<td>Other</td>
<td>139</td>
<td>1.9</td>
<td>125</td>
<td>1.41</td>
</tr>
<tr>
<td>Unknown</td>
<td>904</td>
<td>12</td>
<td>1,038</td>
<td>11.68</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1,472</td>
<td>19.6</td>
<td>1,546</td>
<td>17.39</td>
</tr>
<tr>
<td>Female</td>
<td>6,039</td>
<td>80.4</td>
<td>7,342</td>
<td>82.61</td>
</tr>
<tr>
<td>Trans-gender</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Recorded Disability</td>
<td>110</td>
<td>1.5</td>
<td>134</td>
<td>1.51</td>
</tr>
</tbody>
</table>

*Workforce numbers did rise in-year after community services staff from Hambleton, Richmondshire, Middlesbrough and Redcar and Cleveland transferred to the trust in April 2011*
Health and wellbeing

A free ten-week ‘shape up’ programme was launched for staff committed to managing their weight and gain new skills to support long-term lifestyle changes. The service aims to:

- Limit further weight gain
- Achieve modest weight loss
- Get into a regular eating pattern
- Balance the types of food that staff eat
- Become more physically active
- Learn new lifestyle skills
- Sustain their changes

Olympic 2012 workforce project

The trust was successful in winning a bid for funding to support the health and wellbeing agenda using the Olympics as a theme. The project involves running taster sessions for various sporting activities staff can enrol onto, with the aim they will be encouraged to take part, increase their activity levels and improve their overall health, as well as hopefully continuing with their chosen sporting activity on a longer term basis.

Health advocates

The occupational health team continues to look for staff who have a real interest in health and wellbeing to train to become health advocates, acting mainly as a promoter and sign-poster for health at work. All health advocates receive one-day of training (free to attend) where they will meet other health advocates and gain knowledge, information and skills essential for promoting health and wellbeing throughout the workplace.

Staff engagement

Staff engagement continues to be at the heart of the workforce strategy group and divisions and directorates were involved in a range of activities to enhance staff engagement, communication and motivation.

Health and safety

The trust takes all reasonable steps to secure the health and safety of staff who may be exposed to the risk of aggression, violence or abuse in the workplace.

Tackling violence and aggression requires careful co-ordination and planning to bring together various clinical and management approaches to this serious issue. While it is rare for serious assaults to occur, the level of harm to any individual from assault or abuse can affect staff in different ways, and as an organisation we promote a zero tolerance approach to violence.

In 2011/2012, the trust saw a 16% drop in the number of assaults against staff from 157 incidents to 131. These included the number of assaults by patients with cognitive problems and alcohol-related assaults.
“We’ve worked together to provide an innovative approach to pharmacy services that will deliver real benefits to patients and the NHS”
Partnerships and Engagement

South Tees Hospitals NHS Foundation Trust Annual Report 2012

Partnership is essential to our work in delivering and designing healthcare services around the needs of patients and carers. We achieve this through meaningful engagement - and involvement - with patients, carers, staff and our healthcare partners and other agencies to shape current and future service delivery.

Looking at the future sustainability of children’s and maternity services

During the spring, leading GPs and hospital clinicians began a period of engagement with the public on the future of children’s and maternity services at the Friarage Hospital.

Members of the Hambleton, Richmondshire and Whitby Clinical Commissioning Group (CCG) started a three-month public engagement exercise from April 2012, involving meetings, focus groups, surveys.

Since the autumn, the CCG has been in discussions with clinicians and managers from the trust about the future of children’s and maternity services after senior doctors raised concerns regarding their long-term sustainability.

These were backed by an independent report by the National Clinical Advisory Team (NCAT), who provide clinical experts to support, advise and guide the local NHS on service reconfiguration proposals to ensure safe, effective and accessible services for patients.

The review team’s advice following a visit to the Northallerton hospital, is that while a first class service is currently being provided by staff, the inpatient paediatric service at the Friarage is not sustainable for the future because:

- Of the difficulty of maintaining a workforce with the right skills, and
- If children are sick and need inpatient care, they should be cared for in a unit which has a full range of paediatric services backed up by high dependency and intensive care facilities, which the Friarage Hospital cannot provide.

The report also recognised that any changes in children’s services would, in turn, have an impact on the maternity service as paediatricians have to be available if there are complications with the baby at birth and to cover the special care baby unit.

While children’s services at the Friarage are highly valued by the local population, our ability to deliver and sustain such high quality services has come under increasing pressure.

A lot more work still needs to be done to understand what would be the best model of care for the future, which is why, with the CCG, we are having wider discussions with the local population.

As local leaders of the NHS, we are committed to the future of the Friarage and are determined it continues to be a high quality hospital providing safe and sustainable services and the front-door into local healthcare for the local population.

People can access further information or give their feedback in a number of ways:

Website: www.nyypct.nhs.uk/friarage

Social media: visit web page above for links to Facebook and Twitter

Email: nyy-pct.friarage@nhs.net

Telephone: 0800 06 88 000

Write to: Hambleton, Richmondshire and Whitby CCG, FREEPPOST RSHB-UTRR-LZUA, The Hamlet, Hornbeam Park, Harrogate HG2 8RE

Information can also be found on the trust’s website at www.southtees.nhs.uk
Partnerships and Engagement

Unique partnership pilot launched to improve support for older patients

A unique partnership was launched with the WRVS to help improve hospital support for older patients and the vulnerable.

Over the years, the WRVS has been one of the trust’s most valued supporters, raising hundreds of thousands of pounds for various pieces of equipment but their last donation of £35,000 is being put towards something different.

To reflect current changes in the health service to move care closer to patients’ homes, the money will part-fund a pilot project offering a new model of patient support service.

Already the WRVS runs the independent living for older people (ILOP) service in Middlesbrough, which cares for many of the people who are also the trust’s patients, and its experience in other parts of the country has shown there is greater scope to recruit and manage volunteers to play a greater role in supporting people needing hospital care. The pilot scheme will:

• Specifically look at the opportunities to integrate volunteers into ward teams and identify other volunteering options
• Identify how volunteers can help to improve the discharge process
• Develop strong links with the ILOP service
• Forge links with other third sector groups and develop a third sector forum that adds value to the WRVS’ work in the trust
• Identify future funding options for the new model of patient support service.

Centralised service for bereaved families

A new bereavement service has opened for families whose loved ones have died in hospital. The dedicated centralised service at James Cook means that instead of having to make a painful journey back onto the hospital ward to collect medical certificates and then attend an appointment at Middlesbrough register office, families can now book one appointment with a small team who handle the entire process.

The trust has worked closely with Middlesbrough Council to provide the new service and a registrar works full-time on site five days a week. The new facility has three rooms – one for the bereavement team, a relatives’ room and the registrar’s office.

Under the new service, when someone dies on a ward, staff will hand the family a bereavement booklet explaining that someone from the service will telephone them the next working day and an appointment is then booked.

The team also acts as a signposting service for relatives and the rest of the trust and will liaise with the coroner’s office, if necessary, and funeral directors.

New pharmacy

Sainsbury’s and Healthcare at Home was chosen by the trust to provide its outpatient dispensing operation at James Cook. The facility is a first for Sainsbury’s which until now has concentrated on opening pharmacies in its supermarkets across the country.

The new pharmacy has better - and longer - opening hours for patients and also provides additional services to visitors and staff which are not currently available. As it is open longer hours, it also helps departments, such as accident and emergency, and clinics which run later on a day.

Summary Care Record

The summary care record (SCR) is an electronic patient summary containing key clinical information from the GP record which gives healthcare staff faster, easier access to essential information about a patient and helps them provide safe treatment when they need care in an emergency.

As part of a pilot scheme at James Cook, the SCR was rolled out in parts of the hospital - accident and emergency, wards 1 and 15 and ward 28 - allowing clinicians to gain access to patient information which is held by GPs (subject to the patient’s consent).

It is hoped this patient safety initiative will help to reduce the risk of prescribing errors and adverse reactions to prescribed medication; increase efficiency and effectiveness by reducing time, effort and resource required to share information
across different NHS organisations and increase quality of patient care.

Our partnership with the military

A special presentation was held in-year to celebrate the trust’s continued links with the military through the ministry of health defence hospital unit (MDHU) at the Friarage.

Both organisations benefit from close working arrangements, MDHU staff have the opportunity to develop their clinical skills for use on operations while the trust benefits from the input of staff who have gained experience on duty.

Our volunteers and charities

We would like to thank our volunteers, patients, carers, staff and local communities who, throughout the year, have organised fundraising events and given donations and legacies.

Your support has really made a difference to the lives of people who need the trust’s services and while it is impossible to mention everyone individually, we do gratefully acknowledge everyone for their generosity and support.

At the trust we do have a general charitable fund (South Tees General Charitable Fund) but in line with many other NHS charities, we took the decision to adopt a more proactive approach to fundraising and in August 2011 set up a charities office as part of the chief executives department.

Through this we can provide more advice and support to fundraisers as well as those staff within the trust who manage individual charitable funds.

Our charity has a total of 376 charitable funds to support hospitals, wards and services, and over the last year received a total of £1.32million in donations.

As well as the hundreds of people who raised money for us over the last year, we also received a number of legacies, the largest of which was for £212,162 bequeathed to the paediatric department at James Cook.

Our staff are always very touched and grateful when patients and relatives remember the care they gave in this way, and here are just some of the other legacies that we have also received in the last year:

- £25,000 for the palliative care team at James Cook
- £20,302 to buy equipment at James Cook
- £25,000 for the general purpose fund at James Cook
- £19,221 for Redcar Primary Care Hospital
- £4,805 for Middlesbrough district nurses comfort fund

Further details are available in the trust’s general charitable funds annual report which is available from the charities office at James Cook.

Changing healthcare services - health and well-being boards

The government has released a number of white papers setting out their intentions to radically change healthcare services. The new approach empowers individuals to make healthy choices and shifts control from central government to local authorities to ensure the needs of local communities are better addressed.

The key changes are:

- Improved patient choice around healthcare providers and treatment available
- Establishing an independent commissioning body
- Transfer of commissioning to GPs and the abolition of primary care trusts (PCTs) and strategic health authorities (SHAs)
- Transfer of public health responsibility and budget to the local authority
- Creation of a health and well-being board which will have statutory responsibility to drive forward health priorities for the local area
- Creation of Healthwatch (at local and national levels) to promote and support the involvement of local people in health and social care decisions
- Greater integration and partnership working between key agencies

Health and well-being boards are being established in each local authority area to act as a statutory body to coordinate all local health provision from April 2013 and will act as the decision-making body for all components of the health transformation programme.
In Middlesbrough, for example, the shadow board consists of the:

- Chief executive of the council (chair)
- Executive member for public health
- Director of environment and social care
- Director of children families and learning
- Locality director of public health
- Chair of the Middlesbrough clinical consortia
- Chief executive of NHS Tees (PCT)
- Chief Executive of South Tees Hospitals NHS Foundation Trust
- Vice chairman of Tees, Esk and Wear Valleys NHS Foundation Trust

The trust will be a major contributor to these boards and recognises the key role they play as part of broader plans to modernise the NHS.

Through them we hope to ensure stronger democratic legitimacy and involvement, strengthen our working relationships between health and social care, and encourage the development of more integrated commissioning of services.

As a result, patients and the public should experience more joined-up services from the NHS and local councils in the future. The boards will also help give communities a greater say in understanding and addressing their local health and social care needs.
Over 5,000 telephones and over 800 miles of cabling connect our communications equipment - which would stretch from John O’Groats to Land’s End.
In 2011, 5,685 babies were born in our hospitals.
Carbon management plan

The trust now has an approved carbon reduction management plan to reduce the organisation’s carbon emissions with the main objectives of:

- Ensuring the delivery of an achievable and challenging carbon management plan
- Embedding a process of engagement and cultural change so that carbon management becomes part of routine management of the trust at both strategic and operational levels

We have set ourselves a target of reducing carbon dioxide (CO2) emissions from our operations by 25% - the equivalent of 7,285 tonnes - by 2014/2015 from the 2009/2010 levels (29,141 tonnes).

We are also working with our partners in the wider health economy to reduce carbon emissions in the community and have identified four key themes for action on carbon reduction:

- Improvements to the build environment - investing in improvements to the built environment (engineering and building) to improve emergency efficiency
- Behavioural change - raising awareness and changing behaviours and attitudes among staff towards carbon reduction. This includes a targeted reduction in carbon as a result of business-related travel
- Policy alignment - reviewing existing policies and procedures to ensure carbon management is embedded in the routine management of the trust at strategic and operational level
- Community engagement - working with our colleagues in community services to look at real opportunities to reduce carbon emissions in the community and to ensure the commissioning of health services takes carbon reduction into consideration

To help take this important agenda forward we also appointed an energy and sustainability advisor in-year to lead on initiatives to reduce our carbon emissions, waste management, water use and all other organisational impacts on the internal and external environment.

As the largest public sector organisation, the NHS is committed to reducing its own carbon footprint to protect the health and future wellbeing of the population it serves.

At South Tees, we want to play a leading role in developing a sustainable NHS and combating climate change. We have developed our own strategy to minimise - by the sustainable management of energy, water, transport and waste - the environmental impact of our buildings and operations.

Sustainability

South Tees Hospitals NHS Foundation Trust Annual Report 2012
As part of our cancer redevelopment, the new Endeavour Building was also designed to achieve an ‘excellent’ BREEAM rating - the standard for best practice in sustainable building design - and has used many sustainable technologies including a ground-source heat pump, rainwater harvesting and natural ventilation principles.

Old boilers have also been replaced at Eggleston Court (home to our IT staff) and the haematology day unit fitted with high efficiency boilers.

In 2012/2013 we plan to introduce solar thermal panels on both the James Cook and Friarage sites and a biomass boiler at the Friarage, as well as launching a number of behavior change campaigns including ‘switch it off’!

A summary of the trust’s performance in reducing its carbon footprint in 2011/2012 is show below:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Waste minimisation and management</td>
<td>Absolute values for total amount of waste produced by the trust</td>
<td>2,194 tonnes</td>
<td>2,081 tonnes</td>
<td>Expenditure on waste disposal</td>
</tr>
<tr>
<td>Finite resources</td>
<td>Water</td>
<td>355,633 m³</td>
<td>343,373 m³</td>
<td>Water</td>
</tr>
<tr>
<td></td>
<td>Gas</td>
<td>110,273 GJ</td>
<td>108,296 GJ</td>
<td>Gas</td>
</tr>
<tr>
<td></td>
<td>Electricity</td>
<td>269,429 GJ</td>
<td>261,869 GJ</td>
<td>Electricity</td>
</tr>
</tbody>
</table>
Centralised recycling

The first phase of a project to centralise recycling of waste began at James Cook after the trust’s private sector partner Carillion - which is responsible for waste collection at the hospital - appointed recycling company, Sita UK, both to manage recycling and to raise staff awareness and skills to support their efforts.

It was also the start of our efforts to push the target of achieving a 30% reduction of landfill disposal to a recycling route.

A wide range of materials are targeted for recycling including general waste, dry mix recycling, cardboard, paper, food, plastics, linen, wood, metal, green waste, mattresses and electrical items.

Since the introduction of the scheme in January, recycling of waste has increased by 15% but we are committed to increase these rates even further in both clinical and non-clinical areas and are also exploring the opportunities to introduce recycling in other hospitals, such as the Friarage Hospital.

Good corporate citizenship model

The Good Corporate Citizenship Assessment Model was produced by the Sustainable Development Commission in 2006 and later revised in 2009 in co-operation with the NHS Sustainable Development Unit.

It is a tool that helps organisations to assess their contribution to sustainable development and its emphasis is putting social, economic and environmental considerations at the heart of decision-making; ensuring day-to-day activities support, rather than hinder, progress with sustainable development and using your organisation’s purchasing power, influence and resources to help deliver strong, healthy and sustainable communities.

The six key areas of the model are travel, procurement, facilities management, workforce, community engagement and buildings and we are using the tool as another way of introducing sustainable development into the work of the organisation as a whole.

Legacy Award

The trust, in partnership with its design and construction partners, was commended in the Constructing Excellence in the North East Awards for the cancer redevelopment, which included building a stand-alone radiotherapy department - the Endeavour Unit.

The commendation was made in the ‘legacy award’ for applying sustainable construction principles, applying sustainable development principles and delivering a sustainable legacy.

Staff’ travel survey

As part of Department of Health guidelines and the trust’s responsibility as a healthcare provider, we have a healthy transport/travel policy. Given the current pressures on car parking - in particular on the James Cook site - a staff travel survey was sent to all staff working in the Middlesbrough hospital.

The aim of the survey was to get a snapshot of how staff travel to work and what would encourage them to use other forms of transport other than their car. The response rate was 44%.

In summary, single person car journeys had reduced to 78% - the lowest since 2002 - although we recognise this is still a high number. All other modes of travelling to work showed an increase - walking doubled, cycling increased from 2% to 5% and public transport remained the same.

This was a good result for the trust and shows all the work we have done to promote the healthy transport/travel policy is starting to have a positive effect on changing staff culture.

In 2012/2013, our main focus will be car sharing and improving our existing staff scheme, although we are also looking to develop a one-stop shop on the environmental desk so all travel needs can be addressed in one area.

We have also been an active partner in the Tees Valley at looking to develop a rail halt at the back of the hospital.
Sustainability

South Tees Hospitals NHS Foundation Trust Annual Report 2012

The staff travel survey is now being shared with colleagues in Middlesbrough Council, local bus operators, the trust's bicycle user group (BUG), Middlesbrough transport partnership and Middlesbrough transport theme group and the Healthy Towns project.

Bike lockers/cycle compound
The trust has individual lockers on both its acute hospitals sites, which are free to rent for a small deposit. At James Cook, where we have 265 lockers, there is currently a waiting list and we are in the process of installing a cycle compound which consists of 60 ‘sheffield stands’ enclosed in a clear plastic unit. This will be accessed by swipe card only and monitored by CCTV.

Six lockers, and a sheffield stand rail, has also been installed at the Eggleston Court site, where many IT staff are based, and this is operated on a first come first served basis.

Bike salary sacrifice
In year the trust also ran a bike salary sacrifice scheme through ‘Bikes for the NHS’ and 116 members of staff purchased bicycles. The scheme will now run on a rolling schedule.

Car sharing
As the trust's staff travel survey showed us that over a third of staff would be willing to try car-sharing as a more environmentally friendly option, we are in the process of setting up a car sharing database in partnership with Liftshare.

This is a bespoke car sharing scheme, which links into the largest car-sharing database in the UK, and for staff in the trust's car sharing scheme benefits include reduced car parking fees, free taxi rides home in cases of emergency and guaranteed parking.

Emergency planning and preparedness
The Civil Contingencies Act (CCA) 2004 places a number of statutory duties on the trust as a category 1 responder. These duties include:

- Risk assessment to inform contingency planning
- Emergency planning
- Business continuity planning
- Co-operation with other responders to enhance co-operation and efficiency
- Information sharing with other responders
- Warning, informing and advising the public in the event of an emergency

Our duties under the act are encompassed in the NHS Emergency Planning Guidance (2005) which sets out general principles to guide all NHS organisations in developing their ability to respond to a major incident or emergency:

“Health care organisations will protect the public by having a planned, prepared and where possible practiced response to incidents and emergency situations which affect the provision of normal services.”

With the transfer of community services in April 2011, further work was carried out on the major incident plan to integrate their major incident response arrangements with the trust's existing ones to create a single major incident plan.

As the trust needs to be resilient to a range of business disruptions such as fire, unexpected loss of staff, loss of information - to name a few - we also have a statutory duty to be prepared for these risks to our ability to deliver critical services.

Business continuity management (BCM) helps manage the risks to an organisation by ensuring that the services it delivers can continue operating to, at least, a pre-determined minimum level, in the event of a major disruption and we have started to roll-out a BCM system for the organisation.
We also took part in a major incident exercise in October - Exercise Peregrine - which tested the region’s major trauma system response and casualty management during a ‘mock’ incident involving a hazardous material, resulting in multiple casualties. The exercise was successful and highlighted many examples of good practice, which have been incorporated into the trust’s own plans.

Our priorities for 2012/2013 are to:

• Continue to raise awareness of emergency planning and resilience within the organisation
• Conduct a trust-wide simulated major incident exercise
• Develop and test whole hospital evacuation plans for each of the trust’s acute and community hospitals in line with Department of Health guidance
• Review and update the pandemic influenza operational response plan and supporting arrangements in line with current Department of Health guidelines
• Develop and test business continuity plans
• Review and update the heatwave plan
• Continue to develop the emergency planning training and exercise programme
“You should be proud to have such expert, efficient and dedicated staff. They are the trust’s biggest asset”
Every NHS foundation trust should be headed by an effective board of directors, since the board is collectively responsible for the exercise of the powers and the performance of the NHS foundation trust.

This is done through its role of:

- Providing effective and proactive leadership of the NHS foundation trust within a framework of processes, procedures and controls which enable risk to be assessed and managed
- Ensuring compliance with its terms of authorisation, its constitution, mandatory guidance issued by Monitor, relevant statutory requirements and contractual obligations
- Setting the trust’s strategic aims (at least annually) and leadership of the trust
- Ensuring the quality and safety of healthcare services, education, training and research are delivered and applying the principles and standards of clinical governance set out by the Department of Health, the Care Quality Commission and other relevant NHS bodies
- Exercising its functions effectively, efficiently and economically
- Setting the trust’s vision, values and standards of conduct and ensuring that its obligations to its members, patients and other stakeholders are understood, communicated clearly and met
- Note advice from - and consider the views of the Council of Governors

The South Tees’ Board is made up of six executive directors and seven non-executive directors, including the chairman. It also has two non-voting executive directors - the director of human resources and the director of IT and health records.

All directors must take decisions objectively in the interests of the NHS foundation trust and all members of the Board have joint responsibility for every decision regardless of their individual skills or status - the concept being that both non-executive directors and executive directors share the same responsibility.

This does not impact upon the particular responsibilities of the chief executive as the accountable officer.

As part of their role as members of a unitary board, non-executive directors have a particular duty to ensure appropriate challenge is made and scrutinise the performance of the executive management in meeting agreed goals, objectives and financial and clinical quality controls.

Non-executive directors are responsible for determining appropriate levels of remuneration of executive directors and have a prime role in appointing, and where necessary, removing executive directors and in succession planning.

Responsibility for the appointment of the chairman and non-executive directors resides with a committee of the Council of Governors, which comprises of three members of the Council and two directors (including at least one non-executive director).

Executive directors are appointed by the nominations committee of the Board on a permanent contract and two new appointments were made in-year – the director of finance and the director of human resources.

The role of the nominations committee, which is a sub-committee of the Board of Directors, is to review the Board and made recommendations for changes where appropriate.

The committee will also establish the nominations process for the identification and nomination of the executive directors and confirms the appointment of executive directors, with the exception of the chief executive.

Membership is flexible as members of the Council of Governors are also appointed to the committee for appointments where the Council of Governors has responsibility – the posts of chairman and non-executive directors.
In 2011/2012, membership included the chairman Deborah Jenkins, non-executive director Pauline Singleton, director of human resources Chris Harrison and governors Maureen Rutter, Mary Bilous and Jean Herbert.

The trust used one of the UK's leaders in executive search to help with the appointment of the director of finance and also went to external advert through the Chartered Institute of Professional Development for the director of human resources post.

The make-up of the Board of Directors is set out in a table on page 77 to 79 and includes details of background, committee membership and attendance.

The Board may delegate any of its powers to a committee of directors or to an executive director and these matters are set out in the Scheme of Decisions reserved to the Board and the Scheme of Delegation.

Decision making for the operational running of the trust is delegated to the management group, which comprises of executive directors and chiefs of service.

The board has an annual schedule of business which ensures it focuses on its responsibilities and the long-term strategic direction of the trust. Meetings to conduct its business, are held monthly in public (normally on the last Tuesday of each calendar month) and Board members also attend seminars and training throughout the year.

A rigorous evaluation of the board’s performance - and that of its committees and individual directors - is based on the Nolan principles of selflessness, integrity, objectivity, accountability, honesty, transparency and leadership.

Individual directors have had detailed appraisals in their roles using a range of techniques. An appraisal process is in place with regular review of objectives set by the chief executive.

A baseline assessment of skills, experience and competencies of all board members has been carried out to help inform an on-going development programme.

The chairman appraises the performance of the non-executives and makes recommendations to the Council of Governors, while the chairman’s appraisal is led by the senior independent director who makes a recommendation to the Council of Governors.

An annual appraisal process is in place and non-executive directors are involved in regular development activities including board workshops, seminars, conferencing and one-to-one coaching.

We consider we have the appropriate balance and completeness in the board’s membership to meet the requirements of an NHS Foundation Trust. The board maintains its register of interests and can confirm there are no material conflicts of interest in the board.

As far as the directors are aware, there is no relevant audit information of which the auditors are unaware.

The directors have also taken all of the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.
## Board of Directors

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Tenure</th>
<th>Board of Directors</th>
<th>Audit</th>
<th>Remuneration Committee</th>
<th>Nominations Committee</th>
<th>Council of Governors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deborah Jenkins MBE</td>
<td>Trust chairman since August 2008. Deborah is also chief executive of TDI - The Derwent Initiative, a national charity which promotes an inter-agency response to sexual offending - a visiting professor on leadership to the University of Newcastle and chair of the Barnard Castle Vision Partnership. Deborah is also the chairman of the nominations committee.</td>
<td>12/12</td>
<td>N/A</td>
<td>2/2</td>
<td>2/2</td>
<td>5/5</td>
<td></td>
</tr>
<tr>
<td>David Kirby</td>
<td>Deputy chairman. David joined the Board in June 2005 and is a chartered public finance accountant. David’s role as deputy chairman was reviewed in April 2012 and extended until 30 June 2013.</td>
<td>12/12</td>
<td>7/7</td>
<td>2/2</td>
<td></td>
<td>5/5</td>
<td></td>
</tr>
<tr>
<td>Pauline Singleton</td>
<td>Senior independent director. Pauline has been a non-executive director since February 2003 and is a retired teacher. (Extended tenure ends 31 January 2014).</td>
<td>10/12</td>
<td>N/A</td>
<td>2/2</td>
<td>1/2</td>
<td>4/5</td>
<td></td>
</tr>
<tr>
<td>George Ewart</td>
<td>Dr Ewart has been a non-executive director since July 2006. He spent eight years as general manager of ICI Wilton on Teesside and went on to be both chief executive and chair of ICI in India. (Current tenure ends 30 June 2012).</td>
<td>10/12</td>
<td>6/7</td>
<td>1/2</td>
<td></td>
<td>2/5</td>
<td></td>
</tr>
<tr>
<td>Hugh Lang</td>
<td>Hugh Lang was group airports director of Peel Airports Group from 2008 - 2010, with responsibility for the management and operation of Liverpool John Lennon Airport, Robin Hood Doncaster Sheffield Airport and Durham Tees Valley Airport. Following the sale of Peel Airports in 2010, Hugh continues to provide both Peel Airports and a range of UK and European airport/aviation companies with strategic advisory services. In both his airport capacity and as chairman of Tees Valley Unlimited (the governing body of the Tees Valley City region), Hugh has particular interests in the long term economic development of the region and the key drivers required to deliver positive growth. (Current tenure ends 5 January 2014).</td>
<td>11/12</td>
<td>5/7</td>
<td>1/2</td>
<td></td>
<td>5/5</td>
<td></td>
</tr>
<tr>
<td>Brenda Thompson</td>
<td>Brenda has been a non-executive director since September 2008 and is an executive member for public health and sport at Middlesbrough Council. (Tenure expires 31 August 2015).</td>
<td>11/12</td>
<td>N/A</td>
<td>1/2</td>
<td></td>
<td>2/5</td>
<td></td>
</tr>
<tr>
<td>Henrietta Wallace</td>
<td>Henrietta joined us as a non-executive director in August 2007 and has an MSc in public health from the London School of Hygiene and Tropical Medicine, a BA in human sciences from Oxford and gained a scholarship to St John’s College in Oxford in 1984. (Tenure expires 31 July 2014).</td>
<td>11/12</td>
<td>6/7</td>
<td>2/2</td>
<td></td>
<td>4/5</td>
<td></td>
</tr>
</tbody>
</table>
The Board of Directors

South Tees Hospitals NHS Foundation Trust Annual Report 2012

**Board of Directors**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Appointment Date</th>
<th>Committee Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simon Pleydell</td>
<td>chief executive</td>
<td>12/12</td>
<td>2/7 2/2</td>
</tr>
<tr>
<td>Tricia Hart</td>
<td>deputy chief executive / director of nursing / patient safety</td>
<td>10/12</td>
<td></td>
</tr>
<tr>
<td>Professor Robert Wilson</td>
<td>medical director</td>
<td>12/12</td>
<td>1 1 2/5</td>
</tr>
<tr>
<td>Jill Moulton</td>
<td>director of planning</td>
<td>12/12</td>
<td></td>
</tr>
<tr>
<td>Susan Watson</td>
<td>director of operational services</td>
<td>12/12</td>
<td>1 4/5</td>
</tr>
<tr>
<td>John Roebuck</td>
<td>director of finance (retired April 2011)</td>
<td>1/1</td>
<td></td>
</tr>
<tr>
<td>Jon Connolly (acting director of finance May 2011 to January 2012)</td>
<td></td>
<td>7/9 3/4</td>
<td></td>
</tr>
<tr>
<td>Chris Newton</td>
<td>director of finance</td>
<td>3/3</td>
<td>2/2 1/1</td>
</tr>
<tr>
<td>Sue Covill</td>
<td>director of human resources*</td>
<td>1/1</td>
<td></td>
</tr>
</tbody>
</table>

*Miss Covill joined the trust in November 2002 from Harrogate Health Care Trust where she worked as director of human resources and has extensive NHS experience in personnel.*
### Members’ interests
*(From 1 April 2011 to 31 March 2012)*

**Deborah Jenkins**  
Chief executive - The Derwent Initiative  
Director - Kindling Ltd (own company)  
Chair - Barnard Castle Vision  
Advisory board - Newcastle University Business School  
Chair - Northern Neonatal Network.

**Simon Pleydell**  
Member - NHS Employers policy board  
Member - NHS Employers company board  
Member of council - Newcastle University  
Sister - Dr V M Pleydell, shadow accountable officer of Hambleton, Richmondshire and Whitley Clinical Commissioning Group

**Sue Covill** - *(to 30 April 2011)*  
Member - Harrogate and Craven Carers’ Resource  
Member - Ripon and Harrogate Branch of the Alzheimer’s Society

**Joanne Dewar**  
Member - County Durham and Darlington NHS Foundation Trust

**George Ewart**  
Member - Marie Curie Cancer Care

**Tricia Hart**  
Governor - University of Teesside  
Visiting professor - University of Teesside  
Honorary associate - North East Leadership Academy

**David Kirby**  
Member - North Yorkshire County Council independent panel for members expenses

**Hugh Lang**  
Director - North East Tourism Advisory Board  
Director - Skyports Europe Ltd  
Non executive director - WeighAhead Ltd

**Brenda Thompson**  
Middlesbrough councillor and executive member - Public Health and Sport  
Trustee and honorary treasurer - Edward Guy Foundation for Hospice Care

**Henrietta Wallace**  
Trustee - UNITE Mediation Ltd - charitable organisation

**Rob Wilson**  
Honorary professor - Durham University

---

### Board of Directors

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Role</th>
</tr>
</thead>
</table>
| Andrew Thacker        | acting director of human resources* (May 2011 to Feb 2012)               | Board of Directors - 8/9  
                       |                                                                          | Audit - 2/2  
                       |                                                                          | Remuneration Committee - 0/5 |
| Chris Harrison        | director of human resources*                                             | Board of Directors - 2/2  
                       |                                                                          | Audit - 1/1 |
| Joanne Dewar          | director of IT & health records*                                         | Board of Directors - 8/12  
                       |                                                                          | Audit - 0/5 |

*These are non-voting members of the Board of Directors*
“We had wonderful care and attention by very professional and committed employees”
The audit committee is responsible for monitoring and reviewing matters such as the integrity of financial statements of the trust, our system of internal control and the internal audit function.

The committee is chaired by the trust’s non-executive/deputy chairman and has a further three non-executive directors in its membership as below:

Mr David Kirby - chair  
Dr George Ewart OBE  
Mr Hugh Lang  
Ms Henrietta Wallace

Its terms of reference are approved by the Board of Directors and reviewed each year.

The committee has an annual business plan which shows how it plans to discharge its responsibilities under its terms of reference and the business plan is monitored throughout the year.

There were seven formal meetings in-year and minutes of each meeting along with any recommendations are reported to the Board by the chairman of the audit committee. The audit committee presents an annual report detailing its work to the Board each year. Committee members carry out a self-assessment each year.

Its main duties throughout the year were:

- **Financial reporting**

  The audit committee monitored the integrity of the financial statements of the trust and any formal announcements relating to the trust’s financial performance, reviewing significant financial reporting judgments contained in them.

  The committee received - and recommended to the Board of Directors for approval - the trust accounts and annual governance report (formerly statement of internal control) and the charitable funds accounts for 2010/2011 in this period.

- **Governance, risk management and internal control**

  The committee reviewed the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the trust’s activities (both clinical and non-clinical) that supported the trust’s objectives.

  The committee received the trust’s assurance framework and various audit reports concerning these matters, during this period.

  During the year, reports were received outlining the progress made in planned counter fraud work and general issues concerning the NHS counter fraud service (CFS).

  The committee also reviewed the findings of any other relevant significant assurance functions, both internal and external to the trust and considered the implications to the governance of the trust.

- **Internal audit**

  The committee ensured there was an effective internal audit function established by management that met mandatory internal audit standards and provided appropriate independent assurance to the audit committee, chief executive and the Board of Directors.

  The committee received the internal audit plan, internal audit annual report and progress reports in this period.
The audit committee reviewed and monitored the external auditor’s independence and objectivity and the effectiveness of the audit process.

The committee received and reviewed external audit plans and routine reports, along with regular private discussions with the external auditors and internal audit. External audit colleagues attended each meeting.

The audit committee reviewed arrangements by which staff of South Tees Hospitals NHS Foundation Trust may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.

The committee reviewed the work of other committees within the trust whose work could provide relevant assurance to the audit committees.

The committee satisfied themselves on the assurance that could be gained from the clinical audit function.

The company secretary was the formal secretariat for the committee and ensured that co-ordination of papers and minutes were produced in accordance with the chairman of the committee.

The committee reports to the Board of Directors annually on its work in support of the annual governance statement, specifically commenting on the fitness for purpose of the assurance framework, robustness of risk management in the trust and the integration of governance arrangements.

The trust has a process approved by governors, for the agreement of non-audit services. In accordance with its delegated authority the committee approved one such engagement during the year.

“I feel a lot healthier already and I have more energy”
This is the unaudited part of the remuneration report.

The Board of Directors has an established remuneration committee composed of non-executive directors.

The committee has responsibility for setting the terms and conditions of office, including remuneration (pay and benefit entitlements) and allowance of the executive directors of the Board (and the two non-voting associate executive directors - the director of human resources and the director of IT and health records).

The remuneration committee does not have a direct role in relation to the pay of the chairman and the other non-executive directors as this responsibility lies with the Council of Governors, guided by Monitor's code of governance for foundation trusts.

Between April 2011 and March 2012, the remuneration committee met twice in June and February. Both the chief executive and acting director of human resources attended both of these meetings.

Having reviewed the policy for - and structure of - corporate directors’ pay in 2008/2009, there were no amendments to this in 2011/2012.

The current policy used job evaluation scores to set the job size and each salary is then calculated as a percentage of the chief executive’s salary based on the relative score.

The chief executive’s salary is benchmarked against similar organisations using information provided by the Income Data Service.

Each year, the chief executive presents a report to the remuneration committee which summarises the performance of individual directors against their agreed objectives. Given the current economic climate, the remuneration committee agreed there should be no cost of living rise or incremental progression for any corporate director in 2011/2012.

The tenure (length) of employment for non-executive directors is set out in the trust’s constitution and is four years for the chairman and non-executive directors, and then subject to re-appointment.

Any term beyond six years is subject to rigorous review by the Council of Governors. Non-executive directors may serve more than nine years subject to an annual re-appointment.

For corporate directors, appointments are not time limited and the period for serving notice is three months. Termination payments are usually contractual but may be varied by the decision of the remuneration committee and depend on Treasury approval.

No extra contractual termination payments were made to directors in 2011/2012.

Contractual provision for early termination is not appropriate as the contracts are not fixed term. Liability for early termination is, therefore, not calculated. The trust’s remuneration reports were subject to a full external audit.

The director of human resources and the director of IT and health records are non-voting members of the Board of Directors and do not have voting influence in directing or controlling the major activities of the trust and have not been included in this remuneration report as a result.

The rest of the remuneration report on the following two pages is the audited element.
Remuneration report

South Tees Hospitals NHS Foundation Trust Annual Report 2012

Salary and allowances

<table>
<thead>
<tr>
<th>Name and Title</th>
<th>2011-12 Salary &amp; Allowances (bands of £5,000)</th>
<th>Other remuneration (bands of £5,000)</th>
<th>Benefits in Kind (to the nearest £100)</th>
<th>2010-11 Salary &amp; allowances (bands of £5,000)</th>
<th>Other remuneration (bands of £5,000)</th>
<th>Benefits in Kind (to the nearest £100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mrs Deborah Jenkins MBE, chairman</td>
<td>£50 - £55</td>
<td>£50 - £55</td>
<td>£50 - £55</td>
<td>£50 - £55</td>
<td>£50 - £55</td>
<td>£50 - £55</td>
</tr>
<tr>
<td>Dr George Ewart, non-executive member</td>
<td>£10 - £15</td>
<td>£10 - £15</td>
<td>£10 - £15</td>
<td>£10 - £15</td>
<td>£10 - £15</td>
<td>£10 - £15</td>
</tr>
<tr>
<td>Mrs Pauline Singleton, non-executive member</td>
<td>£10 - £15</td>
<td>£10 - £15</td>
<td>£10 - £15</td>
<td>£10 - £15</td>
<td>£10 - £15</td>
<td>£10 - £15</td>
</tr>
<tr>
<td>Mrs Henrietta Wallace, non-executive member</td>
<td>£10 - £15</td>
<td>£10 - £15</td>
<td>£10 - £15</td>
<td>£10 - £15</td>
<td>£10 - £15</td>
<td>£10 - £15</td>
</tr>
<tr>
<td>Mrs Brenda Thompson, non-executive member</td>
<td>£10 - £15</td>
<td>£10 - £15</td>
<td>£10 - £15</td>
<td>£10 - £15</td>
<td>£10 - £15</td>
<td>£10 - £15</td>
</tr>
<tr>
<td>Mr Hugh Lang, non-executive member</td>
<td>£10 - £15</td>
<td>£10 - £15</td>
<td>£10 - £15</td>
<td>£10 - £15</td>
<td>£10 - £15</td>
<td>£10 - £15</td>
</tr>
<tr>
<td>Mr John Roebuck, director of finance</td>
<td>£10 - £15</td>
<td>£10 - £15</td>
<td>£135 - £140</td>
<td>17</td>
<td>£10 - £15</td>
<td>£135 - £140</td>
</tr>
<tr>
<td>Mr Chris Newton, director of finance</td>
<td>£35 - £40</td>
<td>£35 - £40</td>
<td>£35 - £40</td>
<td>17</td>
<td>£35 - £40</td>
<td>£35 - £40</td>
</tr>
<tr>
<td>Mr Jon Connolly, acting director of finance</td>
<td>£55 - £60</td>
<td>£55 - £60</td>
<td>£55 - £60</td>
<td>17</td>
<td>£55 - £60</td>
<td>£55 - £60</td>
</tr>
<tr>
<td>Mrs Jill Moulton, director of facilities and planning</td>
<td>£130 - £135</td>
<td>£130 - £135</td>
<td>£130 - £135</td>
<td>17</td>
<td>£130 - £135</td>
<td>£130 - £135</td>
</tr>
<tr>
<td>Mrs Susan Watson, director of operations</td>
<td>£135 - £140</td>
<td>£135 - £140</td>
<td>£135 - £140</td>
<td>17</td>
<td>£135 - £140</td>
<td>£135 - £140</td>
</tr>
<tr>
<td>Mrs Tricia Hart, director of nursing</td>
<td>£145 - £150</td>
<td>£145 - £150</td>
<td>£145 - £150</td>
<td>17</td>
<td>£145 - £150</td>
<td>£145 - £150</td>
</tr>
<tr>
<td>Mr Simon Pleydell, chief executive</td>
<td>£205 - £210</td>
<td>£205 - £210</td>
<td>£205 - £210</td>
<td>17</td>
<td>£205 - £210</td>
<td>£205 - £210</td>
</tr>
<tr>
<td>Professor Rob Wilson, medical director</td>
<td>£175 - £180</td>
<td>£35 - £40</td>
<td>£145 - £150</td>
<td>17</td>
<td>£145 - £150</td>
<td>£25 - £30</td>
</tr>
</tbody>
</table>

The figures for Benefits In Kind relate to lease cars. John Roebuck left the trust on the 30 April 2011. Jon Connolly was acting director of finance from 3 May 2011 to 2 January 2012. Chris Newton became director of finance with effect from 3 January 2012.

Hutton Review of Fair Pay

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation’s workforce.

The banded remuneration of the highest paid director at South Tees Hospitals NHS Foundation Trust in the financial year 2011-12 was £205,803 (2010-11 £205,798). This was 8.4 times (2010-11 8.5 times) the median remuneration of the workforce, which was £24,785 (2010-11 £24,394). This exercise has included all staff employed by the foundation trust during the financial period, regardless of whether they were still employed at 31 March. The remuneration figures used are based on the cost of the whole time equivalent of all staff identified as part of this exercise.

In 2011-12, 11 (2010-11, 11) employees received remuneration in excess of the highest paid director. Remuneration ranged from £13,903 to £260,672 (2010-11 £13,653 to £237,365). The starting point for the ranges for the financial periods are based on the minimum agenda for change pay scales.

Total remuneration includes salary, non-consolidated performance-related pay, benefits in kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.
A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member’s accrued benefits and any contingent spouse’s pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the institute and Faculty of Actuaries.

Real Increase in CETV

This reflects the increase in the CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Chief executive

31 May 2012
“It’s just amazing what they can do now - I know other people who have been left with scars and they are paranoid about them. It’s nice not to have a big scar to worry about when you go on holiday”
Our Council of Governors is made up of 34 governors, the majority are elected to represent public, patient and carer, and staff governors. The rest represent the views of our key external partners, including local authorities, universities, voluntary and carer organisations.

The make-up includes 21 elected seats and 13 nominated seats:

- Public – Middlesbrough (5), Redcar and Cleveland (5), Hambleton and Richmondshire (5), Rest of England (1)
- Patient and/or carer (2)
- Staff (3)
- Key external partners nominated onto the Council of Governors (13)

Together our governors play a vital role in the governance of the trust in line with the organisation’s terms of authorisation. The Council of Governors has a number of statutory duties including:

- Appointing (or removing) the chairman and non-executive directors of the trust
- Approving the appointment of the chief executive
- Deciding on the pay, allowances and other terms and conditions of office for the chairman and non-executive directors
- Appointing (or removing) the trust’s external auditors
- Contributing to the trust’s annual plan
- Receiving the trust’s annual report, annual financial and quality accounts.

Ultimately the role of the Council of Governors is holding the Board of Directors collectively to account for the performance of the trust, and ensuring that the Board of Directors acts in such a way that it does not breach the terms of the foundation trust’s authorisation.

We value the contribution the Council of Governors makes to the trust in discharging its statutory responsibilities, but individually each governor also makes their own contribution, involving themselves in the work of the trust in different ways and also bringing their different perspectives to the development of services.

The chairman acts as a key link between the Council of Governors and Board of Directors, but throughout the year, non-executive and executive directors have continued to seek ways of developing a greater understanding of the views of governors and members through their regular attendance at Council meetings, working together in a number of sub-groups, and also listening to their views at a series of membership engagement events. Governors have also attended Board of Director meetings.

The Council of Governors had previously set a target of recruiting 5,000 members by the end of 2011/2012 and with the support of governors we now have more than 5,600 local people signed up as members through a series of recruitment roadshows at local community events as well as working closely with other local foundation trusts to stage joint recruitment drives.

The Council this year approved a three-year membership strategy with an annual membership recruitment target of 500 new members, and in response to a communication audit in which they were involved in during 2010/2011, the governors helped to pilot a series of membership engagement events.

The Council’s membership sub-group is now considering the evaluation of the pilots to determine an engagement programme for 2012/2013.
During the last year governors have again been involved in the annual appraisal of the chairman and decided to re-appoint her to the post for a further three-year term of office.

They have also taken an active role in deciding to re-appoint two other non-executive directors for a further three years. They have also approved the reappointment of the trust’s senior independent director and deputy chairman.

Although governors do not have a statutory role in the appointment of executive directors, the trust values their views as representatives of patients, carers and members of the public so governors were this year involved in the recruitment process for new finance and human resources directors.

The trust values the views of governors in determining service developments and changes, and during the last year they have had detailed discussions on the potential future of community services following their integration into the trust, and also proposals for the future of paediatric and maternity services at the Friarage.

As these two key developments move forward during 2012/2013 and we continue to engage the public in both discussions and, potentially, formal consultation, the aim is to continue to also actively involve governors so they can represent the views of the members they represent to the Board of Directors and also share information with members about the proposals.

As well as being involved in key governance and service development issues, individual governors also represent the Council at a host of trust events from attending the annual Nightingale conference where the trust’s nurses share best practice to sitting on the judging panel of the trust’s annual Star awards that recognise and reward excellence amongst the organisation’s staff.

The changing structure of the NHS means that the Council of Governors needs to keep the make-up of its elected and appointed members under review, alongside other aspects of the trust’s constitution.

Over the next year the Council will consider how to replace appointed governors representing local primary care trusts and LiNK (Local Involvement Network) organisations.

In March 2012 elections were held in all constituencies to find a total of 12 representatives to join the trust’s Council of Governors and helping to influence the development of local hospital and community services over the next three years.

A total of 31 people put themselves forward and more than 2,500 (2,529) staff, patients and local people cast their votes. The results were as follows:

**Public constituencies**
- Hambleton and Richmondshire (4 seats) - Plym Auty, Noel Beal, David Bentley and Janet Crampton
- Middlesbrough (2 seats) - Keith Martin and Alan Parton
- Redcar and Cleveland (3 seats) - William Davis, Alan Leighton and John Race
- Rest of England (1 seat) - Shahrzad Connolly

**Patient/carer constituency (1 seat)**
- Elaine Lewis

**Staff constituency (1 seat)**
- Julie Harms

The trust holds a register of governors’ interests which is available to members of the public by contacting the chairman’s office at The James Cook University Hospital.
### Elected governors

<table>
<thead>
<tr>
<th>Name</th>
<th>Tenure</th>
<th>Constituency</th>
<th>5 meetings from April 2010 to March 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Mike Batty</td>
<td>3 yrs from April 2011 (resigned October 2011)</td>
<td>Hambleton &amp; Richmondshire</td>
<td>1/9</td>
</tr>
<tr>
<td>*Jean Herbert</td>
<td>3 yrs from April 2011</td>
<td>Hambleton &amp; Richmondshire</td>
<td>4/5</td>
</tr>
<tr>
<td>Jeff Hillyer</td>
<td>3 yrs from May 2009 (resigned September 2011)</td>
<td>Hambleton &amp; Richmondshire</td>
<td>2/2</td>
</tr>
<tr>
<td>Neal Robinson</td>
<td>3 yrs from May 2009 (term now finished)</td>
<td>Hambleton &amp; Richmondshire</td>
<td>2/5</td>
</tr>
<tr>
<td>Judith Rowlands</td>
<td>3 yrs from May 2009 (term now finished)</td>
<td>Hambleton &amp; Richmondshire</td>
<td>3/5</td>
</tr>
<tr>
<td>Plymouth</td>
<td>3 yrs from April 2012</td>
<td>Hambleton &amp; Richmondshire</td>
<td>n/a</td>
</tr>
<tr>
<td>Noel Beal</td>
<td>3 yrs from April 2012</td>
<td>Hambleton &amp; Richmondshire</td>
<td>n/a</td>
</tr>
<tr>
<td>David Bentley</td>
<td>3 yrs from April 2012</td>
<td>Hambleton &amp; Richmondshire</td>
<td>n/a</td>
</tr>
<tr>
<td>Janet Crampton</td>
<td>3 yrs from April 2011</td>
<td>Hambleton &amp; Richmondshire</td>
<td>n/a</td>
</tr>
<tr>
<td>*Norman Leslie</td>
<td>3 yrs from April 2012</td>
<td>Middlesbrough</td>
<td>5/5</td>
</tr>
<tr>
<td>Keith Newton</td>
<td>3 yrs from April 2011</td>
<td>Middlesbrough</td>
<td>5/5</td>
</tr>
<tr>
<td>Gabriela Rea</td>
<td>3 yrs from April 2011</td>
<td>Middlesbrough</td>
<td>2/5</td>
</tr>
<tr>
<td>Ingrid Robinson</td>
<td>3 yrs from May 2009 (term now finished)</td>
<td>Middlesbrough</td>
<td>3/5</td>
</tr>
<tr>
<td>Alan Taylor</td>
<td>3 yrs from May 2009 (term now finished)</td>
<td>Middlesbrough</td>
<td>5/5</td>
</tr>
<tr>
<td>Keith Martin</td>
<td>3 yrs from May 2012</td>
<td>Middlesbrough</td>
<td>n/a</td>
</tr>
<tr>
<td>Alan Parton</td>
<td>3 yrs from May 2012</td>
<td>Middlesbrough</td>
<td>n/a</td>
</tr>
<tr>
<td>Macy Bennett</td>
<td>Serving the remainder of a three-year tenure from 2009 (term now finished)</td>
<td>Redcar and Cleveland</td>
<td>2/5</td>
</tr>
<tr>
<td>*William Davis</td>
<td>3 yrs from April 2012</td>
<td>Redcar and Cleveland</td>
<td>5/5</td>
</tr>
<tr>
<td>Coleen Milligan</td>
<td>3 yrs from May 2009 (term now finished)</td>
<td>Redcar and Cleveland</td>
<td>5/5</td>
</tr>
<tr>
<td>Peter Sotheran</td>
<td>3 yrs from April 2011</td>
<td>Redcar and Cleveland</td>
<td>5/5</td>
</tr>
<tr>
<td>Jacqueline Wesson</td>
<td>3 yrs from April 2011</td>
<td>Redcar and Cleveland</td>
<td>4/5</td>
</tr>
<tr>
<td>*Alan Leighton</td>
<td>3 yrs from April 212</td>
<td>Redcar and Cleveland</td>
<td>n/a</td>
</tr>
<tr>
<td>Jonh Race</td>
<td>3 yrs from April 2012</td>
<td>Redcar and Cleveland</td>
<td>n/a</td>
</tr>
<tr>
<td>*David Cleary</td>
<td>3 yrs from April 2011</td>
<td>Patient and/or carer of patient</td>
<td>5/5</td>
</tr>
<tr>
<td>*Elaine Lewis</td>
<td>3 yrs from April 2012</td>
<td>Patient and/or carer of patient</td>
<td>4/5</td>
</tr>
<tr>
<td>Shahrzad Connolly</td>
<td>3 yrs from April 2012</td>
<td>Rest of England (vacant seat)</td>
<td>n/a</td>
</tr>
<tr>
<td>Mary Bilous</td>
<td>3 yrs May 2009 (term now finished)</td>
<td>Staff</td>
<td>4/5</td>
</tr>
<tr>
<td>Fiona Bryce</td>
<td>3 yrs from May 2009 (resigned August 2011)</td>
<td>Staff</td>
<td>0/2</td>
</tr>
<tr>
<td>Di Pennie</td>
<td>3 yrs from April 2012</td>
<td>Staff</td>
<td>1/9</td>
</tr>
<tr>
<td>David Whitehead</td>
<td>3 yrs from April 2011</td>
<td>Staff</td>
<td>2/5</td>
</tr>
<tr>
<td>Julie Harris</td>
<td>3 yrs from April 2012</td>
<td>Staff</td>
<td>n/a</td>
</tr>
</tbody>
</table>

### Appointed governors

<table>
<thead>
<tr>
<th>Name</th>
<th>Tenure</th>
<th>Partner organisation</th>
<th>5 meetings from April 2010 to March 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prof Alastair Burt</td>
<td>Tenure renewed in 2012</td>
<td>Newcastle University</td>
<td>2/5</td>
</tr>
<tr>
<td>Veronica Fegan</td>
<td>Serving the remainder of a 3 yr tenure (April 2012) (resigned December 2011)</td>
<td>Redcar and Cleveland PCT</td>
<td>2/3</td>
</tr>
<tr>
<td>Francis Foggins</td>
<td>3 yrs from April 2012</td>
<td>UNK</td>
<td>1/1</td>
</tr>
<tr>
<td>Tony Hall</td>
<td>Tenure extended in 2012</td>
<td>North Yorkshire County Council</td>
<td>4/5</td>
</tr>
<tr>
<td>Mike Hird</td>
<td>3 yrs from May 2009 (Resigned December 2011)</td>
<td>Middlesbrough PCT</td>
<td>2/3</td>
</tr>
<tr>
<td>Prof David Hunter</td>
<td>Tenure renewed 2012</td>
<td>Durham University</td>
<td>1/5</td>
</tr>
<tr>
<td>Tristan Leavroy</td>
<td>Serving the remainder of a 3 yr tenure from June 2011 (April 2012) Stepped down in January 2012</td>
<td>Redcar and Cleveland PCT</td>
<td>2/3</td>
</tr>
<tr>
<td>Prof Caroline Macdonald</td>
<td>Tenure renewed in 2012</td>
<td>Teesside University</td>
<td>0/5</td>
</tr>
<tr>
<td>Mike Robinson</td>
<td>Tenure renewed in 2012</td>
<td>Middlesbrough Council</td>
<td>3/5</td>
</tr>
<tr>
<td>Maureen Rutter</td>
<td>Tenure renewed in 2012</td>
<td>MacMillan Cancer Support</td>
<td>4/5</td>
</tr>
<tr>
<td>Jenny Shepherd</td>
<td>Left in December 2011</td>
<td>UNK</td>
<td>3/3</td>
</tr>
<tr>
<td>Lynne Webb-Thorius</td>
<td>Tenure renewed in 2012</td>
<td>The Princess Royal Trust,</td>
<td>5/5</td>
</tr>
</tbody>
</table>

In line with organisational changes within the NHS and the local environment, there are currently four vacant nominated governor posts. This will be reviewed and addressed by the Council of Governors as part of its annual review of the Constitution in October 2012.

* Denotes current Governors

* Denotes where existing councillors have been re-elected to the Council of Governors
“From the minute I arrived I was put at ease by your marvellous unflappable staff”
Membership
South Tees Hospitals NHS Foundation Trust Annual Report 2012

As a Foundation Trust, we are still part of the NHS but independent from the Department of Health and directly accountable to our local community. This means we give greater say in how we’re run to local people, staff and all those who use our services, including patients, their families and carers.

Our members reflect these groups and help us ensure that we are providing the very best service we can - a service built around the needs of the community.

The trust has three existing membership constituencies - public, patient and/or carer and staff - broken down into:

- **Public constituency** - members of the public who live locally in Middlesbrough, Redcar and Cleveland, Hambleton and Richmondshire or in the rest of England.
  
  This includes past and present patients, volunteers and carers while the rest of England constituency differs from the patient/carer one as there is no requirement for members to have been a patient/carer in the preceding ten years.

- **Patient constituency** - patients and/or carers of patients

- **Staff** - who automatically become members but can opt out if they wish

Anyone aged 16 or over from the above groups is eligible to become a member and at the end of March, the trust had 5424 members, an increase of 637 from 2011.

This was due to a very positive recruitment programme covering the constituent areas, including the multi-cultural event at Mela Festival in Middlesbrough, Borrowby show, Thirsk races, Guisborough town fair and Freshers’ week at Teesside University.

Once again we worked in partnership with other local foundation trusts to run joint recruitment events and showcase local NHS services and these were well received by the public.

A total of 283 members were deleted from the membership database during the year due to a data cleansing exercise in the autumn of 2011 and natural losses.

The overall membership figures remain fairly static within the ethnic and socio-economic groups and to maintain this position it is intended to run a similar recruitment timetable during 2012/2013 based on the evident success of last year’s programme.

The membership target of 5000 set by the Council of Governors was reached ahead of schedule in the early part of 2011 and in developing and approving a new membership communication and engagement strategy, the Council of Governors decided to set a new target of recruiting 500 new members each year.

“Ask and you receive - they are very attentive and caring - even down to the woman who delivers the newspaper!”
To improve its engagement of members the trust piloted three engagement events in 2011 including:

- a presentation in Redcar Primary Care Hospital about community nursing
- a ‘sneaky peek’ tour around the new Endeavour Unit at The James Cook University Hospital before it opened
- a presentation at the Friarage Hospital around the development of local orthopaedic services

All the events were positively evaluated by attendees and the Council of Governors membership sub-committee is considering running a similar programme during 2012/2013.

More information about becoming a member is available on the trust’s website at [www.southtees.nhs.uk](http://www.southtees.nhs.uk) or if you would like further information you can contact 01642 835616. Members can also contact their own constituency representatives on the number above or email them at [gov@stees.nhs.uk](mailto:gov@stees.nhs.uk)
### Staff constituency

<table>
<thead>
<tr>
<th>Last year (2011/12)</th>
<th>2012/13 Estimated</th>
</tr>
</thead>
<tbody>
<tr>
<td>As at start (April 1)</td>
<td>4,218</td>
</tr>
<tr>
<td>New members</td>
<td>802</td>
</tr>
<tr>
<td>Members leaving</td>
<td>283</td>
</tr>
<tr>
<td>At year end (March 31)</td>
<td>4,737</td>
</tr>
</tbody>
</table>

### Public constituency - breakdown by catchment

<table>
<thead>
<tr>
<th></th>
<th>Hambleton and Richmondshire</th>
<th>Middlesbrough</th>
<th>Redcar and Cleveland</th>
<th>Rest of England</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1,557</td>
<td>1,546</td>
<td>1,457</td>
<td>177</td>
<td>4,737</td>
</tr>
</tbody>
</table>

### Staff constituency

<table>
<thead>
<tr>
<th>Last year (2011/12)</th>
<th>2012/13 Estimated</th>
</tr>
</thead>
<tbody>
<tr>
<td>As at start (April 1)</td>
<td>8,832</td>
</tr>
<tr>
<td>New members</td>
<td>1,112</td>
</tr>
<tr>
<td>Members leaving</td>
<td>887</td>
</tr>
<tr>
<td>At year end (March 31)</td>
<td>9,057</td>
</tr>
</tbody>
</table>

### Patient constituency

<table>
<thead>
<tr>
<th>Last year (2011/12)</th>
<th>2012/13 Estimated</th>
</tr>
</thead>
<tbody>
<tr>
<td>As at start (April 1)</td>
<td>571</td>
</tr>
<tr>
<td>New members</td>
<td>136</td>
</tr>
<tr>
<td>Members leaving</td>
<td>20</td>
</tr>
<tr>
<td>At year end (March 31)</td>
<td>687</td>
</tr>
</tbody>
</table>

### Public constituency

#### Age (years):

<table>
<thead>
<tr>
<th></th>
<th>Number of members</th>
<th>Eligible membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 16</td>
<td>2</td>
<td>5,529</td>
</tr>
<tr>
<td>17 - 21</td>
<td>281</td>
<td>25,481</td>
</tr>
<tr>
<td>22+</td>
<td>4,283</td>
<td>361,122</td>
</tr>
<tr>
<td>Unknown</td>
<td>171</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>4,737</td>
<td></td>
</tr>
</tbody>
</table>

#### Ethnicity:

<table>
<thead>
<tr>
<th></th>
<th>Number of members</th>
<th>Eligible membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>4,402</td>
<td>380,804</td>
</tr>
<tr>
<td>Mixed</td>
<td>15</td>
<td>2,247</td>
</tr>
<tr>
<td>Asian</td>
<td>124</td>
<td>7,471</td>
</tr>
<tr>
<td>Black</td>
<td>17</td>
<td>648</td>
</tr>
<tr>
<td>Other</td>
<td>17</td>
<td>1,005</td>
</tr>
<tr>
<td>Unknown</td>
<td>162</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>4,737</td>
<td></td>
</tr>
</tbody>
</table>

#### Socio-economic groupings:

<table>
<thead>
<tr>
<th></th>
<th>Number of members</th>
<th>Eligible membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC1</td>
<td>2,910</td>
<td>134,990</td>
</tr>
<tr>
<td>C2</td>
<td>1,157</td>
<td>54,327</td>
</tr>
<tr>
<td>D</td>
<td>198</td>
<td>57,344</td>
</tr>
<tr>
<td>E</td>
<td>502</td>
<td>56,141</td>
</tr>
<tr>
<td>Unknown</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>4,737</td>
<td></td>
</tr>
</tbody>
</table>
“What will stay with me is the ‘thoughtfulness of staff’ - they noticed the small things which mattered to us”
Summary of financial performance

Financial performance
This summary covers the period from 1 April 2011 to 31 March 2012.

Key targets
The trust must meet a number of targets, as set by Monitor and detailed in their Compliance Framework.

Financial risk ratings
A number of key financial measures are translated into financial risk ratings, which are reviewed on a quarterly basis, based on trust’s actual performance. Our financial risk rating at the end of March 2012 is expected to be 3, and subject to confirmation by Monitor.

<table>
<thead>
<tr>
<th>Financial Ratio</th>
<th>Actual Ratios 2011/12</th>
<th>Approved Ratios 2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum dividend cover</td>
<td>9.0</td>
<td>&gt;1.0</td>
</tr>
<tr>
<td>Minimum interest cover</td>
<td>3.1</td>
<td>&gt;2.0</td>
</tr>
<tr>
<td>Minimum debt service cover</td>
<td>1.9</td>
<td>&gt;1.5</td>
</tr>
<tr>
<td>Maximum debt service to revenue</td>
<td>3.5%</td>
<td>&lt;10.0%</td>
</tr>
</tbody>
</table>

The trust has satisfactorily met the requirements set by Monitor.

Prudential Borrowing Code
The trust must comply with Monitor’s Prudential Borrowing Code (PBC), which sets both an absolute limit on the cumulative amount of outstanding borrowing throughout the year and a series of ratios which cannot be breached (the cap ratio test). The trust’s performance against these measures is set out in the following tables:

<table>
<thead>
<tr>
<th>Prudential borrowing limit</th>
<th>31 March 2012 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total long term borrowing limit set by Monitor</td>
<td>158,000</td>
</tr>
<tr>
<td>Actual long term borrowing at 31 March</td>
<td>143,071</td>
</tr>
<tr>
<td>Working capital facility agreed by Monitor</td>
<td>33,000</td>
</tr>
<tr>
<td>Actual working capital borrowing at 31 March</td>
<td>0</td>
</tr>
</tbody>
</table>

“Staff treat you with respect”
Summary of financial performance

South Tees Hospitals NHS Foundation Trust Annual Report 2012

Statement of comprehensive income

The statement at 31 March 2012, showed a deficit of £4.8 million. This includes impairment charges amounting to £8 million arising from revaluation losses on trust land and buildings (further information to support impairment charges is available in the full set of accounts).

Taking account of this adjustment, the trust achieved a £3.2 million surplus against a planned surplus of £2 million. The make-up of the variances from plan is as follow:

<table>
<thead>
<tr>
<th></th>
<th>£m</th>
<th>% of budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay</td>
<td>4.50</td>
<td>1.47</td>
</tr>
<tr>
<td>Non pay</td>
<td>6.20</td>
<td>3.12</td>
</tr>
<tr>
<td>Income</td>
<td>(11.90)</td>
<td>2.34</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>(1.20)</strong></td>
<td><strong>1.20</strong></td>
</tr>
</tbody>
</table>

Summary of financial performance

<table>
<thead>
<tr>
<th>Statement of comprehensive operating income</th>
<th>31 March 2012 £000</th>
<th>Restated 2010/2011 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating income</td>
<td>522,789</td>
<td>468,384</td>
</tr>
<tr>
<td>Operating expenses</td>
<td>(509,756)</td>
<td>(450,443)</td>
</tr>
<tr>
<td><strong>Operating Surplus</strong></td>
<td><strong>13,033</strong></td>
<td><strong>17,941</strong></td>
</tr>
<tr>
<td>Finance Costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finance income</td>
<td>272</td>
<td>79</td>
</tr>
<tr>
<td>Finance expenses - financial liabilities</td>
<td>(15,439)</td>
<td>(14,386)</td>
</tr>
<tr>
<td>Finance expenses - unwinding of discount on provisions</td>
<td>(40)</td>
<td>(40)</td>
</tr>
<tr>
<td>PDC Dividends payable</td>
<td>(2,618)</td>
<td>(4,899)</td>
</tr>
<tr>
<td><strong>Net Finance Costs</strong></td>
<td><strong>(17,825)</strong></td>
<td><strong>(19,246)</strong></td>
</tr>
<tr>
<td>Deficit for the year</td>
<td>(4,792)</td>
<td>(1,305)</td>
</tr>
<tr>
<td>Other comprehensive income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revaluation gains and impairment losses on property, plant and equipment</td>
<td>2,443</td>
<td>5,382</td>
</tr>
<tr>
<td>Other reserve movements</td>
<td>(12)</td>
<td>21</td>
</tr>
<tr>
<td><strong>TOTAL COMPREHENSIVE (EXPENSE)/INCOME FOR THE PERIOD</strong></td>
<td><strong>(2,361)</strong></td>
<td><strong>4,098</strong></td>
</tr>
<tr>
<td>Prior period adjustments</td>
<td>0</td>
<td>(45,782)</td>
</tr>
<tr>
<td><strong>TOTAL COMPREHENSIVE EXPENSE FOR THE YEAR</strong></td>
<td><strong>(2,361)</strong></td>
<td><strong>(41,684)</strong></td>
</tr>
</tbody>
</table>
Statement of financial position

The following statement details the financial situation of the trust at the end of the financial period. At the end of March, the trust held £239.6million in property, plant and equipment and £5million of net current assets.

Within the current assets, the trust held cash amounting to £30.5million at the year end.

In accordance with IFRS, the PFI scheme at The James Cook University Hospital is classified as on the balance sheet. Other fixed assets include land and buildings at the Friarage Hospital in Northallerton and items of equipment on both sites.

At the formation of NHS trusts, assets (land, buildings, equipment and working capital) transferred to the new trusts. The value of these assets is in effect the public’s equity stake in the trust and is known as Public Dividend Capital (PDC). It is similar to company share capital and as with company shares, a dividend is payable, in this case to the Department of Health. It is calculated at 3.5% of net relevant assets.

At the end of 2011/2012, the trust had £154million on PDC.

<table>
<thead>
<tr>
<th>Statement of changes in taxpayer’s equity</th>
<th>Public dividend capital (PDC) £000</th>
<th>Retained earnings £000</th>
<th>Revaluation reserve £000</th>
<th>Other reserves £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restated taxpayers’ equity at 1st April 2011</td>
<td>154,107</td>
<td>(96,644)</td>
<td>28,268</td>
<td>26,488</td>
<td>112,219</td>
</tr>
<tr>
<td>Changes in taxpayers’ equity for 2011-12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total comprehensive income for the period:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retained deficit for the year</td>
<td>0</td>
<td>(4,792)</td>
<td>0</td>
<td>0</td>
<td>(4,792)</td>
</tr>
<tr>
<td>Revaluation gains / (losses) and impairment losses on property plant and equipment</td>
<td>0</td>
<td>0</td>
<td>2,443</td>
<td>0</td>
<td>2,443</td>
</tr>
<tr>
<td>Other transfers between reserves</td>
<td>0</td>
<td>1,110</td>
<td>(1,110)</td>
<td>(12)</td>
<td>(12)</td>
</tr>
<tr>
<td>Total comprehensive income for the year</td>
<td>0</td>
<td>(3,682)</td>
<td>1,333</td>
<td>12</td>
<td>(2,361)</td>
</tr>
<tr>
<td>Taxpayers’ equity at 31 March 2012</td>
<td>154,107</td>
<td>(100,326)</td>
<td>29,601</td>
<td>26,476</td>
<td>109,858</td>
</tr>
</tbody>
</table>
Summary of financial performance

South Tees Hospitals NHS Foundation Trust Annual Report 2012

<table>
<thead>
<tr>
<th>Statement of financial position</th>
<th>31 March 2012 £000</th>
<th>Restated position at 31 March 2011 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-current assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>239,594</td>
<td>237,299</td>
</tr>
<tr>
<td>Intangible assets</td>
<td>1,640</td>
<td>1,651</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>1,865</td>
<td>2,224</td>
</tr>
<tr>
<td><strong>Total non-current assets</strong></td>
<td>243,099</td>
<td>241,174</td>
</tr>
<tr>
<td><strong>Current assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inventories</td>
<td>8,487</td>
<td>8,628</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>31,639</td>
<td>24,739</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>30,526</td>
<td>23,088</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td>70,652</td>
<td>56,455</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td>313,751</td>
<td>297,629</td>
</tr>
<tr>
<td><strong>Current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>(59,184)</td>
<td>(38,427)</td>
</tr>
<tr>
<td>Borrowings</td>
<td>(5,884)</td>
<td>(7,102)</td>
</tr>
<tr>
<td>Provisions for liabilities and charges</td>
<td>(471)</td>
<td>(303)</td>
</tr>
<tr>
<td><strong>Net current assets/(liabilities)</strong></td>
<td>5,113</td>
<td>10,623</td>
</tr>
<tr>
<td><strong>Total assets less current liabilities</strong></td>
<td>248,212</td>
<td>251,797</td>
</tr>
<tr>
<td><strong>Non-current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>0</td>
<td>(100)</td>
</tr>
<tr>
<td>Borrowings</td>
<td>(137,187)</td>
<td>(138,202)</td>
</tr>
<tr>
<td>Provisions for liabilities and charges</td>
<td>(1,167)</td>
<td>(1,276)</td>
</tr>
<tr>
<td><strong>Total assets employed</strong></td>
<td>109,858</td>
<td>112,219</td>
</tr>
<tr>
<td><strong>Financed by taxpayers’ equity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public dividend capital</td>
<td>154,107</td>
<td>154,107</td>
</tr>
<tr>
<td>Retained earnings</td>
<td>(100,326)</td>
<td>(96,644)</td>
</tr>
<tr>
<td>Revaluation reserve</td>
<td>29,601</td>
<td>28,268</td>
</tr>
<tr>
<td>Other reserves</td>
<td>26,476</td>
<td>26,488</td>
</tr>
<tr>
<td><strong>Total taxpayers’ equity</strong></td>
<td>109,858</td>
<td>112,219</td>
</tr>
</tbody>
</table>

The trust aims to comply with the Confederation of British Industry (CBI) better payments practice code. This means that we aim to pay 95% of our creditors within 30 days of receipt of a valid invoice. The trust did not quite meet this target, paying 94% of invoices within 30 days. This was the same as in 2010/2011 and an improvement on 2009/2010 (91%).
The following table identifies the significant movements in cash flows during the financial period and provides support to the previous statements.

<table>
<thead>
<tr>
<th>Statement of cash flows</th>
<th>2011/12 £000</th>
<th>Restated 2010/11 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash flows from operating activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating surplus from continuing operations</td>
<td>13,033</td>
<td>17,941</td>
</tr>
<tr>
<td><strong>Non-cash income and expense</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation and amortisation</td>
<td>13,452</td>
<td>13,529</td>
</tr>
<tr>
<td>Impairments</td>
<td>9,187</td>
<td>11,435</td>
</tr>
<tr>
<td>Reversal of impairments</td>
<td>(1,222)</td>
<td>(3,292)</td>
</tr>
<tr>
<td>(Increase)/decrease in trade and other receivables</td>
<td>(6,553)</td>
<td>3,408</td>
</tr>
<tr>
<td>Decrease/(increase) in inventories</td>
<td>141</td>
<td>(127)</td>
</tr>
<tr>
<td>Increase/(decrease) in trade and other payables</td>
<td>20,657</td>
<td>(664)</td>
</tr>
<tr>
<td>Increase/(decrease) in provisions</td>
<td>59</td>
<td>(42)</td>
</tr>
<tr>
<td>Other movements in operating cash flows</td>
<td>636</td>
<td>1,838</td>
</tr>
<tr>
<td><strong>Net cash generated from operations</strong></td>
<td>49,390</td>
<td>44,026</td>
</tr>
<tr>
<td><strong>Cash flows from investing activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest received</td>
<td>122</td>
<td>79</td>
</tr>
<tr>
<td>Purchase of intangible assets</td>
<td>(294)</td>
<td>(136)</td>
</tr>
<tr>
<td>Purchase of property, plant and equipment</td>
<td>(20,968)</td>
<td>(24,325)</td>
</tr>
<tr>
<td>Sales of property, plant and equipment</td>
<td>0</td>
<td>27</td>
</tr>
<tr>
<td><strong>Net cash used in investing activities</strong></td>
<td>(21,140)</td>
<td>(24,355)</td>
</tr>
<tr>
<td><strong>Cash flows from financing activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loans received</td>
<td>5,000</td>
<td>15,000</td>
</tr>
<tr>
<td>Loans repaid</td>
<td>(624)</td>
<td>0</td>
</tr>
<tr>
<td>Capital element of finance lease rental payments</td>
<td>(2,277)</td>
<td>(2,499)</td>
</tr>
<tr>
<td>Capital element of Private Finance Initiative obligations</td>
<td>(4,700)</td>
<td>(4,249)</td>
</tr>
<tr>
<td>Interest paid</td>
<td>(606)</td>
<td>(227)</td>
</tr>
<tr>
<td>Interest element of finance leases</td>
<td>(548)</td>
<td>(581)</td>
</tr>
<tr>
<td>Interest element of Private Finance Initiative obligations</td>
<td>(14,285)</td>
<td>(13,578)</td>
</tr>
<tr>
<td>PDC Dividend paid</td>
<td>(2,772)</td>
<td>(4,774)</td>
</tr>
<tr>
<td><strong>Net cash used in financing activities</strong></td>
<td>(20,812)</td>
<td>(10,908)</td>
</tr>
<tr>
<td>Increase in cash and cash equivalents</td>
<td>7,438</td>
<td>8,763</td>
</tr>
<tr>
<td>Cash and cash equivalents at 1 April</td>
<td>23,088</td>
<td>14,325</td>
</tr>
<tr>
<td>Cash and cash equivalents at 31 March</td>
<td>30,526</td>
<td>23,088</td>
</tr>
</tbody>
</table>
Summary of financial performance

South Tees Hospitals NHS Foundation Trust Annual Report 2012

Income
The trust’s operating income in the period to the end of March 2012, amounted to £523 million. The providers of funding included the following:

Where our income comes from

- Income from activities (PCTs) - £483,660,000
- Income from activities (other NHS) - £20,413,000
- Other income from activities - £7,324,000
- Other operating activity - £11,392,000

Expenditure
Operating expenses amounted to £510 million in the period to the end of March 2012.

This expenditure can be analysed as follows:

- Salary and wages - £312,746,000
- Supplies and services - £83,728,000
- Premesis - £15,754,000
- Drug costs - £35,730,000
- Depreciation / impairment - £22,639,000
- Other - £39,159,000
Capital expenditure

The trust invested £20.6 million into the development and acquisition of property, plant and equipment in the 2011/2012 financial year. The major schemes included:

- **Oncology** (expenditure of £10 million)
  Completion of construction work and procurement of specialised equipment to expand existing radiotherapy services to meet anticipated growth in demand together with environmental improvements to chemotherapy treatment areas.

- **Radiology** (expenditure of £1 million)
  Replacement of existing equipment within angiography with associated environmental improvements and refurbishment works to treatment suites and control rooms.

- **Generic high dependency unit** (expenditure of £2.9 million)
  Creation of a centralised high dependency unit, that brings together existing bed provision from surgery and acute medicine.

- **Equipment replacement programmes** (expenditure of £1.2 million)
  Investment in planned replacement, rolling and emergency medical equipment and information technology.

Risk management

The trust has a range of risk management processes in place. These are set out in the annual governance statement. These measures have allowed the trust to manage the financial risks it faced during 2011/2012.

External audit

The trust’s external auditor is PricewaterhouseCoopers. The audit fee for the financial period ending 31 March 2012 was £64,000 excluding VAT. The fee covered work on the statutory audit and quality account and additional work in connection with asset revaluation. The work was undertaken under the Monitor’s Audit Code for NHS foundation trusts.

The summary of financial performance has been approved by the Board.

Chief executive

31 May 2012
Summary of financial performance

South Tees Hospitals NHS Foundation Trust Annual Report 2012

Annual Governance Statement 2011/2012

Scope of responsibility

As accounting officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust’s policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of South Tees Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised - and the impact should they be realised - and to manage them efficiently, effectively and economically. The system of internal control has been in place in South Tees Hospitals NHS Foundation Trust for the year ended 31 March 2012 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

As accountable officer and chief executive, I have overall responsibility for ensuring that there are effective risk management and integrated governance systems in place in the trust for meeting all statutory requirements and adhering to guidance issued by Monitor in respect of governance and risk management.

Some aspects of risk are delegated to the trust’s executive directors:

- The medical director is responsible for clinical governance
- The deputy chief executive and director of nursing and patient safety is responsible for infection prevention and control, health and safety and is overall lead for risk management and patient safety with support from the assistant director of nursing and patient safety, the trust Solicitor and deputy director of healthcare governance and quality.

The director of nursing and patient safety is also responsible for reporting to the Board of Directors on the implementation of the risk management and patient safety strategies

- The director of nursing and patient safety is the management lead for the risk and assurance sub-group, to ensure a fully integrated and joined up system of risk and control management is in place on behalf of the Board
- The director of finance provides the strategic lead for financial risk and the effective co-ordination of financial controls throughout the trust
- The director of human resources is responsible for workforce planning, staffing issues, education and training
- The director of IT and health records is responsible for information governance risks

All chiefs of service, clinical directors and managers have delegated responsibility for the management of risk and patient safety in their areas. Risk is integral to their day-to-day management responsibilities. It is also a requirement that each individual division produces a divisional/directorate patient safety and risk management plan, which describes the local application (including the responsibilities of key staff) of the trust’s patient safety and risk management strategy.

All members of staff have responsibility for participation in the risk/patient safety management system through:

- Awareness of risk assessments which have been carried out in their place of work and to comply with any control measures introduced by these risk assessments
- Compliance with all legislation relevant to their role
Following all trust policies and procedures particularly risk management and incident reporting policies which are available to all staff electronically through the intranet

- Reporting all adverse incidents and near-misses via the trust incident reporting system
- Attending regular training as required ensuring safe working practices
- Awareness of the trust's patient safety and risk management strategies and their own divisional/directorate patient safety and risk management plan and
- Knowing their limitations and seeking advice and assistance in a timely manner when relevant

The trust recognises the importance of supporting staff. All employees, including members of the Board, clinicians, managers, permanent, temporary and locum staff, are provided with appropriate risk management training by the trust’s risk management team. Training includes:

- Corporate induction training when staff join the trust
- Mandatory update training for all staff every two years and
- Targeted training on specific areas including risk assessment, incident reporting and incident investigation

The trust seeks to learn from good practice through trust communication media and education sessions. Managers produce and distribute lessons learned reports following investigations of incidents.

The risk and control framework

The risk management strategy outlines how governance works in practice across the organisation, including how the trust's performance management systems contribute to an effective system of internal control; ensuring delivery of key objectives and management of risk across all areas in the organisation. The strategy is supported by a range of detailed trust policies and accompanying guidance. The strategy describes:

- A clear framework of accountability and delegated responsibility for risk
- A clearly defined committee structure that supports the risk management process
- A statement defining the organisation's appetite which was reviewed and agreed by the Board when the current risk management strategy was developed. The organisation's risk management appetite recognises there is a degree of risk in every activity that it undertakes and its appetite for risk will depend upon the impact of the risk on the organisation’s strategic direction, the likelihood of it materialising and the effect on the organisation’s reputation and image. However South Tees Hospitals NHS Foundation Trust will be more risk averse in areas of its business where, if it failed, there would be an impact on the safety of our patients and people, the quality of care that we provide and the reputation of the organisation
- Detailed, defined processes for identifying and evaluating risks. Tools available include a standard process for scoring the consequence and likelihood of risks
- An electronic risk register providing a comprehensive, standardised record of risks at divisional and corporate level. This allows risks to be managed consistently
- A dedicated risk management team supporting the risk management process and
- Training processes to support staff to deliver their risk management objectives

The management of risk is monitored at all levels. The risk and assurance sub-group has a rolling programme of presentations from divisions to review local risk management arrangements and to receive a report on risks managed on divisional risk registers. Minutes of these meetings are reported through the committee structure to the Board. Divisions are also required to present their divisional risk registers at quarterly performance reviews with the chief executive, medical director, and the director of nursing/patient safety.

Each month, the executive directors review risks to the corporate objectives which are identified on the assurance framework. They also provide updates to the operational risks identified on the corporate risk register and review any risks which
Summary of financial performance

have been escalated for possible inclusion on the corporate risk register. The corporate risk register is then reviewed by the integrated governance committee which advises on any risks which require detailed reporting to the Board. The assurance framework and any escalated corporate risks are considered by the Board of Directors each month. The Board of Directors also receive a quarterly progress report on the delivery of the strategic objectives.

The information governance steering group ensures that the trust complies with legislation and standards relating to information risks and is chaired by the trust’s Caldicott Guardian. The Board of Directors has accepted any residual risks in the interest of patient care and business continuity and has agreed the information risk management (IRM) framework for the trust.

The trust has a continuous work programme to further embed the IRM framework in the organisation, ensuring that any data security risks are highlighted by departmental staff (information asset administrator – IAA), reported to the divisional/department manager (information asset owner – IAO) and then discussed with the director of IT and health records (senior Information risk owner – SIRO).

With regards to data security incidents, the trust has recently updated its serious untoward incident (SUI) procedure. All data security incidents are incorporated within this procedure and are subject to the same levels of risk treatment.

The trust is 73% compliant with the revised information governance toolkit standards which equates to a rating of unsatisfactory. There are two standards which are not met at level 2:

- At the end of March, 70% of staff had undertaken information governance training against a target of 95%. This compares to a submission of 86% in 2010/2011 when organisations were given until June to submit compliance figures.

To address this issue a training post has been established to provide a dedicated resource to ensure compliance going forward into 2012/2013. The trainer’s main role will be to provide training, promote the electronic training module and to ensure that electronic reporting systems are accurate. Reviews of staff compliance with information governance training will be done on a scheduled basis across the whole year.

- The trust does not have systems in place to ensure the pseudonymisation of all flows of patient identifiable information where appropriate for secondary user purposes.

Critical systems affected by this standard have been reviewed and adequate controls are in place to mitigate this risk.

The performance data used by the trust is split into two key areas:

- Clinical data items, related to the accuracy of clinically coded data
- Administrative data items - relates to other data items related to the patient’s care pathway

The trust undertakes a number of processes to validate and provide assurance of the quality of the data used within the trust:

- Participation in external clinical coding audits undertaken by the Audit Commission
- Internal programme of specialty level clinical coding audits
- Live validation of clinically coded data
- Weekly validation of NHS numbers
- Weekly validation of patients’ GP details
- Internal audits to review accuracy of data used for specific performance reports, ie cancer targets, 18-week targets etc

To assist in the above the trust uses a number of sources external to the trust to facilitate this including:

- NHS Information Centre – SUS Data quality dashboards
- Audit Commission – external clinical coding audits
- Audit Commission – PbR National Benchmarker
- CHKS – Signpost – Data quality indicators

The data quality team review information on the NHS Information Centre and CHKS websites routinely to highlight any issues which require further investigation.

Public stakeholders are also involved in managing risks which impact upon the organisation:

- Patients are involved in their own treatment at every level
• The trust consults with patients and the public when developing services and

• The trust maintains close links with social services, working together on the handling of issues such as delayed discharges

The processes set out above, in particular the standardised approaches, the on-going training and monitoring mechanisms, have allowed the trust to embed risk management in the activity of the trust.

The trust’s assurance framework sets out the following:

• What the organisation aims to deliver (corporate/strategic objectives)

• Factors which could prevent those objectives being achieved (principle risks)

• Processes in place to manage those risks (controls)

• The extent to which the controls will reduce the likelihood of a risk occurring (likelihood)

• The evidence that appropriate controls are in place and operating effectively (assurance)

The assurance framework and risk register have identified no significant gaps in control/assurance.

The trust’s risk management processes identified a number of corporate risks throughout the year. The most significant is the trust’s financial position which is subject to a number of risks including the management of the productivity and efficiency (P&E) programme, maintaining adequate cash balances and delivering the capital investment programme.

These factors all contribute to the achievement of a satisfactory financial risk rating. This is against a backdrop of commissioners seeking to reduce the amount of healthcare they purchase which continues to be a risk in 2012/2013.

The foundation trust mitigates these risks through rigorous budgetary control and management of productivity and efficiency schemes which is reported regularly to management group and the Board of Directors.

The foundation trust is registered with the Care Quality Commission (CQC) with no conditions applied to its registration. The James Cook site was inspected by the CQC in January 2012 and was found to be compliant with the essential standards of quality and safety in relation to respecting and involving people who use services, care and welfare of patients, staffing and the monitoring of the quality of service provision.

In March 2012, as part of a nationwide inspection of termination of pregnancy services, the CQC made an unannounced visit to The James Cook University Hospital and then to the Friarage Hospital to assess compliance with the completion of the HSA1 form which provides the evidence that the termination of pregnancy has been performed lawfully.

Feedback from the assessors’ review of patient notes was that the Friarage Hospital was fully compliant however the James Cook site was non-compliant. The areas of non-compliance were:

• The practitioner not clearly indicating if he/she had seen/not seen and examined the patient

• Missing dates

• The practitioners not clearly indicating their name, qualifications and full address

There was no suggestion that the provision of termination services at The James Cook University Hospital should cease as a result of this. Immediate action was taken to address the areas of non-compliance including review of local guidance, a revised process for signing/completing the HSA1 form and an audit tool based on DH guidelines has been implemented. Audits conducted on records of all patients undergoing termination of pregnancy since the inspection have shown 100% compliance.

The informal feedback and the actions taken have been reviewed and approved by the Board of Directors. The CQC have not yet issued a formal report. A further unannounced inspection can be expected at some point in the near future.

The organisation uses an internet-based assurance system to assess compliance against the CQC standards and to record sources of evidence to support the declaration. The CQC quality and risk profile is reviewed each month and reported by exception to the integrated governance committee.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with.
Summary of financial performance

South Tees Hospitals NHS Foundation Trust Annual Report 2012

This includes ensuring that deductions from salary, employer’s contributions and payments into the scheme are in accordance with the scheme rules and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Control measures are in place to ensure that all the organisation’s obligations under equality, diversity and human rights legislation are complied with.

The foundation trust has undertaken risk assessments and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation’s obligations under the Climate Change Act and the adaptation reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

The trust has a comprehensive system that sets strategic and annual objectives. The Board of Directors sets these objectives with regard to the economic, efficient and effective use of resources. The objectives set reflect national and local performance targets for standards of patient care and financial targets to deliver this care within available resources.

Within these targets, the trust includes specific productivity and efficiency improvements. These are identified from a range of sources including internal review, such as internal audit, and external organisations such as the NHS Litigation Authority, the Audit Commission and other benchmarking agencies.

During 2011/2012, the trust worked with an external consultancy company to undertake comprehensive benchmarking across four dimensions of hospital performance; quality, operations, workforce and finance, which highlighted focus areas for future productivity work. The action plans to deliver the improvements identified have been included in the trust’s integrated business plan for 2012/2013.

It has been recognised by the organisation that the schemes need to be tracked and monitored closely to ensure cost control, benefits realisation and quality monitoring within an assurance framework. In order to ensure this tracking and monitoring is achieved, the organisation has established a programme assurance office.

The trust has a robust monitoring system to ensure it delivers the objectives it identifies. Ultimate responsibility lies with the Board who monitor performance through reports to its monthly meetings. Underpinning this is a system of monthly reports on financial and operational information to the trust’s executive management group, clinical divisions and other management units. Reporting at all levels includes detail on the achievement against productivity and efficiency targets.

The trust operates within a governance framework of standing orders, standing financial instructions and other processes. This framework includes explicit arrangements for:

- Setting and monitoring financial budgets
- Delegation of authority
- Performance management and
- Achieving value for money in procurement

The governance framework is subject to scrutiny by the trust’s audit committee and internal and external audit.

Annual quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare a quality report for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports which incorporate the above legal requirements in the NHS foundation trust annual reporting manual.

For the development of the 2011/2012 quality report, the trust has used a range of sources of feedback from staff, patients, governors and external stakeholders to identify the priorities for quality improvement. This information was presented to the Board who approved the following quality improvement priorities for 2012/2013:

- Further reductions in healthcare acquired infections
- Improving the patient experience of discharge from hospital
• Improving nutrition
• Delivering the right care at the right time in the right place
• Improving communication

Board responsibility for the quality report rests with the director of nursing and patient safety and the medical director. The production of the quality report is overseen by the directorate of healthcare governance. Each quality priority has a clinical lead and a board lead identified who are responsible for identifying the initiatives which will drive improvements and the measurements which will be used to gauge progress.

A mid-year progress report on the quality priorities is presented to the integrated governance committee and the Council of Governors. The data used to report the trust’s quality performance is taken from national data submissions, clinical audit, national benchmarking systems, quality observatories and patient surveys.

Quality and safety metrics are reported quarterly to the Board through the integrated governance committee and compliance with national performance targets is reported to the Board on a monthly basis. The data used in the quality report is taken from these regular reports.

The quality initiatives described in the quality report demonstrate progress across a range of measures but also those where there is scope for further improvement. The mechanisms for assuring the accuracy of the data used is described in the ‘risk and control framework section’ above and a number of performance and quality indicators have been subject to internal audit review.

Further assurance that the report is accurate and representative was gained by sharing the quality report with PCT commissioners, LIKNs and overview and scrutiny committees, as required by national regulation.

The external auditors will provide a signed limited assurance report on the content of the quality report and mandated indicators in the annual report. The signed limited assurance report will be submitted to Monitor by 25 June 2012.

Review of effectiveness

As accounting officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust, who have responsibility for the development and maintenance of the internal control framework.

I have drawn on the content of the quality report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the audit committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the assurance framework and on controls reviewed as part of internal audit’s work. It is his overall opinion that significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation’s objectives, and that controls are generally being applied consistently.

However, some weakness in the design and inconsistent application of controls put the achievement of particular objectives at risk. As part of the head of audit’s opinion he has informed me that there are no significant control issues which he would wish to bring to my attention for potential disclosure.

However, as part of my review, I am also required to review the findings of all internal audit work in order to satisfy myself that any significant control issues have been disclosed within the annual governance statement. As part of this process the corporate directors have reviewed the limited assurance reports issued during the year and have not identified any significant gaps in the adequacy of the controls in place.

The following groups and committees are involved in maintaining and reviewing the effectiveness of the system of internal control:

• The Board of Directors has overall accountability for delivery of patient care, statutory functions and Department of Health requirements
Summary of financial performance

South Tees Hospitals NHS Foundation Trust Annual Report 2012

- Audit committee oversees the maintenance of an effective system of internal control and reviews the annual governance statement
- Integrated governance committee ensures that a fully integrated approach is taken when considering whether the trust has in place systems and processes to support individuals, teams and corporate accountability for the delivery of safe patient-centred, high quality care. The committee considers the assurance framework and corporate risk register each month and identifies corporate risks for escalation to the Board of Directors
- The clinical standards sub-group ensures delivery of the highest clinical standards across the trust to support patient safety and quality of care
- Risk and assurance sub-group monitors and reviews the risk, control and governance processes which have been established in the organisation and the associated assurance process to ensure robust mechanisms for the management of risk and assurance. The agenda includes a monthly review of incidents and complaints and the quarterly review of claims to improve the identification of trends and common issues
- Organisational capability sub-group ensures the organisation develops first class leadership, effective team working and innovative HR practices to support the delivery of the core theme of organisational capability

Review and assurance mechanisms are in place and the trust continues to develop arrangements to ensure that:

- Management, including the Board, regularly reviews the risks and controls for which it is responsible
- Reviews are monitored and reported to the next level of management
- Changes to priorities or controls are recorded and appropriately referred or actioned
- Lessons which can be learned, from both successes and failures, are identified and promulgated to those who can gain from them and
- Appropriate level of independent assurance is provided on the whole process of risk identification, evaluation and control

Conclusion

The trust has not identified any significant control issues for the financial year ending 31 March 2012, which require reporting within this statement

My review confirms that South Tees Hospitals NHS Foundation Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

Chief executive

31 May 2012
Independent auditors’ statement to the Council of Governors of South Tees Hospitals NHS Foundation Trust

We have examined the summary financial statement for the year ended 31 March 2012 which comprises the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers’ Equity, the related notes and the information in the Remuneration Report that is described as having been audited.

Respective responsibilities of directors and auditors

The directors are responsible for preparing the Annual Report and summary financial statement, in accordance with directions issued by the Independent Regulator of NHS Foundation Trusts (‘Monitor’).

Our responsibility is to report to you our opinion on the consistency of the summary financial statement within the Annual Report with the statutory financial statements and the Directors’ Remuneration Report and its compliance with the relevant requirements of the directions issued by Monitor.

We also read the other information contained in the Annual Report and consider the implications for our statement if we become aware of any apparent misstatements or material inconsistencies with the summary financial statement.

This statement, including the opinion, has been prepared for, and only for, the Council of Governors of South Tees Hospitals NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006 (the Act) and for no other purpose. We do not, in giving this opinion, accept or assume responsibility for any other purpose or to any other person to whom this statement is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Opinion

In our opinion the summary financial statement is consistent with the statutory financial statements and the Remuneration Report of South Tees Hospitals NHS Foundation Trust for the year ended 31 March 2012 and complies with the relevant requirements of the directions issued by Monitor.

PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
89 Sandyford Road
Newcastle upon Tyne

Directors’ Statement

The auditors have issued unqualified reports on the full annual financial statements; the part of the directors’ remuneration report that is described as having been audited; and on the consistency of the directors’ report with those annual financial statements.

The auditors report on the full annual financial statements contained no statement on any of the matters on which they are required, by the Audit Code for NHS Foundation Trusts, to report by exception.
Our mission is to deliver world-class outcomes, dependable safety and an outstanding experience for patients, their families and carers.
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Part One
Ensuring we keep our patients safe and free from harm is crucial to providing consistent high quality care and remains very much at the heart of everything we do at South Tees Hospitals NHS Foundation Trust.

Staff have to be our ambassadors - our ‘eyes and ears’ - if we want to continue to embrace - and improve - our patient safety culture, particularly at a time when there are lots of challenges and pressures in healthcare.

I am pleased to say there were many examples of initiatives in this report which have enhanced the safety, experience and outcomes for all patients in 2011/2012.

Our work for piloting a campaign which has helped hospital trusts reduce harm from pressure ulcers, falls, urinary catheters and blood clots, earned the patient safety team a national Safety Express award from the Department of Health.

The team have also shared their experiences with others and initiated the roll-out of the safety thermometer - which helps clinical areas examine their own practices and implement changes in their working environment.

The progress we have made since the first Quality Account was produced two years ago has been impressive but as the organisation sets out its key priorities for 2012/2013, we acknowledge there is always more we can do.

Our partnership with community services colleagues from Hambleton, Richmondshire, Middlesbrough, Redcar and Cleveland has presented a real opportunity to make continuous clinical improvements, bring healthcare closer to home and lower waiting times.

We will also continue to learn from others by benchmarking with other hospitals, sharing good practice and, of course, listening to what people say about us.

As an organisation we remain committed to finding new ways of improving the safety and quality of our healthcare services.

I am pleased therefore, to have the opportunity to present our Quality Account for 2011/2012 which I believe to be a fair and accurate report of our quality and standards of care.

Simon Pleydell, chief executive
Part Two
Review of progress with the 2011/2012 quality priorities.

In the 2010/2011 quality account we identified the following areas for quality improvement focus:

- Further reducing healthcare associated infections
- Focus on discharge management to improve patient care
- To improve standards and delivery of nutritional care across the trust
- Continue to focus on reducing avoidable deaths in hospital (reduce risk adjusted hospital mortality/reduce hospital standardised mortality rate)
- Improving end of life care

Part three of the quality account provides details of the work done to support these quality improvements during 2011/2012. The following section summarises the progress made against the goals identified for each priority area:

### Priority 1
Further reducing healthcare associated infections.

For 2011/2012 our goal was to continue to reduce MRSA bacteraemia and Clostridium difficile cases and to have no more than 4 MRSA bacteraemia and 112 hospital attributed cases of Clostridium difficile.

The table below shows that the trust was successful in achieving this goal.

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Contractual target</td>
<td>24</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Number reported</td>
<td>9*</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>% reduction compared to previous year</td>
<td>decrease</td>
<td>25% decrease</td>
<td>33% decrease</td>
</tr>
<tr>
<td>% reduction compared to previous year</td>
<td>decrease</td>
<td>67% decrease</td>
<td></td>
</tr>
<tr>
<td>Contractual target</td>
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<td>116</td>
<td>112</td>
</tr>
<tr>
<td>Number reported</td>
<td>141</td>
<td>125</td>
<td>67</td>
</tr>
<tr>
<td>% reduction compared to previous year</td>
<td>decrease</td>
<td>47% decrease</td>
<td>11% decrease</td>
</tr>
<tr>
<td>% reduction compared to previous year</td>
<td>decrease</td>
<td>46% decrease</td>
<td></td>
</tr>
</tbody>
</table>

Data Source: Trust apportioned MRSA counts from HPA website (www.hpa.org.uk)
Data Source: Counts of Trust apportioned Clostridium Difficile cases taken from HPA (www.hpa.org.uk)
*The 2009/2010 quality account reported total MRSA bacteraemias – from 2010/2011 this was changed to report only those attributed to the trust.
**In 2011/2012 the trust’s target and the numbers of cases reported includes community hospitals.
Priorities for improvement

South Tees Hospitals NHS Foundation Quality Account 2011/2012

Priority 2
Focus on discharge management to improve patient care, improve clinical outcomes and reduce re-admissions.

The position against the goals for 2011/2012 is described below:

- For appropriate pathways we aimed to send out at least 98% of discharge summaries within 24 hours of discharge. At the end of March 2012 across the trust as a whole 84% of discharge summaries were issued within 24 hours. While the target was not met there was improvement from the baseline of 80% in March 2011 and at individual specialty level some did exceed the 98% target. Work continues to drive further improvement.

- Giving patients a planned date of discharge improves their experience by allowing them to plan around their expected discharge and gives them more confidence when returning home. In March 2011, 25% of patients were given a planned date of discharge and we set an improvement target to exceed 60% in the acute trust by the end of 2011/2012. At the end of March 2012, 56% of patients had a planned date of discharge which is a significant improvement on the previous year but misses the target we set.

Some divisions performed particularly well; neurosciences (92%), cardiothoracic services (92%) and women and children (75%), and we are looking at these areas to see what lessons we can learn to improve compliance across the whole trust. Further detail of the on-going work we are doing to improve the discharge process is described in part three of this report.

Priority 3
To improve standards and delivery of nutritional care across the trust.

For 2011/2012, the trust’s goals were to ensure all patients are screened to assess their risk of malnutrition and this is appropriately acted upon. Progress towards the targets we set is described below:

- Improve the percentage of patients who have a malnutrition risk assessment within 24 hours of admission. At the end of March 2012 our audits showed

  - In the acute hospitals compliance was 88% compared to 81% in the previous year
  - In the community nursing services across Middlesbrough, Redcar and Cleveland and Hambleton and Richmondshire, there was compliance of 99% with the requirement to screen for malnutrition. All localities met their targets for nutritional screening and ensuring that appropriate care plans are in place
  - In Middlesbrough, Redcar and Cleveland community hospitals 93% of patients were screened for malnutrition in 24 hours. This data is not available in a comparative format for Hambleton and Richmondshire community hospitals and this is an area of work for 2012/2013

- Ensure that at least 95% of patients who trigger intervention following a malnutrition risk assessment receive it. Our audits showed that we did not achieve this standard in the acute hospitals and at the end of March 2012 80% of patients in this category had documented actions recorded in their notes when intervention was triggered. Further details on this and the steps we are taking to address this are described in part three of this report
Priority 4

Continue to focus on reducing avoidable deaths in hospital (reduce risk adjusted hospital mortality/reduce hospital standardised mortality rate).

In 2011/2012 the trust’s goal was to achieve a year-on-year improvement in the Risk Adjusted Mortality Index (RAMI). The long-term trend showing a consistent year-on-year reduction is described in detail in part three. In the 12 months January to December 2011, the RAMI was 80.3 compared to 91.8 for the previous 12 months.

Priority 5

Improving end of life care.

For 2011/2012, the trust’s goal was to provide high quality care with dignity and compassion to all patients who are nearing the end of their lives. This was measured in the following ways:

• To increase the number of dying patients on an end of life care pathway. For the acute hospital our target was to improve from the 2010/2011 baseline of 84% to more than 92%, and the local audit at the end of 2011/2012 showed 92% compliance. In community nursing the target was to improve from the baseline of 70% to more than 90% which was achieved with an end-of-year position of 98%.

• To record the preferred place of care in all patients whose care is managed on the end of life care pathway and to monitor the number of patients who achieve this. During 2011/2012 an audit was undertaken which showed that in the acute hospital 80% of patients who died achieved their preferred place of care and in the community the compliance was 97%.

• To reduce admissions/readmissions of patients from care homes at the end of life - this work is on-going.

Further detail of the work to improve end of life care is reported in part three.
Priorities for improvement

South Tees Hospitals NHS Foundation Quality Account 2011/2012

Quality priorities for 2012/2013

The process to select the quality priorities for improvement in 2012/2013 across South Tees Hospitals NHS Foundation Trust acute and community services is described in Part three. The areas chosen were those that were identified most frequently in the consultation process; these were supported and approved by the Board and the Council of Governors. For 2012/2013 the quality account priorities are grouped under the three domains of quality, patient safety, clinical effectiveness and patient experience and the work we plan to do to make improvements in these areas is described below.

Patient Safety

Priority 1 - Continue to focus on discharge management in order to improve patient care, improve clinical outcomes and reduce re-admissions

Rationale:
Ensuring that the process of discharging a patient from hospital or community health service is planned, timely, supported by good documentation and effectively communicated is key to ensuring that patients do not stay in hospital longer than they need to and that when they leave hospital they, and others, involved in their care know what to expect and how to manage any on-going healthcare needs.

The trust’s goals are:

• To provide timely and quality discharge documentation and communication to patients and carers, GPs and community hospitals/care homes.
• All patients will be given a planned date of discharge to improve the patient experience while receiving healthcare during their hospital stay and to give them more confidence when returning home.

Initiatives for 2012/2013

• Roll-out of new discharge documentation
• All complex discharge patients to have a completed discharge plan
• All patients transferred from an acute to a community bed to have a transfer plan
• Care co-ordination/case management model to be agreed and implemented
• Nurse/therapy-led discharge to be the default
• Ensure effective handover/e-discharge within 24 hours to inform primary care and community services
• Ensure discharge on planned date of discharge or before is the norm

Monitoring

• Percentage of complex discharge patients with a completed discharge checklist
• Percentage of patients transferred with a complete discharge checklist
• Number of e-discharge summaries issued within 24 hours of discharge
• Number of patients who achieve planned date of discharge
• Audit of the quality of information in discharge summaries

Progress will be reported through quarterly performance and CQUIN reports to the Board and a mid-year quality account progress report to the integrated governance committee and the Council of Governors.

Implementation leads Deputy director of service transformation

Board sponsor Director of operational services
Priority 2 - Further reducing healthcare associated infections

Rationale:
Ensuring we know what to do to avoid infection and actually doing this for every patient are two crucial components of delivering safe, clean care. Adopting a ‘zero tolerance’ approach to infection requires leadership and constant vigilance at all levels in the trust.

We are working very hard to continue to bring down rates of healthcare associated infections (HCAI) but we can never be complacent in this area - one patient with any healthcare associated infection is one too many.

The trust’s goals are:
- To continue to reduce MRSA bacteraemia and C.difficile cases assessed by delivery of the 2012/2013 improvement targets of no more than 3 MRSA bacteraemia and 80 trust-attributed cases of Clostridium difficile.
- To continue to improve the infection prevention and control (IPC) skills and knowledge of all trust staff in relation to their role in reducing all healthcare associated infections (HCAI).
- To continue to maintain adherence to The Health and Social Care Act 2008 - code of practice for health and adult social care on the prevention and control of infections and related guidance.

Initiatives for 2012/2013
- Fully embed the HCAI action plan repository
- Review of HCAI communication and reporting
- Re-design the IPC training portfolio
- Complete an IPC team review to provide a seamless trust-wide service

Monitoring
- Monthly reporting of MRSA and C.difficile to the Board
- Monitoring of the HCAI action plan repository compliance will be through the Board of Directors monthly reports and the infection prevention action group. The exception reports will identify any non-compliance
- Assess revised communication and reporting process through user feedback
- Monitor IPC training figures
- IPC team review will be monitored through the IPC executive group

Implementation leads
- Infection control doctors
- Assistant director of nursing (deputy director of infection prevention control)
- Clinical matrons

Board sponsor
Deputy chief executive and director of nursing and patient safety
Priorities for improvement

Clinical effectiveness

Priority 3 - To continue to improve standards and delivery of nutritional care across the trust

Rationale:

Today, an unacceptable number of people are becoming malnourished when they are in hospital. They become malnourished because they do not get food 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 patients to recover.

It is not acceptable to this organisation that our patients may become malnourished, and that malnutrition is not being detected and treated in hospital and in community settings.

This trust has 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.

Although the organisation has made significant improvements during 2011/2012, it is felt that this is an area where further improvements can be made to fully achieve the trust’s goals.

For 2012/2013 the trust’s goals are:

- To achieve greater than 90% of patients being screened to assess their risk of malnutrition within 24 hours of admission and ensure this is appropriately acted on
- To ensure we meet the needs of patients who require help with eating or drinking
- To 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 health

Initiatives for 2012/2013

Implementation of the trust’s food and nutrition strategy:

- To address all aspects of the delivery of nutrition and hydration to our patients
- To promote a culture of ‘Food First’ in the organisation
- To implement packages of competency based training for food and nutrition across the organisation

Nutritional screening:

- Exploring opportunities to extend nutritional screening to short-stay and outpatient areas
- On-going monthly monitoring of compliance with completion of the malnutrition screening tool

Assisted Feeding:

- Implementation of standard operating procedures for delivery of food and drinks at ward level
- Employ a creative approach to optimise the mealtime experience
Catering:

- Introduce new steam concept meals across areas in the trust where demand and mealtimes are unpredictable e.g. maternity, high dependency areas
- Explore options for provision of a menu that is locally sourced and minimises the carbon footprint, while meeting nutritional standards and reflecting patient choice
- Ensuring effective processes are in place to capture patient feedback in relation to delivery of food and hydration and employ a ‘you said, we did’ approach
- To review the trust’s protected mealtime policy to ensure patients are not interrupted during mealtimes unnecessarily

Monitoring

- Measuring of compliance with malnutrition risk assessment
- In community hospitals measuring the number of patients requiring fluid balance monitoring who receive it
- Undertake a review of the quality of the completed fluid balance charts in the community hospitals
- Undertake a programme of in-year audits and patient involvement exercises
- Nutrition action plan will include targets for improvement

Progress will be reported through quarterly CQUIN reports to the Board and a mid-year quality account progress report to the integrated governance committee and the Council of Governors

Implementation leads

Director of nutrition and dietetics (chair nutritional standards committee (NSC), clinical standards representative)
Clinical manager, dietetics (chair, food and nutrition group)
Lead clinical matrons for nutrition (NSC, food and nutrition, essence of care, hydration)
Lead consultant for nutrition (nutrition team)
Assistant director of nursing (patient experience)
Assistant director hotel services

Board sponsor

Deputy chief executive and director of nursing and patient safety
Patient experience

Priority 4 - Improve communication

Rationale:

Issues with communication are often cited as a contributory factor in complaints. Improving communication with patients around their discharge arrangements and their medication is highlighted in patient surveys.

The trust’s goal is:

To ensure that patients feel staff communicate with them in a clear and understandable way.

Initiatives for 2012/2013

- If patients have to wait longer than expected in outpatient clinics provide an explanation for the long waiting time and the expected duration of the wait
- Improve the provision of information leaflets to patients
- Improve communication with patients relating to medications at time of discharge
- Support and train staff in breaking bad news and having difficult conversations
- Ensure that hospital passports are actively used by healthcare staff caring for patients with learning difficulties

Monitoring

- Incorporate questions relating to communication in the quarterly patient experience surveys
- Reducing incidents coded as ‘communication’ compared to the 2011/2012 baseline
- Reducing the number of complaints where poor communication is a key factor compared to the 2011/2012 baseline
- Undertake an audit of the use of hospital passports for patients with learning difficulties

Progress with be reported through bi-annual patient experience strategy reports and a mid-year quality account progress report to the integrated governance committee and the Council of Governors.

Implementation leads

Deputy director of nursing

Board sponsor

Deputy chief executive and director of nursing and patient safety
Priority 5 - Right care, right place, right time (reduce delays, improve patient flow and cancellations)

Rationale:

Ensuring patients receive the required level of care in the most appropriate setting for their needs - which reflects their choice - is key to providing safe, effective care which is also a positive experience for patients and their families.

The trust’s goals are:

• To develop an integrated system of services, which enables the care of patients to be delivered in a safe, effective and more timely way

• To ensure that each patient’s on-going care needs are assessed at the earliest possible point in the care pathway and a plan of care (agreed with the patient’s families and other agencies) is implemented in a timely manner

• To reduce delays and have minimum cancellations

• Reduce the number of patients admitted to wards other than their own speciality due to capacity pressures

Initiatives for 2012/2013

• Develop the intermediate tier of services in the community, including the virtual ward and rapid response team

• Care co-ordination/case management model to be agreed and implemented

• Development and implementation of divisional transformation plans to achieve outcomes identified in the strategic blueprint

Monitoring

• Strategic blue-print outcome measures (to be finalised)

• All projects will be monitored through the project assurance office

Progress will be reported through project reports to the Board and a mid-year quality account progress report to the integrated governance committee and the Council of Governors.

Implementation leads

Deputy director of service transformation

Board sponsor

Director of operational services
Priorities for improvement

South Teess Hospitals NHS Foundation Quality Account 2011/2012

Statements of assurance from the Board

Review of services

During 2011/2012, South Teess Hospitals NHS Foundation Trust provided and/or sub-contracted 110* NHS services (*contractual activity by treatment function).

The trust has reviewed all the data available to them on the quality of care of these NHS services.

The income generated by the NHS services reviewed in 2011/2012 represents 100% per cent of the total income generated from the provision of NHS services by the trust for 2011/2012.

Participation in clinical audit

South Tees Hospitals NHS Foundation Trust has a well-structured clinical audit programme which adapts to the needs of the trust and now includes the community services division. We know that high quality clinical audit enhances patient care and safety, and provides assurance of continuous quality improvement.

During 2011/2012, 23 national clinical audits on the National Clinical Audit and Patient Outcomes Programme (NCAPOP) and five national confidential enquiries covered NHS services that the trust provides.

During that period, we participated in 96% (22) national clinical audits on the National Clinical Audit and Patient Outcomes Programme (NCAPOP) and 100% national confidential enquiries of those which we were eligible to participate in.

The national clinical audits and national confidential enquiries the trust was eligible to participate in during 2011/2012 are listed below together with the number of cases submitted to each audit or enquiry, if applicable:

<table>
<thead>
<tr>
<th>National Clinical Audit</th>
<th>Participation/progress</th>
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</thead>
<tbody>
<tr>
<td>Cancer:</td>
<td></td>
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<tr>
<td>Bowel cancer (NBOCAP)</td>
<td>Continuous data collection</td>
</tr>
<tr>
<td>Head and neck cancer (DAHNO)</td>
<td>Continuous data collection</td>
</tr>
<tr>
<td>National lung cancer (NLCA)</td>
<td>Continuous data collection</td>
</tr>
<tr>
<td>Oesophago-gastric cancer</td>
<td>Continuous data collection</td>
</tr>
<tr>
<td>Women and children:</td>
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<tr>
<td>National neonatal audit (NNAP)</td>
<td>Continuous data collection</td>
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<tr>
<td>Peadiatric intensive care (RICA Net)</td>
<td>Continuous data collection</td>
</tr>
<tr>
<td>Diabetes, (RCPH national paediatric diabetes audit)</td>
<td>Continuous data collection</td>
</tr>
<tr>
<td>Heavy menstrual bleeding (HMB) clinics</td>
<td>Continuous data collection</td>
</tr>
<tr>
<td>Childhood epilepsy (epilepsy 12)</td>
<td>100% of requested data submitted</td>
</tr>
<tr>
<td></td>
<td>Baseline questionnaire distributed in (1 February 2011 to 31 January 2012). One-year follow-up questionnaire sent to patients’ homes (February 2012 to February 2013). Data collection period closed November 2011. Our unit selected for inter-related reliability study in April 2012. Final report will be launched in September 2012</td>
</tr>
<tr>
<td>Heart:</td>
<td></td>
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<tr>
<td>------------------------------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>Adult cardiac surgery</td>
<td>Continuous data collection</td>
</tr>
<tr>
<td>Coronary interventions</td>
<td>Continuous data collection</td>
</tr>
<tr>
<td>Myocardial ischaemia (MINAP)</td>
<td>Continuous data collection</td>
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<tr>
<td>Heart rhythm management</td>
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<tr>
<td>Heart failure</td>
<td>Continuous data collection</td>
</tr>
<tr>
<td>Acute stroke (SINAP)</td>
<td>Continuous data collection</td>
</tr>
<tr>
<td><strong>Long-term conditions:</strong></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>Inflammatory bowel disease (IBD) audit</td>
<td>National report published February 2012 - local report to be presented to clinical standards sub committee</td>
</tr>
<tr>
<td>Pain database</td>
<td>Year two (September 2010-2011) case mix data. Patient outcomes and experience data collection Year three (September 2011-September 2012)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Older people:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The carotid interventions audit</td>
<td></td>
</tr>
<tr>
<td>Hip fracture database</td>
<td>Continuous data collection</td>
</tr>
<tr>
<td>National confidential enquires (NCE):</td>
<td></td>
</tr>
<tr>
<td>National confidential enquiry into maternal and child health (CEMACH) /perinatal mortality MBRRACE-UK)</td>
<td>Continuous data collection</td>
</tr>
<tr>
<td>NCEPOD alcoholic liver disease</td>
<td>100% of requested data submitted - enquiry continues into 2012/2013</td>
</tr>
<tr>
<td>NCEPOD bariatric surgery</td>
<td>Organisational questionnaire submitted. At the time of the study, South Tees did not offer this surgical procedure.</td>
</tr>
<tr>
<td>NCEPOD subarachnoid haemorrhage</td>
<td>100% of requested data submitted - enquiry continues into 2012/2013</td>
</tr>
<tr>
<td>NCEPOD cardiac arrest procedures</td>
<td>100% data submitted. National report pending</td>
</tr>
<tr>
<td>Risk factors (National Health Promotion in Hospitals Audit)</td>
<td>South Tees was unable to participate in this audit for this round due to lack of resources.</td>
</tr>
</tbody>
</table>
Priorities for improvement
South Tees Hospitals NHS Foundation Quality Account 2011/2012

Listed below are other national clinical audits the trust has and continues to participate in:

- Vascular Society of Great Britain & Ireland: vascular society database (VSSGBI VSD)
- Intensive Care National Audit & Research Centre (ICNARC): case management programme dataset (CMPD)
- National elective surgery patient reported outcome measures: 4 operations
- National Infarct Angioplasty Project (NIAP) adult cardiac interventions: coronary angioplasty
- National Joint Registry: hip and knee replacements
- Renal Replacement Therapy (Renal Registry)
- Trauma Audit Research Network (TARN): severe trauma
- NHS Blood and Transplant: potential donor audit
- National Comparative Audit of Blood Transfusion
- British Thoracic Society: respiratory diseases (COPD)
- Diabetes (RCPH National Paediatric diabetes Audit)
- National cardiac arrest audit
- Coronary Angioplasty (NICOR)
- Potential donor audit
- National Audit of Seizure Management (NASH)
- BTS Paediatric Asthma
- BTS - Emergency use of oxygen, adult community acquired pneumonia, non-invasive ventilation (adults), pleural procedures, adult asthma, bronchiectasis
- Parkinson’s Disease
- Care of the Dying in Hospital (NCDAH) - South Tees did not submit data for the NCDAH. We carry out our own, more indepth audit, looking at a larger sample than the national audit and included quality of the care pathway. A new document “Care pathway for last days of life” is a common document that has been introduced to all areas in the South Tees locality
- National Diabetes inpatient audit - presentation to clinical standards in April 2012
<table>
<thead>
<tr>
<th>Title of audit</th>
<th>Review and Action Plans/ Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCEPOD Perioperative case study</td>
<td>Audit findings were presented to clinical standards sub group in March 2012. A gap analysis is to be undertaken in conjunction with the consent to treatment audit (carried out in March 2012). Some issues raised were extended length of time for fasting before surgery and communication needed improving. Further work is planned and will be reported back to clinical standards in May 2012</td>
</tr>
<tr>
<td>National Audit of the Management of Familial Hypercholesterolaemia (FH)</td>
<td>Results of audit presented to clinical standards sub-group. Local audit being carried out to follow-up the national audit and establish the implications of identifying the predicted FH relatives of affected cases in the UK</td>
</tr>
<tr>
<td>Trauma Audit Research Network (TARN)</td>
<td>Themed report 2011 Issue 1 - thoracic injuries - report showed that South Tees performance is in the top 15 hospitals with the highest statistics for excess survivors per 100 patients over a four-year period</td>
</tr>
<tr>
<td>Diabetes National Impatient Audit</td>
<td>There has been marginal improvement in medication incidents; e-prescribing is planned for the future. 50% of patients are referred to diabetes specialist nurses within 72 hours of admission. More specialist nurse time is required in this area</td>
</tr>
<tr>
<td>National Falls Audit</td>
<td>South Tees action plan used by the Royal College of Physicians as an example of best practice. Strengths include pain control, thromboprophylaxis, use of integrated fracture care pathway, attempt at mobilisation within 24 hours, multifactorial risk assessments, continence assessments, gait and balance assessments, clinical assessment of osteoporosis, involvement of patient or carer in discharge arrangements. Areas to improve are early assessment by orthogeriatrician, operation waiting times, assessment by occupational therapist, home hazards assessments, reduction of psychotropic and sedative drugs, intervention plans to be shared with patients. There is now a fragility fracture nurse in post</td>
</tr>
<tr>
<td>Potential Donor Audit</td>
<td>The number of donors had fallen with the single largest contributor to this being a low consent rate. Consent rates were also low in another large trust in the area, suggesting this was a regional issue. The trust has done well with all of the other key performance indicators outperforming national averages for the identification of potential donors, referral to the donation team and approach to families.</td>
</tr>
</tbody>
</table>
Priorities for improvement

South Tees Hospitals NHS Foundation Quality Account 2011/2012

<table>
<thead>
<tr>
<th>Stroke Improvement National Audit Programme (SNAP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The trust has put a lot of investment into stroke. The introduction of weekend clinics, weekend stroke specialist reviews, weekend therapy working and an increase in nursing levels has made a great difference and most patients are seen by a consultant. Majority of patients are admitted into the stroke unit within four hours of arrival.</td>
</tr>
</tbody>
</table>

Local Clinical Audits

Examples of local clinical audits reviewed by the provider in 2011/2012 with actions planned to improve the quality of healthcare provided are presented in the table below:

<table>
<thead>
<tr>
<th>Title of Audit</th>
<th>Review and Action Plans/ Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust-wide record keeping audit:</td>
<td>The results remain consistent with the previous years’ audits - Implementation of standardised documentation is imminent, which will address the issues identified in the audit</td>
</tr>
<tr>
<td>Sepsis audit</td>
<td>The audit has shown a reduction in mortality, from 53% to 36%. This is due to heightened awareness and increased timely recognition and treatment. There has been a significant improvement in the times to delivery of all elements of care. Further actions are trust-wide education access to specialist nurse advice for the staff, visible aids, sepsis screening tool, stickers and tags to be placed on all thermometers, screen savers to be introduced across trust personal computers. posters, sepsis 6 boxes to be launched across every ward and department</td>
</tr>
<tr>
<td>Deterioration patient audit</td>
<td>A regional comparison audit with Safer Care North East deteriorating patients’ regional strategy group. The trust has performed extremely well against the standards. There were seven standards with partial compliance and 15 fully compliant standards</td>
</tr>
<tr>
<td>Trust-wide medications policy</td>
<td>The overall results were positive, demonstrating a good knowledge and general compliance with the policy Areas for improvement are around legibility and signing of drug charts, allergy documentation, route of administration, ‘as required’ medication prescribing. Actions taken are - circulation of a pharmacy newsletter providing audit results and advice for prescribers highlighting the main areas for concern General review of postgraduate training Review of the need for all grades of staff undergoing continuing training and updates on prescribing Pilot ‘Safe prescribing standards - check and correct’ as a method of staff training and development</td>
</tr>
</tbody>
</table>
An internal audit report of the clinical audit process in South Tees has been published. The following are being implemented in response to the report:

- A rolling programme of presenting national and trust-wide priority clinical audits to committees is being introduced in 2012/2013 to ensure there is appropriate scrutiny of results and facilitate action planning.
- Annual clinical audit plans from all directorates are to be submitted by the end of June every year.
- A matrix to assess potential risk areas is to be implemented, ensuring that ‘high’ risk audits (any procedures/protocols etc. that may pose a risk to patient safety/staff financial risk) are highlighted and built into the annual plan.

Improvements have been made in the clinical audit services during 2011/2012 including:

- Standardised reporting across the trust. The report template includes sections to show re-audit results which clearly show any improvements in practice.
- Standardised registration proforma introduced, with all registrations being authorised by the directorate clinical audit lead. This has helped to ascertain the level of audit activity and also ensured that any projects undertaken are clinical audit, and if not, are referred to the research and development department.
- Clinical audit training is well attended. Feedback from candidates is that the course is informative and helpful. The course is also available for community staff.
- The majority of ‘local’ audits have been supported by the central clinical audit team.
- Closer working relationships with directorate and divisional clinical audit personnel, which has improved with the implementation of the clinical audit policy in 2010.

<table>
<thead>
<tr>
<th>VTE Thromboprophylaxis audit</th>
<th>Improvements have been made since the appointment of the anticoagulation team. Compliance with appropriate thromboprophylaxis in March 2011 was 68%. This has increased to 90% in March 2012.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The management and investigation of hyperglycaemia in patients with acute coronary syndrome (ACS) in The James Cook University Hospital coronary care unit clinical audit prize winner 2011</td>
<td>From published data and anecdotal evidence, control and investigation of hyperglycaemia on coronary care unit is of high quality. This audit cycle has improved compliance, but not yet achieved the aim of 100% compliance. While it is disappointing that 100% compliance has not yet been achieved, it is worthwhile putting our achievement into a wider context, comparing our local results with the closest national comparator - MINAP data - the James Cook has significantly higher compliance when benchmarked against national data. Some of the interventions to improve practice further are:</td>
</tr>
<tr>
<td></td>
<td>• Simplification of nursing pathway, removal of all non-essential elements</td>
</tr>
<tr>
<td></td>
<td>• Improved visibility of pathways. ‘Green for glucose’ campaign - pathways on green paper to improve visibility in notes</td>
</tr>
<tr>
<td></td>
<td>• Requirement to check lab glucose against initial glucometer reading and follow protocol according to the higher value</td>
</tr>
</tbody>
</table>
Priorities for improvement

South Tees Hospitals NHS Foundation Quality Account 2011/2012

Commitment to research as a driver for improving the quality of care and patient experience

Participation in clinical research demonstrates we are committed to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment options and recognise that active participation in research leads to improved patient outcomes.

The number of patients receiving NHS services provided or sub-contracted by South Tees Hospitals NHS Foundation Trust that were recruited during 2011/2012 to participate in research approved by a research ethics committee was 2,500. There are currently 114 portfolio studies reporting recruitment.

Goals agreed with commissioners - use of the CQUIN payment framework

A proportion of the organisation’s income in 2011/2012 was conditional on achieving quality improvement and innovation goals agreed between us and NHS Tees and North Yorkshire and York (primary care trusts), through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2011/2012 and for the following 12-month period are available on request from the performance management department, South Tees Hospitals NHS Foundation Trust, The James Cook University Hospital, Marton Road, Middlesbrough TS4 3BW or email performance.management@stees.nhs.uk

The income conditional upon achievement of the CQUIN measures in 2011/2012 was £6,790,625. Of this, the trust received a payment of £5,740,636.

What others say about us

Statements from the Care Quality Commission

“The CQC has registered South Tees Hospitals NHS Foundation Trust to provide services”

We do not have any conditions on registration.

The Care Quality Commission has not taken enforcement action against the organisation during 2011/2012.

South Tees Hospitals NHS Foundation Trust had a planned review by the Care Quality Commission (CQC) on 6 January 2012 and the full report is available on the trust and CQC website. The findings for the unannounced inspection visit were:

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

The CQC found that The James Cook University Hospital of South Tees Hospitals NHS Foundation Trust was meeting this standard.

The CQC found that people were treated with dignity and respect. They were given clear information about treatment options and were involved in making decisions and choices about their care and treatment, including discharge arrangements.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

The CQC found that The James Cook University Hospital of South Tees Hospitals NHS Foundation Trust was meeting this standard.

People received effective, safe and appropriate care, treatment and support that meets their needs.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

The CQC found that The James Cook University Hospital of South Tees Hospitals NHS Foundation Trust was meeting this standard.

The CQC found that people were safe and their health and welfare needs were met by sufficient numbers of appropriate staff.
Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The CQC found that The James Cook University Hospital of South Tees Hospitals NHS Foundation Trust was meeting this standard.

The CQC found that the trust had good systems in place to audit and monitor the quality of services it provides.

The day the CQC visited the trust (Friday 6 January 2012) was exceptionally busy across the hospitals and community services so the assessors witnessed the true challenges we face as a large and complex organisation.

The Secretary of State also asked the CQC to inspect termination of pregnancy services across the NHS and independent sector in March 2012. The James Cook and Friarage sites were inspected on 22 March and we are awaiting the formal report.

Data quality

NHS number and general medical practice code validity

South Tees Hospitals NHS Foundation Trust submitted records during 2011/2012 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% for admitted patient care;
  - 99.7% for outpatient care; and
  - 98.9% for accident and emergency care.

- Included the patient’s valid General Practice Code was:
  - 99.2% for admitted patient care
  - 98.9% for outpatient care and
  - 99.8% for accident and emergency care

Information governance toolkit attainment levels

The information governance (IG) toolkit uses a framework of standards, which are designed to ensure organisational compliance with statutory and mandatory requirements concerning the management of patients, staff and corporate information. The IG toolkit has been developed as the principal mechanism by which IG policy can be broken down into measurable components in order to assess an organisation’s performance annually through a system of self-assessment and audit. The IG toolkit enables the organisation to develop a strategy and annual work programme to raise the level of compliance year-on-year, and also improve its information risk management process. A toolkit score level of 0-1 equates to a grade red and a score level of 2-3 equates to a grade green.

For South Tees Hospitals NHS Foundation Trust the information governance assessment report overall score for 2011/2012 was 73% and was graded red (unsatisfactory).

The two standards in where the trust did not achieve level 2 were:

**Requirement 9-112** - To ensure organisational compliance with the law and central guidelines relating to information governance (IG) staff must receive appropriate training. Therefore, IG training is mandatory for all staff, (comparable to health and safety training) and staff IG training needs should be routinely assessed, monitored and adequately provided for.

At the end of March 2012, 70% of staff had received IG toolkit training against a target of 95%. An action plan is being developed to ensure we are able to improve on this and attain the required standard during 2012/2013.

**Requirement 9-324** - A fundamental principle of the Data Protection Act 1998 is to use the minimum personal data to satisfy a purpose and to strip out information relating to a data subject that is not necessary for the particular processing being undertaken. This principle is aligned with the Caldicott Principles familiar to NHS and social care organisations and is supported by both common law confidentiality obligations and the Human Rights Act 1998 which provides a privacy right for individuals.
Priorities for improvement

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The trust is not currently fully compliant with this requirement. Actions to address this are:

• The head of information is working closely with the IG department to identify alternative process change, along with suitable tools required, to establish an internal safe haven for information exchange and pseudonymisation functionality for secondary use purposes.

• An action plan is in place and a draft standard operating procedure for the secondary use of data has been developed and is under consultation.

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

• Review of trust data quality strategy and supporting policies
• On-going weekly validations of key data items/fields
• Training and awareness of data quality issues
• Use of external toolkits, i.e. CHKS, SUS and Audit Commission, to identify data quality issues and implement solutions

Clinical coding error rate

South Tees Hospitals NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

• Primary diagnoses were 3.5% incorrect
• Secondary diagnoses were 2.5% incorrect
• Primary procedures were 2.1% incorrect
• Secondary procedures were 0% incorrect

These results should not be extrapolated further than the actual sample audited. The audit sample was 100 ophthalmology and 100 random selections from secondary users service (SUS).
Continuous quality improvement is part of the trust's culture. It is at the heart of our values and drives our objective setting, and we are continuously exploring new ways to improve quality and safety.

In September 2010, quality and safety information on all foundation trusts in England was collated from publicly available data (CQC rating, Dr Foster safety score, mortality data, infection rates, Monitor rating, patient and staff satisfaction scores).

Organisations that performed in the top 20% on all indicators were invited to consider participation in a collaboration of high performing NHS foundation trusts called the QUEST network, the objective of which is to share best practice and pursue excellence in clinical outcomes. South Tees Hospitals NHS Foundation Trust joined the network in the first wave of 11 trusts in February 2011.

In its first year, collaborative members agreed to work on three improvement programmes designed to test ways of delivering a better and safer service with the aim to achieve greater outcomes at an accelerated pace:

- Mortality reduction
- Reducing the number of hospital re-admissions
- Harm-free care (four harms - venous thromboembolism (VTE), pressure ulcers, catheter associated urinary tract infection (CA-UTI) and falls) This work stream is to be delivered under the banner of ‘Safety Express’.

Safety thermometer is a prevalence survey to measure the level of harm-free care at a particular point in time. Initially the trust piloted the use of the safety thermometer in four acute wards at The James Cook University Hospital.

In line with the trust's revised patient safety strategy and corporate objectives this has increased to 42 clinical inpatient areas, which includes all community hospital wards. Monthly meetings are held with the project leads in the four areas of harm to discuss the data in order to focus improvement support to clinical areas.

The trust routinely uses a range of quality and safety measures to assess performance and identify additional areas for improvement. Quality measures covering patient safety, clinical effectiveness and patient experience have been built into templates known as ‘dashboards’, which show performance at departmental, divisional and trust level.

At monthly performance meetings executive directors meet with staff from each division so that actions can be agreed to improve performance where necessary. A simple traffic-light grading system helps to quickly show areas that may be weaker in performance so that actions can be taken to improve that area.

This information is shared with the Board of Directors, Council of Governors, senior clinicians and managers to provide assurance the trust is on target to deliver its key targets.

The following sections review a range of quality workstreams undertaken during 2011/2012 including further detail on the work undertaken in relation to the priorities which were identified in the 2010/2011 quality account.
Patient Safety

Reducing healthcare associated infections (HCAI)

Reducing healthcare acquired infections has been a quality improvement priority in each of the trust’s quality accounts and is supported by continued implementation and monitoring of the trust’s three-year healthcare associated infection (HCAI) strategy. During 2011/2012 there continued to be a year-on-year improvement in the number of healthcare associated infections.

A range of initiatives were identified at the start of the year to support improvements in this area and the following section provides an update on our progress:

2011/2012 was the second year of the infection prevention and control link practitioners’ programme which includes promoting ward level ownership and accountability for infection prevention and control audits, observations and teaching. This programme has helped to reinforce infection prevention messages at ward level. The third year of the programme has now begun and will be monitored as part of the 2012/2013 priorities.

The trust has developed a trust-wide decontamination strategy, which includes clear roles and responsibilities and monitoring arrangements around patient equipment cleaning and decontamination (commodes, mattresses, etc). The strategy will be implemented and monitored through the decontamination steering group.

During 2011/2012 the organisation reinforced the importance of prioritising ‘time to isolation’ for patients with suspected C. difficile and staff have been educated in the importance of isolating patients in single rooms on the basis of symptoms rather than waiting for test results. ‘Time to isolation’ is monitored through the C. difficile outbreak meetings, root cause analysis on MRSA bacteraemia and C. difficile cases and routine infection prevention control patient surveillance

During 2011/2012 a programme of HCAI related ‘patient experience’ surveys was implemented. A robust monitoring and reporting process is under development to allow the analysis of themes and sharing of any lessons back to the clinical teams and to influence the training programme.

The infection prevention and control (IPC) team have developed a risk assessment tool for ward/department use to be led by IPC link practitioners. A standardised escalation protocol is to be developed to ensure that infection risks are identified on divisional risk registers so that they are subject to robust scrutiny and actively managed to reduce risks.
The graphs below show the considerable progress in reducing hospital associated infections with MRSA and C.difficile which has been made in recent years:

**Number of post 48 hour MRSA bacteraemias per 100,000 bed-days for North East Acute Trusts**

Data Source: Trust apportioned MRSA counts from HPA website (www.hpa.org.uk) Bed days from Department of Health KH03 returns (www.dh.org.gov.uk)

**Number of post 72 hour cases of Clostridium Difficile per 100,000 bed-days for North East Acute Trusts**

Data Source: Counts of Trust appointed Clostridium Difficile cases taken from HPA (www.hpa.org.uk) Bed days (for individuals age 2 years and above) from Hospital Episode Satistics (HES)
Reducing falls

Patient falls are among the most common patient safety incidents reported in hospitals and are a leading cause of death in people ages 65 or older. The trust has joint falls management policies with both the Tees and North Yorkshire primary care trusts which aim, as far as possible, to reduce the incidence of falls and fall-related injuries for the populations served.

The number of falls incidents reported in the acute hospital continues to reduce:

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<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls incidents</td>
<td>2,426</td>
<td>2,181</td>
<td>2,162</td>
<td>2,075</td>
</tr>
<tr>
<td>reported in hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Falls per 1000 bed</td>
<td>6.88</td>
<td>6.24</td>
<td>6.14</td>
<td>6.66</td>
</tr>
<tr>
<td>days</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Data Source: Falls incidents - DATIX incident reporting system bed days - local patient administration system

In addition to monitoring the number of falls incidents reported, the trust also reviews the number of falls in the context of the number of beds occupied by patients. This rate of falls has shown a year-on-year reduction until 2011/2012 when the rate has increased. This is partly due to the work we are doing to reduce the occupancy of acute hospital beds and in 2011/2012 there were 6,000 fewer occupied bed days compared to the previous year which impacts on the calculation of the rate of falls. The other contributory factor is the change in the case mix of patients cared for in the acute hospital beds with a higher proportion of elderly patients who are at greater risk of falling while in hospital.

Acute Hospitals: Number of falls / % involving fracture
April 2010 to March 2012

Data Source: Falls incidents - DATIX incident reporting system
There were 34 falls resulting in a fracture in patients in the acute hospital setting. This compares with 26 during 2010/11. The table below shows the number of falls which have resulted in a fracture over the last four years:

<table>
<thead>
<tr>
<th>Year</th>
<th>Falls resulting in a fracture in the acute hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008/2009</td>
<td>44</td>
</tr>
<tr>
<td>2009/2010</td>
<td>33</td>
</tr>
<tr>
<td>2010/2011</td>
<td>26</td>
</tr>
<tr>
<td>2011/2012</td>
<td>34</td>
</tr>
</tbody>
</table>

Data Source: Falls incidents - DATIX incident reporting system

Falls data for community hospitals shows that in 2011/2012 there were 412 falls incidents reported which equates to a rate of 7.8 falls per 1000 bed days. The case mix of the patients in the community hospitals is different to that in the acute hospital and there are slight differences in the categorisation of falls incidents between the acute and community hospitals which will be standardised in 2012/2013.
There were seven falls resulting in a fracture in the community hospitals during 2011/2012. There is no comparative trend data as the community services were previously delivered in a different configuration using different incident reporting systems.

It is disappointing that we have not been able to sustain the reduction in fractures resulting from a fall seen last year and this remains an area of focus for patient safety work in the trust. Analysis of the occasions when patients fall has shown that in the majority of cases the fall occurred from the bed or when patients got out of bed without support. The trust has invested in new adjustable height beds and additional bed rails. We are reviewing the use of sedation at night and have introduced the process of ‘intentional rounding’ across all acute and community wards. ‘Intentional rounding’ is a process where health professionals carry out regular checks with individual patients at set intervals to ensure they have everything they need close to hand or to provide support if the patient needs to leave their bed.

**Improving wound care**

Pressure ulcers represent a major burden of sickness and reduced quality of life for patients creating significant difficulties for patients, their carers and families. During 2011/2012, the trust has continued to be proactive in its approach to achieve year-on-year improvements in the identification of both pressure ulcers and moisture lesions, highlighting those patient groups at risk and implementing early intervention to prevent development and deterioration of skin damage.

The trust policy on pressure ulcer management has been revised to cover acute and community settings and now includes both pressure ulcers and moisture lesions. Staff receive monthly training alongside one-to-one departmental updates in the identification, assessment, reporting and documentation processes. Incident reports are monitored monthly in conjunction with the lead nurse for wound care to ensure repetitions and correct gradings are monitored and filtered to ensure accuracy. A root cause analysis is carried out for all grade three and four pressure ulcers to ensure lessons are learned through the development of action plans and monitoring.

An annual point prevalence audit took place in March 2011. This audit reviews all the inpatients across the acute and community hospital settings at a point in time and is not influenced by the continuous drive to improve the incident reporting culture in the trust, which we expect to lead to better recognition and increased incident reporting.

![Acute hospital acquired pressure ulcer prevalence](data:image/png;base64,iVBORw0KGgoAAAANSUhEUgAAAIoAAAD2CAYAAAAw5oXlAAAgAElUXbahAAAAAAElFTkSuQmCC)

<table>
<thead>
<tr>
<th>Acute hospital acquired pressure ulcer prevalence</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients audited</td>
<td>901</td>
<td>879</td>
<td>949</td>
<td>917</td>
<td>850</td>
</tr>
<tr>
<td>% with hospital acquired pressure ulcer</td>
<td>8.88%</td>
<td>5.4%</td>
<td>5.8%</td>
<td>3.3%</td>
<td>2.82%</td>
</tr>
<tr>
<td>% with grade 1 or 2 hospital acquired pressure ulcer</td>
<td>7.88%</td>
<td>4.3%</td>
<td>5.2%</td>
<td>3.3%</td>
<td>2.82%</td>
</tr>
<tr>
<td>% with a grade 3 or 4 hospital acquired pressure ulcer</td>
<td>1%</td>
<td>1%</td>
<td>0.6%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Data source: local point prevalence audits
Prevalence audits were carried out in the community hospitals for the first time in 2011/2012. The most recent audit showed the prevalence of hospital acquired pressure ulcers to be 3.2% in the community hospitals with no grade 3 or 4 hospital acquired pressure ulcers.

Improving discharge management

Improving discharge management was identified as a priority in last year’s quality account and continues to be a high priority area of work.

During 2011/2012 we have made progress with a number of initiatives relating to discharge. In addition to the measures reported in part two of the quality account this work included the following:

- The trust audited accuracy of discharge summaries in quarter one. This showed that although a number of standards showed good compliance there was scope for improvement. The audit has been repeated in March 2012 and the results will be used to focus further work in 2012/2013
- Enhanced recovery pathways in colorectal, MSK, gynaecology and urology commenced during 2011/2012. This initiative will be rolled out to vascular surgery and breast surgery during the coming year
- The sending out of discharge summaries to GP Practices electronically using a combined approach with North Tees and Hartlepool NHS Foundation Trust is currently being tested
- The discharge percentage by time of day has improved. In October only 52% of our patients had been discharged by 4pm whereas in March the position was 74%
- The implementation of risk stratified follow-up calls is progressing with the readmissions project and is in place in the cardiothoracic division and acute medicine. Surgery is piloting their scheme

Improving discharge remains an area of focus which is integral to our work to improving the patient pathway and will continue to be a quality account priority for 2012/2013.

Clinical effectiveness

Reducing unnecessary deaths in hospital - mortality

The importance of reporting mortality statistics at Board level, a process which is now embedded in South Tees, was highlighted in the Francis Report into the failures at the Mid-Staffordshire Trust (February 2010). Historically there has been a range of ways of calculating mortality statistics which has caused problems when comparing hospitals across the country and identifying organisations with excessive mortality. Following the Francis Report, the Department of Health established a national group to make recommendations about use of mortality measures by hospitals. The group recommended the development of a new hospital mortality measure - the Summary Hospital-level Mortality Indicator (SHMI). The SHMI reports all hospital mortality plus deaths within 30 days of discharge from hospital, using data linked from death certificates to hospital activity data. South Tees Hospitals NHS Foundation Trust routinely monitors three mortality measures; unadjusted mortality, the risk adjusted mortality index (RAMI) and the summary hospital-level mortality indicator (SHMI).

Unadjusted mortality is a simple measure of the number of deaths as a percentage of patient inpatient episodes. Looking at the trend from April 2005 to December 2011, we see a small but steady decline with the death rate falling from 1.5% to 1.27%. In November 2010, the trust had an unadjusted mortality rate below 1% for the first time since current reporting arrangements were established. The comparison to a peer group of hospitals (ie those trusts that are similar to South Tees) is shown opposite:
The risk adjusted mortality index (RAMI 2010) is an index statistically calculating individual patient risk based on data in the national 2008/2009 database. Risk adjusted mortality is falling across the NHS. Values below 100 reflect better performance while values over 100 indicate that there were more deaths than expected using the 2008/2009 adjustment. The RAMI compares the actual deaths to the number of expected deaths using a methodology developed by CHKS, a benchmarking company. This takes account age, sex and all recorded diagnoses and procedures and predicts the risk using a logistical regression model. The graph below, drawn from the regional hospital mortality monitoring reports, shows RAMI for South Tees compared to the North east region and England averages for July 2008 to June 2011.
Review of Quality

South Tees Hospitals NHS Foundation Quality Account 2011/2012

Using more recent data available internally to the trust, the 12 months from January - December 2011 was 80.3, compared to 91.8 for the previous 12 months.

Comparison between RAMI and unadjusted mortality rate over time shows a slight downward trend in unadjusted mortality rate and a much more dramatic decrease in RAMI.

The summary hospital level mortality indicator (SHMI) is the new hospital-level indicator which reports all deaths in hospital and all deaths that occur within 30 days of discharge from hospitals across the NHS in England. It compares the observed number of deaths for each hospital with the number expected from a statistical model that takes account of patients’ age, sex, method of admission to hospital and co-morbidities. SHMI was introduced to standardise mortality reporting so that national comparisons can be made.

The SHMI for the trust within North east hospitals for the period July 2010 to June 2011 was 96. This means there were fewer deaths than might be expected statistically and we had one of the best results in the North east of England.

Following integration of community services, monitoring of mortality was extended to include community hospitals. Data for Carter Bequest, East Cleveland, Guisborough and Redcar Primary Care Hospitals is available from 2008. Data for the Friary, Rutson and Lambert Hospitals is included from April 2011.

Over the period January to December 2011, there were 202 deaths recorded in community hospitals, averaging 16.8 per month over the period. The overall unadjusted mortality rate was 10%, significantly higher than that for the two acute hospitals in the trust - the James Cook and the Friarage (unadjusted mortality rate of 1.27% over the same period). This is because of the very different nature of the services provided in the community hospitals and the high proportion of patients who receive palliative and terminal care in them.

Work to identify further opportunities to reduce mortality continues and from quarter four 2011/2012 all directorates will review all deaths in hospital to ensure that avoidable factors which may contribute to mortality are identified and addressed.

Unadjusted Mortality Rates - Community Hospitals
April 2008 to December 2011

Data Source; Local Patient Administration System
Readmissions

A number of patients return to hospital within 30 days of discharge. 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 down to their rehabilitation not progressing as planned.

In South Tees, unplanned readmission rates within 30 days of discharge from hospital are around the same in 2011 as they were in 2010, averaging 6.98% in 2011 compared to 7.02% in 2010. We will continue to focus on readmissions because it is an important measure of quality.
Review of Quality

South Tees Hospitals NHS Foundation Quality Account 2011/2012

Improve standards and delivery of nutritional care across the trust.

Recent national studies have shown that an unacceptable number of people are becoming malnourished when they are in hospital. They become malnourished because they don’t get food 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.

This trust has 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. To 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 care plan.

During 2011/2012, we have made progress with a number of initiatives relating to nutrition. In addition to the measures reported in part two of the quality account this work included the following:

• To improve compliance with malnutrition screening, the risk assessment tool has been further revised to reflect feedback from the clinical matrons. The updated tool has been piloted in three areas across the trust, and will be introduced trust-wide from March 2012. The pilot will be supported by a training programme delivered by the nutrition nurse specialist
• An ‘ask for a snack’ campaign was run in January 2012 at James Cook and March 2012 at the Friarage, plus Middlesbrough, Redcar and Cleveland community hospitals, to raise awareness of the extra snacks available between meals in the hospitals, and the importance of encouraging patients to take these as part of a high protein, calorie diet. In March 2012 a new ‘medium risk / MUST 1’ high protein, high calorie patient information pack was launched to raise patient awareness. The campaign will be taken to each ward / relevant clinical area across the trust
• Daily diet sheets have been produced and implemented to be used by ward staff (nursing and catering) to communicate patients’ dietary requirements - including whether high protein menus, between meal snacks and / or assistance with feeding are required
• During 2011/2012 the trust implemented the use of a malnutrition screening tool for children and achieved 100% compliance with the use of the tool at the end of March 2012
• The trust achieved its objective to maintain or improve the 95% compliance with the nutritional standards for catering
• Nutrition roadshows were carried out in January 2012 (James Cook) and March 2012 (Friarage)
• A volunteer / buddy system is underway to provide assistance with feeding and the mealtimes volunteers group meets regularly to discuss progress. A training programme is being addressed
• The use of red jug lids to identify patients requiring assistance with drinks is in place across both acute hospital sites
• Kitchen communication boards and red tray system to identify patients who require help with feeding have been introduced in community hospitals
• Patient experience event has been held to involve patients in evaluating food choices

Patient experience and the environment

Improving end of life care

The publication of the first national End of Life Care Strategy (July 2008) has seen an unprecedented focus on the care of people nearing the end of their lives. The role of the acute hospital trust in the delivery of end of life care is essential if this vision is to be realised. Although evidence suggests that the majority of people would prefer to die in their own homes, in reality around 60% of deaths occur in hospitals. In light of this, South Tees Hospitals NHS Foundation Trust has a responsibility to ensure that it has the organisational processes and procedures in place to aid patient choice, along with an educated workforce who are able to deliver that choice in a timely and effective manner.

The trust has around 2,000 inpatient deaths per year. With present focus on reducing re-admissions and reducing inpatient stay, end of life care provision has the potential to deliver on these important agendas.

During 2011/2012 we have made progress with
a number of initiatives relating to end of life care. In addition to the measures reported in part two of the quality account this work included the following (data sources are local audits)

- Accident and emergency are continuing to inform the consultant in palliative medicine of ‘inappropriate’ admissions for further investigation to help reduce the number of dying patients unnecessarily admitted to hospital
- The Macmillan discharge project continues which has increased the number of terminally ill patients in hospital who are discharged home to die which improves compliance with the patients’ wishes and reduces the use of acute hospital beds
- The palliative care consultant has implemented a programme of presentations to directorates across the trust to raise awareness of steps to consider which will improve the notification to primary care colleagues of patients who are terminally ill. Written guidance has also been produced and is in process of being printed. This will support improving access to appropriate support at the end of life

Patient surveys and experience

Patients rate trust highly in outpatient survey

Patients were satisfied with the high quality care and treatment they received at the trust, according to the Care Quality Commission’s (CQC) 2011 outpatient survey.

Significantly, the trust was placed in the highest scoring 20% of NHS trusts in England by patients when asked about their overall opinion of dignity, respect and care when being examined or treated.

In the survey, patients were asked a series of questions relating to their experience as an outpatient during April or May 2011, including outpatient clinics run with the accident and emergency departments such as fracture clinics.

The trust was in the category of ‘best performing 20 per cent of trusts’ for more than half of all the benchmarked questions asked (23 out of 39) and was not placed as ‘red’ - the 20% of trusts with the lowest scoring threshold - in any category. Our results included:

- Scores of 95 out of 100 for patients being treated with dignity and respect at the outpatients department and given enough privacy when discussing their condition or treatments
- A score of 93 out of 100 for the doctor listening to what they had to say
- A score of 93 out of 100 for having confidence and trust in an NHS professional

Listening to the views and experiences of patients, their carers and families is invaluable in helping to improve the quality of services we provide - their opinions will always remain one of the most important markers by which we measure our performance.

Areas where improvements could be made were also identified in the survey and include patients receiving copies of letters sent between hospital doctors and the family GP.

Work has already started to determine the best approach to improve the trust’s performance in these areas.

The report is the fourth national survey of adult outpatients (aged 16 or over) in NHS hospitals in England and almost 73,000 patients who visited one of 163 acute or specialist NHS trusts took part - a national response rate of 53 per cent. At South Tees, 490 patients (58%) responded.

Improving the ward environment for dying patients receives national praise

A hospital ward refurbishment - including a purpose-built palliative care bay to improve facilities for patients at the end of their lives - has received national praise. Ward nine, which cares for patients with respiratory problems at The James Cook University Hospital, was highly commended in the Building Better Healthcare Awards.

The redevelopment, completed as part of The King’s Fund ‘Enhancing the Healing Environment Programme for End of Life Care’ in partnership with the Department of Health, was runner-up in the estates and facilities category ‘Best Response to DH Policy Award’.
Ward nine, which was completed last year, had a radical make-over including a new relatives room, palliative care facility (created from a former six bedded bay allowing patients more privacy and dignity) and a modern nurses station. Patients’ relatives and staff were intrinsic to the changes made to the £320,000 refurbishment carried out by company Interserve.

The project was overseen by a South Tees team including the deputy director of planning, divisional manager for acute medicine, a consultant in palliative medicine, a senior nurse in planning and the managing director of Endeavour - the trust's private sector partner.

**A passport to improved communication and experience**

Traffic-light coded hospital ‘passports’ devised by Tees Esk and Wear Valleys NHS Foundation Trust were adopted by the trust to improve the experience of patients who have learning disabilities when they are admitted to hospital.

The passport enables patients with learning disabilities and their carers to provide staff with important information such as how they prefer to be communicated with, how they prefer to take tablets and medicines, how they may show they are in pain and what level of support they will need.

A copy of the passport is kept in the patient’s hospital records and has three pages:

- A red page for vital information including personal and medical details
- An amber page which contains information on things that are really important to the patient in helping staff care for them
- And a green page which contains personal preferences as to what the patient likes and dislikes

The overall aim of the passport is to improve communication between patients with learning disabilities, their carers’ and hospital staff and reduce the frustration patients and carers sometimes find having to keep repeating the same details to different healthcare professionals.

This way the patient can hopefully have an improved experience of the hospital while being an inpatient.

**Young people on interview panel**

Young people are leading the way in patient participation by being involved in staff recruitment interviews.

Following on from the work done for ‘You’re Welcome’ - quality criteria for young people in hospital - members of the young persons group at James Cook held a focus group as part of the interview process for the post of paediatric intensive care unit manager.

The group visited the unit beforehand and familiarised themselves with the environment before meeting and chatting to the prospective candidates in a focus group setting to gain insight into their ideas and priorities for children and young people who are critically ill.

Using a scoring system, the group then fed back their views to the formal interview panel while a staff focus group was also held so both patients and staff were involved in the recruitment of the new manager.

The involvement of children and young people in planning our services is crucial and feedback from the young people involved highlighted that they felt valued and that it greatly increased their confidence.

**Identification of local improvement priorities**

In order to establish the priorities for the quality account, engagement has taken place with staff, patients and key external stakeholders. Information has been collated from a number of sources including surveys, questionnaires, complaints and direct feedback.

**Staff**

- Matrons/senior nurses (questionnaire)
- Clinical directors and chiefs of service
- Patient safety conference (questionnaire)
- Community services reference group
Patients
- Issues identified in local and national surveys
- Local Essence of Care audit
- Complaints and PALS data
- Choices website

Council of Governors
- Direct feedback at Council of Governors meetings

External Stakeholders
- Local Improvement networks (LINks)
- Overview and scrutiny committees (OSC)
- Care Quality Commission quality and risk profile
- Incidents reported by external organisations

The feedback from the consultation was presented to the Board of Directors in March 2011 who agreed the five quality priorities described in part two.

Overview of the quality of care based on performance in 2011/2012 against indicators.

The trust performed well against the national performance measures:

Performance against key national priorities

<table>
<thead>
<tr>
<th>MONITOR Compliance Framework 2011/12</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2011/12 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare associated infections (HCAI)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clostridium difficile year on year reduction of infection rates</td>
<td>141</td>
<td>125</td>
<td>67</td>
<td>112</td>
</tr>
<tr>
<td>Reducing Post 48 hour MRSA Bacteraemia rates</td>
<td>13</td>
<td>6</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer waits 2 week wait target</td>
<td>95.4%</td>
<td>93.3%</td>
<td>94.1%</td>
<td>93%</td>
</tr>
<tr>
<td>2 week wait breast symptom referrals - % seen within 2 weeks</td>
<td>96.3%</td>
<td>96.2%</td>
<td>95.9%</td>
<td>93%</td>
</tr>
<tr>
<td>Cancer wait 31 day wait for first definitive treatment for all cancers</td>
<td>98.6%</td>
<td>98.1%</td>
<td>98.9%</td>
<td>96%</td>
</tr>
<tr>
<td>Cancer wait 31 day wait for subsequent drug treatments for all cancers</td>
<td>100%</td>
<td>99.9%</td>
<td>100%</td>
<td>98%</td>
</tr>
<tr>
<td>Cancer wait 31 day wait for subsequent surgery treatments all cancers</td>
<td>98.8%</td>
<td>98.8%</td>
<td>99.1%</td>
<td>94%</td>
</tr>
<tr>
<td>Cancer wait 31 day wait for subsequent radiotherapy treatments all cancers</td>
<td>N/A</td>
<td>99.5%</td>
<td>98.7%</td>
<td>94%</td>
</tr>
<tr>
<td>Cancer wait 62 day wait for the first definitive treatment for all cancers</td>
<td>88.3%</td>
<td>82.5%</td>
<td>87%</td>
<td>85%</td>
</tr>
<tr>
<td>Cancer wait 62 day wait for treatment of all cancers referred from a National screening service.</td>
<td>92.5%</td>
<td>94.7%</td>
<td>94.5%</td>
<td>90%</td>
</tr>
</tbody>
</table>

18 weeks referral to treatment time (RTT)

18 Week referral to treatment time (RTT) for admitted patients | 93.3% | 95.4% | 92.1% | 90% |
18 Week RTT for non-admitted patients | 98.6% | 98.8% | 98.8% | 95% |

Accident and emergency

4 hour maximum wait in A&E from arrival to admission, transfer or discharge | 98.9% | 98.4% | 97.5% | 95% |
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability.
Review of Quality

South Tees Hospitals NHS Foundation Quality Account 2011/2012

Annex 1: Statements from primary care trusts, Local Involvement Networks and Overview and Scrutiny Committees.

Statement from NHS Tees:

This narrative has been jointly approved by NHS Tees and NHS South Tees Clinical Commissioning Group

“NHS Tees is the collaborative commissioner of NHS services across Teesside and consists of NHS Hartlepool, NHS Stockton-on-Tees, NHS Middlesbrough and NHS Redcar and Cleveland. NHS Tees has actively engaged the nascent Clinical Commissioning Groups (CCGs) on the quality agenda and welcomes the opportunity to submit a joint statement on the Annual Quality Account for South Tees Hospitals NHS Foundation Trust.

NHS Tees and NHS South Tees Clinical Commissioning Group can confirm that to the best of its ability, the information provided within the Annual Quality Account is an accurate and fair reflection of the Trust's performance for 2011/12.

During 2011/12 we have continued to provide joint robust challenge through our Clinical Quality Review Groups (CQRGs) to drive improvements in the quality of services and outcomes for patients. The CQRGs involve key stakeholders who focus on a significant range of topics including all aspects of safety, clinical effectiveness and patient experience. South Tees Hospitals NHS Foundation Trust has been open and transparent in their approach to working with commissioners and has responded positively to constructive clinical challenge.

During 2011/12, clinical members of NHS Tees have continued to work with the Trust to raise the profile of the patient safety agenda. This has involved attendance at the annual Nightingale Awards highlighting the nursing contribution to the QIPP agenda. In addition, the Trust has extended an invitation to NHS Tees and CCGs to contribute to several key work streams including the Adult Safeguarding Committee.

As part of their continued desire to be transparent providers, to improve care and reduce harm South Tees Hospitals NHS Foundation Trust has involved the commissioners in the sharing of lessons learned following serious incidents in relation to Health Care Associated Infections. NHS Tees is working with the CCGs to embed this model of best practice.

The Trust has also worked extremely hard across acute and community settings in working with NHS Tees and CCG representatives in agreeing, implementing and delivering a challenging Commissioning for Quality and Innovation (CQUIN) scheme in 2011/12. This approach will be maintained in 2012/13.

NHS Tees and CCGs will continue to work very closely with relevant key staff groups during the transition period to facilitate a seamless handover of commissioner responsibilities at the end of March 2013. This will involve working with the Trust in ensuring that the commissioning, provision and monitoring of safe clinical care remains a key priority. The hard work and dedication of staff across acute and community settings are recognised and the overall commitment of the Trust to improving patient safety is very much welcomed.

NHS Tees and NHS South Tees CCG look forward to continuing to work in partnership with South Tees Hospitals NHS Foundation Trust during 2012/13 to further improve the quality of services that the Trust provides for the people of Teesside."

Yours sincerely

Bev Reilly
Associate Director/Board Nurse
Patient Safety, Quality and Safeguarding
Statement from NHS North Yorkshire and York:

South Tees Hospitals NHS Foundation Trust
Quality account statement 2012

As an associate commissioner, NHS North Yorkshire and York are pleased to be able to review and comment on South Tees Hospitals NHS Foundation Trust quality account for 2011/2012.

Over the past 12 months we have worked hard together as Commissioners and Providers to improve the quality of patient services for the residents of North Yorkshire, particularly those within the Hambleton, Richmondshire and Whitby localities. Through the contract management process the trust has provided assurance to us as Commissioners, by sharing a range of data and quality metrics which have assured us of the quality of patient services.

The quality account for South Tees Hospitals NHS Foundation Trust provides a clear, accurate, and open story of the quality of patient care provided. We are especially pleased to note the following achievements:

- South Tees Hospitals are one of the highest scoring 20% of trusts in England in the Care Quality Commission’s Outpatient Survey 2011.
- The use of “passports” to improve the care of patients with learning disabilities
- The James Cook University Hospital was highly commended in the Building Better Healthcare Awards
- Workshops to help cancer patients combat the visible side-effects of treatment (and feel better about themselves) now run at the holistic cancer care centre.
- Young people sit on the interview panels as part of the recruitment process

South Tees Hospitals NHS Foundation Trust has also demonstrated significant improvements across the CQUIN indicators for 2011/12. Indicators for 2012/2013 are currently being agreed for both Acute and Community CQUINS with the Trust and Hambleton, Richmond and Whitby CCG.

The priorities identified in the quality account for 2012/2013 clearly identify the three elements of quality i.e. patient safety, clinical effectiveness and patient experience and have a real synergy with the outcomes we are seeking to achieve across the whole health economy and focus on:-

**Patient safety**
- Discharge management
- Further reducing healthcare associated infections

**Clinical effectiveness**
- To improve standards and delivery of nutritional care

**Patient experience**
- Improve communication
- Right care, right place, right time (reduce delays, improve patient flow and cancellations)

As a commissioner we commend this quality account for its accuracy, honesty, and openness. We recognise that South Tees Hospitals NHS Foundation Trust strives to deliver good quality patient care, and we look forward to working with the trust to bring about further improvements in quality during 2012/2013.

Julie Bolus
Director of nursing, NHS North Yorkshire and York
Review of Quality

Statement from Middlesbrough, Redcar and Cleveland and North Yorkshire LINks

All the LINks were pleased to see that South Tees Trust has made significant improvements over the last 12 months and that plans and initiatives are in place to continue working towards further improvements over the next 12 months.

Regular meetings between the LINk’s and the Trust have continued throughout the year, Host teams meeting quarterly and LINk members twice a year. These meetings have enabled any concerns and issues to be raised and discussed are felt to be a positive way of engaging and working together. The LINk values the good working relationship with the Trust and the opportunity to take part in activities including the PEAT inspections and commenting on the Quality Account. In addition the opportunity to feed in patient experiences and carry out Enter and View visits.

LINk would recommend that the final version is in a suitable format and font size for ease of reading and that different versions are available for all sections of the public.

The comments below are a joint response from Middlesbrough, Redcar and Cleveland and North Yorkshire LINks.

Quality Account 2011/2012

Part Two - Priorities for Improvement 2012/2013

Patient Safety

Priority 1 - Continue to focus on discharge management in order to improve patient care, improve clinical outcomes and reduce re-admissions

- Members were pleased to see that the Trust continues to focus on discharge management in order to improve patient care and that the initiative for nurse/therapy-led discharge is to be the default over the coming year. However, it would be useful to see the statistics for this type of discharge within the monitoring of this priority in order to measure its success.

Priority 2 - Further reducing Healthcare associated infections

- It is very good news that the level of healthcare associated infections has fallen again this year and remains under the allocated target. Members would like to see this downward trend continue regardless of whether it remains a priority.

Clinical Effectiveness

Priority 3 - To continue to improve standards and delivery of nutritional care across the trust

- Members were pleased that the Trust recognises the importance of the link between nutrition and health and wellbeing and have, amongst other initiatives, included ‘Employ a creative approach to optimise the mealtime experience’.

- As well as achieving overall goals, the LINk would welcome this information broken down to show how each ward/area of the Trust was contributing to the figures. Anecdotal evidence reported to the LINk’s would suggest that there are wide variances across the Trust in achieving good nutritional standards.

Patient Experience

Priority 4 - Improve communication

- It is appreciated that improving communication can be difficult to measure and it is pleasing to hear that the Trust is implementing new initiatives in this area. The LINk’s feel that whilst supporting these new initiatives there is wider work to be done in improving communication between health staff and patients and carers and hope that this will be encouraged across the Trust.

- LINks would hope that the current coding of ‘Communication’ remains as it is in 2011/12 in order to accurately compare with the baseline in future years.

Priority 5 - Right care, right place, right time (reduce delays, improve patient flow and cancellations)

Although it is good to see that this is a priority area within the Quality Account, the LINk is unsure how the new initiatives will improve the rate of cancellations.
Members would like to know more about the plans and how the Trust intends to implement them and what the impact will be on patients and their families.

The LINk’s would like regular progress reports throughout the year on progress towards achieving this.

The LINks did not identify any significant omissions of concern.

Statement from North Yorkshire County Council

Quality Accounts (QAs) are now in their 3rd year and throughout that period the North Yorkshire Scrutiny of Health Committee (SoHC) has had a good deal of involvement with the South Tees Hospitals NHS Foundation Trust. The Committee therefore feels it is well placed to offer comment on the Trust’s QA and indeed welcomes the opportunity to do so. This involvement has demonstrated to elected members that the Trust has entered into the spirit of QAs and that within the Trust there is a culture of continuous service improvement in terms of:

- Patient safety
- Clinical effectiveness; and
- Patient experience.

Against this background the Committee supports the Trust’s quality priorities in 2012/13 across these three domains. We particularly support the ongoing attention to discharge management, efforts to further reduce healthcare associated infections and the continued efforts to improve the standard and delivery of nutritional care. As part of Patient Experience, the Committee feels that efforts to improve communication and the “Right care, right place, and right time” initiative complement each other well.

The process which the Trust has followed in producing its QA demonstrates a commitment towards involving patients and the public and a willingness to engage with the Scrutiny of Health Committee.

Finally it is significant that the Trust has again been named as one of CHKS’ (part of Capita PLC) 40 Top Hospitals in 2012. The award is based on the evaluation of 22 indicators of clinical effectiveness, health outcomes, efficiency, patient experience and quality of care. The efforts of management and staff at the Trust are commended.

County Councillor Jim Clark

Chairman - North Yorkshire Scrutiny of Health Committee
Review of Quality

South Tees Hospitals NHS Foundation Quality Account 2011/2012

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 2010 as amended to prepare quality accounts for each financial year.

Monitor 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 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 2011/2012;
- 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 2011 to June 2012
  - Papers relating to quality reported to the Board over the period April 2011 to June 2012
  - Feedback from the commissioners dated 17 May 2012 to 24 May 2012
  - Feedback from governors dated 10 May 2012
  - Feedback from LINks dated 18 May 2012
  - Feedback from North Yorkshire County Council Scrunity of Health dated 29 May 2012
  - The trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 28 May 2012
  - The (latest) national patient survey 20 April 2012
  - The (latest) national staff survey 20 March 2012
  - The head of internal audit’s annual opinion over the trust’s control environment dated 24 May 2012
  - CQC quality and risk profiles dated 12 April 2012
  - The quality report presents a balanced picture of the NHS foundation trust’s performance over the period covered
  - The performance information reported in the quality report is reliable and accurate
  - There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
  - The data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the quality report has been prepared in accordance with Monitor’s annual reporting guidance (which incorporates the quality accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the quality report (available at www.monitorhhsft.gov.uk/annualreportingmanual)
- The quality report presents a balanced picture of the NHS foundation trust’s performance over the period covered
- The performance information reported in the quality report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the quality report has been prepared in accordance with Monitor’s annual reporting guidance (which incorporates the quality accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the quality report (available at www.monitorhhsft.gov.uk/annualreportingmanual)

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

Simon Pleydell – chief executive
31 May 2012
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 account (the ‘quality report’) and specified performance indicators contained therein.

Scope and subject matter

The indicators in the quality report that have been subject to limited assurance consist of the national priority indicators as mandated by Monitor:
• Clostridium difficile (pages 117 and 149) and
• 62 day maximum wait referral to treatment – all cancers (page 149).

We refer to these national priority indicators collectively as the “specified 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 following assessment criteria (the “Criteria”):

Clostridium-difficile:
• Patients aged two or more
• A positive laboratory test result for Clostridium difficile recognised as a case according to the trust’s diagnostic
• Positive results on the same patient more than 28 days apart are reported as separate episodes, irrespective of the number of specimens taken in the intervening period, or where they were taken and
• The trust is deemed responsible. This is defined as a case where the sample was taken on the fourth day or later of an admission to that trust (where the day of admission is day one).

Cancer – maximum waiting time 62 days from urgent GP referral for first treatment for all cancers:
• The indicator is expressed as a percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer
• An urgent GP referral is one which has a two week wait from the date that the referral is received to first being seen by a consultant (see http://www.dh.gov.uk/Prod_Consum_Dh/groups/dh_digitalassets/documents/digitalasset/dh_103431/pdf);
• The indicator only includes GP referrals for suspected cancer (i.e. excludes consultant upgrades and screening referrals and where the priority type of the referral is National Code 3 – two week wait);
• The clock start date is defined as the date that the referral is received by the trust; and

The Directors are also responsible for their assertion and the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual (“FT ARM”) issued by the Independent Regulator of NHS Foundation Trusts (“Monitor”). In particular, the Directors are responsible for the declarations they have made in their Statement of Directors’ Responsibilities.
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 does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM;
- The quality report is materially inconsistent with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria.

We read the quality report and consider whether it addresses the content requirements of the FT ARM, 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 2011 to June 2012
- Papers relating to quality reported to the Board over the period April 2011 to June 2012
- Feedback from the commissioners dated 17/05/2012 and 24/05/2012
- Feedback from LINks dated 18/05/2012
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2012
- The latest national patient survey dated 20/04/2012
- The latest national staff survey dated 20/03/2012
- The Head of Internal Audit's annual opinion over the trust's control environment dated 24/05/2012
- CQC quality and risk profiles dated 12/04/2012 and
- North Yorkshire County Council Scrutiny of Health Committee comments dated 29 May 2012.

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 Board of Governors in reporting South Tees Hospitals 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 2012, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. 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 save 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 '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 reporting the indicators;
- Making enquiries of management;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
• Comparing the content requirements of the FT ARM to the categories reported in the Quality Report; and

• Reading the documents.

A limited assurance engagement is less 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 impact 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 thereof, may change over time. It is important to read the quality report in the context of the assessment criteria set out in the FT ARM and the Directors’ interpretation of the Criteria included above.

The nature, form and content required of quality reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts/organisations/entities.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the quality report, which have been 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:

• The quality report does not incorporate the matters required to be reported on as specified in annex 2 to Chapter 7 of the FT ARM;

• The quality report is materially inconsistent with the sources specified above; and

• The specified indicators have not been prepared in all material respects in accordance with the Criteria.

PricewaterhouseCoopers LLP
Chartered Accountants
Newcastle upon Tyne

The maintenance and integrity of the South Tees Hospitals NHS Foundation Trust’s website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.
Review of Quality

South Tees Hospitals NHS Foundation Quality Account 2011/2012

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

A&E
Accident and emergency (usually refers to a hospital casualty department).

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

Audit Commission
The Audit Commission regulates the proper control of public finances by local authorities and the NHS in England and Wales. The Commission audits NHS trusts, primary care trusts and strategic health authorities to review the quality of their financial systems. It also publishes independent reports which highlight risks and good practice to improve the quality of financial management in the health service, and, working with the Care Quality Commission, undertakes national value-for-money studies. Visit: wwwauditcommissiongov.uk

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

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.
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. Primary care trusts 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. Visit: www.dh.gov.uk/en/publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091443

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 but with responsibility for government policy for England alone on health, social care and the NHS.

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

Emergency
An urgent unplanned episode of care.

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

Global trigger tool
This is a trigger tool which reviews case notes in order to help identify and measure adverse events. Randomly selected clinical records are reviewed to identify any events which may have caused harm to patients, so any necessary changes can be put in place to reduce harm.

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

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.

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.

Local Involvement Networks
Local Involvement Networks (LINks) are made up of individuals and community groups which work together to improve local services. Their job is to find out what the public like and dislike about local health and social care. They will then work with the people who plan and run these services to improve them. This may involve talking directly to healthcare professionals about a service that is not being offered or suggesting ways in which an existing service could be made better. LINks also have powers to help with the tasks and to make sure changes happen.

Monitor
The independent regulator responsible for authorising, monitoring and regulating NHS foundation trusts.

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

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

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. Visit: www.cqc.org.uk/usingcareservices/healthcare/patientsurveys.cfm

Overview and Scrutiny Committees
Since January 2003, every local authority with responsibilities for social services (150 in all) has had the power to scrutinise local health services. Overview and scrutiny committees take on the role of scrutiny of the NHS – not just major changes but the 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 healthcare.

Periodic reviews
Periodic reviews are reviews of health services carried out by the Care Quality Commission (CQC). The term ‘review’ refers to an assessment of the quality of a service or the impact of a range of commissioned services, using the information that the CQC holds about them, including the views of people who use those services. Visit: www.cqc.org.uk/guidanceforprofessionals/healthcare/nhstaff/periodicreview2009/10.cfm
Primary care trust
A primary care trust is an NHS organisation responsible for improving the health of local people, developing services provided by local GPs and their teams (called primary care) and making sure that other appropriate health services are in place to meet the needs of local people.

Providers
Providers are the organisations that provide NHS 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). From 2009/2010, the CQC has registered 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. Visit: www.ic.nhs.uk/services/the-secondary-uses-service-sus/using-this-service/data-quality-dashboards.

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

South Tees Hospitals NHS Foundation Trust
Includes the Friarage Hospital (FHN) and The 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.

Special review
A special review is a review carried out by the Care Quality Commission (CQC). Special reviews and studies are projects that look at themes in health and social care. They focus on services, pathways of care or groups of people. A review will usually result in assessments by the CQC of local health and social care organisations. A study will usually result in national-level findings based on the CQC’s research.